Board of Governors

Regular Meeting

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

Video Conference Call and

1240 South Loop Road, Alameda, CA 94502

AGENDA

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

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

and

1509 Reisling Way
St. Helena, CA 94574

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 id 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 July 12th, 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) JUNE 11th, 2024, FINANCE COMMITTEE MEETING MINUTES

b) JUNE 14th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

c) JUNE 14th, 2024, BOARD OF GOVERNORS MEETING MINUTES

d) REVIEW AND APPROVE RESOLUTION RE-APPOINTING BYRON LOPEZ TO DESIGNATED BOARD OF GOVERNORS SEAT (LABOR STAKEHOLDER, SEIU/UNITED HEALTHCARE WORKERS WEST)

e) REVIEW AND APPROVE RESOLUTION RE-APPOINTING REBECCA GEBHART TO DESIGNATED BOARD OF GOVERNORS SEAT (AT-LARGE SUBJECT KNOWLEDGE EXPERTISE)

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

b) FINANCE COMMITTEE

7. CEO UPDATE

8. BOARD BUSINESS

a) REVIEW AND APPROVE MAY 2024 MONTHLY FINANCIAL STATEMENTS

b) UPDATE TO FY24 BUDGET

c) UNSATISFACTORY IMMIGRATION STATUS (UIS) PRESENTATION

d) TARGETED RATE INCREASE (TRI) PRESENTATION

e) OVERVIEW AND DISCUSSION OF TRILOGY DOCUMENTS

9. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE – APRIL & MAY

b) QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE – APRIL & MAY

c) COMMUNITY ADVISORY COMMITTEE – JUNE

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 July 9th, 2024, by 12:00 p.m.

Brenda Martinez, Clerk of the Board

EXECUTIVE SUMMARY APPENDIX

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PRESENTATIONS APPENDIX

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

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SUPPORTING MATERIALS APPENDIX

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Consent Calendar

Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

June 11th, 2024
8:00 am – 9:05 am

SUMMARY OF PROCEEDINGS

Meeting Conducted in-person and by Teleconference.

Committee Members in-person: Dr. Rollington Ferguson, Gil Riojas, James Jackson (arrived late)
Committee Members absent: Yeon Park

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

Alliance Staff in-person and on Conference Call: Matt Woodruff, Dr. Donna Carey, Tiffany Cheang, Sasi Karaiyan, Richard Golfin III, Anastacia Swift, Lao Paul Vang, Ruth Watson, Shulin Lin, Carol van Oosterwijk, Linda Ly, Brenda Martinez, Renan Ramirez, Danube Serri, Christine Corpus

CALL TO ORDER, ROLL CALL, AND INTRODUCTIONS

Dr. Ferguson called the Finance Committee meeting to order at 8:00 am. A Roll Call was then conducted.

Representatives from the finance committee and team were acknowledged, including those from both budget and accounting.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

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

a.) CEO UPDATE

Matt Woodruff provided updates to the committee on the following:

- **Annual DHCS Audit**

  Starting next week, the Alliance will be undergoing its annual DHCS audit. At Friday's Compliance Advisory Committee meeting, Mr. Richard Golfin will review the various file pulls, our current concerns leading into the audit, and any updates we have so far. Further details from the audit will be discussed both this Friday and at the July meeting, where we will go into greater depth about the findings.

- **Membership and Single Plan Model Change**

  Regarding the single plan model change, it took the state about three months to provide all our numbers. We are now confident in our overall numbers moving forward with the single plan model. As of April, our membership stands at 405,000 members, and we expect May's preliminary enrollment to be similar. We anticipate finishing the fiscal year with around 405,000 members.

  Of the 81,000 Anthem lives that transferred to us in January, approximately 55,000 were reassigned to AHS and the Community Health Center Network (CHCN), their original medical homes. On the undocumented side, we received nearly 35,000 members, which is more than the 30,000 we initially expected. Of these, 7,000 came from Anthem. Consequently, our undocumented population has more than doubled in the first three months of the calendar year.

Question: Rebecca Gebhart inquired about the transition of Anthem undocumented members to their original medical homes under Health Pack. Matt clarified that unless members actively opted otherwise, they were reassigned to AHS and CHCN

Matt continued stating that the important thing that we are now seeing with the single plan model change is just the overall increase in day-to-day production. Authorizations have risen by 45%, claims by 50%, and there has been a 1% increase in community support. It is important to note that this coincides with the monthly influx of members following the program. Furthermore, ECM experienced an increase of almost 40% in the first three months of the year. This clearly demonstrates the operational impact of the single plan model on our organization. As we continue forward, we are closely evaluating staffing needs and our current state in preparation for upcoming developments.

- **State Recoupment**

  The state will recoup $59 million from the Alliance in May and June. Gil will discuss this in his upcoming report, noting that April showed financial losses primarily attributed to the IBNP of long-term care members. Acknowledging the recoupment, we agree with the state's assessment regarding the higher costs associated with approximately 900 to 1,000 Anthem members in long-term care, who are generally sicker compared to our previous long-term care population. This necessitated significant financial provisioning for their care needs.

  As Gil reviews the April financials, it is important to note that as of June 30, the Alliance projects a shortfall of $5.5 million post-recoupment.

  Question: Rebecca asked if we have a sense of why the Anthem members are sicker than our members. Matt responded proportion-wise, excluding Kaiser, we had 300,000 lives in December and 1,400 long-term care members, Anthem had 81,000, and roughly 900 long-term care members. They had a lot more long-term members based on their overall population, and so it's hard to say why, but it could have been that those members were actively choosing to go to Anthem. Gil added that it has been observed that not only is the long-term care category of aid affected, but also other aid categories show higher acuity levels in long-term care services. This suggests increased acuity across various aid categories for long-term care. This phenomenon may result from enrollees not being correctly categorized for aid, and possibly inadequate care in SPD or Optional Expansion. Consequently, there may be an accumulation of required long-term care services upon their transition to the alliance.

- **Cuts to Budget**

  It was decided based on retroactive rate cuts received, that Gil and the Budget team collaborated to implement necessary reductions in our Fiscal Year '25 budget to achieve breakeven. Items eliminated from the budget include the Board Grant Program, the Community Reinvestment Program, several Provider Grants, and Employee Travel Expenses. Retained in the budget is Virus Protection Grant for the time being, as well as the Provider Recruiting Incentive Program, aimed at assisting community providers in recruiting and retaining doctors, behavioral health clinicians, and other necessary medical personnel,

  The program has been launched, announced by press release, and is currently accessible on our website. Following this report, further outreach to providers will be conducted. There has been initial interest from at least two FQs regarding its implementation timeline.

  Brief discussion on TRI: Dr. Ferguson questioned the possibility of delaying TRI. Matt clarified that TRI has already been postponed. We have received the funds, however, distribution details from the State following the Governor's May revise are still pending as of June. Verbal assurances suggest an extension of the TRI deadline to December 31st. Gil noted ongoing

accrual of funds earmarked for TRI payouts, pending distribution. Discussion on TRI initially set for today will be postponed until July to allow for further updates and action.

Matt finished his update by adding that the violence prevention grant remains in place for the time being.

Informational update to the Finance Committee. Voting is not required.

Before moving on to the next agenda item, Dr. Ferguson acknowledged that Mr. James Jackson had joined the meeting at 8:13 am, and that the Committee now has a quorum to be able to move on to the voting items on the agenda.

b.) REVIEW AND APPROVE APRIL MONTHLY FINANCIAL STATEMENTS

APRIL 2024 Financial Statement Summary

Enrollment:

As previously mentioned, in April, the Alliance continued to experience increases in enrollment. Enrollment increased by 1,233 members since March, to 405,174 members, with primary increases in our Child, Adult, and Optional Expansion Categories of Aid. SPD and Duals remained flat, and for the third month in a row we saw a slight increase in our Group Care line of business.

Net Income:

For the month ending April 30th, 2024, the Alliance reported a Net Loss of $8.3 million (versus budgeted Net Loss of $876,000). The unfavorable variance is attributed primarily to higher than anticipated Medical and Administrative Expenses. For the year-to-date, the Alliance recorded a Net Income of $21.2 million versus a budgeted Net Income of $16.8 million.

Premium Revenue:

For the month ending April 30th, 2024, actual Revenue was $159.6 million vs. our budgeted amount of $158.6 million, which is on target with where we thought we would be by the end of April.

Medical Expense:

Actual Medical Expenses for the month were $165.4 million, vs. budgeted amount of $153.0 million. For the year-to-date, actual, and budgeted Medical Expenses were $1.4 billion. Drivers leading to the favorable variance can be seen on the tables on page 11, with further explanation on pages 11 and 12.

Medical Loss Ratio:

Our MLR ratio for this month was reported at 103.6%. Year-to-date MLR was at 94.9%.

Administrative Expense:

Actual Administrative Expenses for the month ending April 30th, 2024 were $10.2 million vs. our budgeted amount of $8.9 million. Our Administrative Loss Ratio (ALR) is 6.4% of our Revenue for the month, and 5.3% of Net Revenue for year-to-date.

Other Income / (Expense):

As of April 30th, 2024, our YTD interest income from investments show a gain of $25.8 million.

YTD claims interest expense is $691,000.

Managed Care Organization (MCO) Provider Tax:

For the month ending April 30th, 2024, we reported $113.7 million unbudgeted MCO Tax Revenue, and $108.3 million unbudgeted MCO Tax Expense.

Tangible Net Equity (TNE):

For April, the DMHC requires that we have $62.4 million in TNE, and we reported $345.2 million, leaving an excess of $282.8 million. As a percentage we are at 554%, which remains well above the minimum required.

Cash and Cash Equivalents:

We reported $609.8 million in cash; $424.8 million is uncommitted. Our current ratio is above the minimum required at 1.58 compared to regulatory minimum of 1.0.

Capital Investments:

We have spent $1.2 million on Capital Assets year-to-date. Our annual capital budget is $1.6 million.

Motion: A motion was made by James Jackson, and seconded by Dr. Rollington Ferguson, to accept and approve the April 2024 Financial Statements.

Motion Passed

No opposed or abstained.

c.) REVIEW AND APPROVE FY25 PRELIMINARY BUDGET

Gil presented the preliminary budget for fiscal year 2025, commencing July 1st, 2024. He acknowledged the Budget team's efforts, particularly Carol vanOosterwijk, Linda Ly, Debora Bertasi, Hermelinda Wirth, and Annie Phetinta, who have worked diligently since February on the budget process. He then provided a PowerPoint presentation on the FY25 Preliminary Budget.

Highlights:

- **2025 Projected Net Income:** $376 thousand.
- **Projected Tangible Net Equity (TNE) Excess at 6/30/25**: $245.1 million, which is 439% of required TNE. The Alliance remains financially strong.
- **Year-end Enrollment**: 5,000 higher than June 2024; Fiscal Year member months are 350,000 higher than the prior year. Enrollment peaks at 410,000 in June 2025.
    - Approximately 78,000 members transitioned from Anthem as AAH became the sole Medi-Cal Plan in January 2024.
    - Approximately 48,000 Kaiser members disenrolled from the Plan in January 2024.
    - Approximately 30,000 undocumented members aged 26-49 joined the Plan in January 2024.
    - Redeterminations assumed complete by June 30, 2024.
    - Medi-Cal enrollment projected to grow slightly over FY 2025.
    - Group Care Enrollment projected to remain unchanged at 5,600 members.
- **Premium Revenue**: $2.0 billion in FY 2025, an increase of $269.8 million (15.3%) from FY 2024.
    - 98% from Medi-Cal, 2% from Group Care.
    - Medi-Cal base rates assumed to increase by 4.6% per member/per month, equating to a $90.0 million increase in premium revenue, driven by a full year of the mandated Medi-Cal Targeted Rate Increase.
    - Higher Medi-Cal enrollment contributes $149.8 million in revenue.
    - Per-member-per-month Group Care premium increases by 19.6% in July 2024.

- **Fee-for-Service and Capitated Medical Expense**: $1.9 billion in FY 2025, an increase of $252.2 million (15.3%) from FY 2024.
  - Medical Expense:
    - 98% for Medi-Cal, 2% for Group Care.
    - Medical loss ratio of 96.0%, an increase of 0.7% over FY24.
    - Higher Medi-Cal enrollment volume contributes $180.7 million in medical expense.
    - Community Supports expenditures projected at $35.1 million.
  - Hospital and Provider Rates:
    - FY25 hospital contracted rates increase by $46.9 million over FY 2024.
    - Professional capitation rates increase by $22.5 million, driven by the Targeted Rate Increase program.
- **Administrative Department Expenses**: $11.4 million higher than FY 2024, representing 5.5% of revenue.
  - Staffing includes 726 full-time equivalent employees by June 30, 2025.
  - 101 new positions requested for FY 2025:
    - Operations (48), Healthcare Services (20), Information Technology (8), Analytics (7), Compliance (7), Finance/Vendor Management (6), Integrated Planning (3), Executive/Legal (2)
  - 30 FTEs related to D-SNP implementation.
  - Temp hires for anticipated short-term needs total 13 (Admin. 10 and Clinical 3).
- **Clinical Department Expenses**: $3.6 million lower than FY 2024, comprising 2.5% of revenue.
- **2024 Projected Net Loss**: $5.5 million.
- **Unfavorable Revenue Recoupments**: Totaling $87.1 million in FY 2024, the majority for prior years.
  - Unfavorable Revenue Accruals in FY 2024 Include:
    - CY 2023 Retroactive Med-Cal Rate Reduction: $59.0 million.
    - CY 2023 Major Organ Transplants Risk Corridor Payback: $10.0 million.
    - Jul '19 – Dec '20 Bridge Period Risk Corridor Payback: $9.0 million.
    - CY 2022 Major Organ Transplants Risk Corridor Payback: $7.0 million.
    - CY 2022 MCO Tax Expense: $1.2 million.
    - Jul '21 - Apr '24 Date of Death Audit Recoupment: $0.9 million.
    - Total Unfavorable Revenue Accruals: $87.1 million.
- **Community Support and Expenditures**: Budget allocates $35 million for community supports an increase compared to the $24 million in FY2024.
  - New Community Supports for FY25 include Sobering Centers (Jul-24), Short-Term Post Hospitalization (Jan-25), and Day Habilitation (Jan-25).
  - CS Revenue included FY24 Medi-Cal Base Rates is $7.0 million. FY25 rates are incomplete.
- **Capital Expenditures**:
  - Full Year budget is $1.7M for capitalized purchases. This is an increase of $500K from FY24. Totals include $1.7M for IT hardware and $30K for building improvements.
- **Material Areas of Uncertainty**:
  - AAH has not received Medi-Cal premium rates for CY 2025.
  - The revenue forecast is calculated on the current mix of UIS/SIS members. Material changes in the SIS/UIS member mix will impact results.
  - We are reserving for a CY 2024 rate reduction, based on DHCS messaging. There is a risk that the reduction may be larger than anticipated.
  - Medical Expense includes assumptions regarding the relative acuity of new populations that joined the Plan in January 2024, existing members, and departing

members. The relative costs of these cohorts will have significant impact on medical loss ratios.
  - Contract changes for hospitals and delegated providers in projections have not been finalized.
  - CY 2024 Major Organ Transplants Risk Corridor Liability will continue to be evaluated.
  - MCO Tax Expense may be greater than anticipated MCO Tax Revenue.
  - Additional Community Supports expense for previously unsubmitted, or denied for incorrectly coded claims may be paid in FY 2024.

Gil concluded by emphasizing ongoing evaluation and adaptation to potential changes, aiming to refine projections and mitigate financial risks for the upcoming fiscal year. Informational slides included: medical-health ratio by line of business, category of aid, population by category of aid, and expenses and revenue by category of aid.

Motion: A motion was made by James Jackson, and seconded by Gil Riojas, to accept and approve the FY25 Preliminary Budget for presentation to the Board of Governors.

Motion Passed

No opposed or abstained.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 9:05 a.m.

Compliance Advisory Committee Meeting Minutes

COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes
Friday, June 14th. 2024
10:30 a.m. – 11:30 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

CALL TO ORDER

Committee Members Attendance: Byron Lopez, Rebecca Gebhart, Richard Golfin III

Remote: None

Committee Members Excused: Dr. Kelley Meade

1. CALL TO ORDER

The regular Compliance Advisory Committee meeting was called to order by Byron Lopez 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) May 10th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

Motion: A motion was made by Bryon Lopez and seconded by Rebecca Gebhart 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 Findings and Plan Responses
2. 2024 DHCS Routine Full Medical Survey 2024
   a. Overview:
      i. 2024 is the calendar year for the audit, DHCS is the auditing agency. It's a routine audit meaning it is regularly scheduled and not triggered by an error.
      ii. There are six categories reviewed in the audit: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Improvement, and Administrative and Organizational Capacity
      iii. Audit Period – June 1, 2023 through May 31, 2024
   b. Overview of the number and Scope of files in survey:
      i. The survey plan submits universes, and these universes can have thousands of lines of member information. The State has proprietary algorithms and from those algorithms they select specific files from the universe data that we provided. There were more than 420 files submitted in the six categories.
         a. For an example of this process, if you look at UM PA, the Plan would have provided a UM Prior Authorization universe, which includes auth number information, and then from that information the State would flag individual files to request, the UM team will go and create those files, bookmark them and send them back to the State.
      ii. **Question:** Section 1.5 UM CHCN are other delegates requested to look at their UM files or are they looking at CHCN [because] There was an issue last [time]?
         1. **Answer**: CHCN provides files likely because they are our largest partner not because of any specific issue.
         2. **Answer Extended:**
            Routinely we'll have CHCN selected and every year we get our transportation provider selected. Transportation is a focus for the State and CHCN is our largest partner.
   c. Pre-Survey Plan Observations
      i. 2024 Claims Observations
         a. A small volume of ER claims selected were denied incorrectly due to a system issue. Claims is working with IT to remediate the systemic issue. Impacted claims for the audit period have been corrected.
            1. This particular observation may end up in a finding, but it would not be a repeat finding. The system issue has been fixed, and we also queried our system for any claims which had a similar situation and we analyzed and corrected those claims if necessary. We believe this will be a potential finding because it showed up in the universe of claims selected by the State and we found a two of those claims were incorrect.
         b. *Risk for Repeat Finding:* None. 2023 Findings were related to Prop 56 payment and payment involving non-contracted mid-level providers.
      ii. **Question**: So this wasn't a human issue, this was a program configuration issue?

1. **Answer**: For one of the claims it was a human issue and for the other claim it was not a human issue it was a system configuration or programing issue.

2. We went in and we corrected that programming issue and then we also looked at similar [claims] as well up on the human side. That individual was trained and attested to the training. Unfortunately, we have to hit these 100%. So even if only one falls out for the entire twelve months, it is a potential finding.

d. 2024 UM Observations

   i. Based on supplementary questions that the state asked we think that their focus will be:

      1. Continuity of Care
      2. Prior Authorizations
      3. Early Periodic Screening and Diagnostic and Treatment (EPSDT)
      4. CCS
      5. Transportation
      6. Care Coordination across Departments and Agencies
      7. Clinical Production Lines (BH, LTSS, UM, CM)

   ii. The State has also asked a lot of questions about how authorizations are managed across all clinical production lines.

   iii. There were no findings under UM during the 2023 Audit.

e. 2024 Delegate Observations

   i. We anticipate that there may be one (1) delegate finding and potentially it would be a repeat finding even though it's slightly different than the finding that we had last year in regards to the delegate, CHCN.

   ii. There are 28 case files that were requested. Out of those 28 case files, we noticed some trends around evaluating continuity of care and verifying timely access before redirection to in-network providers.

      a. Cases related to services which were provided at Stanford.

   iii. Overall authorization processing requirements:

      a. We missed turnaround times on one case, which could result in a finding.

      b. We were missing NOA letter translations in the members preferred primary language, which could also result in a finding.

f. 2024 FWA Observations

   i. For fraud, waste and abuse, we had a number of observations.

      a. Three of the cases involved our transportation provider.

      b. Three cases were referred by the Department of Justice to the plan.

         1. Some of them have to do with provider fraud, identity theft.

      c. One case was referred by the Department of Health Care Services.

d. Once case involved stolen identity

ii. We do not anticipate that any of these observations will result in a repeat finding.

g. 2024 Grievance Observations

i. Potential risk for exempt grievances cases that were resolved by Member Services with a referral to CM or BH for care coordination. Could be flagged as misclassified standard grievances.

ii. There is a potential for a repeat finding of the 2023 Finding 4.1.6 Grievance Identification: The Plan did not process and resolve all member expressions of dissatisfaction as grievances.

a. Exempt grievances are closed within the next business day and standard grievance have a 30-day resolution timeframe.

h. 2024 Privacy Observations

i. Four (4) potential privacy incidents were not categorized correctly in HealthSuite. These cases were not referred to the Privacy Office timely. This caused an internal reporting delay greater than 24 hours which would have impacted reporting to DHCS.

ii. The Privacy Office has 24 hours to file a privacy related form with the State, but over the past two years with the support of IT and Member Services, we've implemented an electronic forwarding system which allows some of our frontline staff to flag potential privacy issues and get them to the Privacy Office timely to meet our 24-hour reporting timeframe.

iii. There were no findings under HIPAA/Privacy during the 2023 Audit, however, there is a risk of a finding for these incidents missing the 24-hour timeline.

i. 2024 IHA Observations

i. IHA is an area that many health organizations struggle with.

ii. There were records that are missing preventative health screenings, and some records show IHA completed with a specialist. It is possible for specialist to complete the forms, generally an IHA is completed by a PCP.

iii. There is a possibility of a repeat finding for 2023 finding 2.1.1.

a. This is a people problem, not a process problem.

2. 2024 Survey Preparations

a. Outcomes and Insights

i. SMEs were prepared for their interview sessions.

ii. They were comfortable answering the questions and passing off to another SME when applicable.

iii. Clarifying questions were asked when needed.

iv. Mock Audit questions shared.

v. Compliance continues to meet and work with the SMEs on any additional questions to further assist with preparation for the onsite interviews.

3. LHPC Plan Feedback

a. Highlighted feedback for the auditors in transportation.

    i. Transportation is an annual focus because it is a huge expense for the State.

3. Compliance Dashboard

    a. No Update Due to 2024 DHCS Routine Full Medical Survey.

b) MEDI-CAL PROGRAM UPDATES

- No Updates

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a) None

8. STAFF UPDATES

a) None

9. UNFINISHED BUSINESS

a) None

10. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

a) None

11. ADJOURNMENT

Vice Chair Byron Lopez adjourned the meeting at 11:30 am.

Board of Governors Meeting Minutes

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, June 14th, 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), Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Jody Moore, Yeon Park, Dr. Evan Seevak, Supervisor Lena Tam, Natalie Williams

Board of Governors Remote: James Jackson, Dr. Noha Aboelata (Vice-Chair)

Board of Governors Excused: Andrea Ford, Dr. Kelley Meade, Andrea Schwab-Galindo

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

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

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL OR MODIFICATIONS

There were no modifications to the agenda.

4. INTRODUCTIONS

There were no introductions.

5. CONSENT CALENDAR

a) **MAY 7th, 2024, FINANCE COMMITTEE MEETING MINUTES**

b) **MAY 10th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES**

c) **MAY 10th, 2023, BOARD OF GOVERNORS MEETING MINUTES**

d) **2023 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM EVALUATION**

e) **2024 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM DESCRIPTION**

f) **2023 UTILIZATION MANAGEMENT PROGRAM EVALUATION**

g) **2024 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION**

h) **2023 QUALITY IMPROVEMENT – PROGRAM EVALUATION**

i) **2024 QUALITY IMPROVEMENT – PROGRAM DESCRIPTION**

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Dr. Evan Seevak to approve the Consent Calendar Agenda Items 5a through 5i.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, James Jackson, Byron Lopez, Dr. Marty Lynch, Jody Moore, Yeon Park, Dr. Evan Seevak, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

Comment: Dr. Marty Lynch would like to get a summary of our evaluation data on different care management programs.

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

Byron Lopez provided an update on the June 14th Compliance Advisory Committee meeting. The committee presented a report on compliance activities, including updates and observations from the 2024 DHCS Routine Full Medical Survey.

b) FINANCE COMMITTEE

Dr. Ferguson provided an update on the Finance Committee meeting held on June 11th. The April 2024 financials were discussed, and the FY25 Draft Budget was presented.

7. CEO UPDATE

Highlights:

Single Plan Model

- Total membership as of April 2024 is 405,174.
- Approximately 81,000 members transitioned from Anthem to Alameda Alliance on January 1, 2024.
- Prior to the MCP transition, 54,620 Anthem members assigned to AHS or CHCN have been reassigned to AHS and CHCN since the transition to the Alliance.
- Undocumented members
  - In December 2023, 30,565 undocumented residents were enrolled into the Alliance. As of April 1st, 64,815 undocumented residents are Alliance members.
  - 7.334 undocumented Anthem members assigned to AHS or CHCN have been reassigned to AHS and CHCN since joining the Alliance.
- Total authorization volume in December 2023 was 5,098 compared to 7,393 in April 2024.
- A 50% increase in claims since the single plan transition
- 380 providers added since January 2024
- A 1% increase in confirmed member utilization since the single plan model transition

Community Supports

- The Alliance is receiving $7 million in FY25 funding from DHCS for Community Support.
- The Alliance estimates that we will spend approximately $35 million to support the CS program in Fiscal Year 2025, compared to $24 million in Fiscal Year 2024.

Budget Changes for End of FY 24

- State recouped $59 million for Calendar Year 2023 and Calendar Year 2024 from the Alliance in the months of May and June
- Acuity adjustment
- Biggest recoupment was in long-term care services
- For FY24, we had projected a year-end net income of $23 million and are now looking at a potential $5.5 million loss.

FY25 Budget Changes

- Programs that have been cut are Board Grants, Community Reinvestment, Other Grants, and provider grants
- FY25 travel will be subject to CEO/CFO approval
- Employee benefit cost sharing may need to increase depending on contract negotiations
- The Board will be made aware of any additional changes that may need to be put into place during the final budget adoption in December.

Question: Are there items in the State's budget in the May revise and in the current negotiation that would further impact the Alliance?

Answer: If our rates decrease, they will adjust them based on the state's budget. This will also impact on the Targeted Rate Increase (TRI). We can expect more information when the Governor's budget is released.

8. BOARD BUSINESS

a) REVIEW AND APPROVE APRIL 2024 MONTHLY FINANCIAL STATEMENTS

During the meeting, the Chief Financial Officer, Gil Riojas, presented a general overview of the financial statements for April 2024. The complete packet, containing all the details, had already been presented to the Finance Committee earlier in the week.

To summarize, for the month ended April 30th, 2024, the Alliance had enrollment of 405,174 members, a Net Loss of $8.3 million and 554% of required Tangible Net Equity (TNE).

Highlights:

<u>Enrollment</u>

- Total enrollment increased by 1,233 members since March 2024
- Total enrollment increased by 43,489 members since July 2023.

<u>Net Income</u>

- For the month ended April 30th, 2024:
  - Actual Net Loss: $8.3 million.
  - Budgeted Net Loss $876,000
- For the fiscal YTD ended April 30th, 2024:
  - Actual Net Income: $21.2 million
  - Budgeted Net Income: $16.8 million

<u>Premium Revenue</u>

- For the month ended April 30th, 2024:
  - Actual Revenue: $159.6 million
  - Budgeted Revenue: $158.6 million

- For the fiscal YTD ended April 30th, 2024:
  - Actual Revenue: $1.5 billion
  - Budgeted Revenue: $1.5 billion

<u>Medical Expense</u>

- For the month ended April 30th, 2024:
  - Actual Medical Expense: $165.4 million
  - Budgeted Medical Expense: $153.0 million

- For the fiscal YTD ended April 30th, 2024:
  - Actual Medical Expense: $1.4 billion
  - Budgeted Medical Expense: $1.4 billion

<u>Medical Loss Ratio (MLR)</u>

The Medical Loss Ratio was 103.6% for the month and 94.9% for the fiscal year-to-date.

Administrative Expense

- For the month ended April 30th, 2024:
  - Actual Administrative Expense: $10.2 million
  - Budgeted Administrative Expense: $8.9 million

- For the fiscal YTD ended April 30th, 2024:
  - Actual Administrative Expense: $79.4 million
  - Budgeted Administrative Expense: $84.7 million

Other Income/ (Expense)

- Fiscal year-to-date net investments show a gain of $25.8 million.
- Fiscal year-to-date claims interest expense due to delayed payment of certain claims or recalculated interest on previously paid claims is $691,000.

Managed Care Organization (MCO) Provider Tax

- For the month ended April 30th, 2024:
  - $113.7 million unbudgeted MCO Tax Revenue
  - $108.3 million unbudgeted MCO Tax Expense

Tangible Net Equity (TNE)

- Required TNE $62.4 million
- Actual TNE $345.2 million
- Excess TNE $282.8 million
- TNE % of Required TNE 554%

Capital Investment

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

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Dr. Evan Seevak to approve the April 2024 monthly financial statement.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez-Patterson, Jody Moore, Yeon Park, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

b) REVIEW AND APPROVE FY25 DRAFT BUDGET PRESENTATION

During the FY25 Draft Budget presentation, Chief Financial Officer Gil Riojas discussed the challenging news of reductions and rate changes for calendar years 24 and 25. He emphasized the importance of advocating for community support and explained the need to convey the value of these benefits beyond just the numbers to the DHCS. Riojas highlighted the significance of presenting a solid argument for why these benefits are essential for the community's well-being, especially in discussions with the DHCS and not just with the actuaries. It is evident that the equation for some of these benefits does not work out in the organization's favor. As a result,

further discussions with the state will be necessary to emphasize the importance of these essential support services for the future.

<u>Question:</u> Can County leadership partner with us in these conversations, or is this primarily a conversation with DHCS?

<u>Answer:</u> Once we know the future of community support, we should discuss it with the County and the State to bring everyone together and advocate for the valuable services.

<u>Question</u>: Are we going to engage our assembly and elected officials?

<u>Answer</u>: We addressed this matter on two recent occasions, engaging in discussions regarding our observations and desired actions. We anticipate further developments in the future.

Highlights:

- 2025 Projected Net Income of $376,000.
- The projected Tangible Net Equity (TNE) excess at 6/30/25 of $245.1 million is 439% of the required TNE. The Alliance remains financially strong.
- Year-end enrollment is 5,000 higher than June 2024; Fiscal Year member months are 350,000 higher than the prior year. Enrollment peaks at 410,000 in June 2025.
- Premium Revenue is $2.0 billion in FY 2025, an increase of $269.8 million (15.3%) from FY 2024.
- Fee-for-Service and Capitated Medical Expense is $1.9 billion in FY 2025, an increase of $252.2 million (15.3%) from FY 2024.
- Administrative Department Expenses are $11.4 million higher than FY 2024 and represent 5.5% of revenue.
- Clinical Department Expenses are $3.6 million lower than FY 2024 and comprise 2.5% of revenue.
- 2024 Projected Net Loss of $5.5 million
- Unfavorable Revenue recoupments totaling $87.1 million in FY 2024. The majority of these are from prior years.

<u>Question</u>: Regarding the 2023 Major Organ Transplants Risk Corridor Payback, is there an understanding of the reasons behind the lower-than-anticipated number of major organ transplants?

<u>Answer</u>: Our team is currently focusing on two primary areas. First, we are reviewing our process for referring patients to specialists to get on the transplant list. We have noticed that some of our members have been denied placement on the list due to not meeting the necessary criteria, particularly related to chronic conditions, behavioral health issues, and substance abuse problems. We are investigating why our denial numbers are higher than expected and examining how these numbers are calculated at the state level to determine any inaccuracies in the data.

Motion: A motion was made by Natalie Williams and seconded by Dr. Marty Lynch to approve the FY25 Draft Budget.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez-Patterson, Jody Moore, Yeon Park, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

c) MEDICARE PRESENTATION

Tome Meyers, Executive Director, Medicare Programs, provided the board with an update on Medicare. Items of discussion included:

- Dual Eligible Special Needs Plans (D-SNPs) in CA
- MA D-SNP Product Timeline
- Alameda County Medicare Landscape
- Member & Provider Engagement
- Stars Measures Overview
- Medicare Stars Scoring and Rating Methodology
- Challenges & Risks
- Closing Statements/Next Steps

Highlights:

- Provider Medicare Advantage D-SNP overview with CHCN (April 30th) and AHS (May 8th)
- May 17th – received comments from DMHC for all submissions related to Medicare License Expansion Filing
  - AAH response is due to DMHC by June 16th.
- Medicare provider contract & Medicare product amendment (for vendors) is being finalized with a goal to start provider contracting in July 2024
- TruCare optimization and D-SNP core systems upgrades started May 22nd
- In Development: Dental & Vision RFP, Branding RFQ, Current PBM Services, Provider Outreach Services, Model of Care (MOC), IT Strategy, Supplemental Benefits Structure, Stars Playbook & Workplan

Question: We are unfamiliar with bidding in Medi-Cal. Could you please provide more information on what is required?

Answer: In Medicare, we need to market the product to members and incent them to enroll. Our bid design will include different supplemental benefits and vendors to compete with Kaiser. We will go through a thorough evaluation with Milliman to ensure everything is sound. We need to take several steps to prepare for this from a module perspective. After that, we will file it with CMS. The bid design is quite complex and requires expertise in both benefits and finance.

<u>Question</u>: In terms of the design, does that live in the model of care and in the supplemental benefits structure? How would the Board and the Consumer Advisory Committee be involved and give input into the design of the benefits or to learn about what is a standard benefit design so that we could potentially give input to it.

<u>Answer</u>: The model of care refers to healthcare services and quality improvement, focusing on how these services are provided and the additional benefits that support them.

We have a standard Medicare benefit design that is consistent nationwide. In addition to this, we need to consider what Kaiser is offering and then determine what additional coverage is required based on the community's needs. We are open to discussing this with the board. It is important to keep in mind that this is a competitive and sales-oriented product. The details are confidential once we submit our bid until they are made public. Therefore, we will not be aware of Kaiser's offerings, and they will not be aware of ours.

<u>Question</u>: Regarding provider outreach, are you anticipating expanding the provider network for the Medicare product?

<u>Answer</u>: We plan to focus on our existing Medicaid network and collaborate with them as our primary strategy. However, we also need to meet CMS network adequacy requirements, and we have identified some gaps that we need to address by contracting with additional specialists. Our third approach involves looking at our current Medicaid duals with an income of $40,000 or more, seeing where they are currently receiving care, and comparing it with our network to identify gaps in care that need to be addressed for better continuity moving forward.

<u>Comment</u>: Dr. Ferguson is impressed with Matt and the team's progress and movement.

Informational item only.

9. STAFF UPDATES

There were no staff updates.

10. UNFINISHED BUSINESS

None.

11. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

A request was made to provide a summary of the Trilogy documents at the next board meeting.

12. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

13. CLOSED SESSION

a) CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION

Significant exposure to litigation, one (1) potential case.
(Paragraph (2) or (3) of subdivision (d) of GOV. CODE, § 54956).

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

The Board convened into a Closed Session at 1:35 p.m. The Board Chair reopened the meeting at 2:03 pm.

No reportable action was taken in the Closed Session.

14. ADJOURNMENT

Chair Gebhart adjourned the meeting at 2:04 p.m.

Respectfully submitted by: Brenda Martinez, Clerk of the Board.

RESOLUTION RE-APPOINTING BYRON LOPEZ TO LABOR STAKEHOLDER SEAT

RESOLUTION NO. 2024-

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS REAPPOINT MR. BYRON LOPEZ TO THE LABOR STAKEHOLDER SEAT TO THE ALAMEDA ALLIANCE FOR HEALTH BOARD OF GOVERNORS

WHEREAS, Mr. Byron Lopez's current term as an Alameda Alliance for Health (Alliance) Board of Governors member, in the Labor Stakeholders Seat (Regular #2), expires July 28, 2024; and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors nominate Mr. Byron Lopez for reappointment to the Labor Stakeholders Seat (Regular #2), pursuant to Section 3.C of the Alliance *Bylaws*; and

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

WHEREAS, the Alliance Board of Governors desires to nominate Mr. Byron Lopez for reappointment to the Alliance Board of Governors (Regular #2); and

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

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

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

SECTION 1. That the Alliance Board of Governors approves the Chief Executive Officer's recommendation to nominate Mr. Byron Lopez for reappointment to Labor Stakeholders Seat (Regular #2), on the Alliance Board of Governors, as created pursuant to Section 3.D.6 of the Alliance *Bylaws*.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors reappoint by majority vote Mr. Byron Lopez to the Labor Stakeholders Seat (Regular #2), on the Alliance Board of Governors.

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

PASSED AND ADOPTED by the Board at a meeting held on the 12th day of July 2024.

____
CHAIR, BOARD OF GOVERNORS

ATTEST:

____
Secretary

RESOLUTION RE-APPOINTING REBECCA GEBHART TO AT-LARGE SUBJECT KNOWLEDGE EXPERTISE SEAT

RESOLUTION NO. 2024-

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS REAPPOINT MS. REBECCA GEBHART TO THE AT-LARGE SUBJECT KNOWLEDGE EXPERTISE SEAT TO THE ALAMEDA ALLIANCE FOR HEALTH BOARD OF GOVERNORS

WHEREAS, Ms. Rebecca Gebhart's current term as an Alameda Alliance for Health (Alliance) Board of Governors member, in the At-Large Subject Knowledge Expertise Seat (Regular #5), expired June 12, 2024; and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors nominate Ms. Rebecca Gebhart for reappointment to the At-Large Subject Knowledge Expertise Seat (Regular #5), pursuant to Section 3.C of the Alliance *Bylaws*; and

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

WHEREAS, the Alliance Board of Governors desires to nominate Ms. Rebecca Gebhart for reappointment to the Alliance Board of Governors (Regular #5); and

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

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

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

SECTION 1. That the Alliance Board of Governors approves the Chief Executive Officer's recommendation to nominate Ms. Rebecca Gebhart for reappointment to the At-Large Subject Knowledge Expertise Seat (Regular #5), on the Alliance Board of Governors, as created pursuant to Section 3.D.8 of the Alliance *Bylaws*.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors reappoint by majority vote Ms. Rebecca Gebhart to the At-Large Subject Knowledge Expertise Seat (Regular #5), on the Alliance Board of Governors.

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

PASSED AND ADOPTED by the Board at a meeting held on the 12th day of July 2024.

____
CHAIR, BOARD OF GOVERNORS

ATTEST:

____
Secretary

CEO Update

Matthew Woodruff

To: Alameda Alliance for Health Board of Governors

From: Matthew Woodruff, Chief Executive Officer

Date: July 12th, 2024

Subject: CEO Report

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

	May	YTD
Medi-Cal	($28.5M)	($10.4M)
Group Care	($718K)	$2.4M
Total	($29.2M)	($8.0M)

  - **Revenue was $126.9 million in May 2024 and $1.6 billion Year-to-Date (YTD)**.
    - Medical expenses were $150.0 million in May and $1.6 billion for the fiscal year-to-date; the medical loss ratio is 118.3% for the month and 96.8% for the fiscal year-to-date.
    - Administrative expenses were $8.7 million in May and $88.2 million year-to-date; the administrative loss ratio is 6.9% of net revenue for the month and 5.5% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 514% of the required DMHC minimum, representing $254.5 million in excess TNE.
  - **Total enrollment in May 2024 was 405,279**, an increase of 105 Medi-Cal members compared to April.
- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - All Regulatory Metrics were met.
  - **Non-Regulatory Metrics:**
    - All non-Regulatory Metrics were met.
- **Alliance Updates:**
  - **Long Term Care Discussion**
  - **Demographics**
    - Please attached power point describing the demographics of the Alliance employees
  - **DHCS Audit**

- The Alliance completed our annual DHCS audit. The Plan is currently reviewing the closing conference comments from DHCS, but we believe we could have as many as twenty-three findings.

- **Pay Equity Salary Survey**
  - We will work to implement the needed changes during our annual review process this August and September.

- **Medicare Overview**
  - **D-SNP Readiness**
    - Alameda Alliance for Health (AAH) Medicare Advantage (MA) Duals Eligible Special Needs Plan (D-SNP) will begin serving members on January 1st, 2026.
    - The RFP for Dental Benefit Services has been released, and the Alliance executed a SOW with Chapman Consulting for provider engagement, awareness, education, and coordination of Medicare provider contracting meetings, which will start in July.
    - Completed Medicare branding demos with 3 different agencies, solidified IT project management plan approach, and kicked off Medicare organizational structure exercise with department leads.
    - Received approval from the Administrative Oversite Committee (AOC) on Standard Operating Procedure (SOP) policy, template, example, and guide.
    - The Alliance has in development the following items: Vision & Hearing RFP, Medicare Provider Amendment, Current PBM – Services Agreement Medicare Changes, Model of Care (MOC), IT Strategy, Supplemental Benefits Structure, & Stars Playbook/Workplan.
  - **D-SNP Supplemental Benefits Comparison Chart**

	Alameda County HMO D-SNPs 2024					Public Plan HMO D-SNPs 2024				
	CVS H4982-008	Elevance H4471-007	Molina Healthcare H0838-024	Imperial Health Plan H5496-011	Kaiser Permanente H8794-004	Health Plan San Mateo H6019-001	LA Care H1224-001	Santa Clara Family Health Plan H4045-001	CalOptima H5433-001	Community Health San Diego H6248-001
	★★★	Too new	★★1/2	★★★1/2	Too new*	Too new**	Too new	Too new	★★★	Too new
	Aetna Medicare Preferred Plan	Anthem Dual Advantage	Brand New Day Dual Access Plan	Imperial Dual Plan	Kaiser Medicare Medi-Cal Plan North	CareAdvantage	L.A. Care Medicare Plus	DualConnect	OneCare, a Medicare Medi-Cal Plan	CommuniCare Advantage
Vision	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dental	✓	✓	✓	✓	✓	✗	✓	✗	✗	✓
Hearing	✓	✓	✓	✓	✗	✗	✗	✗	✓	✗
Transportation	✓	✓	✓	✓	✗	✗	✓	✗	✓	✓
Fitness	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗
Telehealth	✓	✓	✓	✓	✓	✗	✓	✓	✗	✗
In-Home Support Services	✗	✗	✗	✓	✗	✗	✓	✗	✓	✗
Health Education	✓	✗	✓	✗	✓	✗	✓	✓	✗	✗
OTC Allowance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Personal Emergency Response System	✓	✓	✓	✓	✗	✗	✓	✗	✗	✗
Acupuncture	✓	✓	✓	✗	✓	✗	✓	✗	✗	✗
Chiropractic Services	✓	✓	✓	✓	✗	✗	✓	✗	✗	✗
Meals for Short Duration	✓	✓	✓	✓	✗	✗	✓	✗	✗	✗
Worldwide Emergency	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓

*Consolidated H contracts

**Plan refiled H contracts

- **Incentive Program Updates**
  - **Program #1 – CalAIM Incentive Payment Program**
    - Description & Purpose:
      - CalAIM's Enhanced Care Management (ECM) and Community Supports (CS) programs began launching on January 1st, 2022.
      - The purpose of this incentive program is to expand ECM and Community Supports by building capacity, investing in delivery system infrastructure, addressing disparities and equity, adding community support, and improving quality.
      - Any provider or community-based organization is invited to apply for incentive funding. In order to qualify for funding, the participating organizations are required to join the Alliance's ECM and Community Supports program, and to meet specified outcomes and performance measures.
    - Program Years: **1/1/2022 – 6/30/2024**
    - Maximum allocation to Alameda Alliance: **$14.8 million (year 1); $15.1 million (year 2)**
    - Earned incentive dollars: **$19.4 million**
    - Payments Issues to IPP Providers and Organizations: **$17.0 million**
    - State Guidance: DHCS APL 21-016
    - Current Status:
      - For Program Year 1 (1/1/2022-12/31/2022), AAH earned $14.8M which was 100% of eligible funds. Funds were distributed to ten (10) providers and organizations to support the ECM and CS programs.
      - For Program Year 2 (1/1/2023-12/31/2023), AAH earned $4.56M which was 60% of eligible funds. Funds have been distributed to twelve (12) providers and organizations to support the ECM and CS programs.
      - The Submission 4 report for the lookback period of 7/1/2023-12/31/2023 was submitted to DHCS on March 1st, 2024; AAH is still awaiting feedback from DHCS.
      - For Program Year 3 (1/1/2024-6/30/2024, AAH completed the review of Wave 4 IPP Applications and awarded funding to two (2) entities to support CS programs.

  Program #2 – Student Behavioral Health Incentive Program
    - Description & Purpose:
      - Statewide $389 million is designated over a three-year period (January 1, 2022-December 31, 2024) for incentive payments to Medi-Cal managed care plans that meet predefined goals and

metrics. The goals and metrics are associated with targeted interventions that increase access to preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for TK-12 children in public schools. Public charter schools are also included.

  - The purpose of this incentive program is to invest in three priority areas of school-based behavioral health services: planning and coordination, infrastructure, prevention and early intervention.

- Program Years: **1/1/2022 - 12/31/2024**
- Maximum allocation to Alameda Alliance: **$9.7 million**
- Earned incentive dollars: **$7.4 million.**
- Payments issued to SBHIP Partners: **$6.6 million**
- State Guidance: DHCS APL 23-035
- Current Status:
  - The Alliance worked with the eleven (11) Local Education Agencies (LEAs) to submit the third Bi-Quarterly Report (BQR) for the measurement period of 1/1/2024-6/30/2024; the report was submitted to DHCS on June 27th, 2024. Earnable dollars for this submission is $1.1M.

Program #3 – Housing and Homelessness Incentive Program

- Description & Purpose:
  - This incentive program is built upon the DHCS' quality strategy and the Home- and Community Based Spending Plan. The spending plan focuses on addressing homelessness and unhoused people and encompasses the community-based residential continuum pilots for older, frail adults and disabled populations. The plan includes the assisted living waiver waitlist, community care expansion program, and other services.
  - Address homelessness and housing insecurity as social determinants of health. Developing a local homelessness plan will be jointly created with Alameda County Health (formerly Alameda County Health Care Services Agency or HCSA) and Alameda Alliance and submitted to the DHCS. The existing partnership that originated during the Whole Person Care and Health Home Pilots (2017 – 2021) would be extended to build more capacity and to support more referrals for housing services, and to better coordinate housing needs.
  - This incentive program enables further investing in the expansion of street medicine, data management systems, and staffing to attain three measurement areas: 1) local partnerships to address disparities and equity, 2) infrastructure to support housing navigation, and 3) service delivery and member engagement.

- Program Years: **1/1/2022 - 3/31/2024**
- Maximum allocation to Alameda Alliance: **$44.3 million**
- Earned incentive dollars: **$38.0 million**
- Payments issued: **$17.9 million**
- State Guidance: DHCS APL 22-007
- Current Status:
  - The Alliance has issued $13.1M in HHIP payments to Alameda County Health for the completion of deliverables including Housing Financial Supports Progress Reports, Street Medicine data, analytics, Housing Community Supports (HCS) Capacity Building progress reports, a HCS Legal Services pilot, and funding that supported the 2024 Point-in-Time (PIT) count. The Alliance extended its agreement with HCSA to provide additional time for the HCS Capacity Building work as hiring challenges were identified by HCS providers; this work has been extended through June 2024.
  - On May 31st, the Alliance announced the approval of ten (10) newly funded projects, totaling $1.3M, with SBHIP LEA partners that aim to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.). MOUs for this program are currently in development.
  - On June 3rd, the Alliance released a program to the community to reinvest earned HHIP dollars (up to $10 million) and increase partnerships within the community to support HHIP program goals. Five (5) informational sessions for eleven (11) organizations interested in the program were held in June; the application period closes July 18th.

Program #4 – Behavioral Health Integration Incentive Program (Completed)

- Description & Purpose:
  - The incentive program is designed to incentivize improvement of physical and behavioral health outcomes, care delivery efficiency, and patient experience. The goal is to increase provider network integration at all levels of integration (those just starting behavioral health integration in their practices as well as those that want to take their integration to the next level), focus on new target populations or health disparities, and improve the level of integration or impact of behavioral and physical health. **This incentive program ended on December 31st, 2022.**
- Program Years: **1/1/2021 - 12/31/2022**
- Maximum allocation to Alameda Alliance: **$3.2 million**
- Earned incentive dollars: **$3.2 million**
- Payments issued to providers: **$3.0 million awarded** to three contracted providers (Community Health Center Network, Lifelong Medical Care and

Bay Area Community Health). AAH was allowed to keep $200k to cover program administrative costs so all available funds have been expended.

- State Guidance: DHCS APL 22-021

LTC Plan

Goal

Align member's care and needs to all available resources

Long-term Care membership increased 35%

(Dec 2023-June 2024)

Current LTC Membership is 2,838

What is working well

- LTC intensive case management and education
  - Collaboration with facilities for discharge planning and linking members with benefits to support community living

Calendar Year	LTC → Community Discharges
1/2023-12/2023	143
1/2024-present	142

LTC Team Interfaces with Members/Providers

- LTSS team
  - Uses UM processes to identify potential member and provider needs
  - Gives ongoing provider education
- LTSS Social Workers are on-site at facilities
  - Building relationships with members and providers
- LTSS RNs identify and refer members to resources for medical, behavioral, and social needs

LTC AID Codes

- Goal:
  - Match LTC members to LTC aid codes
    - Maximize benefits and services
- Ongoing Interventions:
  - LTSS working with facilities to correct aid codes
- Future plans:
  - Collaborate within AAH to develop additional processes for aid code correction

LTC Levels of Care

- Goal: match member care needs to LTC stay levels
  - Update LTC Stay Levels
  - Improve internal systems to allow alignment of member care needs with LTC stay levels

Thanks!

Questions?

Details: LTC Levels of Care

NF-A

- NF-A care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of his/her ability.
- Member requires skilled nursing care or observation on an ongoing intermittent basis and 24-hour supervision to meet his health needs.
- Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis.

NF-B

- Skilled Nursing Level of Care (CCR Title 22 Section 51335 (j) In order to qualify for skilled nursing facility services, a member shall have a medical condition which needs visits by a physician at least every 60 days and constantly available skilled nursing services.
- Member must have needs for:
  - Need for patient observation, evaluation of treatment plans, and updating of medical orders by the responsible physician
  - Need for constantly available skilled nursing services. A patient may qualify for nursing home services if the patient has one or more of the potentially qualifying conditions.
  - A condition which needs therapeutic procedures
  - Dressing of postsurgical wounds, decubitius, leg ulcers, etc
  - Tracheostomy care, nasal catheter maintenance
  - Indwelling catheter in conjunction with other conditions
  - Gastrostomy feeding or other tube feeding
  - Colostomy care for initial or debilitated patients.
  - Bladder and bowel training for incontinent patients

Expand LTC Intensive Nurse and Social Worker Management of LTC Members

May decrease ED Visits

- Support members in managing issues that are sending them to the ER
- Work with facilities to identify gaps that are sending members to the ER
- Increase Transitional Care Services

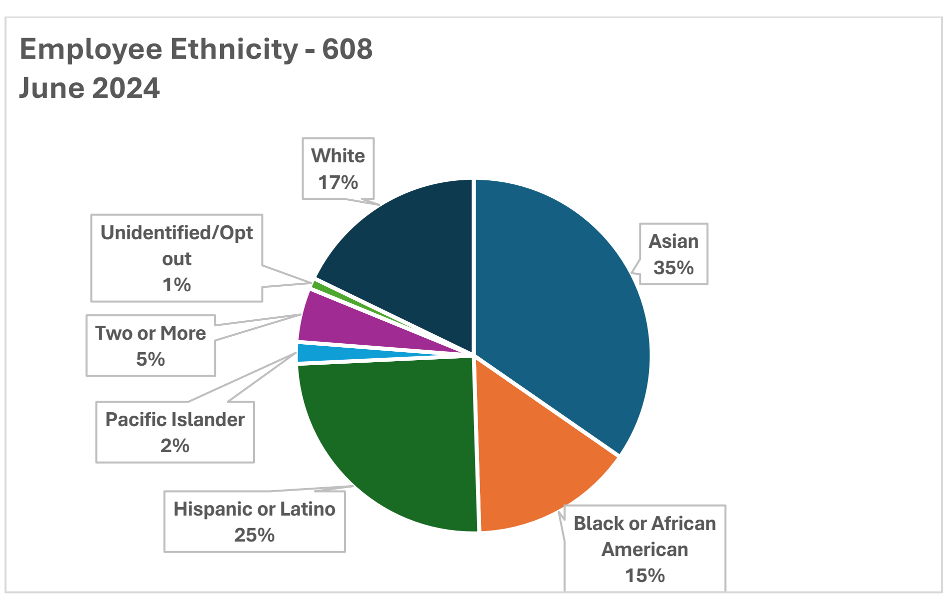
May Decrease Re-Admissions

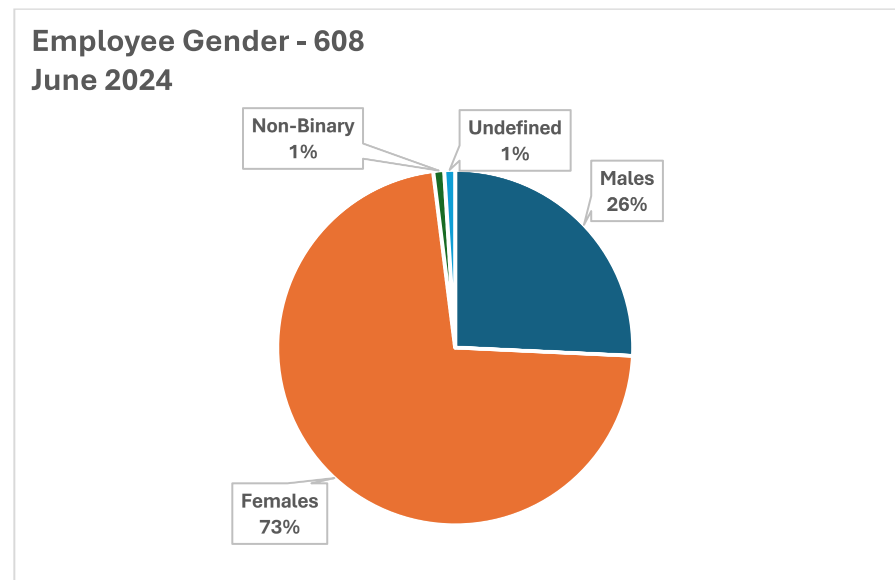
- Support members in managing issues that are sending them to the ER
- Work with facilities to identify gaps that are sending members to the ER
- Increase Transitional Care Services

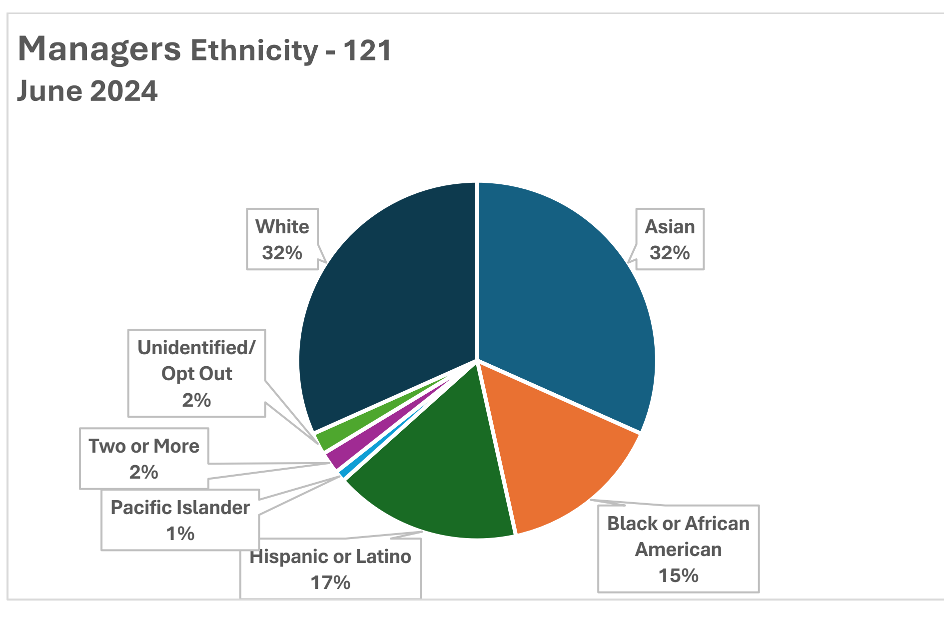
May Increase Discharges to the Community

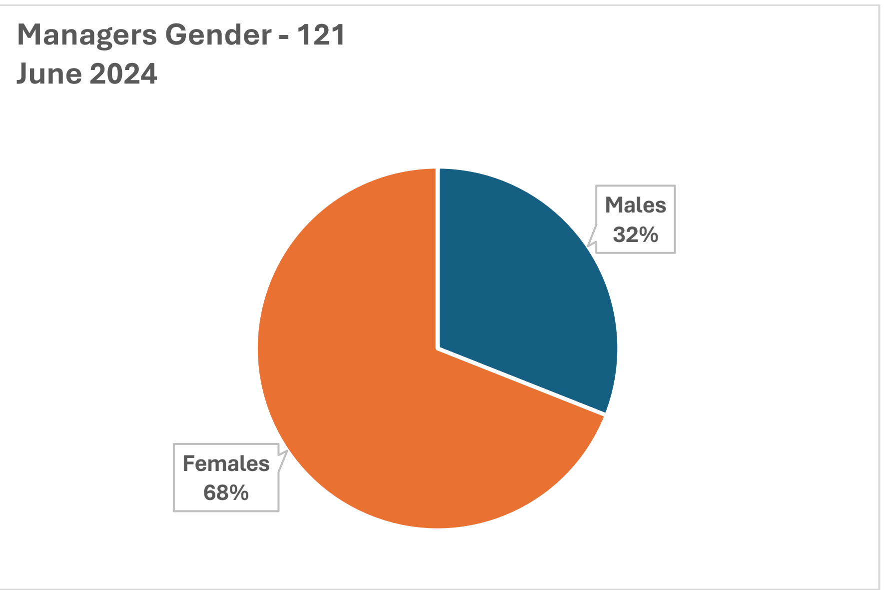
- Onsite SW visits to collaborate on discharge planning
- Increase referrals to ECM
- Increase referrals to CS
- Increase knowledge of available waivers members can be eligible for

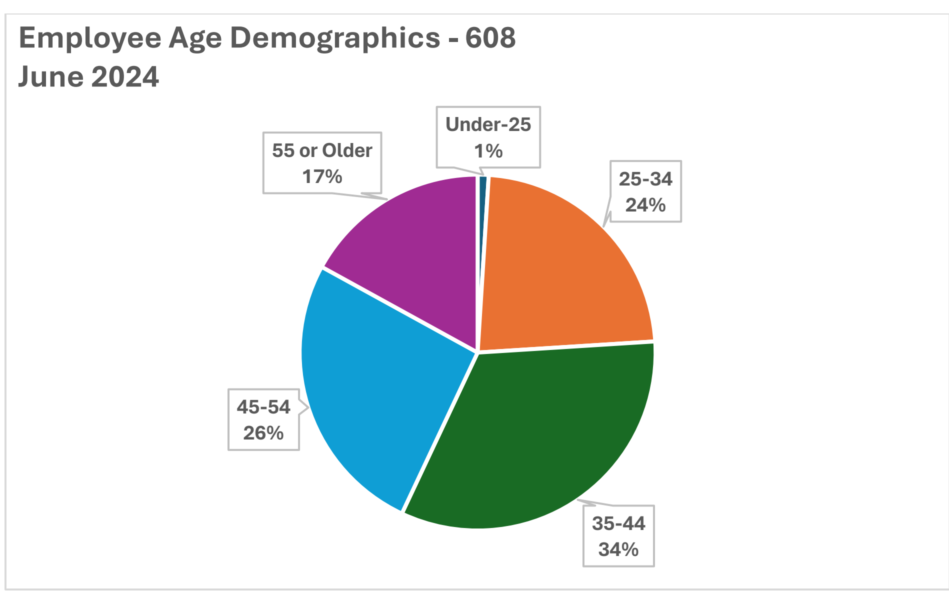
AAH Employee Demographics Data Report June 2024





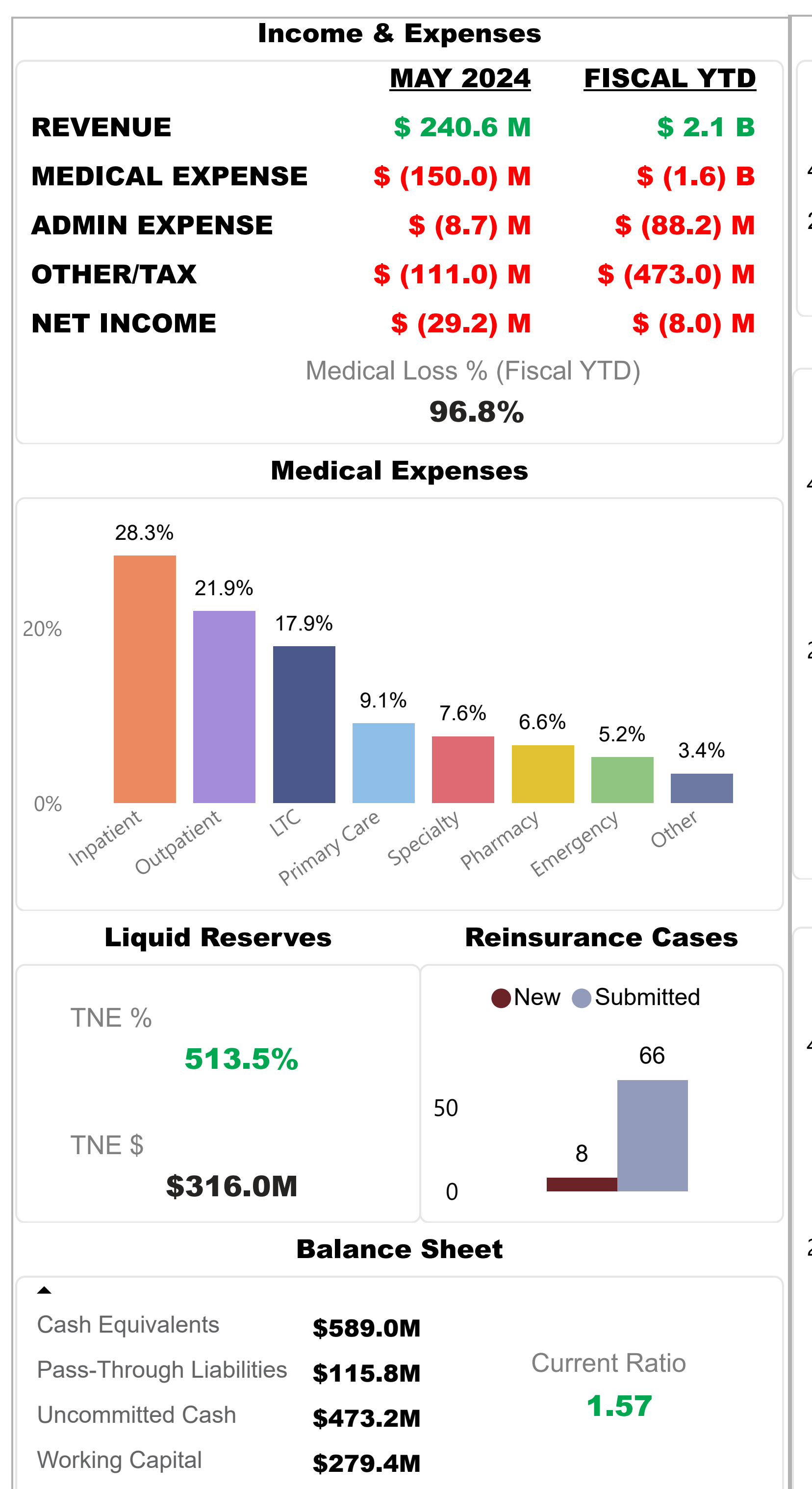





Employee Age Demographics - 608
June 2024
Under-25
1%
55 or Older
17%
25-34
24%
45-54
26%
35-44
34%

Executive Dashboard

Financials



Income & Expenses

	MAY 2024	FISCAL YTD
REVENUE	$ 240.6 M	$ 2.1 B
MEDICAL EXPENSE	$ (150.0) M	$ (1.6) B
ADMIN EXPENSE	$ (8.7) M	$ (88.2) M
OTHER/TAX	$ (111.0) M	$ (473.0) M
NET INCOME	$ (29.2) M	$ (8.0) M

Medical Loss % (Fiscal YTD)
96.8%

Medical Expenses

Liquid Reserves

TNE %
513.5%

TNE $
$316.0M

Reinsurance Cases

Balance Sheet

Cash Equivalents	$589.0M
Pass-Through Liabilities	$115.8M
Uncommitted Cash	$473.2M
Working Capital	$279.4M

Current Ratio
1.57

Membership

By Plan

IHSS | Medi-Cal | Total

	IHSS	Medi-Cal	Total
May 23	5,670	354,512	360,182
Mar 24	5,620	398,364	403,984
Apr 24	5,643	399,584	405,227
May 24	5,640	399,703	405,343

By Network

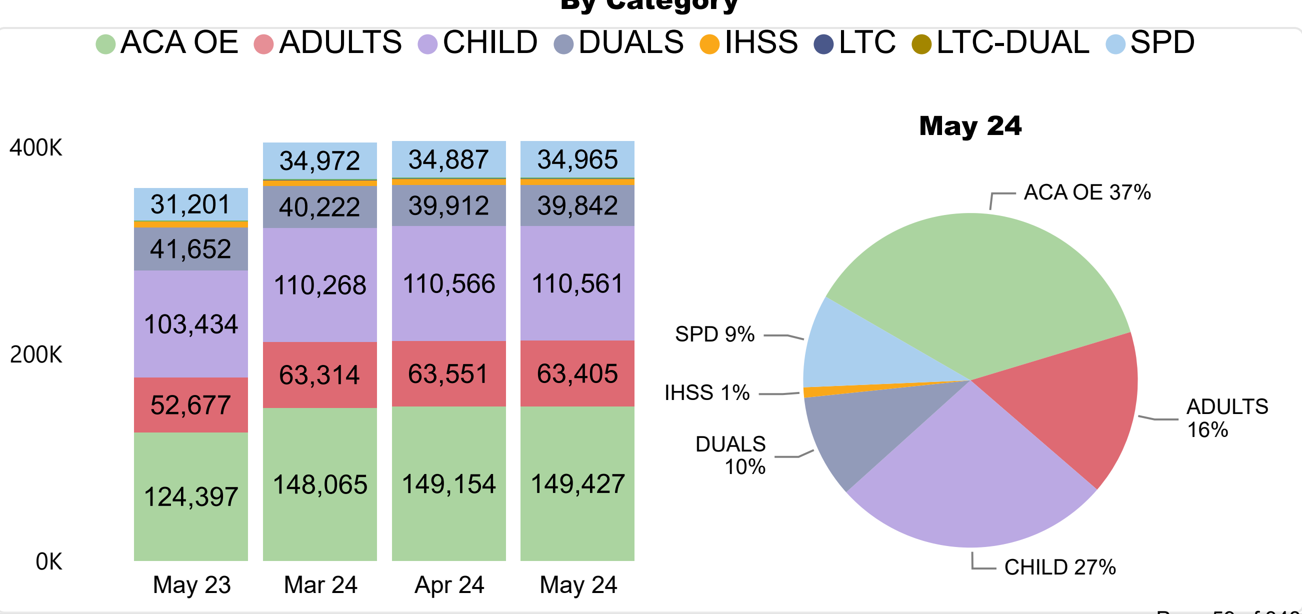
AHS (Direct) | CFMG | CHCN | Independent (Direct) | KAISER

	AHS (Direct)	CFMG	CHCN	Independent (Direct)	KAISER
May 23	67,113	35,138	131,489	74,016	52,426
Mar 24	90,089	43,413	180,692	89,790	
Apr 24	90,630	43,702	181,300	89,595	
May 24	91,118	44,083	181,761	88,381	

May 24

AHS (Direct) 22%
IND (Direct) 22%
CFMG 11%
CHCN 45%

By Category



Claims

Claims Processing

Denied, Paid, Pended, Received, Unfinalized

	Apr 24	May 24	Jun 24
Received	323K	375K	297K
Paid	214K	281K	225K
Unfinalized	181K	130K	155K
Denied	76K	93K	80K
Pended	39K	47K	58K

Average Payment TAT (Days)

Jun 23	Apr 24	May 24	Jun 24
20	13	14	14

Auto Adjudication Rate (%)

Jun 23	Apr 24	May 24	Jun 24
79.3%	86.9%	85.6%	87.5%

Claims Paid ($)

Jun 23	Apr 24	May 24	Jun 24
$82M	$116M	$157M	$116M

Interest Paid ($)

Jun 23	Apr 24	May 24	Jun 24
$49K	$137K	$85K	$84K

Claims Compliance

Processed 30 Cal Days (%) (target 90%)

Jun 23	Apr 24	May 24	Jun 24
90%	93%	92%	90%

Processed 45 Work Days (%) (target 95%)

Jun 23	Apr 24	May 24	Jun 24
100%	100%	100%	100%

Claims Auditing

# of Pre- Pay Audited Claims

Apr 24	May 24	Jun 24
2,893	3,332	3,209

Member Services

	Apr 24	May 24	Jun 24
Inbound Calls	20,951	18,406	16,528
Outbound Calls	9,098	7,985	7,219

Abandoned Call Rate (%) (target 5%)

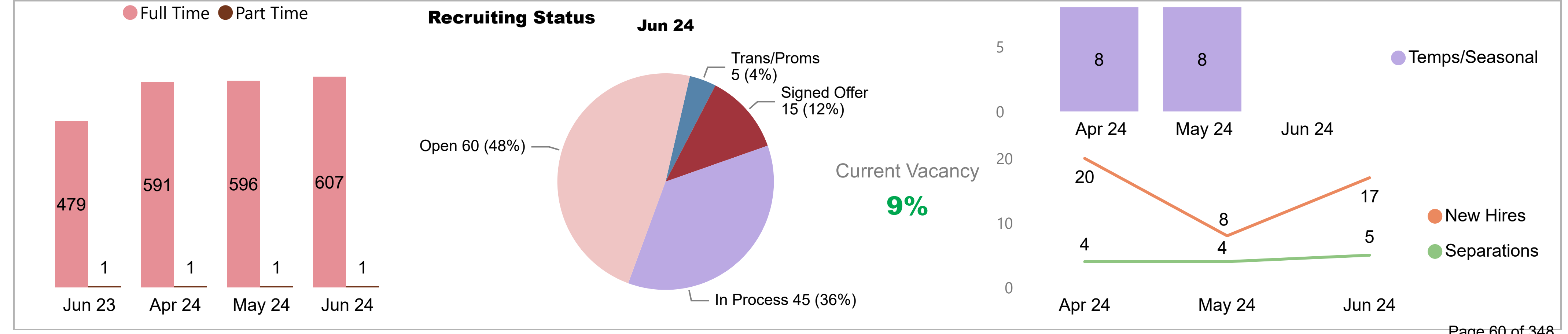
Apr 24	May 24	Jun 24
9%	4%	3%

Calls Answered in 30 Seconds (%) (target 80%)

Apr 24	May 24	Jun 24
84%	93%	94%

Average Call Times	Apr 24	May 24	Jun 24
Wait Time	00:50	00:19	00:15
Call Duration	06:57	06:48	06:55

Human Resources



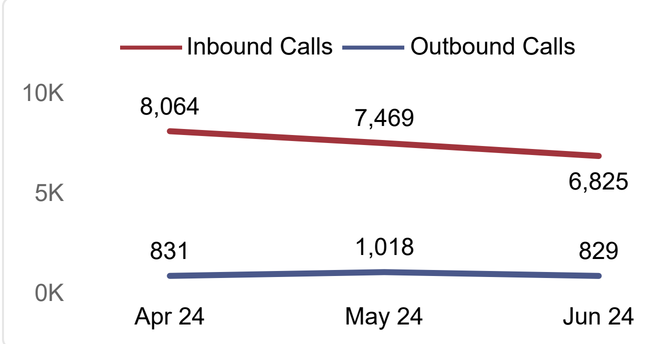
Provider Services

Provider Network

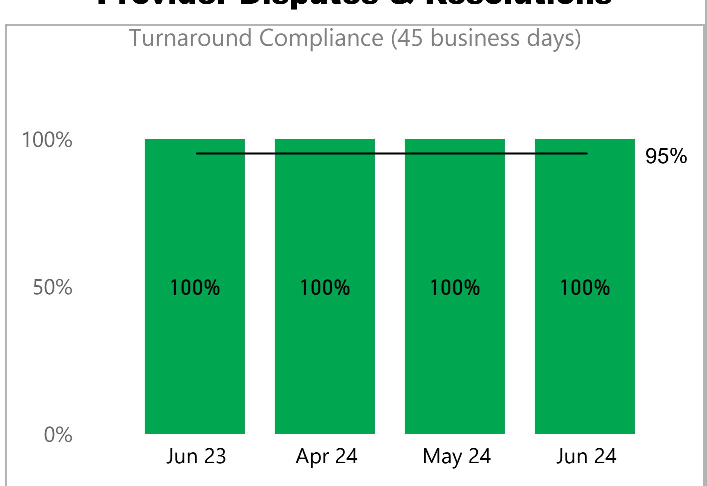
Hospital	17
Specialist	9,973
Primary Care Physician	763
Skilled Nursing Facility	106
Urgent Care	9
Health Centers (FQHCs and Non-FQHCs)	68
TOTAL	**10,936**

Provider Credentialing

Provider Call Center



Provider Disputes & Resolutions



Compliance

Member Grievances

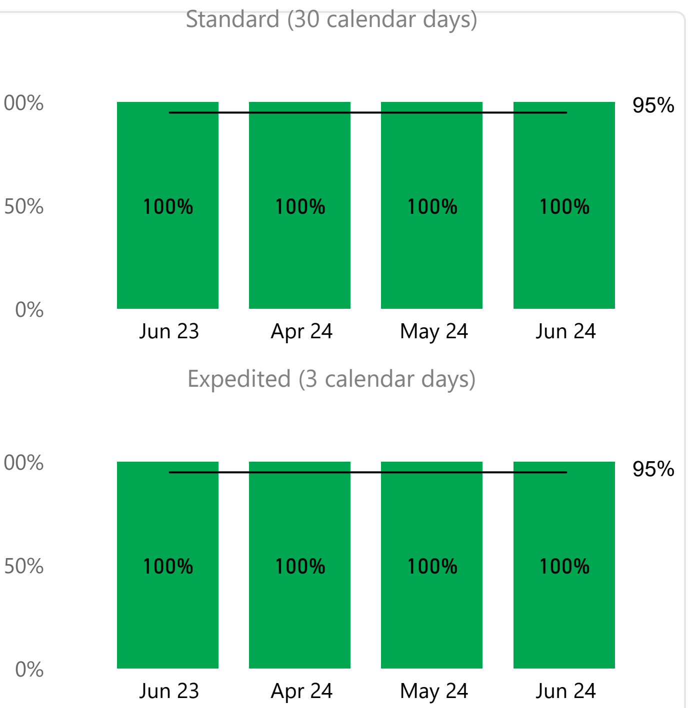
Standard (30 calendar days)

	Jun 23	Apr 24	May 24	Jun 24
Standard (goal 95%)	95%	100%	100%	100%

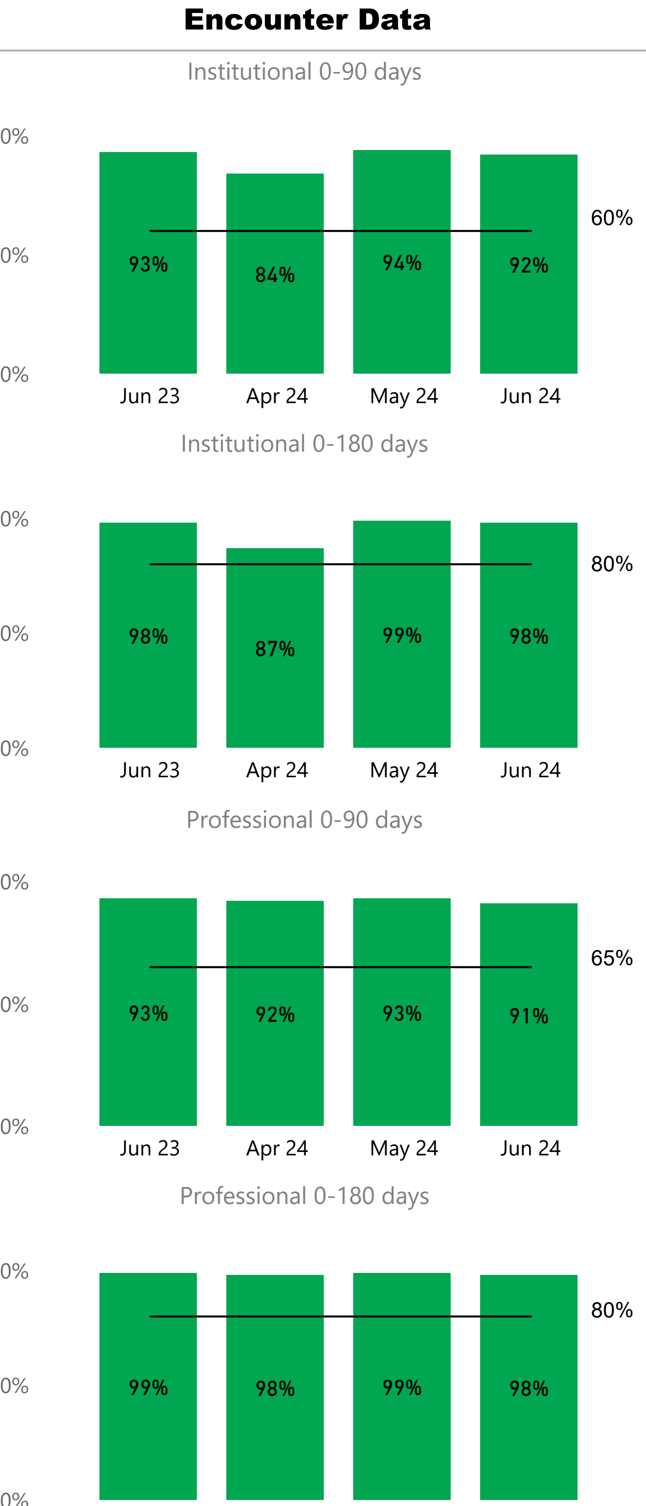
Expedited (3 calendar days)

	Jun 23	Apr 24	May 24	Jun 24
Expedited (goal 95%)	100%	100%	100%	100%

Member Appeals



Encounter Data



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Health Care Services

Authorization Turnaround

Overall % (target 95%)

	Jun 23	Apr 24	May 24	Jun 24
Overall %	95%	96%	97%	98%

Medi-Cal % (target 95%)

	Jun 23	Apr 24	May 24	Jun 24
Medi-Cal %	95%	96%	97%	98%

Group Care %

	Jun 23	Apr 24	May 24	Jun 24
Group Care %	98%	99%	99%	99%

ED Utilization

	Mar 24	Apr 24	May 24
# ED Visits / 1000	40.59	38.50	37.30

Inpatient Utilization

	Mar 24	Apr 24	May 24
Days Per 1000	316.1	292.2	274.9
Admits Per 1000	51.9	50.5	53.7
Average Length of Stay	6.1	5.8	5.1

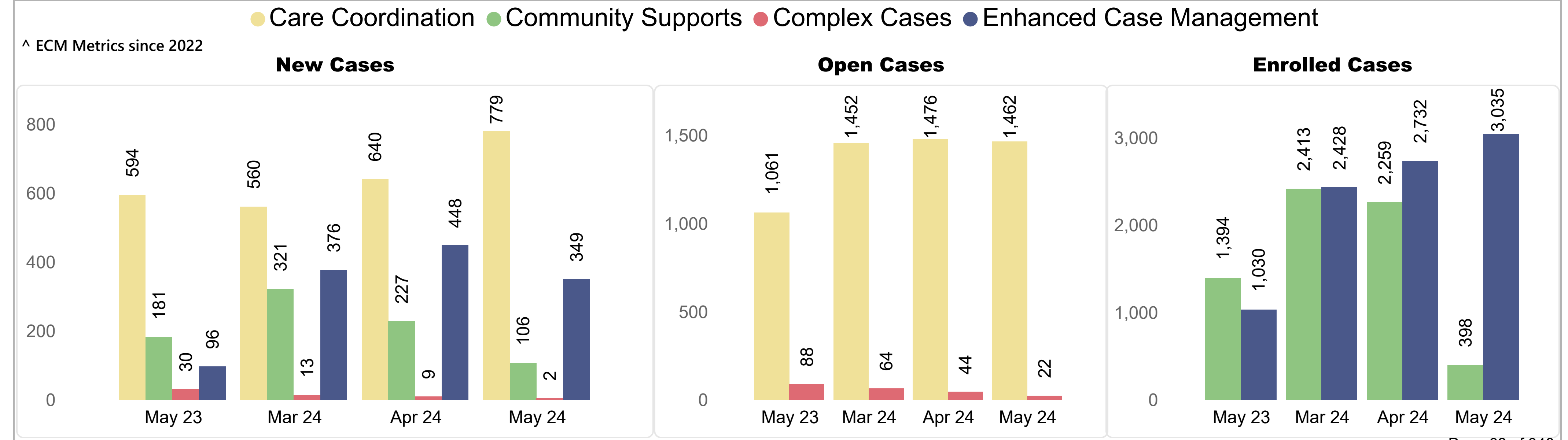
Case Management

Total Cases^

^ ECM Metrics since 2022

	May 23	Mar 24	Apr 24	May 24
New	901	1,270	1,324	1,236
Open	1,149	1,516	1,520	1,484
Enrolled	2,424	4,841	4,991	3,433
Total Open & Enrolled	3,573	6,357	6,511	4,917

Case Management^



Technology (Business Availability)

Applications	Jun 23	Apr 24	May 24	Jun 24
HEALTHsuite System	98.1%	97.8%	100.0%	100.0%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	98.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

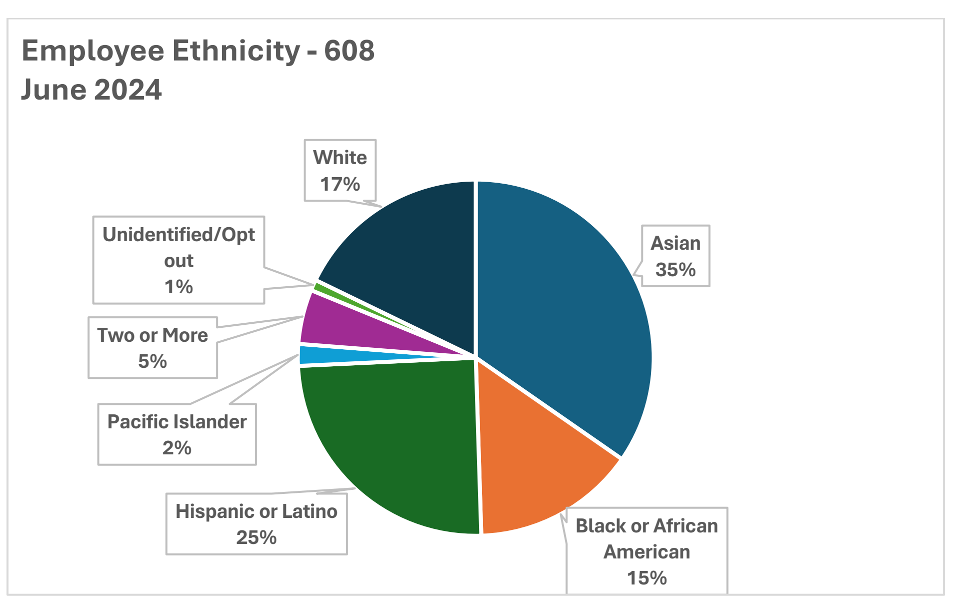
OP Authorization Denial Rates	Jun 23	Apr 24	May 24	Jun 24
Denial Rate Excluding Partial Denials (%)	3.7%	2.8%	2.9%	2.3%
Overall Denial Rate (%)	3.9%	3.0%	3.0%	2.5%
Partial Denial Rate (%)	0.3%	0.2%	0.2%	0.2%

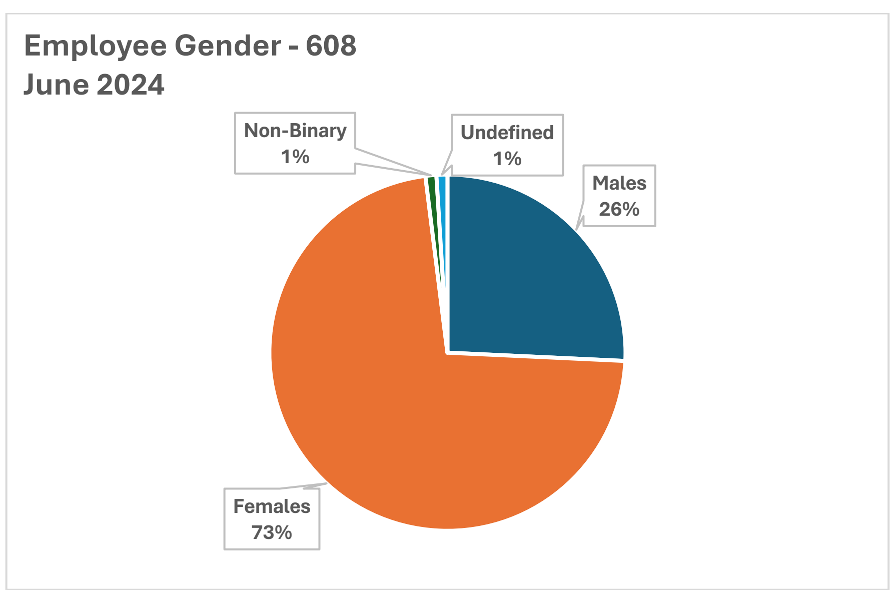
*** IHSS and Medi-Cal Line Of Business**

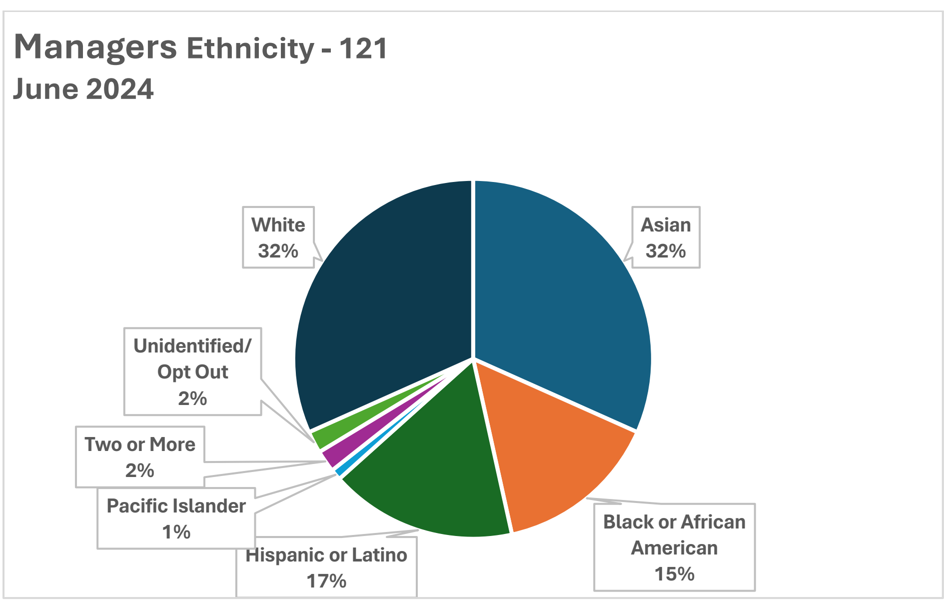
Pharmacy Authorizations

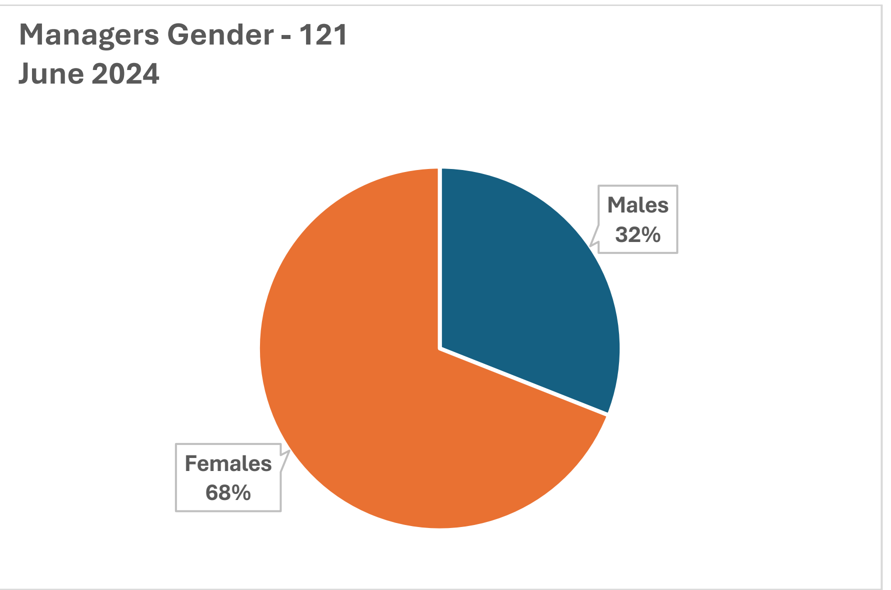
Authorizations	Jun 23	Apr 24	May 24	Jun 24
Approved Prior Authorizations	38	35	39	36
Closed Prior Authorizations	95	76	92	95
Denied Prior Authorizations	50	43	48	55
Total Prior Authorizations	183	154	179	186

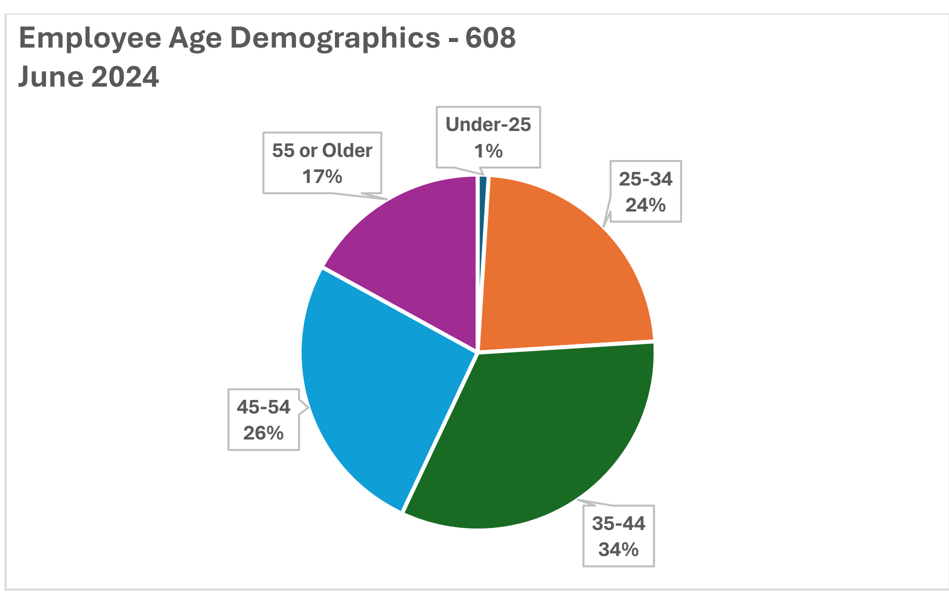
AAH Employee Demographics Data Report June 2024











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

Legislative Tracking

2024 Legislative Tracking List

Late last month, the California State Legislature passed a final 2024-25 state budget and on June 29th, Governor Newsom approved the budget. While the budget process is complete, the legislature has continued to discuss bills during committee hearings before reaching the policy committee deadlines and in advance of summer recess which began July 4th. The legislature will return from recess on August 5th, and they will have until August 31st before the legislative session ends.

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

AB 4 (**Arambula** D) **Covered California: expansion.**
Current Text: Amended: 7/13/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. on 7/13/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

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

AB 47 (**Boerner** D) **Pelvic floor physical therapy coverage.**
Current Text: Introduced: 12/5/2022 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

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

AB 55 (**Rodriguez** D) **Medi-Cal: workforce adjustment for ground ambulance transports.**
Current Text: Amended: 4/27/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

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

AB 236 (**Holden** D) **Health care coverage: provider directories.**
Current Text: Amended: 6/27/2024 html pdf
Status: 6/27/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/26/2024-S. APPR.

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

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

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

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

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

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

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

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

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

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

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

AB 551 (**Bennett** D) **Public Utilities Commission.**
Current Text: Amended: 7/3/2024 html pdf
Status: 7/3/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 7/2/2024-S. APPR.

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

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

AB 564 (**Villapudua** D) **Medi-Cal: claim or remittance forms: signature.**
Current Text: Amended: 4/5/2023 html pdf

Status: 7/2/2024-Failed Deadline pursuant to Rule 61(b)(13). (Last location was HEALTH on 6/14/2023)
Location: 7/2/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Dead	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: physician and provider credentials.**
Current Text: Amended: 7/3/2024 html pdf
Status: 7/3/2024-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 9. Noes 1.) (July 3). Read second time and amended. Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

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

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

Current Text: Introduced: 2/15/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

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

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

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

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

AB 1092 **(Wood D) Health care service plans: consolidation.**
Current Text: Amended: 6/28/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

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

AB 1110 (**Arambula** D) **Public health: adverse childhood experiences.**
Current Text: Amended: 7/10/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

Summary: Would, subject to an appropriation and until January 1, 2027, require the office and the State Department of Health Care Services, while administering the ACEs Aware initiative and in collaboration with subject matter experts, to review available literature on ACEs, as defined, and ancestry or ethnicity-based data disaggregation practices in ACEs screenings, develop guidance for culturally and linguistically competent ACEs screenings through improved data collection methods, post the guidance on the department's internet website and the ACEs Aware internet website, and make the guidance accessible, as specified.

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

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

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

AB 1157 (**Ortega** D) **Rehabilitative and habilitative services: durable medical equipment and services.**
Current Text: Amended: 7/13/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

Summary: Current law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under existing law, essential health benefits includes, among other things, rehabilitative and habilitative services. Current law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define "durable medical equipment" to mean

devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.

AB 1282 **(Lowenthal D) Mental health: impacts of social media.**
Current Text: Amended: 9/1/2023 html pdf
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/11/2023)(May be acted upon Jan 2024)
Location: 9/14/2023-S. 2 YEAR

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

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

AB 1313 **(Ortega D) Older individuals: case management services.**
Current Text: Amended: 4/27/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 7/3/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-S. 2 YEAR

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

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

AB 1316 **(Irwin D) Emergency services: psychiatric emergency medical conditions.**
Current Text: Amended: 6/17/2024 html pdf
Status: 6/25/2024-Read second time. Ordered to third reading.
Location: 6/25/2024-S. THIRD READING

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

Summary: The Lanterman-Petris-Short Act provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled, as defined. The Medi-Cal program is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Pursuant to a schedule

of covered benefits, current law requires Medi-Cal coverage for inpatient hospital services, subject to utilization controls, and with respect to fee-for service beneficiaries, coverage for emergency services and care necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition, as specified. Current law provides for the licensing and regulation of health facilities by the State Department of Public Health and makes a violation of those provisions a crime. Current law defines "psychiatric emergency medical condition," for purposes of providing treatment for emergency conditions, as a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either an immediate danger to the patient or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Current law includes various circumstances under which a patient is required to be treated by, or may be transferred to, specified health facilities for treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition. This bill would revise the definition of "psychiatric emergency medical condition" to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment, under prescribed circumstances. The bill would make conforming changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local program.

AB 1338 **(Petrie-Norris D) Medi-Cal: community supports.**
Current Text: Amended: 4/20/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

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

AB 1359 **(Papan D) California Environmental Quality Act: geothermal exploratory projects: lead agency.**
Current Text: Amended: 6/20/2024 html pdf
Status: 7/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 7. Noes 0.) (July 3). Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

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

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

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

Summary: Current law requires the Medical Board of California, in determining its continuing education requirements,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AB 1895 (**Weber** D) **Public health: maternity ward closures.**
Current Text: Amended: 6/24/2024 html pdf
Status: 7/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 2.) (July 3). Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

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

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. 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: 6/6/2024 html pdf
Status: 6/17/2024-In committee: Referred to suspense file.
Location: 6/17/2024-S. APPR. SUSPENSE FILE

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

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

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

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

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

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires the State Department of Health Care Services to establish the Medically Tailored Meals Pilot Program and the Short-Term Medically Tailored Meals Intervention Services Program, to operate in specified counties and during limited periods for the purpose of providing medically tailored meal intervention services to eligible Medi-Cal beneficiaries with certain health conditions, including congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease. Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under current law, community supports that the department is authorized to approve include, among other things, medically supportive food and nutrition services, including medically tailored meals. This bill would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, through both the fee-for-service and managed care delivery systems, no sooner than July 1, 2026, upon appropriation and subject to federal approval and the issuance of final guidance by the department. The bill would require those interventions to be covered if determined to be medically necessary by a health care provider or health care plan, as specified. The bill would require the provision of interventions for 12 weeks, or longer if deemed medically necessary. The bill would require a Medi-Cal managed care plan to offer at least 3 of 6 listed interventions, with certain conditions for a 7th intervention.

AB 1977 **(Ta R) Health care coverage: behavioral diagnoses.**
Current Text: Amended: 6/24/2024 html pdf
Status: 6/25/2024-Read second time. Ordered to third reading.
Location: 6/25/2024-S. THIRD READING

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from requiring an enrollee or insured previously diagnosed with pervasive developmental

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

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

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

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

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

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

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

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

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

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

AB 2105 (**Lowenthal** D) **Coverage for PANDAS and PANS.**
Current Text: Amended: 6/17/2024 html pdf
Status: 6/25/2024-Read second time. Ordered to third reading.
Location: 6/25/2024-S. THIRD READING

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

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

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

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

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

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

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

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

AB 2129 (**Petrie-Norris** D) **Immediate postpartum contraception.**
Current Text: Amended: 7/3/2024 html pdf
Status: 7/2/2024-Failed Deadline pursuant to Rule 61(b)(13). (Last location was SECOND READING on 7/3/2024)
Location: 7/2/2024-A. DEAD

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

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

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

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require a patient who is 18 years of age or older receiving health care services in a facility, clinic, center, office, or other setting, where primary care services are provided, to be offered the tuberculosis (TB) risk assessment and TB screening test, if TB risk factors are identified, to the extent these services are covered under the patient's health care coverage, except as specified. The bill would also require the health care provider to offer the patient followup health care or refer the patient to a health care provider who can provide followup health care if a screening test is positive. The bill would prohibit a health care provider that fails to comply with these provisions from being subject to any disciplinary action related to their licensure or certification, or to any civil or criminal liability, for that failure. The bill would require the State Department of Public Health to work with stakeholders to implement these provisions, and to notify primary care facilities about these provisions. The bill would make related findings and declarations.

AB 2169 (**Bauer-Kahan** D) **Prescription drug coverage: dose adjustments.**
Current Text: Amended: 3/21/2024 html pdf

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

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

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

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

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

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

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

Summary: Current law requires health care service plans and health insurers to establish and maintain specified application programming interfaces (API), including patient access API, for the benefit of enrollees, insureds, and contracted providers. This bill would, except for Medi-Cal dental managed care contracts, exclude a specialized plan or insurer that issues, sells, renews, or offers a contract or policy covering dental or vision services from the above-described API requirements, and would instead require a specialized plan or insurer that issues, sells, renews, or offers a

contract or policy covering dental or vision services and meets specified enrollment requirements to comply with the above-described API requirements beginning January 1, 2027, or when the final federal rules for impacted payers are implemented, whichever is later.

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

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

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

AB 2237 (Aguiar-Curry D) **Children and youth: transfer of specialty mental health services.**
Current Text: Amended: 6/26/2024 html pdf
Status: 6/26/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/25/2024-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age. This bill would require, when a child or youth 21 years of age or younger who is receiving Medi-Cal specialty mental health services changes residence from one county to another, the receiving county to provide specialty mental health services to the child or youth, if the transfer of those services from one county to another is not otherwise governed by a process established in statute. The bill also would require the State Department of Health Care Services to collect specified data related to the receipt of specialty mental health services by children and youth who move outside of the county where they originally received specialty mental health services, and to include the data in the department's Medi-Cal specialty mental health services performance dashboard. The bill would require the department to issue guidance, as specified, to define the requirements on a receiving county for the continued provision of specialty mental health services, to coordinate and expedite the transfer of services from one county to another, and reduce the burden on children and youth and their caregivers to reestablish services in the receiving county. The bill would authorize the department to implement, interpret, or make specific its provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until regulations are adopted, as specified.

AB 2246 (Ramos D) **Medical Practice Act: health care providers: qualified autism service paraprofessionals.**
Current Text: Amended: 3/18/2024 html pdf
Status: 6/27/2024-In committee: Hearing postponed by committee.
Location: 6/17/2024-S. APPR.

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

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

AB 2250 **(Weber D) Social determinants of health: screening and outreach.**
Current Text: Amended: 6/6/2024 html pdf
Status: 6/17/2024-In committee: Referred to suspense file.
Location: 6/17/2024-S. APPR. SUSPENSE FILE

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

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

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

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

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

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

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

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

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

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

AB 2319 (**Wilson** D) **California Dignity in Pregnancy and Childbirth Act.**
Current Text: Amended: 6/27/2024 html pdf
Status: 7/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 1.) (July 2). Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires the State Department of Public Health to maintain a program of maternal and child health, which may include, among other things, facilitating services directed toward reducing infant mortality and improving the health of mothers and children. Current law requires the Office of Health Equity within the department to serve as a resource for ensuring that programs collect and keep data and information regarding ethnic and racial health statistics, and strategies and programs that address multicultural health issues, including, but not limited to, infant and maternal mortality. Existing law makes legislative findings relating to implicit bias and racial disparities in maternal mortality rates. Current law requires a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an evidence-based implicit bias program, as specified, for all health care providers involved in perinatal care of patients within those facilities. Current law requires the health care provider to complete initial basic training through the program and a refresher course every 2 years thereafter, or on a more frequent basis if deemed necessary by the facility. Current law requires the facility to provide a

certificate of training completion upon request, to accept certificates of completion from other facilities, and to offer training to physicians not directly employed by the facility. Current law requires the department to track and publish data on pregnancy-related death and severe maternal morbidity, as specified. This bill would make a legislative finding that the Legislature recognizes all birthing people, including nonbinary persons and persons of transgender experience. The bill would extend the evidence-based implicit bias training requirements to specified health care providers at hospitals that provide perinatal care, alternative birth centers, or primary care clinics, as specified. The bill would require an implicit bias program to include recognition of intersecting identities and the potential associated biases. The bill would require initial basic training for the implicit bias program to be completed by June 1, 2025, for current health care providers, and within 6 months of their start date for new health care providers, unless exempted.

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

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

AB 2339 (Aguiar-Curry D) **Medi-Cal: telehealth.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 7/2/2024-Read second time. Ordered to third reading.
Location: 7/2/2024-S. THIRD READING

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

AB 2340 (Bonta D) **Medi-Cal: EPSDT services: informational materials.**
Current Text: Amended: 4/4/2024 html pdf
Status: 6/25/2024-Read second time. Ordered to third reading.
Location: 6/25/2024-S. THIRD READING

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

AB 2342 (**Lowenthal** D) **Medi-Cal: critical access hospitals: islands.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 4/25/2024-Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/26/2024)
Location: 4/25/2024-A. DEAD

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

AB 2352 (**Irwin** D) **Mental health and psychiatric advance directives.**
Current Text: Amended: 4/25/2024 html pdf
Status: 7/2/2024-Failed Deadline pursuant to Rule 61(b)(13). (Last location was JUD. on 5/29/2024)
Location: 7/2/2024-S. DEAD

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

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

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

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

AB 2376 **(Bains D) Chemical dependency recovery hospitals.**
Current Text: Amended: 7/3/2024 html pdf
Status: 7/3/2024-From committee: Amend, and do pass as amended and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 11. Noes 0.) (July 3). Read second time and amended. Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

freestanding chemical dependency recovery hospital.

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

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law establishes a schedule of covered benefits under the Medi-Cal program, including incontinence supplies.This bill would add to the schedule of Medi-Cal benefits diapers for infants or toddlers with certain conditions, such as a urinary tract infection and diseases of the skin. The bill would establish diapers as a covered benefit for a child greater than 3 years of age who has been diagnosed with a condition that contributes to incontinence and would establish diapers as a covered benefit for individuals under 21 years of age, if necessary to correct or ameliorate a condition pursuant to specified standards. The bill would limit the diapers provided pursuant to these provisions to an appropriate supply based on the diagnosed condition and the age of the beneficiary. The bill would require the department to seek any necessary federal approval to implement this section.

AB 2449 **(Ta R) Health care coverage: qualified autism service providers.**
Current Text: Amended: 6/3/2024 html pdf
Status: 6/17/2024-In committee: Referred to suspense file.
Location: 6/17/2024-S. APPR. SUSPENSE FILE

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

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

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

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

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

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

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

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

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

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

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

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

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

AB 2699 **(Carrillo, Wendy D) Hazardous materials: reporting: civil liability.**
Current Text: Amended: 4/1/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

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

AB 2701 (**Villapudua** D) **Medi-Cal: dental cleanings and examinations.**
Current Text: Amended: 6/17/2024 html pdf
Status: 6/24/2024-In committee: Referred to suspense file.
Location: 6/24/2024-S. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, one dental prophylaxis cleaning per year and one initial dental examination by a dentist are covered Medi-Cal benefits for beneficiaries 21 years of age or older. Under existing law, 2 dental prophylaxis cleanings per year and 2 periodic dental examinations per year are covered Medi-Cal benefits for beneficiaries under 21 years of age. Current law conditions implementation of those provisions on receipt of any necessary federal approvals, the availability of federal financial participation, and, for beneficiaries 21 years of age or older, funding in the annual Budget Act. This bill would expand the above-described dental benefits, for beneficiaries 21 years of age or older, to at least 2 cleanings and at least 2 examinations per year when medically necessary, as specified in the Medi-Cal Dental Manual of Criteria. The bill would, for purposes of these provisions, include an individual's inability to maintain daily oral hygiene habits, susceptibility to oral health disease or decay, preoperative dental care, or as required by other specified provisions of law, in the definition of "medically necessary," and require the department to update the Medi-Cal Dental Manual of Criteria to conform with this inclusion.

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

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

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

AB 2726 **(Flora R) Specialty care networks: telehealth and other virtual services.**
Current Text: Amended: 4/25/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

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

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

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

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

Summary: Current law requires a victim of sexual assault who seeks a medical evidentiary examination to be provided with one, as specified. Current law prohibits costs incurred by a qualified health care professional, hospital, clinic, sexual assault forensic examination team, or other emergency medical facility for the medical evidentiary examination portion of the examination of the victim of a sexual assault, as described in a specified protocol, when the examination is performed as specified, from being charged directly or indirectly to the victim of the assault. This bill would require a health care service plan or health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2025, to provide coverage without cost sharing for emergency room medical care and followup health care treatment for an enrollee or insured who is treated following a rape or sexual assault. The bill would prohibit a health care service plan or health insurer from requiring, as a condition of providing coverage, (1) an enrollee or insured to file a police report,

(2) charges to be brought against an assailant, (3) or an assailant to be convicted of rape or sexual assault. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2914 **(Bonta D) Health care coverage: essential health benefits.**
Current Text: Amended: 4/10/2024 html pdf
Status: 7/3/2024-From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 11. Noes 0.) (July 3). Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

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

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

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

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

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

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

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

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

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

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

AB 3030 **(Calderon D) Health care services: artificial intelligence.**
Current Text: Amended: 6/27/2024 html pdf
Status: 6/27/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/26/2024-S. APPR.

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

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

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

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

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

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

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

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

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

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

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

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

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

AB 3156 (**Patterson, Joe** R) **Medi-Cal managed care plans: regional center services: beneficiaries with other primary coverage.**
Current Text: Amended: 7/3/2024 html pdf
Status: 7/3/2024-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (July 3). Read second time and amended. Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current federal law, in accordance with third-party liability rules, Medicaid is generally the payer of last resort if a beneficiary has another source of health care coverage in addition to Medicaid coverage. Under the bill, in the case of a Medi-Cal managed care plan enrollee who has other health coverage, as specified, the department would be required to ensure that a provider billing the managed care plan for allowable costs not paid by the other health care coverage does not face administrative requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

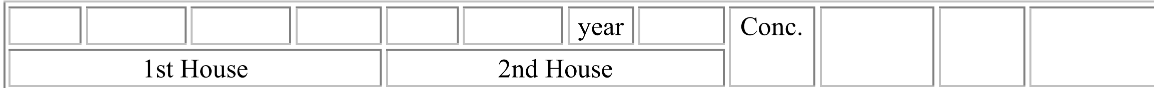
SB 136 **(Committee on Budget and Fiscal Review) Medi-Cal: managed care organization provider tax.**
Current Text: Chaptered: 3/25/2024 html pdf
Status: 3/25/2024-Chaptered by Secretary of State - Chapter 6, Statutes of 2024
Location: 3/25/2024-S. CHAPTERED

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

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

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

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



						year		Conc.			
1st House				2nd House							

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

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

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

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

SB 294 (**Wiener** D) **Health care coverage: independent medical review.**
Current Text: Amended: 5/24/2024 html pdf
Status: 7/2/2024-July 2 set for first hearing. Placed on suspense file.
Location: 7/2/2024-A. APPR. SUSPENSE FILE

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

Summary: The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Current law provides for the regulation of disability insurers by the Department of Insurance. Current law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a

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

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

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

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

SB 339 **(Wiener D) HIV preexposure prophylaxis and postexposure prophylaxis.**
Current Text: Chaptered: 2/6/2024 html pdf
Status: 2/6/2024-Chaptered by Secretary of State - Chapter 1, Statutes of 2024
Location: 2/6/2024-S. CHAPTERED

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

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

SB 363 **(Eggman D) Facilities for inpatient and residential mental health and substance use disorder: database.**
Current Text: Amended: 5/18/2023 html pdf
Status: 9/1/2023-September 1 hearing: Held in committee and under submission.

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

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

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

SB 424 (**Durazo** D) **The Broadband Infrastructure Grant Account and Federal Funding Account.**
Current Text: Amended: 7/2/2024 html pdf
Status: 7/2/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/26/2024-A. APPR.

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

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

SB 427 (**Portantino** D) **Health care coverage: antiretroviral drugs, drug devices, and drug products.**
Current Text: Amended: 4/4/2024 html pdf
Status: 7/2/2024-Failed Deadline pursuant to Rule 61(b)(13). (Last location was DESK on 5/13/2024)
Location: 7/2/2024-A. DEAD

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

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

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

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

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

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

SB 729 (**Menjivar** D) **Health care coverage: treatment for infertility and fertility services.**
Current Text: Amended: 8/14/2023 html pdf
Status: 9/1/2023-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: 7/3/2024 html pdf
Status: 7/3/2024-From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 10. Noes 0.) (July 2). Read second time and amended. Re-referred to Com. on APPR.
Location: 7/2/2024-A. APPR.

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

Summary: The Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), a violation of which is a crime, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. The Knox-Keene Act requires a pharmacy benefit manager under contract with a health care service plan to, among other things, register with the Department of Managed Health Care. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would additionally require a pharmacy benefit manager, as defined, to apply for and obtain a license from the Department of Insurance to operate as a pharmacy benefit manager no later than January 1, 2027. The bill would establish application qualifications and requirements, and would require initial license and renewal fees to be collected into the newly created Pharmacy Benefit Manager Account in the Insurance Fund, to be available to the department for use, upon appropriation by the Legislature, as specified, for costs related to licensing and regulating pharmacy benefit managers. This bill would require a pharmacy benefit manager to file with the department at specified annual intervals 2 reports, one of which discloses product benefits specific to the purchaser, and the other of

which includes information about categories of drugs and the pharmacy benefit manager's contracts and revenues.

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

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

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

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

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

Summary: Would require a health care service plan and a disability insurer, and an entity acting on a plan's or insurer's behalf, to ensure compliance with specific requirements for utilization review, including maintaining telephone access and other direct communication access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conducting peer-to-peer discussions regarding specific patient issues related to treatment. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

SB 1008 (**Bradford** D) **Obesity Treatment Parity Act.**
Current Text: Amended: 4/29/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/6/2024)
Location: 5/16/2024-S. DEAD

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

Summary: Would require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include specified coverage for the treatment of obesity, including coverage for at least one FDA-approved antiobesity medication.

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

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

Summary: Current law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. This bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a solution to collect, aggregate, and display information about beds in specified types of facilities, including licensed community care facilities and licensed residential alcoholism or drug abuse recovery or treatment facilities, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the solution to be operational by January 1, 2026, or the date the State Department of Health Care Services communicates to the Department of Finance in writing that the solution has been implemented to meet these provisions, whichever date is later.

SB 1112 **(Menjivar D) Medi-Cal: families with subsidized childcare.**
Current Text: Amended: 5/16/2024 html pdf
Status: 6/26/2024-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 6. Noes 0.) (June 25). Re-referred to Com. on APPR.
Location: 6/25/2024-A. APPR.

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

Summary: Current law establishes a system of childcare and development services, administered by the State Department of Social Services, for children from infancy to 13 years of age. Existing law authorizes, upon departmental approval, the use of appropriated funds for alternative payment programs to allow for maximum parental choice. Current law authorizes those programs to include, among other things, a subsidy that follows the family from one childcare provider to another, or choices among hours of service. Current law requires the department to contract with local contracting agencies for alternative payment programs so that services are provided throughout the state. Under existing law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered Medi-Cal benefits for individuals under 21 years of age. This bill, subject to any necessary federal approvals and the availability of federal funding, would require the State Department of Health Care Services and the State Department of Social Services to develop a model memorandum of understanding (MOU), and would require the department to authorize Medi-Cal managed care plans and alternative payment agencies to enter an MOU that includes, at a minimum, the provisions included in the model.

SB 1120 **(Becker D) Health care coverage: utilization review.**
Current Text: Amended: 6/20/2024 html pdf
Status: 7/2/2024-VOTE: Do pass as amended, and be re-referred to the Committee on [Appropriations] with recommendation: To Consent Calendar (PASS)
Location: 7/2/2024-A. APPR.

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

Summary: Current law provides for the regulation of disability insurers by the Department of Insurance. Current law generally authorizes a health care service plan or disability insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law requires a health care service plan or disability insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Current law authorizes the Director of the Department of Managed Health Care or the Insurance Commissioner to assess an administrative penalty to a health care service plan or disability insurer, as applicable, for failure to comply with those requirements. This bill would require algorithms, artificial intelligence, and other software tools used for utilization review or utilization management decisions of a health care service plan,

including a specialized health care service plan covering dental services, or disability insurer to comply with specified requirements, including that they be fairly and equitably applied.

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

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

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

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

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

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

SB 1213 **(Atkins D) Health care programs: cancer.**
Current Text: Amended: 4/8/2024 html pdf
Status: 6/5/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (June 4). Re-referred to Com. on APPR.
Location: 6/4/2024-A. APPR.

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

Summary: Current law requires the State Department of Health Care Services to perform various health functions, including providing breast and cervical cancer screening and treatment for low-income individuals. Current law provides that an individual is eligible to receive treatment services if, among other things, the individual has a family income at or below 200% of the federal poverty level as determined by the provider performing the screening and diagnosis. This bill

would provide that an individual is eligible to receive treatment services if the individual has a family income at or below 300% of the federal poverty level as determined by the provider performing the screening and diagnosis.

SB 1236 **(Blakespear D) Medicare supplement coverage: open enrollment periods.**
Current Text: Amended: 4/29/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/13/2024)
Location: 5/16/2024-S. DEAD

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

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

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

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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: 5/2/2024-Failed Deadline pursuant to Rule 61(b)(6). (Last location was HEALTH on 2/29/2024)
Location: 5/2/2024-S. DEAD

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

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

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

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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: 6/20/2024 html pdf
Status: 7/3/2024-Read second time. Ordered to third reading.
Location: 7/3/2024-A. THIRD READING

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

Summary: Current law requires the State Department of Public Health to license, regulate, and inspect health facilities, as specified, including general acute care hospitals. A violation of these provisions is a crime. Under current law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia,

laboratory, radiology, pharmacy, and dietary services. Current law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Current regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. Current law requires a health facility to provide 90 days of public notice of the proposed closure or elimination of a supplemental service, and 120 days of public notice of the proposed closure or elimination of an acute psychiatric hospital. This bill would change the notice period required before proposed closure or elimination of the supplemental service of inpatient psychiatric service or maternity service from 90 days to 120 days. By changing the definition of a crime, this bill would impose a state-mandated local program.

SB 1320 **(Wahab D) Mental health and substance use disorder treatment.**
Current Text: Enrollment: 7/2/2024 html pdf
Status: 7/2/2024-Enrolled and presented to the Governor at 3 p.m.
Location: 7/2/2024-S. ENROLLED

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

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

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

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

(June 25). Re-referred to Com. on APPR.
Location: 6/25/2024-A. APPR.

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

Summary: Current law prohibits a long-term health care facility that participates as a provider under the Medi-Cal program from discriminating against a Medi-Cal patient on the basis of the source of payment for the facility's services that are required to be provided to individuals entitled to services under the Medi-Cal program. Current law prohibits that facility from seeking to evict out of the facility, or transfer within the facility, any resident as a result of the resident changing their manner of purchasing the services from private payment or Medicare to Medi-Cal, except as specified. This bill would require the facility to provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source.

SB 1355 (Wahab D) **Medi-Cal: in-home supportive services: redetermination.**
Current Text: Amended: 4/25/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/6/2024)
Location: 5/16/2024-S. DEAD

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

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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: Rural Hospital Technical Advisory Group.**
Current Text: Amended: 6/27/2024 html pdf
Status: 6/27/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/25/2024-A. APPR.

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

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

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

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

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

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

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

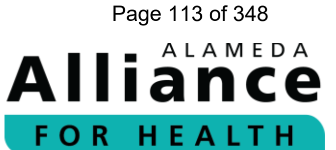
Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Current law sets forth requirements for private duty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

Board Business

UIS Immigration Status Highlights

Presented to the Alameda Alliance Board of Governors

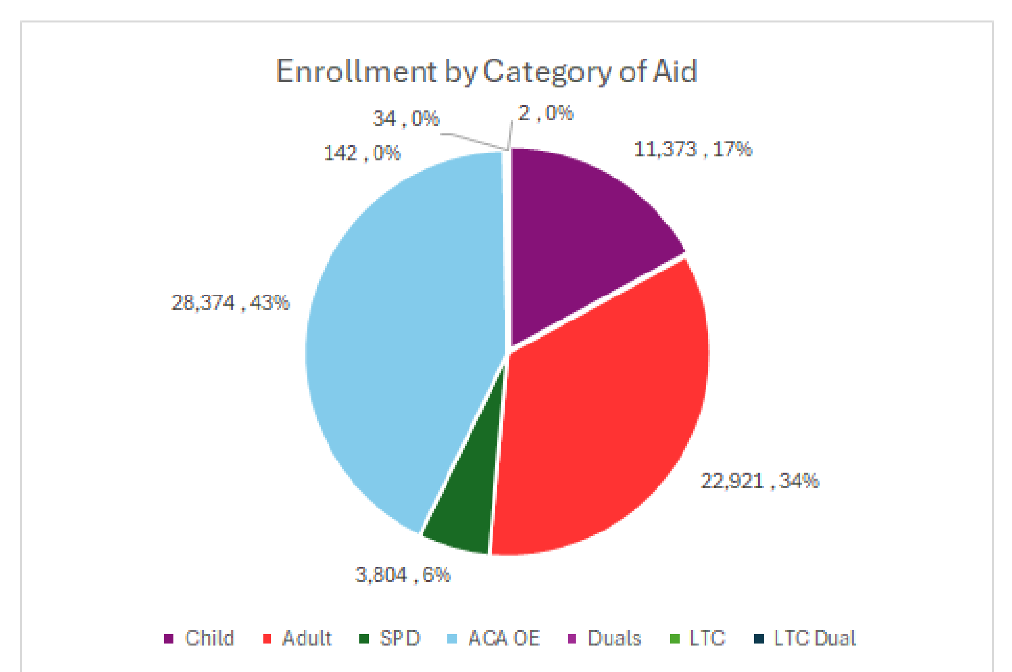
July 12th, 2024

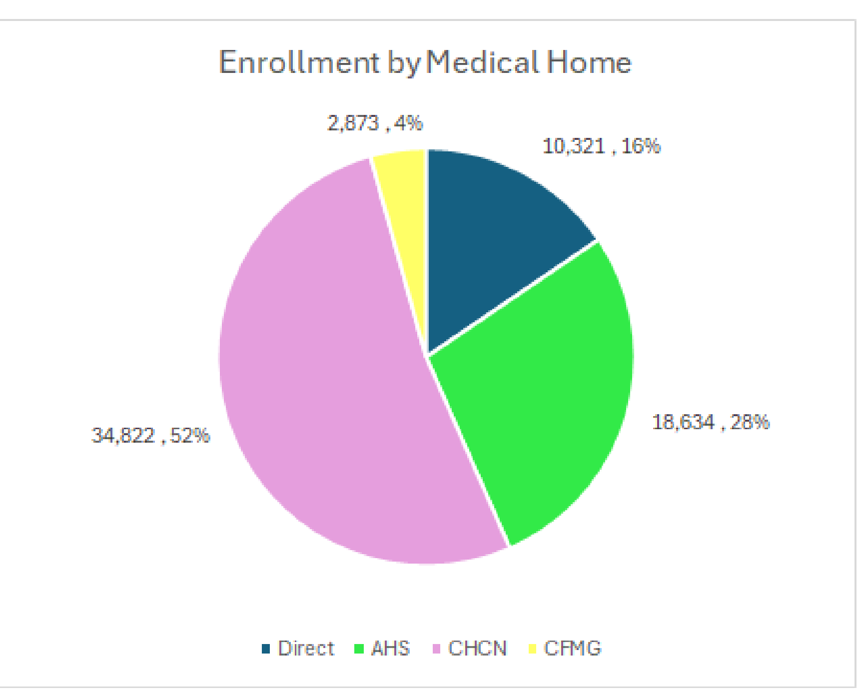


UIS Immigration Status Highlights

- As of May 2024, Alliance had 67,000 undocumented members with unsatisfactory immigration status.
- January 2024 saw a net increase of 30,000 in UIS membership in. This was due to new populations, partially offset by Kaiser members leaving the Plan.
- UIS members represented 17% of Alliance members.
- 36% of Adult members are undocumented; 19% of ACA OE members are undocumented. Of the remaining populations, 9% are undocumented.
- In the first quarter of CY 2024, the Child, ACA OE, Duals, LTC and LTC Dual populations had MLRs above the target Medical Loss Ratio of 90-95%.

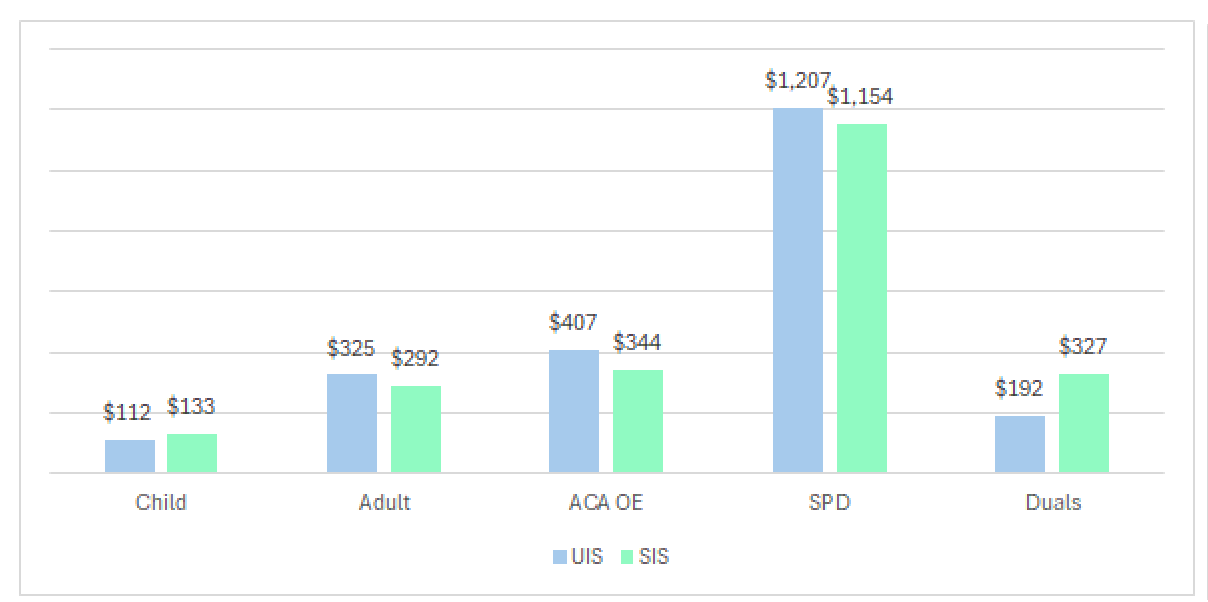
UIS Enrollment - May 2024

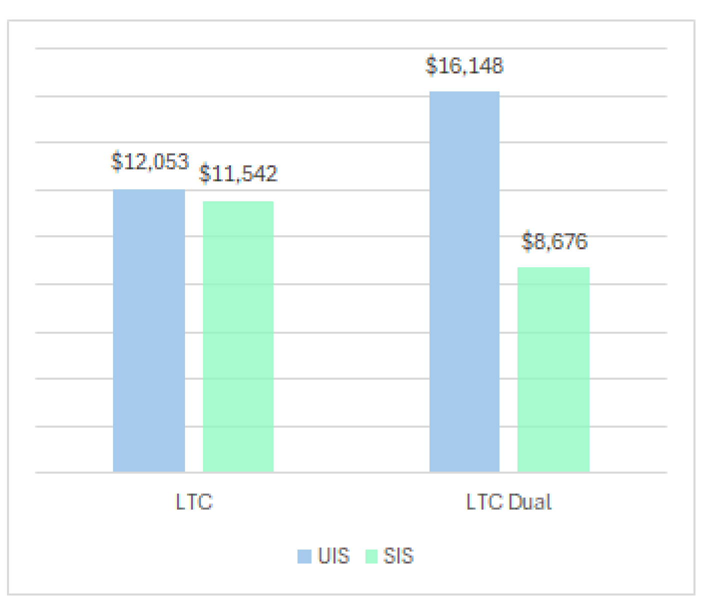




- UIS members represented 17% of Alliance members.
- The majority of UIS members are delegated to CHCN.

UIS/SIS PMPM Base Revenue Comparison





- The Alliance receives more revenue per-member-per-month for UIS Adult, SPD, ACA OE, LTC and LTC Dual members than for SIS members in the same category of aid.
- The Alliance receives more revenue PMPM for SIS Child and Dual members than for UIS members.

Targeted Rate Increase Update

Background:

The California Department of Health Care Services (DHCS) aims to improve access, quality, and equity in Medi-Cal services.

Assembly Bill (AB) 119 authorized a Managed Care Organization (MCO) Provider Tax, effective April 1, 2023, through December 31, 2026.

MCO tax revenues support the Medi-Cal program, including targeted provider rate increases and other investments.

Targeted Rate Increases (TRI):

DHCS is implementing ongoing targeted provider rate increases for primary care, obstetric and doula, and non-specialty mental health services effective for dates of service on or after January 1, 2024.

Rates are set at no less than 87.5% of the lowest 2023 Medicare locality rate in California, inclusive of eliminating AB 97 provider payment reductions and incorporating Proposition 56 supplemental physician payments.

DHCS has released a CY24 Fee Schedule listing over 700 Primary/General care codes to be reimbursed at an increased rate from the prevailing Medi-Cal Fee Schedule.

DHCS requires plans to attest capitated payments are sufficient for capitated networks to meet the applicable requirements of TRI.

2024 and beyond:

DHCS proposed additional targeted increases effective in 2025, these increases may be impacted by the recently passed state budget. We are evaluating the budget to determine if the additional increases will happen next year.

The Alliance has evaluated the proposed CY24 Fee Schedule compared to current AAH contracted provider rates. The majority of Fee-for-Service contracts meet or exceed the new fee schedule amounts.

Existing capitation contracts have been reviewed and assessed for adequacy with TRI requirements. Current rates appear to be sufficient but may change as capitation contracts are negotiated.

Plans are required to retroactively reimburse providers any increases to appropriately coded provider claims back to January 2024.

Next Steps:

On June 20, 2024, DHCS finalized a TRI All Plan Letter (APL) for managed care plans to use as the basis for the changes.

The Alliance has developed a project plan and is working to keep provider groups informed of updated DHCS deadlines.

Revised guidance changes full compliance dates from July 2024 to December 2024.

Any updates to Alliance TRI Policies and Procedures need to be effectuated 90 days from the date of the finalized APL.

Trilogy Documents: Healthcare Services Dept

Donna White Carey, MD, MS

Interim Chief Medical Officer

7/12/24

"

The goal of the HCS Department is to ensure members receive the right service, in the right place, at the right time.

The purpose of the Alliance QIHE Program is to objectively monitor and evaluate the quality, safety, appropriateness, health equity, and outcome of care and services delivered to members of the Alliance.

Quality Program

- Quality Improvement Health Equity Committee (QIHEC)
    - → Access and Availability Committee (AASS)
    - → Cultural and Linguistic Committee (CLSS)
    - → Utilization Management Committee (UMC)
    - → Internal Quality Improvement Committee (IQIC)
    - → Peer Review and Credentialing Committee (PRCC)
    - → Community Advisory Committee (CAC)
    - → Population Health Management Committee
- Population Health Program
- Joint Operations Meetings/Delegate
- Disease Management Program

Quality Program-cont'd

- Quality Measures
  - Healthcare Effectiveness Data Information Set (HEDIS)
  - Consumer Assessment of Health Plan Survey (CAHPS & CG-CAHPS)
  - DHCS non-HEDIS measures
  - DHCS QI projects
  - Managed Care Accountability Sets (MCAS)

Quality Evaluation -2023

- HEDIS (3 below MPL)
- DHCS QI projects
- IHA rates
- Women's Health
- Non-utilizer outreach
- CG-CAHPS

Quality Work plan 2024

- HEDIS/MCAS
  - Meet MPL in all measures
- DHCS QI projects
  - FUM
  - WCC visits for AA children 0-15 months – bring to MPL
- IHA rates
  - Increase by 3%
- Non-utilizer outreach
  - Increase member outreach by 20%

Case Management Society of America (CMSA) defines CM:

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

Case Management Program

- Enhanced Case Management/Community Supports
- Complex Case Management
- Basic Population Health Management
- Care Coordination
- Targeted Case Management
- Transitional Care Services
- Specialized Services
- Behavioral Health
- Long Term Support Services

CM Evaluation - 2023

- Health Risk Assessment (HRA)
- Health Information Forms/Member Evaluation Tools (HIF/MET)
- Care Coordination
- Complex Case Management (CCM)
- Enhanced Case Management (ECM)
- Community Supports (CS)

CM Workplan - 2024

- Community Supports to LTC
- HIF/MET
  - >90% timely completion
- CCM
  - Establish baseline; increase enrollment
- ECM
  - Establish baseline; increase enrollment
- BH
  - 5% increase in cases

The goals of Utilization Management:

- Medically necessary
- Appropriate care or service
- Within covered benefit
- Continuity of care for medical and behavioral health services

Utilization Management (UM) Program

- Inpatient and Outpatient
- Review Types
- Long Term Support Services
  - CBAS
- Behavioral Health
- Special Programs
  - Transplant
  - Palliative Care
  - California Children Services

UM Evaluation - 2023

- Authorization volume
- Denial rates
- Turn-around time
- Re-admissions

UM Work plan - 2024

- Decrease services requiring prior authorization
- Increase staffing
- Expand ADT
- Delegate oversight

Thanks!

Questions?

You can contact me at:

dcarey@alamedaalliance.org

Finance

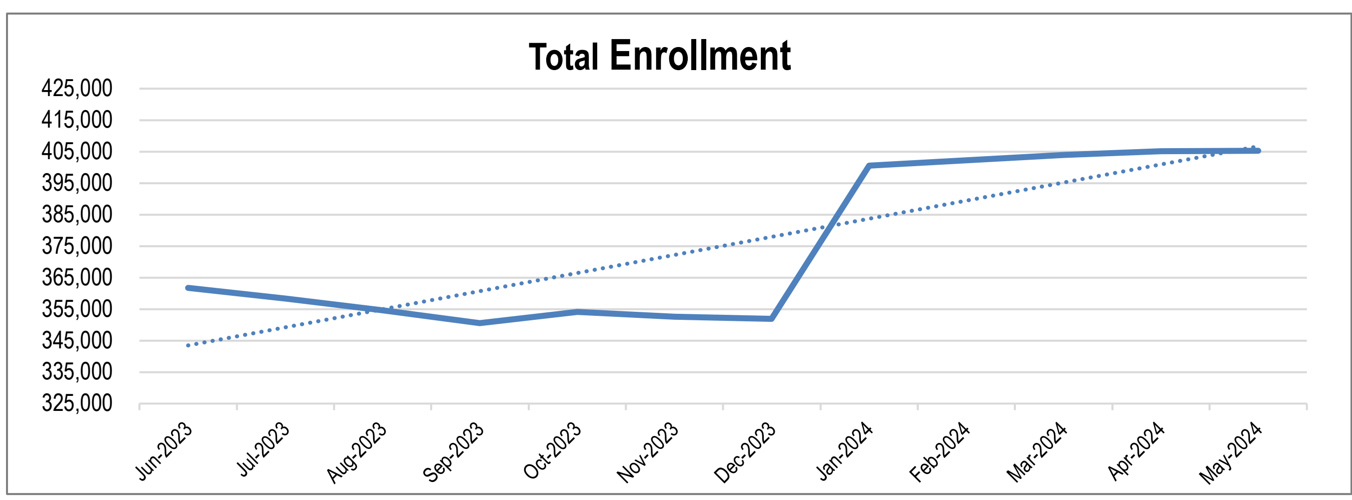
Gil Riojas

To: Alameda Alliance for Health, Finance Committee
From: Gil Riojas, Chief Financial Officer
Date: July 12th, 2024
Subject: Finance Report – May 2024 Financials

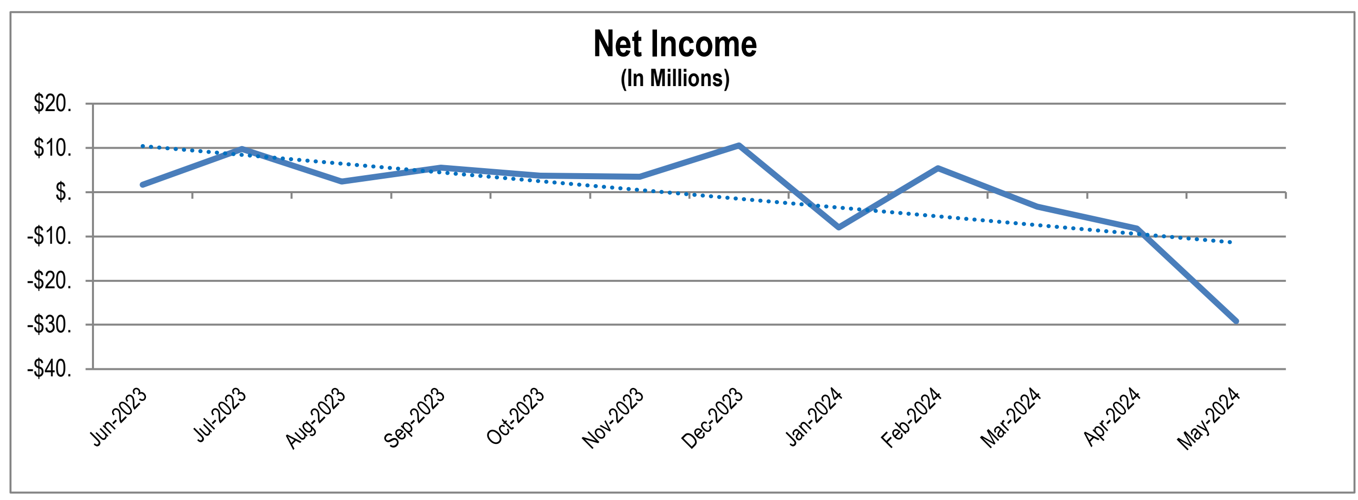
Executive Summary

For the month ended May 31st, 2024, the Alliance experienced a slight increase in enrollment, holding total enrollment at 405K members. A Net Loss of $29.2 million was reported in May. The Plan's Medical Expenses represented 118.3% of revenue. Alliance reserves decreased to 514% of required but remain well above minimum requirements.

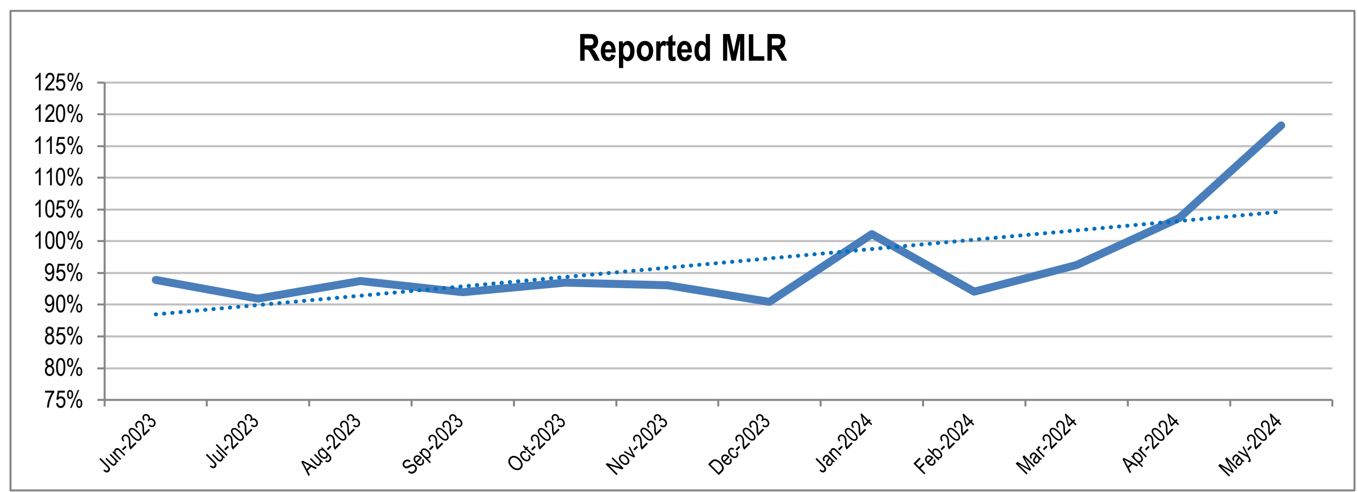
Enrollment – In May, Enrollment increased by 105 members.



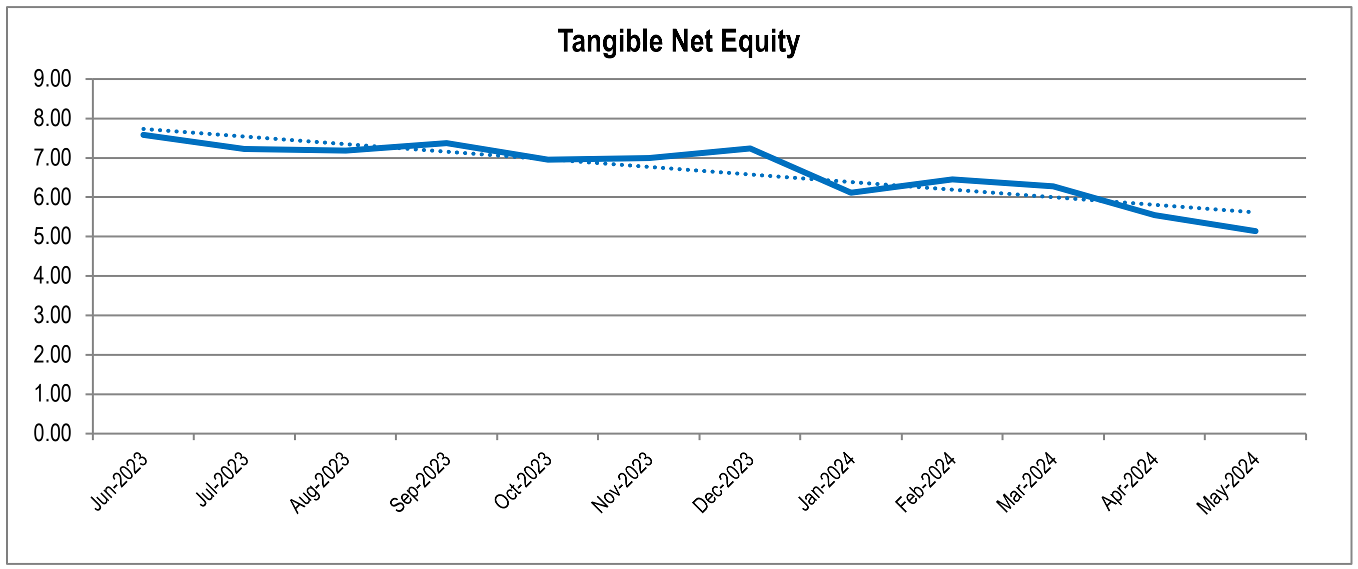
Net Income – For the month ended May 31st, 2024, actual Net Loss was $29.2 million vs. budgeted Net Loss of $5.8 million. Fiscal year-to-date actual Net Loss was $8.0 million vs. Budgeted Net Income of $11.1 million. For the month, Premium Revenue was unfavorable to budget, actual Revenue was $126.9 million vs. budgeted Revenue of $157.2 million.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 118.3% for the month and 96.8% for the fiscal year-to-date. Revenue reductions related to the CY23 acuity adjustment significantly impacted revenue and consequently the MLR, which compares revenue to medical expenses.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $61.5M in reserves, we reported $316.0M. Our overall TNE remains healthy at 514%.



The Alliance continues to benefit from increased non-operating income. For May we reported returns of $2.8M, and year-to-date $28.6M, in the investment portfolio.

To: Alameda Alliance for Health, Finance Committee

From: Gil Riojas, Chief Financial Officer

Date: July 12th, 2024

Subject: Finance Report – May 2024

Executive Summary

- For the month ended May 31st, 2024, the Alliance had enrollment of 405,279 members, a Net Loss of $29.2 million and 514% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$240,598	$2,112,693
Medical Expense	150,026	1,559,465
Admin. Expense	8,721	88,155
MCO Tax Expense	113,731	500,844
Other Inc. / (Exp.)	2,715	27,803
Net Income	**($29,164)**	**($7,968)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	($28,446)	($10,410)
Group Care	(718)	2,442
	($29,164)	**($7,968)**

*Includes costs for Medicare implementation.

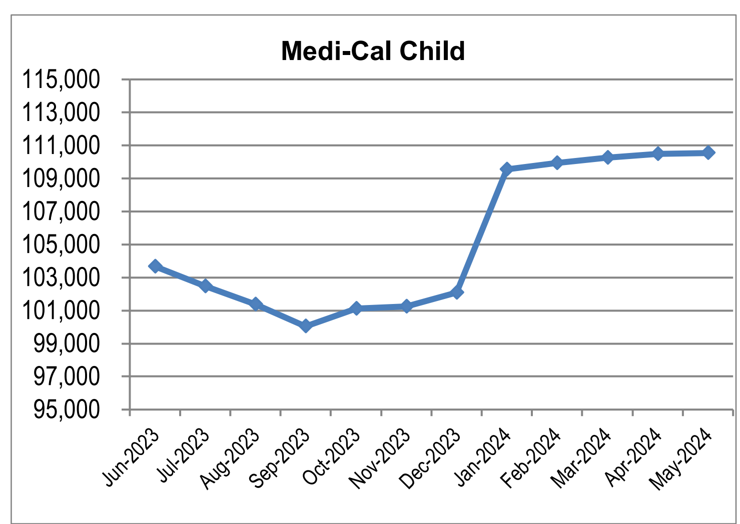
Enrollment

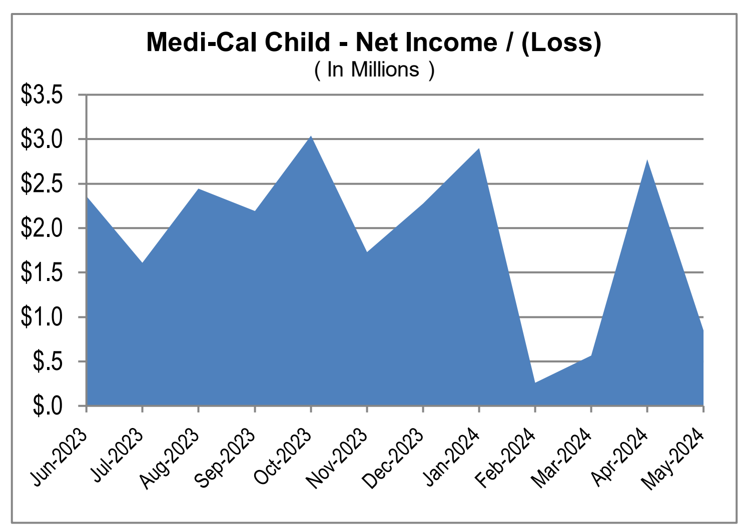
- Total enrollment increased by 105 members since April 2024.
- Total enrollment increased by 43,594 members since June 2023.

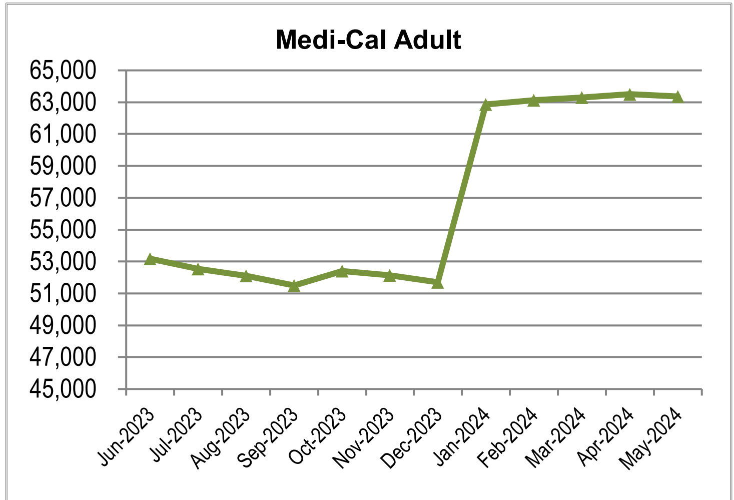
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

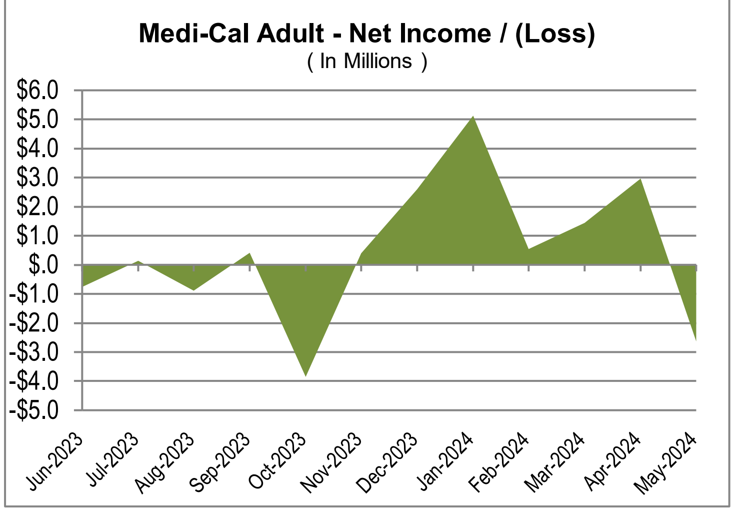
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
63,365	54,769	8,596	15.7%	Adult	628,536	592,296	36,240	6.1%
110,539	97,639	12,900	13.2%	Child	1,159,142	1,103,410	55,732	5.1%
34,965	41,130	(6,165)	-15.0%	SPD	359,799	393,591	(33,792)	-8.6%
39,842	45,412	(5,570)	-12.3%	Duals	449,034	477,262	(28,228)	-5.9%
149,425	142,740	6,685	4.7%	ACA OE	1,466,466	1,457,511	8,955	0.6%
220	176	44	25.0%	LTC	1,921	1,696	225	13.3%
1,283	1,125	158	14.0%	LTC Duals	12,500	11,805	695	5.9%
399,639	**382,991**	**16,648**	**4.3%**	**Medi-Cal Total**	**4,077,398**	**4,037,571**	**39,827**	**1.0%**
5,640	5,507	133	2.4%	Group Care	61,871	61,393	478	0.8%
405,279	**388,498**	**16,781**	**4.3%**	**Total**	**4,139,269**	**4,098,964**	**40,305**	**1.0%**

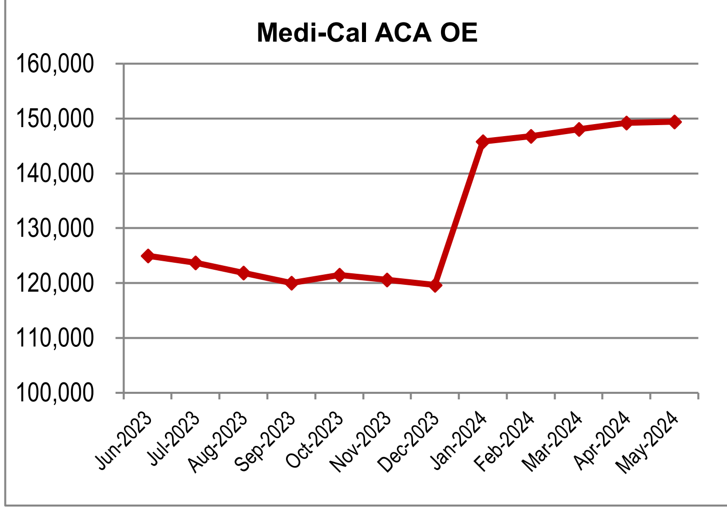
Enrollment and Profitability by Program and Category of Aid

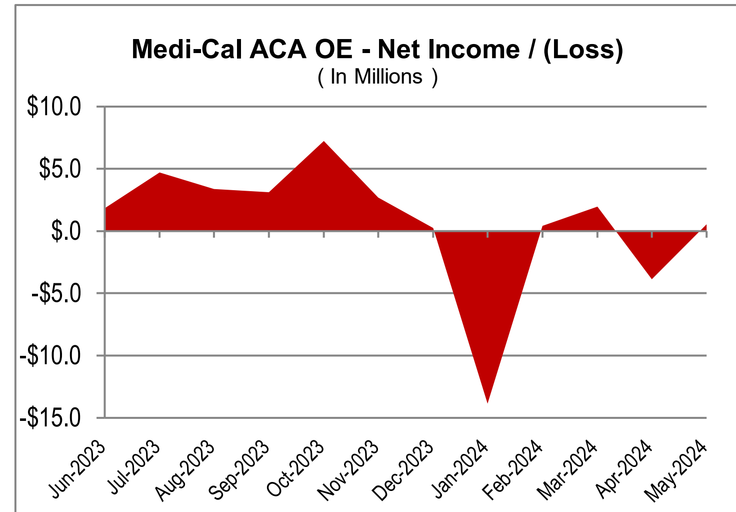




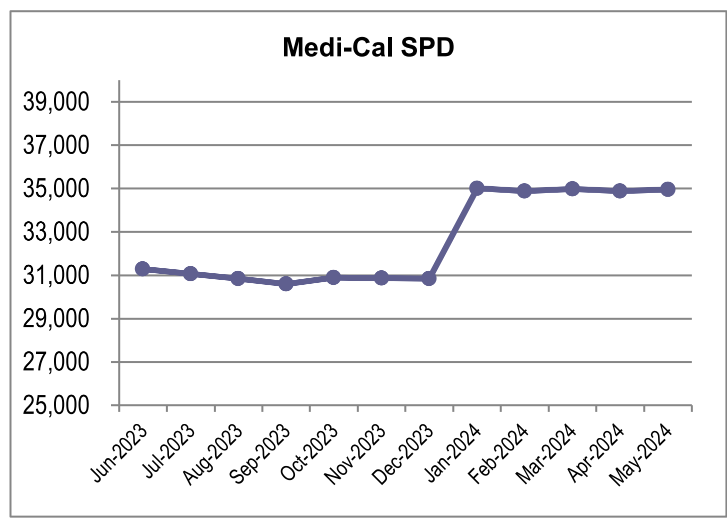


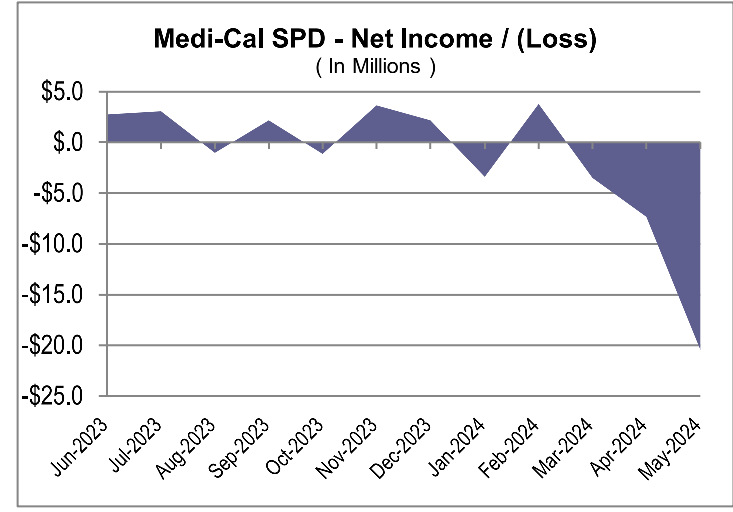


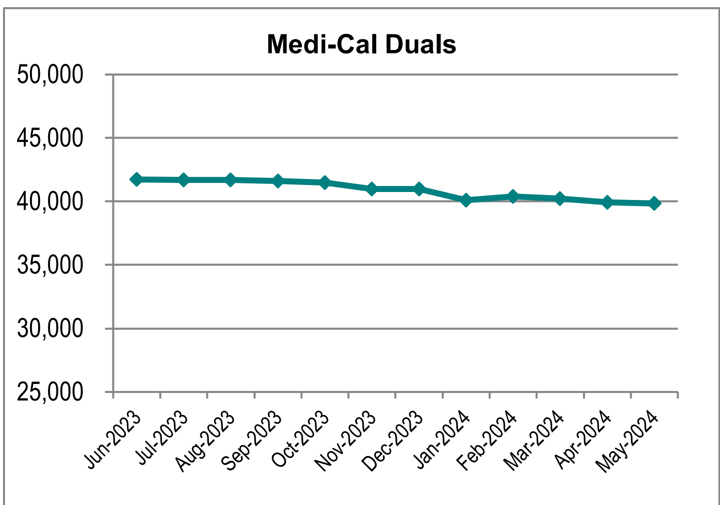


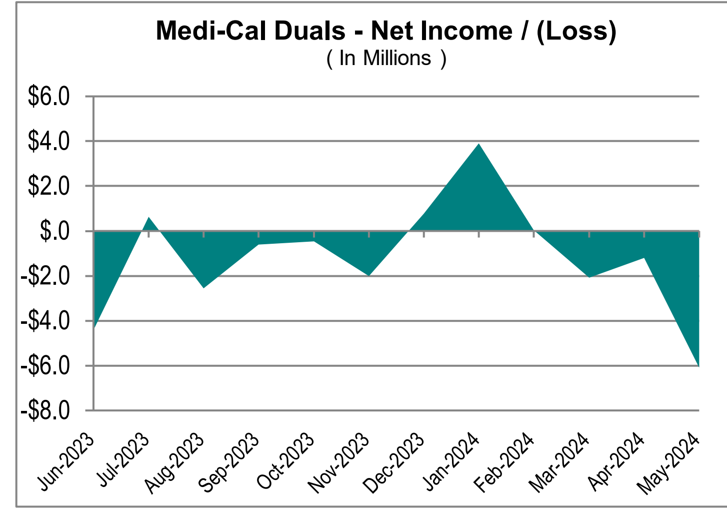


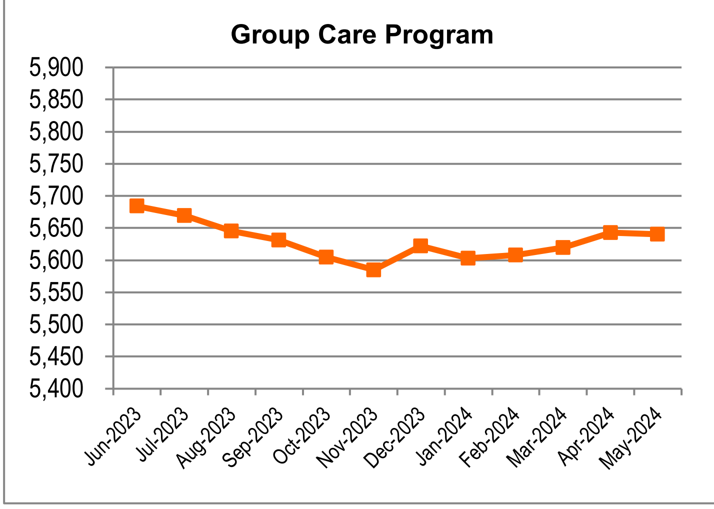
Enrollment and Profitability by Program and Category of Aid

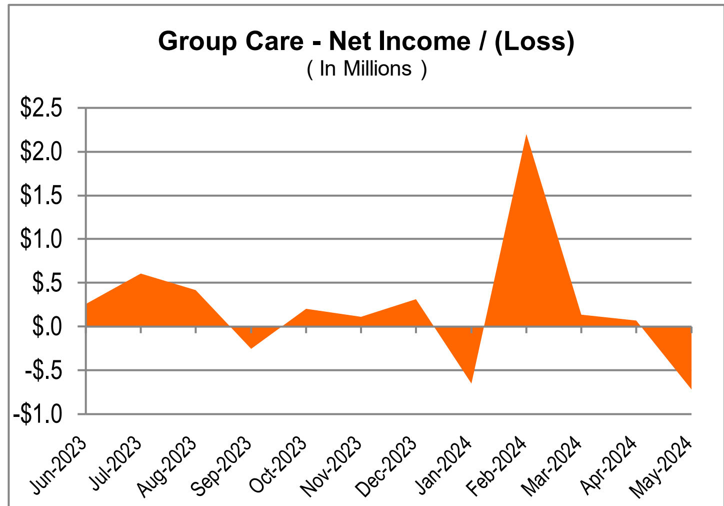




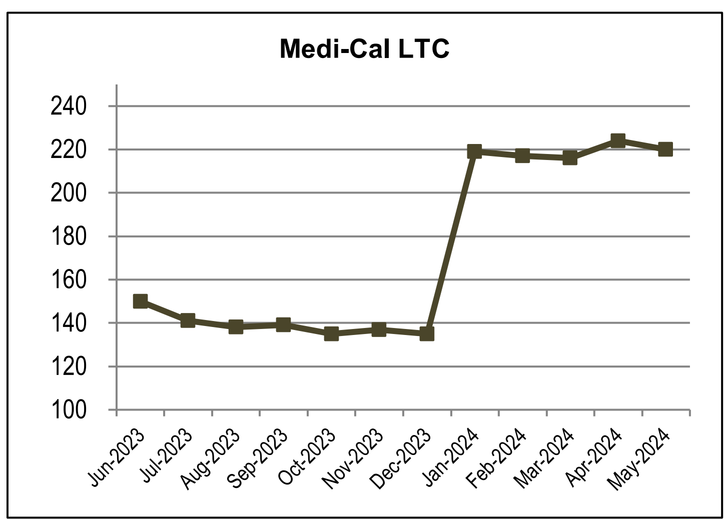


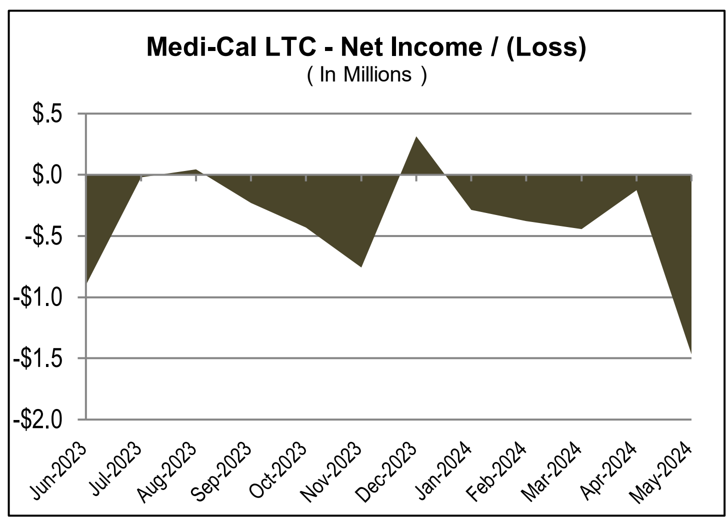


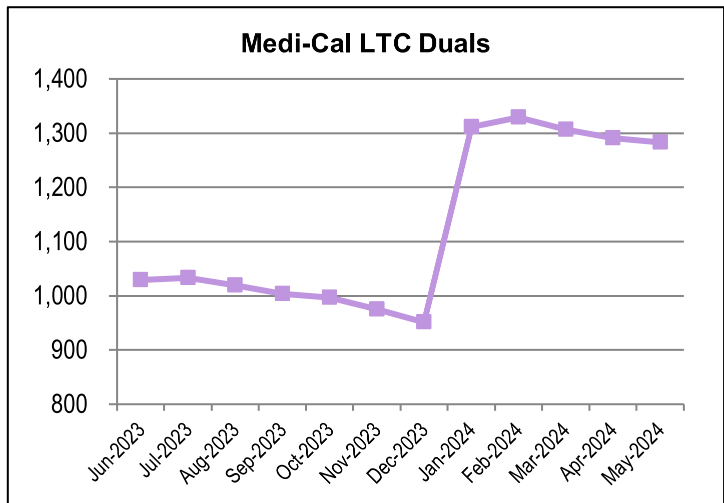


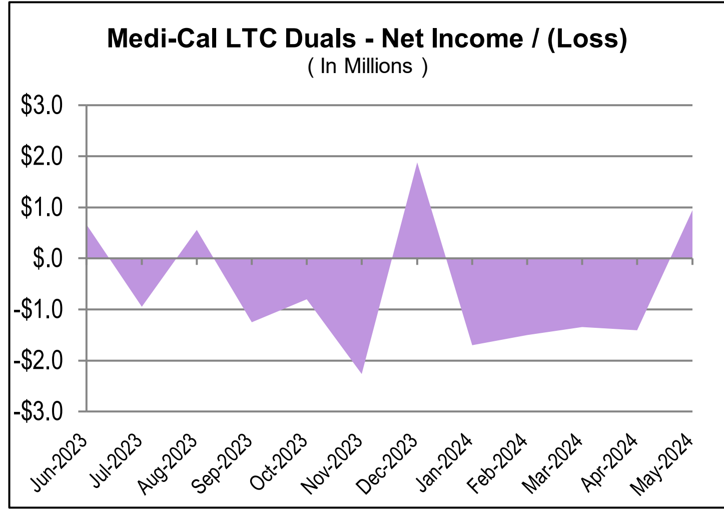


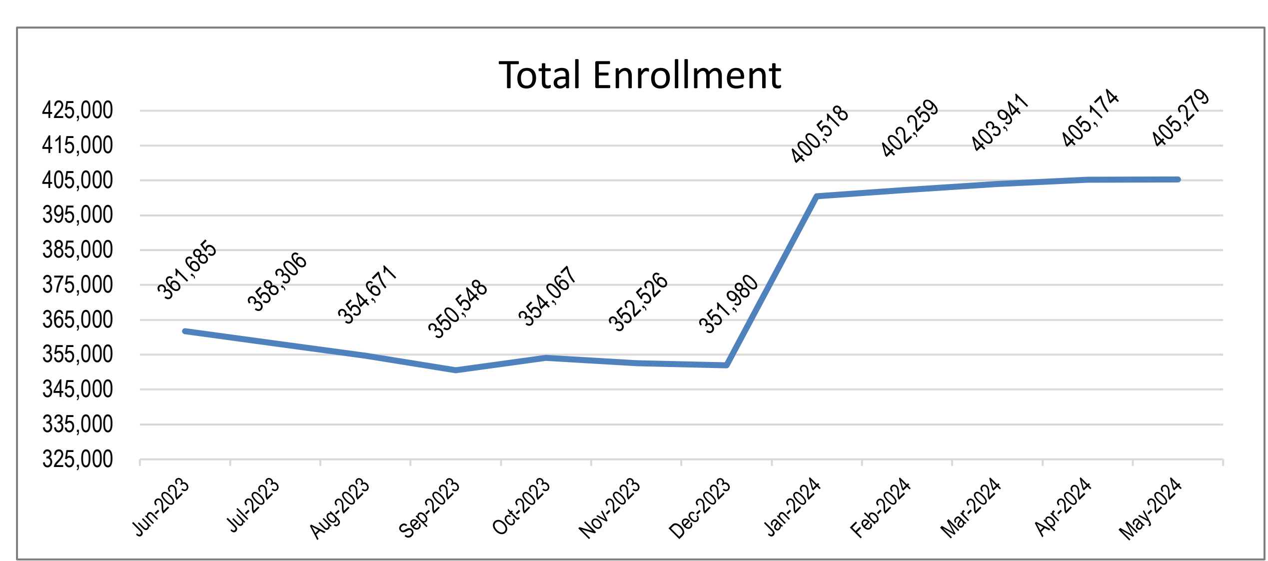
Enrollment and Profitability by Program and Category of Aid

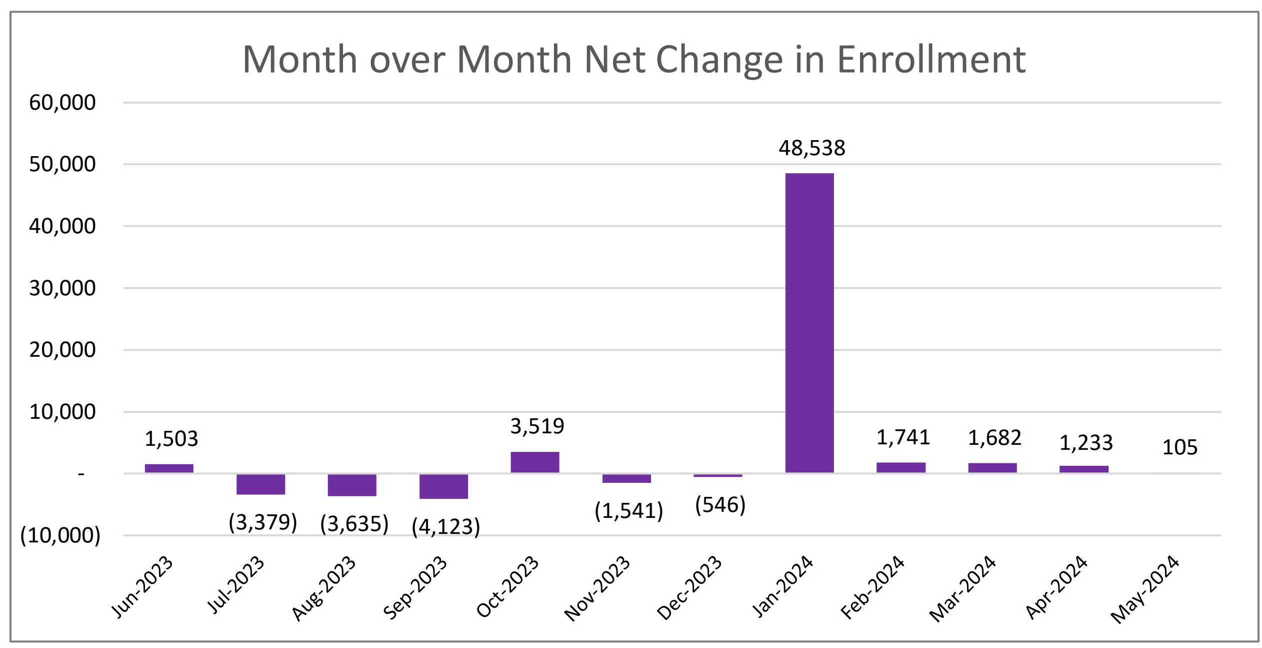








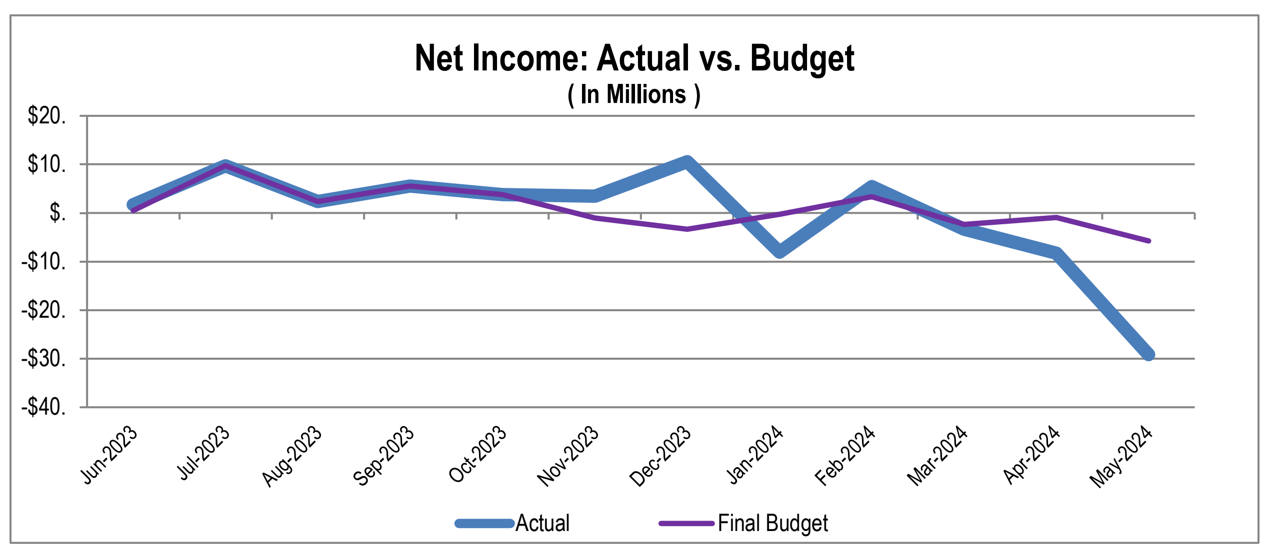




- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and will continue. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the Alliance.
- In January 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 May 31st, 2024:
    - Actual Net Loss $29.2 million.
    - Budgeted Net Loss $5.8 million.

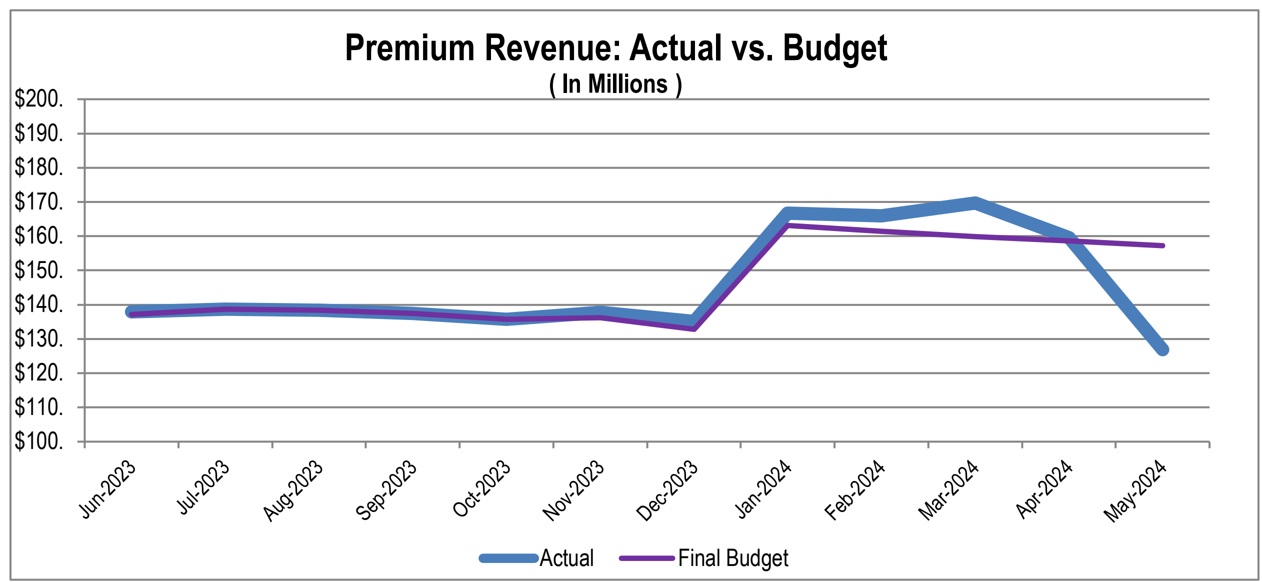


- For the fiscal YTD ended May 31st, 2024:
    - Actual Net Loss $8.0 million.
    - Budgeted Net Income $11.1 million.
- The unfavorable variance of $23.4 million in the current month is primarily due to:
    - Unfavorable $30.3 million lower than anticipated Premium Revenue.
    - Favorable $5.5 million lower than anticipated Medical Expense.
    - Favorable $1.1 million lower than anticipated Administrative Expense.

Premium Revenue

- For the month ended May 31st, 2024:
    - Actual Revenue: $126.9 million.
    - Budgeted Revenue: $157.2 million.

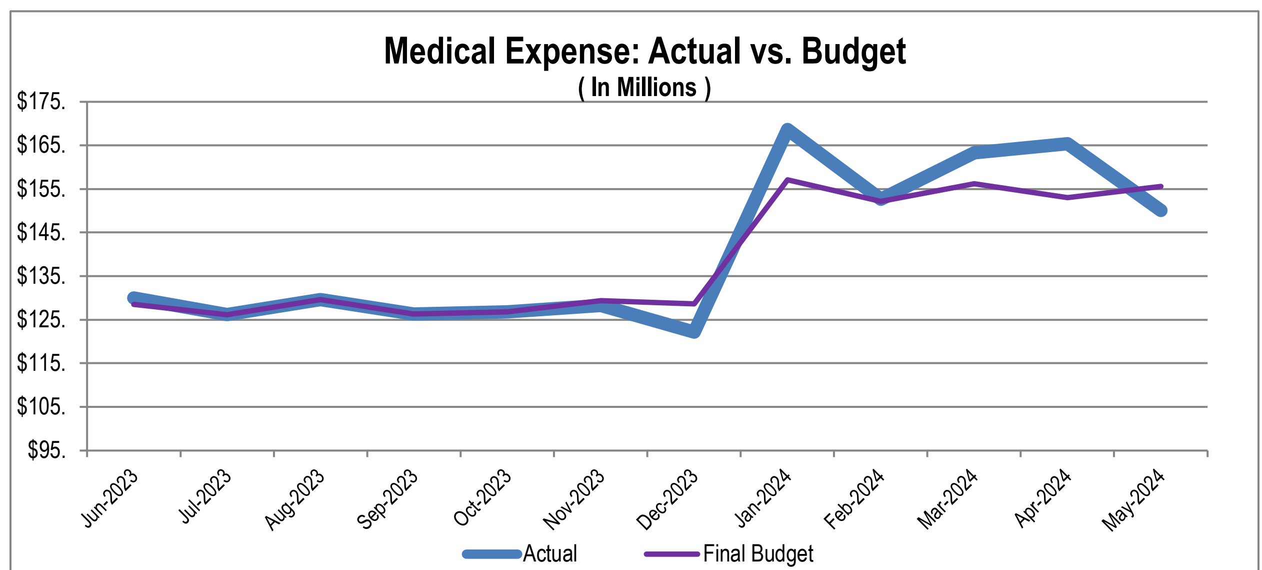
- For the fiscal YTD ended May 31st, 2024:
    - Actual Revenue: $1.6 billion
    - Budgeted Revenue: $1.6 billion.



- For the month ended May 31st, 2024, the unfavorable Premium Revenue variance of $30.3 million is primarily due to the following:
    - Unfavorable Rate Acuity adjustment for CY2023 with greatly lower rates than anticipated.
    - Unfavorable CY2021 Prop56 MEP (Medical Expenditure Percentage) reconciliation results, with corresponding medical expense reduction.
    - The risk corridor analysis for 2023 Major Organ Transplant was completed and an additional unfavorable accrual was made.
    - One-time favorable recoupment related to the decreased DHCS rates for Kaiser during CY2022.
    - Favorable Medi-Cal Capitation Rate variance. Rates were not available at the time of budget and the magnitude of upcoming Targeted Rate Increase (TRI) revenue and expense was unknown and therefore not budgeted.

Medical Expense

- For the month ended May 31st, 2024:
    - Actual Medical Expense: $150.0 million.
    - Budgeted Medical Expense: $155.5 million.
- For the fiscal YTD ended May 31st, 2024:
    - Actual Medical Expense: $1.6 billion.
    - Budgeted Medical Expense: $1.5 billion.



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

- For May, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $9.9 million. Year to date, the estimate for prior years increased by $10.3 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	$246,797,691	$0	$246,797,691	$235,471,698	($11,325,994)	-4.8%
Primary Care FFS	$52,541,618	$22,283	$52,563,901	$66,800,938	$14,259,320	21.3%
Specialty Care FFS	$65,774,863	$98,987	$65,873,849	$69,437,148	$3,662,285	5.3%
Outpatient FFS	$100,061,339	$414,666	$100,476,005	$109,776,044	$9,714,706	8.8%
Ancillary FFS	$136,270,468	$826,996	$137,097,463	$136,162,232	($108,236)	-0.1%
Pharmacy FFS	$102,600,209	$515,272	$103,115,481	$113,412,594	$10,812,385	9.5%
ER Services FFS	$81,341,288	$17,124	$81,358,412	$72,724,434	($8,616,854)	-11.8%
Inpatient Hospital & SNF FFS	$436,338,683	$4,345,250	$440,683,934	$441,394,052	$5,055,369	1.1%
Long Term Care FFS	$275,112,835	$4,080,428	$279,193,263	$234,232,824	($40,880,011)	-17.5%
Other Benefits & Services	$51,055,357	$0	$51,055,357	$55,843,716	$4,788,359	8.6%
Net Reinsurance	($1,750,855)	$0	($1,750,855)	$2,676,176	$4,427,031	165.4%
Provider Incentive	$3,000,000	$0	$3,000,000	$3,000,000	$0	0.0%
	$1,549,143,496	**$10,321,005**	**$1,559,464,501**	**$1,540,931,856**	**($8,211,640)**	**-0.5%**

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	$59.62	$0.00	$59.62	$57.45	($2.18)	-3.8%
Primary Care FFS	$12.69	$0.01	$12.70	$16.30	$3.60	22.1%
Specialty Care FFS	$15.89	$0.02	$15.91	$16.94	$1.05	6.2%
Outpatient FFS	$24.17	$0.10	$24.27	$26.78	$2.61	9.7%
Ancillary FFS	$32.92	$0.20	$33.12	$33.22	$0.30	0.9%
Pharmacy FFS	$24.79	$0.12	$24.91	$27.67	$2.88	10.4%
ER Services FFS	$19.65	$0.00	$19.66	$17.74	($1.91)	-10.8%
Inpatient Hospital & SNF FFS	$105.41	$1.05	$106.46	$107.68	$2.27	2.1%
Long Term Care FFS	$66.46	$0.99	$67.45	$57.14	($9.32)	-16.3%
Other Benefits & Services	$12.33	$0.00	$12.33	$13.62	$1.29	9.5%
Net Reinsurance	($0.42)	$0.00	($0.42)	$0.65	$1.08	164.8%
Provider Incentive	$0.72	$0.00	$0.72	$0.73	$0.01	1.0%
	$374.26	**$2.49**	**$376.75**	**$375.93**	**$1.68**	**0.4%**

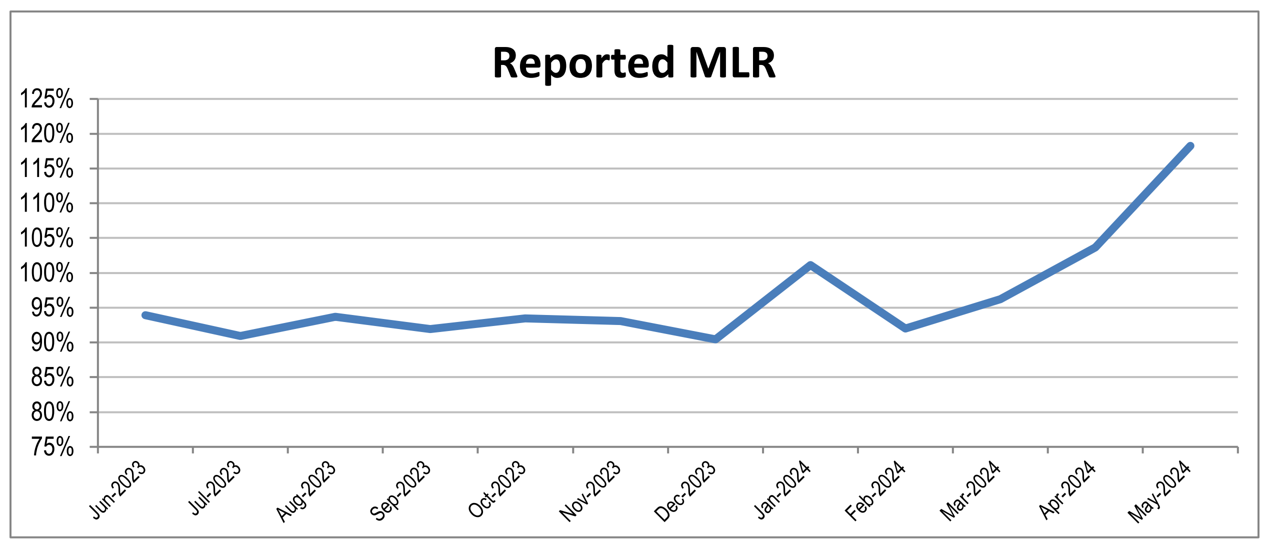
- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $8.2 million unfavorable to budget. On a PMPM basis, medical expense is 0.4% unfavorable to budget. For per-member-per-month expense:
  - Capitated Expense is slightly over budget, largely driven by unfavorable PCP Capitation expense due to inception of Provider Targeted Rate Increases (TRI), partially offset by favorable PCP and Specialty FQHC

expense, and favorable Global subcontract expense related to prior calendar year rate adjustment.

- Primary Care Expense is under budget driven by the low utilization in the ACA OE, SPD and Child aid code categories and a surplus of Prop56 revenue.
- Specialty Care Expense is below budget, driven mostly by less than expected SPD and Dual aid code category utilization.
- Outpatient Expense is under budget due to low lab and radiology utilization and facility other unit cost in all populations except for LTC.
- Ancillary Expense is over budget mostly due to higher than expected utilization in all populations except for the Child category of aid.
- Pharmacy Expense is under budget due to low Non-PBM expense driven by lower utilization in the SPD, ACA OE and Adult aid code categories.
- Emergency Room Expense is over budget driven by high utilization in the ACA OE, Adult, SPD and Child categories of aid.
- Inpatient Expense is over budget driven by high utilization and unit cost in the ACA OE and SPD aid code categories.
- Long Term Care Expense is over budget due to high utilization and unit cost in the SPD, ACA OE and Duals categories of aid.
- Other Benefits & Services is under budget, due to favorable community relations, other purchased, professional and interpreter services, offset by HHIP, IPP and other employee expense.
- Net Reinsurance year-to-date is under budget because more recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported medical expense divided by Premium revenue) was 118.3% for the month and 96.8% for the fiscal year-to-date.



Administrative Expense

- For the month ended May 31st, 2024:
  - Actual Administrative Expense: $8.7 million.
  - Budgeted Administrative Expense: $9.8 million.

- For the fiscal YTD ended May 31st, 2024:
  - Actual Administrative Expense: $88.2 million.
  - Budgeted Administrative Expense: $94.6 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 %**
$5,761,591	$6,805,374	$1,043,782	15.3%	Employee Expense	$55,716,284	$60,408,090	$4,691,806	7.8%
174,984	71,973	(103,011)	-143.1%	Medical Benefits Admin Expense	1,926,588	1,541,128	(385,460)	-25.0%
1,649,680	800,286	(849,394)	-106.1%	Purchased & Professional Services	13,906,045	11,296,961	(2,609,084)	-23.1%
1,135,026	2,164,968	1,029,942	47.6%	Other Admin Expense	16,606,539	21,304,962	4,698,422	22.1%
$8,721,281	$9,842,600	$1,121,319	11.4%	Total Administrative Expense	$88,155,456	$94,551,141	$6,395,684	6.8%

The year-to-date variances include:
- Favorable Employee and Temporary Services variances and delayed Training, Travel, Recruitment, and other employee-related expenses.
- Unfavorable impact of timing for Consulting, Computer Support Services, Other Purchased Services; as well as the change in account bookings for IT-related Licenses and Subscriptions.

The Administrative Loss Ratio (ALR) is 6.9% of net revenue for the month and 5.5% of net revenue year-to-date.

Other Income / (Expense)

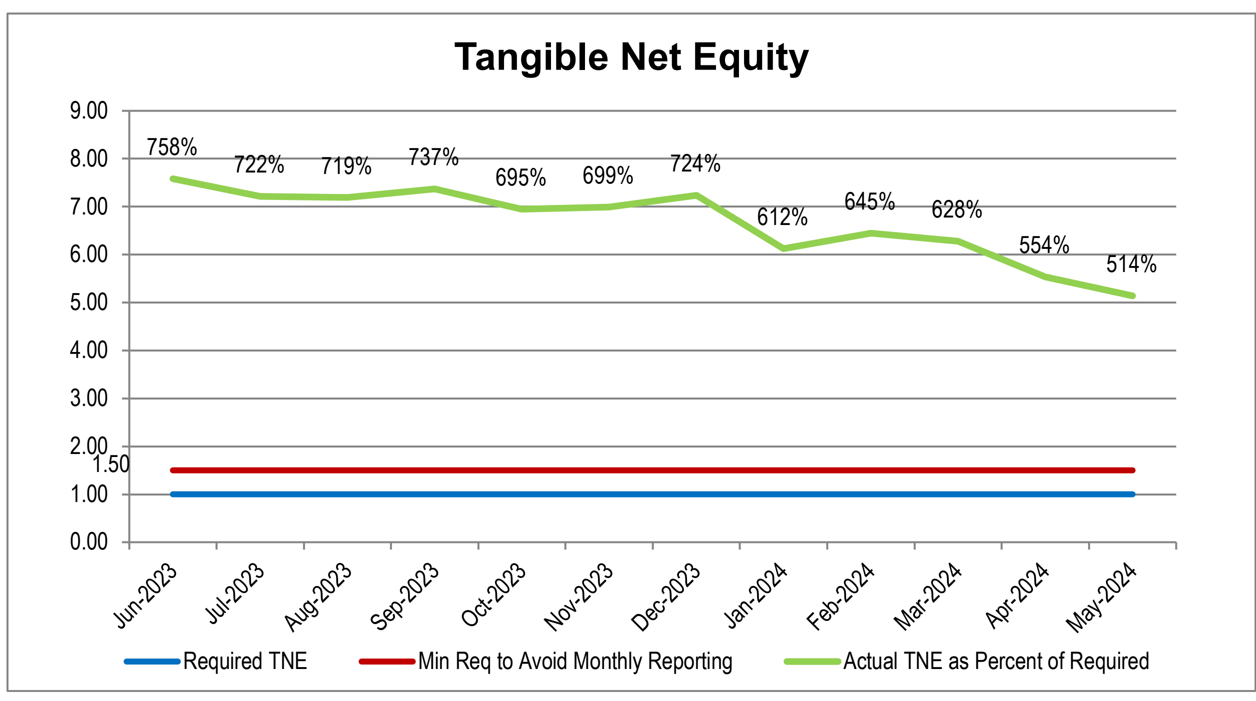
Other Income & Expense is comprised of investment income and claims interest.
- Fiscal year-to-date net investments show a gain of $28.6 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $781,000.

Managed Care Organization (MCO) Provider Tax

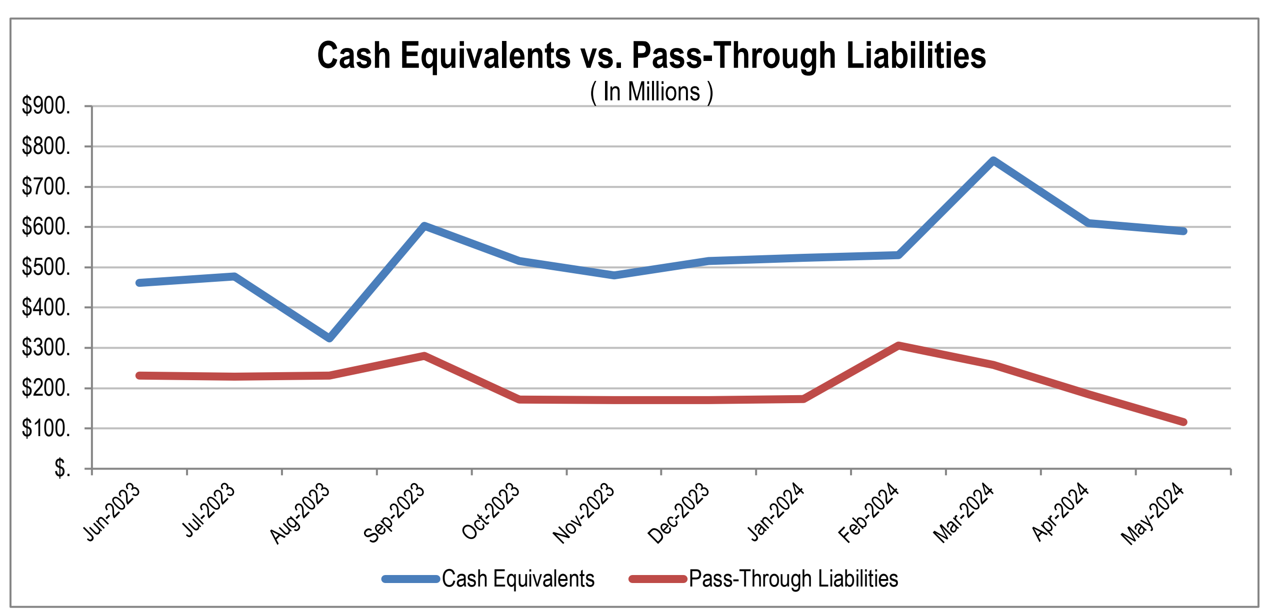
- For the month ended May 31st, 2024:
  - $113.7 million unbudgeted MCO Tax Revenue.
  - $113.7 million unbudgeted MCO Tax Expense.

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 $61.5 million
    - Actual TNE $316.0 million
    - Excess TNE $254.5 million
    - TNE % of Required TNE 514%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $589.0 million
    - Pass-Through Liabilities $115.8 million
    - Uncommitted Cash $473.2 million
    - Working Capital $279.4 million
    - Current Ratio 1.57 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $417,000.
- Annual capital budget: $1.6 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

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

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED MAY 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
399,639	382,991	16,648	4.3%	1. Medi-Cal	4,077,398	4,037,571	39,827	1.0%
5,640	5,507	133	2.4%	2. GroupCare	61,871	61,393	478	0.8%
405,279	**388,498**	**16,781**	**4.3%**	**3. TOTAL MEMBER MONTHS**	**4,139,269**	**4,098,964**	**40,305**	**1.0%**
				REVENUE				
126,867,876	157,162,380	(30,294,503)	(19.3%)	4. Premium Revenue	1,611,824,816	1,619,400,758	(7,575,942)	(0.5%)
113,730,525	0	113,730,525	0.0%	5. MCO Tax Revenue AB119	500,868,447	0	500,868,447	0.0%
$240,598,401	**$157,162,380**	**$83,436,021**	**53.1%**	**6. TOTAL REVENUE**	**$2,112,693,263**	**$1,619,400,758**	**$493,292,505**	**30.5%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$15,622,688	$15,734,405	$111,717	0.7%	7. Capitated Medical Expense	$246,797,691	$235,471,698	($11,325,994)	(4.8%)
				Fee for Service Medical Expenses:				
$48,184,621	$48,654,434	$469,813	1.0%	8. Inpatient Hospital Expense	$440,683,934	$441,394,052	$710,119	0.2%
($2,937,455)	$6,627,964	$9,565,419	144.3%	9. Primary Care Physician Expense	$52,563,901	$66,800,937	$14,237,036	21.3%
$7,596,747	$7,705,252	$108,505	1.4%	10. Specialty Care Physician Expense	$65,873,849	$69,437,148	$3,563,298	5.1%
$15,535,841	$14,267,792	($1,268,049)	(8.9%)	11. Ancillary Medical Expense	$137,097,463	$136,162,232	($935,231)	(0.7%)
$10,921,916	$12,351,383	$1,429,467	11.6%	12. Outpatient Medical Expense	$100,476,005	$109,776,044	$9,300,040	8.5%
$8,972,910	$7,719,500	($1,253,410)	(16.2%)	13. Emergency Expense	$81,358,412	$72,724,434	($8,633,978)	(11.9%)
$12,123,741	$12,390,238	$266,497	2.2%	14. Pharmacy Expense	$103,115,481	$113,412,594	$10,297,113	9.1%
$33,815,954	$23,741,966	($10,073,988)	(42.4%)	15. Long Term Care Expense	$279,193,263	$234,232,824	($44,960,439)	(19.2%)
$134,214,275	$133,458,529	($755,746)	(0.6%)	16. Total Fee for Service Expense	$1,260,362,308	$1,243,940,266	($16,422,042)	(1.3%)
$1,858,638	$5,982,582	$4,123,945	68.9%	17. Other Benefits & Services	$51,055,357	$55,843,716	$4,788,359	8.6%
($1,669,566)	$354,599	$2,024,165	570.8%	18. Reinsurance Expense	($1,750,855)	$2,676,176	$4,427,031	165.4%
$0	$0	$0	0.0%	19. Risk Pool Distribution	$3,000,000	$3,000,000	$0	(0.0%)
$150,026,034	**$155,530,115**	**$5,504,081**	**3.5%**	**20. TOTAL MEDICAL EXPENSES**	**$1,559,464,501**	**$1,540,931,856**	**($18,532,645)**	**(1.2%)**
$90,572,367	**$1,632,265**	**$88,940,102**	**5,448.9%**	**21. GROSS MARGIN**	**$553,228,761**	**$78,468,902**	**$474,759,859**	**605.0%**
				ADMINISTRATIVE EXPENSES				
$5,761,591	$6,805,374	$1,043,783	15.3%	22. Personnel Expense	$55,716,284	$60,408,090	$4,691,806	7.8%
$174,984	$71,973	($103,011)	(143.1%)	23. Benefits Administration Expense	$1,926,588	$1,541,128	($385,460)	(25.0%)
$1,649,680	$800,286	($849,394)	(106.1%)	24. Purchased & Professional Services	$13,906,045	$11,296,961	($2,609,084)	(23.1%)
$1,135,026	$2,164,968	$1,029,942	47.6%	25. Other Administrative Expense	$16,606,539	$21,304,963	$4,698,424	22.1%
$8,721,281	**$9,842,600**	**$1,121,319**	**11.4%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$88,155,456**	**$94,551,141**	**$6,395,685**	**6.8%**
$113,730,525	**$0**	**($113,730,525)**	**0.0%**	**27. MCO TAX EXPENSES**	**$500,844,447**	**$0**	**($500,844,447)**	**0.0%**
($31,879,439)	**($8,210,335)**	**($23,669,104)**	**(288.3%)**	**28. NET OPERATING INCOME / (LOSS)**	**($35,771,142)**	**($16,082,240)**	**($19,688,902)**	**(122.4%)**
				OTHER INCOME / EXPENSES				
$2,715,146	**$2,450,000**	**$265,146**	**10.8%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$27,803,272**	**$27,138,843**	**$664,430**	**2.4%**
($29,164,293)	**($5,760,335)**	**($23,403,958)**	**(406.3%)**	**30. NET SURPLUS (DEFICIT)**	**($7,967,869)**	**$11,056,603**	**($19,024,472)**	**(172.1%)**
118.3%	99.0%	-19.3%	-19.5%	31. Medical Loss Ratio	96.8%	95.2%	-1.6%	-1.7%
6.9%	6.3%	-0.6%	-9.5%	32. Administrative Expense Ratio	5.5%	5.8%	0.3%	5.2%
-12.1%	-3.7%	-8.4%	-227.0%	33. Net Surplus (Deficit) Ratio	-0.4%	0.7%	-1.1%	-157.1%

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

	5/31/2024	4/30/2024	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$17,969,861	$211,550,770	($193,580,908)	-91.51%
Short-Term Investments	571,035,527	398,292,940	172,742,586	43.37%
Interest Receivable	1,526,874	1,202,330	324,544	26.99%
Premium Receivables	162,334,975	242,419,235	(80,084,260)	-33.04%
Reinsurance Receivables	5,300,879	3,468,708	1,832,171	52.82%
Other Receivables	5,268,678	1,536,054	3,732,623	243.00%
Prepaid Expenses	904,521	1,025,943	(121,422)	-11.84%
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	**$773,153,923**	**$868,308,588**	**($95,154,665)**	**-10.96%**
OTHER ASSETS:				
Long-Term Investments	26,748,669	17,177,578	9,571,091	55.72%
Restricted Assets	350,000	350,000	0	0.00%
GASB 87-Lease Assets (Net)	872,837	938,750	(65,913)	-7.02%
GASB 96-SBITA Assets (Net)	4,311,777	4,045,341	266,435	6.59%
TOTAL OTHER ASSETS	**$32,283,282**	**$22,511,669**	**$9,771,612**	**43.41%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	9,842,648	10,167,264	(324,617)	-3.19%
Furniture And Equipment	12,541,393	12,960,779	(419,386)	-3.24%
Leasehold Improvement	903,599	902,447	1,153	0.13%
Internally Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	$38,111,641	$38,854,491	($742,850)	-1.91%
Less: Accumulated Depreciation	($32,612,126)	($33,091,473)	$479,347	-1.45%
NET PROPERTY AND EQUIPMENT	**$5,499,516**	**$5,763,018**	**($263,503)**	**-4.57%**
TOTAL ASSETS	**$810,936,720**	**$896,583,276**	**($85,646,556)**	**-9.55%**
CURRENT LIABILITIES:				
Accounts Payable	2,409,177	4,022,658	(1,613,482)	-40.11%
Other Accrued Liabilities	72,173,398	41,220,647	30,952,750	75.09%
GASB 87 ST Lease Liabilities	922,283	920,407	1,877	0.20%
GASB 96 ST SBITA Liabilities	2,380,680	2,059,611	321,068	15.59%
Claims Payable	34,543,423	34,190,754	352,669	1.03%
IBNP Reserves	245,687,493	261,876,612	(16,189,119)	-6.18%
Pass-Through Liabilities	115,807,452	185,036,972	(69,229,520)	-37.41%
Risk Sharing - Providers	6,629,337	6,629,337	0	0.00%
Payroll Liabilities	8,189,492	9,323,110	(1,133,618)	-12.16%
Deferred Inflow	5,004,985	5,004,985	0	0.00%
TOTAL CURRENT LIABILITIES	**$493,747,720**	**$550,285,093**	**($56,537,373)**	**-10.27%**
LONG TERM LIABILITIES:				
GASB 87 LT Lease Liabilities	71,130	161,150	(90,020)	-55.86%
GASB 96 LT SBITA Liabilities	1,128,698	983,568	145,130	14.76%
TOTAL LONG TERM LIABILITIES	**$1,199,828**	**$1,144,718**	**$55,110**	**4.81%**
TOTAL LIABILITIES	**$494,947,548**	**$551,429,811**	**($56,482,263)**	**-10.24%**
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)	(7,967,869)	21,196,424	(29,164,293)	-137.59%
TOTAL NET WORTH	**$315,989,172**	**$345,153,465**	**($29,164,293)**	**-8.45%**
TOTAL LIABILITIES AND NET WORTH	**$810,936,720**	**$896,583,276**	**($85,646,556)**	**-9.55%**
Cash Equivalents	$589,005,388	$609,843,710	($20,838,322)	-3.42%
Pass-Through	$115,807,452	$185,036,972	($69,229,520)	-37.41%
Uncommitted Cash	$473,197,936	$424,806,738	$48,391,198	11.39%
Working Capital	$279,406,203	$318,023,495	($38,617,292)	-12.14%
Current Ratio	156.6%	157.8%	-1.2%	-0.8%

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,579,692	$7,729,930	$15,428,312	$28,290,192
GroupCare Receivable	2,571,919	0	48,009	(2,540,830)
Total	5,151,611	7,729,930	15,476,321	25,749,362
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	238,018,709	789,427,707	1,409,293,189	2,084,403,071
Premium Receivable	77,512,341	241,398,020	83,915,677	136,568,276
Total	315,531,050	1,030,825,727	1,493,208,866	2,220,971,347
Investment & Other Income Cash Flows				
Other Revenues	(116,152)	477,993	922,631	2,456,764
Interest Income	2,937,935	7,744,735	15,783,235	26,327,596
Interest Receivable	(324,544)	1,044,272	(585,490)	(812,298)
Total	2,497,239	9,267,000	16,120,376	27,972,062
Medical & Hospital Cash Flows				
Total Medical Expenses	(150,026,031)	(478,701,509)	(922,226,664)	(1,559,464,497)
Other Health Care Receivables	(5,568,382)	(3,766,060)	(6,634,246)	(6,733,115)
Capitation Payable	-	-	-	(7,387,555)
IBNP Payable	(16,189,117)	31,471,343	82,215,071	81,183,091
Other Medical Payable	(28,129,004)	(140,104,472)	(28,005,133)	(85,167,912)
Risk Share Payable	-	-	-	1,022,154
New Health Program Payable	-	-	-	-
Total	(199,912,534)	(591,100,698)	(874,650,972)	(1,576,547,834)
Administrative Cash Flows				
Total Administrative Expenses	(8,827,915)	(29,107,902)	(51,146,263)	(89,136,544)
Prepaid Expenses	86,248	1,546,199	3,141,078	3,918,970
Other Receivables	38,763	54,848	63,042	99,849
CalPERS Pension	-	-	-	-
Trade Accounts Payable	329,647	1,161,442	(2,638,653)	366,946
Payroll Liabilities	(1,133,617)	21,957	(366,246)	2,259,605
GASB Assets and Liabilities	177,533	351,686	(19,358)	(176,886)
Depreciation Expense	(479,347)	(352,522)	(154,137)	135,001
Total	(9,808,688)	(26,324,292)	(51,120,537)	(82,533,059)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(113,730,525)	(338,307,791)	(500,844,447)	(500,844,447)
MCO Tax Liabilities	(11,738,225)	(9,900,345)	29,235,147	28,457,224
Total	(125,468,750)	(348,208,136)	(471,609,300)	(472,387,223)
Net Cash Flows from Operating Activities	**(12,010,072)**	**82,189,531**	**127,424,754**	**143,224,655**

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(9,571,100)	(24,421,627)	(19,650,661)	(15,188,136)
Total	(9,571,100)	(24,421,627)	(19,650,661)	(15,188,136)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	742,850	744,209	733,631	(416,545)
Purchases of Property and Equipment	742,850	744,209	733,631	(416,545)
Net Cash Flows from Investing Activities	**(8,828,250)**	**(23,677,418)**	**(18,917,030)**	**(15,604,681)**
Net Change in Cash	**(20,838,322)**	**58,512,113**	**108,507,724**	**127,619,974**
Rounding	0	0	-	0
Cash @ Beginning of Period	609,843,712	530,493,277	480,497,666	461,385,416
Cash @ End of Period	**$589,005,390**	**$589,005,390**	**$589,005,390**	**$589,005,390**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($29,164,287)	($40,736,836)	($32,790,007)	($7,967,865)
Add back: Depreciation & Amortization	(479,347)	(352,522)	(154,137)	135,001
Receivables				
Premiums Receivable	77,512,341	241,398,020	83,915,677	136,568,276
Interest Receivable	(324,544)	1,044,272	(585,490)	(812,298)
Other Health Care Receivables	(5,568,382)	(3,766,060)	(6,634,246)	(6,733,115)
Other Receivables	38,763	54,848	63,042	99,849
GroupCare Receivable	2,571,919	0	48,009	(2,540,830)
Total	74,230,097	238,731,080	76,806,992	126,581,882
Prepaid Expenses	86,248	1,546,199	3,141,078	3,918,970
Trade Payables	329,647	1,161,442	(2,638,653)	366,946
Claims Payable and Shared Risk Pool				
IBNP Payable	(16,189,117)	31,471,343	82,215,071	81,183,091
Capitation Payable & Other Medical Payable	(28,129,004)	(140,104,472)	(28,005,133)	(92,555,467)
Risk Share Payable	-	-	0	1,022,154
Claims Payable				
Total	(44,318,121)	(108,633,129)	54,209,938	(10,350,222)
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	(1,133,617)	21,956	(366,246)	2,259,605
GASB Assets and Liabilities	177,533	351,686	(19,358)	(176,886)
New Health Program	-	-	-	-
MCO Tax Liabilities	(11,738,225)	(9,900,345)	29,235,147	28,457,224
Total	(12,694,309)	(9,526,703)	28,849,543	30,539,943
Rounding	-	-	-	-
Cash Flows from Operating Activities	**(12,010,072)**	**82,189,531**	**127,424,754**	**143,224,655**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$315,531,050	$1,030,825,727	$1,493,208,866	$2,220,971,347
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	5,151,611	7,729,930	15,476,321	25,749,362
Other Income	(116,152)	477,993	922,631	2,456,764
Interest Income	2,613,391	8,789,007	15,197,745	25,515,298
Less Cash Paid				
Medical Expenses	(199,912,534)	(591,100,698)	(874,650,972)	(1,576,547,834)
Vendor & Employee Expenses	(9,808,688)	(26,324,292)	(51,120,537)	(82,533,059)
MCO Tax Expense AB119	(125,468,750)	(348,208,136)	(471,609,300)	(472,387,223)
Net Cash Flows from Operating Activities	**(12,010,072)**	**82,189,531**	**127,424,754**	**143,224,655**
Cash Flows from Investing Activities:				
Long Term Investments	(9,571,100)	(24,421,627)	(19,650,661)	(15,188,136)
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	742,850	744,209	733,631	(416,545)
Net Cash Flows from Investing Activities	**(8,828,250)**	**(23,677,418)**	**(18,917,030)**	**(15,604,681)**
Net Change in Cash	**(20,838,322)**	**58,512,113**	**108,507,724**	**127,619,974**
Rounding	0	0	-	0
Cash @ Beginning of Period	609,843,712	530,493,277	480,497,666	461,385,416
Cash @ End of Period	**$589,005,390**	**$589,005,390**	**$589,005,390**	**$589,005,390**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($29,164,287)	($40,736,835)	($32,790,008)	($7,967,865)
Add Back: Depreciation	(479,347)	(352,522)	(154,137)	135,001
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	74,230,097	238,731,080	76,806,992	126,581,882
Prepaid Expenses	86,248	1,546,199	3,141,078	3,918,970
Trade Payables	329,647	1,161,442	(2,638,653)	366,946
Claims Payable, IBNP and Risk Sharing	(44,318,121)	(108,633,129)	54,209,938	(10,350,222)
Deferred Revenue	0	0	0	0
Other Liabilities	(12,694,309)	(9,526,703)	28,849,543	30,539,943
Total	(12,010,072)	82,189,532	127,424,753	143,224,655
Rounding	-	(1)	1	-
Cash Flows from Operating Activities	**($12,010,072)**	**$82,189,531**	**$127,424,754**	**$143,224,655**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF MAY 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	110,539	63,365	34,965	149,425	39,842	220	1,283	399,639	5,640	-	405,279
Revenue	$44,756,020	$30,031,293	$41,183,980	$85,810,286	$23,870,850	$1,845,966	$10,520,314	$238,018,709	$2,579,692	$0	$240,598,401
Medical Expense	11,062,194	14,595,785	49,787,827	42,505,876	16,878,912	3,174,190	8,830,389	146,835,173	3,189,862	1,000	$150,026,034
Gross Margin	$33,693,827	$15,435,508	($8,603,847)	$43,304,410	$6,991,939	($1,328,224)	$1,689,925	$91,183,537	($610,170)	($1,000)	$90,572,367
Administrative Expense	$530,395	$971,420	$2,727,399	$2,777,813	$714,324	$127,181	$606,372	$8,454,905	$147,939	$118,437	$8,721,281
MCO Tax Expense	$32,452,017	$17,410,528	$10,012,981	$40,870,346	$12,590,812	$52,885	$340,957	$113,730,525	$0	$0	$113,730,525
Operating Income / (Expense)	$711,415	($2,946,440)	($21,344,228)	($343,749)	($6,313,197)	($1,508,290)	$742,596	($31,001,893)	($758,109)	($119,437)	($31,879,439)
Other Income / (Expense)	$135,560	$312,011	$877,971	$888,057	$222,392	$41,807	$197,688	$2,675,486	$39,660	$0	$2,715,146
Net Income / (Loss)	$846,975	($2,634,430)	($20,466,257)	$544,309	($6,090,805)	($1,466,483)	$940,284	($28,326,407)	($718,449)	($119,437)	($29,164,293)
PMPM Metrics:											
Revenue PMPM	$404.89	$473.94	$1,177.86	$574.27	$599.14	$8,390.75	$8,199.78	$595.58	$457.39	$0.00	$593.66
Medical Expense PMPM	$100.08	$230.34	$1,423.93	$284.46	$423.65	$14,428.13	$6,882.61	$367.42	$565.58	$0.00	$370.18
Gross Margin PMPM	$304.81	$243.60	($246.07)	$289.81	$175.49	($6,037.38)	$1,317.17	$228.16	($108.19)	$0.00	$223.48
Administrative Expense PMPM	$4.80	$15.33	$78.00	$18.59	$17.93	$578.09	$472.62	$21.16	$26.23	$0.00	$21.52
MCO Tax Expense PMPM	$293.58	$274.77	$286.37	$273.52	$316.02	$240.39	$265.75	$284.58	$0.00	$0.00	$280.62
Operating Income / (Expense) PMPM	$6.44	($46.50)	($610.45)	($2.30)	($158.46)	($6,855.86)	$578.80	($77.57)	($134.42)	$0.00	($78.66)
Other Income / (Expense) PMPM	$1.23	$4.92	$25.11	$5.94	$5.58	$190.03	$154.08	$6.69	$7.03	$0.00	$6.70
Net Income / (Loss) PMPM	$7.66	($41.58)	($585.34)	$3.64	($152.87)	($6,665.83)	$732.88	($70.88)	($127.38)	$0.00	($71.96)
Ratio:											
Medical Loss Ratio	89.9%	115.6%	159.7%	94.6%	149.6%	177.0%	86.7%	118.1%	123.7%	0.0%	118.3%
Administrative Expense Ratio	4.3%	7.7%	8.7%	6.2%	6.3%	7.1%	6.0%	6.8%	5.7%	0.0%	6.9%
Net Income Ratio	1.9%	-8.8%	-49.7%	0.6%	-25.5%	-79.4%	8.9%	-11.9%	-27.9%	0.0%	-12.1%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE MAY 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	1,159,142	628,536	359,799	1,466,466	449,034	1,921	12,500	4,077,398	61,871	-	4,139,269
Revenue	$294,108,591	$284,638,955	$454,533,663	$724,311,210	$199,475,572	$19,941,190	$107,393,890	$2,084,403,071	$28,290,192	$0	$2,112,693,263
Medical Expense	127,140,412	194,827,327	413,624,570	518,417,572	148,493,189	22,644,503	109,688,859	1,534,836,432	24,621,069	7,000	$1,559,464,501
Gross Margin	$166,968,179	$89,811,628	$40,909,093	$205,893,638	$50,982,383	($2,703,313)	($2,294,970)	$549,566,639	$3,669,122	($7,000)	$553,228,761
Administrative Expense	$5,278,004	$9,585,973	$27,930,402	$28,029,274	$7,954,131	$1,246,778	$5,938,138	$85,962,702	$1,689,977	$502,778	$88,155,456
MCO Tax Expense	$142,581,665	$77,014,471	$44,150,466	$180,128,663	$55,204,337	$236,694	$1,528,151	$500,844,447	$0	$0	$500,844,447
Operating Income / (Expense)	$19,108,510	$3,211,184	($31,171,775)	($2,264,300)	($12,176,085)	($4,186,785)	($9,761,258)	($37,240,509)	$1,979,145	($509,778)	($35,771,142)
Other Income / (Expense)	$1,530,421	$3,025,163	$9,032,992	$8,909,541	$2,518,741	$409,576	$1,913,984	$27,340,418	$462,854	$0	$27,803,272
Net Income / (Loss)	$20,638,931	$6,236,347	($22,138,783)	$6,645,242	($9,657,343)	($3,777,209)	($7,847,275)	($9,900,092)	$2,442,000	($509,778)	($7,967,869)
PMPM Metrics:											
Revenue PMPM	$253.73	$452.86	$1,263.30	$493.92	$444.23	$10,380.63	$8,591.51	$511.21	$457.24	$0.00	$510.40
Medical Expense PMPM	$109.68	$309.97	$1,149.60	$353.51	$330.69	$11,787.87	$8,775.11	$376.43	$397.94	$0.00	$376.75
Gross Margin PMPM	$144.04	$142.89	$113.70	$140.40	$113.54	($1,407.24)	($183.60)	$134.78	$59.30	$0.00	$133.65
Administrative Expense PMPM	$4.55	$15.25	$77.63	$19.11	$17.71	$649.03	$475.05	$21.08	$27.31	$0.00	$21.30
MCO Tax Expense PMPM	$123.01	$122.53	$122.71	$122.83	$122.94	$123.21	$122.25	$122.83	$0.00	$0.00	$121.00
Operating Income / (Expense) PMPM	$16.49	$5.11	($86.64)	($1.54)	($27.12)	($2,179.48)	($780.90)	($9.13)	$31.99	$0.00	($8.64)
Other Income / (Expense) PMPM	$1.32	$4.81	$25.11	$6.08	$5.61	$213.21	$153.12	$6.71	$7.48	$0.00	$6.72
Net Income / (Loss) PMPM	$17.81	$9.92	($61.53)	$4.53	($21.51)	($1,966.27)	($627.78)	($2.43)	$39.47	$0.00	($1.92)
Ratio:											
Medical Loss Ratio	83.9%	93.8%	100.8%	95.3%	102.9%	114.9%	103.6%	96.9%	87.0%	0.0%	96.8%
Administrative Expense Ratio	3.5%	4.6%	6.8%	5.2%	5.5%	6.3%	5.6%	5.4%	6.0%	0.0%	5.5%
Net Income Ratio	7.0%	2.2%	-4.9%	0.9%	-4.8%	-18.9%	-7.3%	-0.5%	8.6%	0.0%	-0.4%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED May 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				
$5,761,591	$6,805,374	$1,043,783	15.3%	Personnel Expenses	$55,716,284	$60,408,090	$4,691,806	7.8%
174,984	71,973	(103,011)	(143.1%)	Benefits Administration Expense	1,926,588	1,541,128	(385,460)	(25.0%)
1,649,680	800,286	(849,394)	(106.1%)	Purchased & Professional Services	13,906,045	11,296,961	(2,609,084)	(23.1%)
(840,767)	496,412	1,337,179	269.4%	Occupancy	3,611,156	5,522,343	1,911,186	34.6%
1,877,757	891,920	(985,837)	(110.5%)	Printing Postage & Promotion	6,489,049	7,089,093	600,044	8.5%
25,054	763,453	738,399	96.7%	Licenses Insurance & Fees	5,958,065	8,427,679	2,469,614	29.3%
72,982	13,183	(59,799)	(453.6%)	Supplies & Other Expenses	548,269	265,848	(282,421)	(106.2%)
$2,959,690	$3,037,226	$77,536	2.6%	Total Other Administrative Expense	$32,439,172	$34,143,052	$1,703,880	5.0%
$8,721,281	$9,842,600	$1,121,319	11.4%	Total Administrative Expenses	$88,155,456	$94,551,141	$6,395,685	6.8%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
3,728,041	3,922,982	194,941	5.0%	Salaries & Wages	36,098,006	35,933,278	(164,728)	(0.5%)
319,166	541,243	222,077	41.0%	Paid Time Off	3,567,804	3,973,617	405,813	10.2%
1,773	4,900	3,127	63.8%	Compensated Incentives	20,296	1,943,932	1,923,636	99.0%
133,377	0	(133,377)	0.0%	Severance Pay	139,537	842,000	702,463	83.4%
63,080	79,391	16,311	20.5%	Payroll Taxes	694,258	707,095	12,836	1.8%
64,341	20,467	(43,875)	(214.4%)	Overtime	390,669	272,261	(118,408)	(43.5%)
337,621	417,281	79,659	19.1%	CalPERS ER Match	3,146,873	3,140,717	(6,155)	(0.2%)
932,458	1,133,019	200,561	17.7%	Employee Benefits	8,529,156	9,340,389	811,233	8.7%
(5,562)	0	5,562	0.0%	Personal Floating Holiday	172,443	169,701	(2,742)	(1.6%)
23,413	35,250	11,837	33.6%	Premium Bi/Multilingual Pay	154,593	167,750	13,157	7.8%
77	0	(77)	0.0%	Prizes	231	0	(231)	0.0%
(400)	0	400	0.0%	Med Ins Opted Out Stipend	12,600	0	(12,600)	0.0%
0	0	0	0.0%	Holiday Bonus	1,402,961	0	(1,402,961)	0.0%
79,320	0	(79,320)	0.0%	Sick Leave	172,016	0	(172,016)	0.0%
2,930	25,070	22,140	88.3%	Compensated Employee Relations	58,733	313,603	254,870	81.3%
18,180	23,200	5,020	21.6%	Work from Home Stipend	184,260	216,695	32,435	15.0%
1,134	3,566	2,432	68.2%	Mileage, Parking & LocalTravel	12,287	33,084	20,797	62.9%
8,404	24,191	15,787	65.3%	Travel & Lodging	113,258	232,406	119,148	51.3%
22,901	173,922	151,020	86.8%	Temporary Help Services	478,061	1,740,570	1,262,509	72.5%
22,448	323,529	301,081	93.1%	Staff Development/Training	244,093	1,007,301	763,208	75.8%
8,887	77,365	68,477	88.5%	Staff Recruitment/Advertising	124,148	373,690	249,542	66.8%
$5,761,591	**$6,805,374**	**$1,043,783**	**15.3%**	**Total Employee Expenses**	**$55,716,284**	**$60,408,090**	**$4,691,806**	**7.8%**
				Benefit Administration Expense				
22,542	21,468	(1,074)	(5.0%)	RX Administration Expense	237,834	232,071	(5,762)	(2.5%)
100,000	0	(100,000)	0.0%	Behavioral Hlth Administration Fees	1,193,429	817,710	(375,719)	(45.9%)
52,442	50,505	(1,937)	(3.8%)	Telemedicine Admin Fees	495,326	491,347	(3,979)	(0.8%)
$174,984	**$71,973**	**($103,011)**	**(143.1%)**	**Total Benefit Administration Expenses**	**$1,926,588**	**$1,541,128**	**($385,460)**	**(25.0%)**
				Purchased & Professional Services				
524,383	313,085	(211,299)	(67.5%)	Consultant Fees - Non Medical	3,054,892	3,708,145	653,253	17.6%
98,073	145,597	47,523	32.6%	Computer Support Services	4,595,337	3,517,826	(1,077,511)	(30.6%)
11,875	12,500	625	5.0%	Audit Fees	130,625	135,000	4,375	3.2%
0	33	33	100.0%	Consultant Fees - Medical	0	233	233	100.0%
216,900	61,196	(155,705)	(254.4%)	Other Purchased Services	1,827,352	860,520	(966,832)	(112.4%)
2,448	1,574	(874)	(55.5%)	Maint.& Repair-Office Equipment	8,997	13,674	4,677	34.2%
0	0	0	0.0%	Maint.&Repair-Computer Hardware	1,180	1,180	0	0.0%
98,767	128,220	29,452	23.0%	Medical Refund Recovery Fees	991,799	1,248,868	257,069	20.6%
192,048	0	(192,048)	0.0%	Software - IT Licenses & Subsc	1,617,445	0	(1,617,445)	0.0%
414,349	41,167	(373,182)	(906.5%)	Hardware (Non-Capital)	999,171	885,746	(113,425)	(12.8%)
38,783	44,565	5,782	13.0%	Provider Relations-Credentialing	374,534	426,453	51,919	12.2%
55,053	52,350	(2,703)	(5.2%)	Legal Fees	280,749	499,316	218,567	43.8%
(3,000)	0	3,000	0.0%	Interpretive Services	23,964	0	(23,964)	0.0%
$1,649,680	**$800,286**	**($849,394)**	**(106.1%)**	**Total Purchased & Professional Services**	**$13,906,045**	**$11,296,961**	**($2,609,084)**	**(23.1%)**
				Occupancy				
(479,347)	53,159	532,506	1,001.7%	Depreciation	135,001	606,650	471,649	77.7%
62,638	62,639	1	0.0%	Building Lease	615,179	686,867	71,689	10.4%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
4,464	5,870	1,406	23.9%	Leased and Rented Office Equipment	32,860	73,509	40,649	55.3%
(3,162)	14,482	17,644	121.8%	Utilities	188,071	208,562	20,491	9.8%
57,023	86,510	29,487	34.1%	Telephone	791,192	917,991	126,799	13.8%
409,983	24,616	(385,367)	(1,565.5%)	Building Maintenance	646,358	344,550	(301,807)	(87.6%)
(892,368)	249,136	1,141,503	458.2%	SBITA Amortization Expense-GASB 96	1,202,495	2,684,213	1,481,718	55.2%
($840,767)	**$496,412**	**$1,337,179**	**269.4%**	**Total Occupancy**	**$3,611,156**	**$5,522,343**	**$1,911,186**	**34.6%**
				Printing Postage & Promotion				
30,258	41,596	11,338	27.3%	Postage	721,231	855,581	134,350	15.7%
0	5,300	5,300	100.0%	Design & Layout	32,670	79,016	46,346	58.7%
84,322	50,967	(33,356)	(65.4%)	Printing Services	1,425,928	1,217,361	(208,567)	(17.1%)
0	6,910	6,910	100.0%	Mailing Services	93,905	98,591	4,686	4.8%
9,413	12,580	3,167	25.2%	Courier/Delivery Service	102,414	110,541	8,126	7.4%
0	333	333	100.0%	Pre-Printed Materials and Publications	1,038	1,167	129	11.0%
3,347	1,250	(2,097)	(167.7%)	Promotional Products	6,594	25,371	18,777	74.0%
0	150	150	100.0%	Promotional Services	(1,253)	5,500	6,753	122.8%
2,226,167	749,500	(1,476,667)	(197.0%)	Community Relations	3,834,277	4,414,639	580,363	13.1%
24,250	23,333	(917)	(3.9%)	Translation - Non-Clinical	272,245	281,326	9,081	3.2%
(500,000)	0	500,000	0.0%	Community Reinvestment Expense	0	0	0	0.0%
$1,877,757	**$891,920**	**($985,837)**	**(110.5%)**	**Total Printing Postage & Promotion**	**$6,489,049**	**$7,089,093**	**$600,044**	**8.5%**
				Licenses Insurance & Fees				
0	0	0	0.0%	Regulatory Penalties	80,000	750,000	670,000	89.3%
26,001	29,000	2,999	10.3%	Bank Fees	318,099	308,587	(9,512)	(3.1%)
0	89,101	89,101	100.0%	Insurance Premium	1,057,904	934,523	(123,380)	(13.2%)
42,682	472,904	430,222	91.0%	Licenses, Permits and Fees	3,346,468	4,463,527	1,117,059	25.0%
(43,629)	172,449	216,077	125.3%	Subscriptions and Dues - NonIT	1,155,594	1,971,042	815,448	41.4%
$25,054	**$763,453**	**$738,399**	**96.7%**	**Total Licenses Insurance & Postage**	**$5,958,065**	**$8,427,679**	**$2,469,614**	**29.3%**
				Supplies & Other Expenses				
11,754	3,929	(7,825)	(199.2%)	Office and Other Supplies	101,217	72,593	(28,624)	(39.4%)
4,306	2,000	(2,306)	(115.3%)	Furniture and Equipment	21,300	39,753	18,453	46.4%
25,468	1,200	(24,268)	(2,022.3%)	Ergonomic Supplies	57,151	22,225	(34,926)	(157.1%)
31,594	5,588	(26,006)	(465.4%)	Meals and Entertainment	88,824	85,013	(3,811)	(4.5%)
(141)	0	141	0.0%	Miscellaneous Expense	22,360	27,948	5,588	20.0%
0	0	0	0.0%	Member Incentive Expense	9,600	14,550	4,950	34.0%
0	0	0	0.0%	Equity & Practice Transformation (EPT)	247,818	0	(247,818)	0.0%
0	100	100	100.0%	Covid-19 IT Expenses	0	700	700	100.0%
0	367	367	100.0%	Covid-19 Non IT Expenses	0	3,067	3,067	100.0%
$72,982	**$13,183**	**($59,799)**	**(453.6%)**	**Total Supplies & Other Expense**	**$548,269**	**$265,848**	**($282,421)**	**(106.2%)**
$8,721,281	**$9,842,600**	**$1,121,319**	**11.4%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$88,155,456**	**$94,551,141**	**$6,395,685**	**6.8%**

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

	Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:						
Cisco Catalyst 9300 - Catalyst Switches	IT-FY24-01	$ -	$ -	**$ -**	$ 50,000	$ 50,000
Cisco Catalyst 8500 - Routers	IT-FY24-02	$ -	$ -	**$ -**	$ 60,000	$ 60,000
Cisco AP-9166 - Access Point	IT-FY24-03	$ -	$ -	**$ -**	$ 10,000	$ 10,000
Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 426,471	$ -	**$ 426,471**	$ 426,371	$ (100)
PURE Storage array	IT-FY24-05	$ -	$ -	**$ -**	$ 300,000	$ 300,000
PKI management	IT-FY24-06	$ -	$ -	**$ -**	$ 20,000	$ 20,000
IBM Power Hardware Upgrade	IT-FY24-07	$ 560,652	$ -	**$ 560,652**	$ 288,629	$ (272,023)
Misc Hardware	IT-FY24-08	$ 7,119	$ -	**$ 7,119**	$ 15,000	$ 7,881
Network / AV Cabling	IT-FY24-09	$ 95,054	$ -	**$ 95,054**	$ 30,000	$ (65,054)
Training Room Projector	IT-FY24-10	$ 12,546	$ -	**$ 12,546**	$ 13,000	$ 454
Conference room upgrades	IT-FY24-11	$ -	$ -	**$ -**	$ 107,701	$ 107,701
Fixed Asset Reclass due to new policy (FN-601)		$ -	$ (387,427)	**$ (387,427)**	$ -	$ 387,427
Hardware Subtotal		**$ 1,101,842**	**$ (387,427)**	**$ 714,414**	**$ 1,320,701**	**$ 606,287**
2. Software:						
Zerto renewal and Tier 2 add	AC-FY24-01	$ -	$ -	**$ -**	$ 126,000	$ 126,000
Fixed Asset Reclass due to new policy (FN-601)		$ -	$ (28,099)	**$ (28,099)**	$ -	$ 28,099
Software Subtotal		**$ -**	**$ (28,099)**	**$ (28,099)**	**$ 126,000**	**$ 154,099**
3. Building Improvement:						
Appliances over 1k new/replacement (all buildings/suites)	FA-FY24-01	**$ -**	$ -	**$ -**	$ -	$ -
ACME Security: Readers, HID boxes, Cameras, Doors (planned/unplanned Maintenance repairs)	FA-FY24-02	$ -	$ -	**$ -**	$ 20,000	$ 20,000
HVAC: Replace VAV boxes, duct work, replace old equipment	FA-FY24-03	$ 18,295	$ -	**$ 18,295**	$ 20,000	$ 1,705
Electrical work for projects, workstations requirement	FA-FY24-04	$ -	$ -	**$ -**	$ 10,000	$ 10,000
1240 Interior blinds replacement	FA-FY24-05	**$ -**	$ -	**$ -**	$ 25,000	$ 25,000
EV Charging stations, if not completed in FY23 and carried over to FY24	FA-FY24-06	**$ 35,399**	$ -	**$ 35,399**	$ 50,000	$ 14,601
Fixed Asset Reclass due to new policy (FN-601)		**$ -**	$ (324,617)	**$ (324,617)**		$ 324,617
Building Improvement Subtotal		**$ 53,694**	**$ (324,617)**	**$ (270,923)**	**$ 125,000**	**$ 395,923**
4. Furniture & Equipment:						
Office desks, cabinets, shelvings (all building/suites: new or replacement)	FA-FY24-17	$ 3,860	$ -	**$ 3,860**	$ 10,000	$ 6,140
Replace, reconfigure, re-design workstations	FA-FY24-18	$ -	$ -	**$ -**	$ 20,000.00	$ 20,000
Fixed Asset Reclass due to new policy (FN-601)		$ -	$ (3,860)	**$ (3,860)**		$ 3,860
Furniture & Equipment Subtotal		**$ 3,860**	**$ (3,860)**	**$ -**	**$ 30,000**	**$ 30,000**
5. Leasehold Improvement						
ExacqVision NVR Upgrade, Cameras/Video System upgrade	FA-FY24-02	$ -	$ 1,153	**$ 1,153**	$ -	$ (1,153)
		$ -	$ -	**$ -**	$ -	$ -
		$ -	$ -	**$ -**	$ -	$ -
Leasehold Improvement Subtotal		**$ -**	**$ 1,153**	**$ 1,153**	**$ -**	**$ (1,153)**
GRAND TOTAL		**$ 1,159,395**	**$ (742,850)**	**$ 416,545**	**$ 1,601,701**	**$ 1,185,156**
6. Reconciliation to Balance Sheet:						
Fixed Assets @ Cost - 5/31/24				**$ 38,111,641**		
Fixed Assets @ Cost - 6/30/23				**$ 37,695,096**		
Fixed Assets Acquired YTD				**$ 416,545**		

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

TANGIBLE NET EQUITY (TNE)

			QTR. END			QTR. END			QTR. END		
	Jul-23	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**
Current Month Net Income / (Loss)	$9,746,933	$2,343,460	$5,514,335	$3,776,499	$3,440,910	$10,563,766	($8,009,058)	$5,392,121	($3,313,721)	($8,258,822)	($29,164,293)
YTD Net Income / (Loss)	$9,746,933	$12,090,393	$17,604,728	$21,381,227	$24,822,137	$35,385,903	$27,376,845	$32,768,966	$29,455,245	$21,196,423	($7,967,870)
Actual TNE											
Net Assets	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178	$359,342,945	$351,333,888	$356,726,008	$353,412,287	$345,153,466	$315,989,172
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$333,703,974**	**$336,047,435**	**$341,561,770**	**$345,338,268**	**$348,779,178**	**$359,342,945**	**$351,333,888**	**$356,726,008**	**$353,412,287**	**$345,153,466**	**$315,989,172**
Increase/(Decrease) in Actual TNE	$9,746,933	$2,343,460	$5,514,335	$3,776,499	$3,440,910	$10,563,766	($8,009,058)	$5,392,121	($3,313,721)	($8,258,822)	($29,164,293)
Required TNE[1]	**$46,228,233**	**$46,744,204**	**$46,352,062**	**$49,676,617**	**$49,894,371**	**$49,622,261**	**$57,429,796**	**$55,347,714**	**$56,252,051**	**$62,358,321**	**$61,532,891**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$69,342,350	$70,116,307	$69,528,093	$74,514,926	$74,841,557	$74,433,391	$86,144,695	$83,021,571	$84,378,076	$93,537,481	$92,299,337
TNE Excess / (Deficiency)	$287,475,741	$289,303,231	$295,209,708	$295,661,651	$298,884,807	$309,720,684	$293,904,092	$301,378,294	$297,160,236	$282,795,145	$254,456,281
Actual TNE as a Multiple of Required	**7.22**	**7.19**	**7.37**	**6.95**	**6.99**	**7.24**	**6.12**	**6.45**	**6.28**	**5.54**	**5.14**

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	Mar-24	Apr-24	May-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	$353,412,287	$345,153,466	$315,989,172
Fixed Assets at Net Book Value	(5,169,098)	(5,539,264)	(5,608,622)	(5,653,388)	(6,079,010)	(5,997,733)	(7,085,899)	(6,961,780)	(5,826,171)	(5,763,018)	(5,499,516)
Net Lease Assets/Liabilities/Interest	(711,429)	(475,037)	(1,115,074)	(727,353)	(662,463)	(1,135,481)	(1,193,576)	(1,033,509)	(879,498)	(859,354)	(681,823)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$328,184,876**	**$330,158,171**	**$335,603,148**	**$339,334,880**	**$342,350,168**	**$352,995,212**	**$343,897,989**	**$349,414,228**	**$347,236,116**	**$339,040,448**	**$310,139,656**
Liquid TNE as Multiple of Required	**7.10**	**7.06**	**7.24**	**6.83**	**6.86**	**7.11**	**5.99**	**6.31**	**6.17**	**5.44**	**5.04**

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Page 1	Actual Enrollment by Plan & Category of Aid
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	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	102,463	101,393	100,038	101,120	101,243	102,088	109,553	109,953	110,250	110,502	110,539		1,159,142
Adult	52,550	52,102	51,499	52,396	52,151	51,696	62,860	63,117	63,293	63,507	63,365		628,536
SPD	31,055	30,840	30,592	30,888	30,865	30,846	35,013	34,875	34,972	34,888	34,965		359,799
ACA OE	123,707	121,819	120,016	121,430	120,573	119,668	145,842	146,757	148,061	149,168	149,425		1,466,466
Duals	41,688	41,715	41,629	41,496	40,997	40,974	40,117	40,403	40,222	39,951	39,842		449,034
MCAL LTC	141	138	139	135	137	135	219	217	216	224	220		1,921
MCAL LTC Duals	1,033	1,019	1,004	997	975	951	1,311	1,329	1,307	1,291	1,283		12,500
Medi-Cal Program	352,637	349,026	344,917	348,462	346,941	346,358	394,915	396,651	398,321	399,531	399,639		4,077,398
Group Care Program	5,669	5,645	5,631	5,605	5,585	5,622	5,603	5,608	5,620	5,643	5,640		61,871
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**	**400,518**	**402,259**	**403,941**	**405,174**	**405,279**		**4,139,269**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)	1,082	123	845	7,465	400	297	252	37		6,869
Adult	(624)	(448)	(603)	897	(245)	(455)	11,164	257	176	214	(142)		10,191
SPD	(225)	(215)	(248)	296	(23)	(19)	4,167	(138)	97	(84)	77		3,685
ACA OE	(1,260)	(1,888)	(1,803)	1,414	(857)	(905)	26,174	915	1,304	1,107	257		24,458
Duals	(43)	27	(86)	(133)	(499)	(23)	(857)	286	(181)	(271)	(109)		(1,889)
MCAL LTC	(9)	(3)	1	(4)	2	(2)	84	(2)	(1)	8	(4)		70
MCAL LTC Duals	4	(14)	(15)	(7)	(22)	(24)	360	18	(22)	(16)	(8)		254
Medi-Cal Program	(3,364)	(3,611)	(4,109)	3,545	(1,521)	(583)	48,557	1,736	1,670	1,210	108		43,638
Group Care Program	(15)	(24)	(14)	(26)	(20)	37	(19)	5	12	23	(3)		(44)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**	**48,538**	**1,741**	**1,682**	**1,233**	**105**		**43,594**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	29.1%	29.1%	29.0%	29.0%	29.2%	29.5%	27.7%	27.7%	27.7%	27.7%	27.7%		28.4%
Adult % of Medi-Cal	14.9%	14.9%	14.9%	15.0%	15.0%	14.9%	15.9%	15.9%	15.9%	15.9%	15.9%		15.4%
SPD % of Medi-Cal	8.8%	8.8%	8.9%	8.9%	8.9%	8.9%	8.9%	8.8%	8.8%	8.7%	8.7%		8.8%
ACA OE % of Medi-Cal	35.1%	34.9%	34.8%	34.8%	34.8%	34.6%	36.9%	37.0%	37.2%	37.3%	37.4%		36.0%
Duals % of Medi-Cal	11.8%	12.0%	12.1%	11.9%	11.8%	11.8%	10.2%	10.2%	10.1%	10.0%	10.0%		11.0%
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%		98.5%
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%		1.5%
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%**

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Page 1	Actual Enrollment by Plan & Category of Aid
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	Actual Jul-23	**Actual Aug-23**	**Actual Sep-23**	**Actual Oct-23**	**Actual Nov-23**	**Actual Dec-23**	**Actual Jan-24**	**Actual Feb-24**	**Actual Mar-24**	**Actual Apr-24**	**Actual May-24**	**Actual Jun-24**	**YTD Member Months**
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027	72,504	78,530	75,141	76,228	104,906	91,656	89,759	89,551	88,353		914,202
Alameda Health System	66,089	65,344	64,133	63,271	63,903	63,545	83,981	89,168	90,086	90,631	91,108		831,259
	140,636	138,371	136,637	141,801	139,044	139,773	188,887	180,824	179,845	180,182	179,461		1,745,461
Delegated:													
CFMG	34,810	34,649	34,144	34,035	35,105	35,399	42,148	43,527	43,412	43,700	44,076		425,005
CHCN	130,230	129,183	127,430	126,705	127,641	128,331	169,483	177,908	180,684	181,292	181,742		1,660,629
Kaiser	52,630	52,468	52,337	51,526	50,736	48,477	0	0	0	0	0		308,174
Delegated Subtotal	217,670	216,300	213,911	212,266	213,482	212,207	211,631	221,435	224,096	224,992	225,818		2,393,808
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**	**400,518**	**402,259**	**403,941**	**405,174**	**405,279**		**4,139,269**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(939)	(2,265)	(1,734)	5,164	(2,757)	729	49,114	(8,063)	(979)	337	(721)		37,886
Delegated:													
CFMG	(441)	(161)	(505)	(109)	1,070	294	6,749	1,379	(115)	288	376		8,825
CHCN	(1,721)	(1,047)	(1,753)	(725)	936	690	41,152	8,425	2,776	608	450		49,791
Kaiser	(278)	(162)	(131)	(811)	(790)	(2,259)	(48,477)	0	0	0	0		(52,908)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	1,216	(1,275)	(576)	9,804	2,661	896	826		5,708
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**	**48,538**	**1,741**	**1,682**	**1,233**	**105**		**43,594**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	39.3%	39.0%	39.0%	40.0%	39.4%	39.7%	47.2%	45.0%	44.5%	44.5%	44.3%		42.2%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	10.0%	10.1%	10.5%	10.8%	10.7%	10.8%	10.9%		10.3%
CHCN	36.3%	36.4%	36.4%	35.8%	36.2%	36.5%	42.3%	44.2%	44.7%	44.7%	44.8%		40.1%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.4%	13.8%	0.0%	0.0%	0.0%	0.0%	0.0%		7.4%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	60.6%	60.3%	52.8%	55.0%	55.5%	55.5%	55.7%		57.8%
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%**

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	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%**

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

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

	Variance Jul-23	Variance Aug-23	Variance Sep-23	Variance Oct-23	Variance Nov-23	Variance Dec-23	Variance Jan-24	Variance Feb-24	Variance Mar-24	Variance Apr-24	Variance May-24	Variance Jun-24	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	1,134	3,080	7,394	9,020	10,427	11,777	12,900		55,732
Adult	0	0	0	0	279	395	5,382	6,329	7,186	8,073	8,596		36,240
SPD	0	0	0	0	131	358	(7,460)	(7,258)	(6,824)	(6,574)	(6,165)		(33,792)
ACA OE	0	0	0	0	(607)	63	(3,355)	(799)	2,128	4,840	6,685		8,955
Duals	0	0	0	0	(413)	(351)	(5,670)	(5,291)	(5,378)	(5,555)	(5,570)		(28,228)
MCAL LTC	0	0	0	0	1	(2)	47	44	42	49	44		225
MCAL LTC Duals	0	0	0	0	(10)	(20)	117	153	148	149	158		695
Medi-Cal Program	0	0	0	0	515	3,523	(3,545)	2,198	7,729	12,759	16,648		39,827
Group Care Program	0	0	0	0	(6)	45	40	59	85	122	133		478
Total	**0**	**0**	**0**	**0**	**509**	**3,568**	**(3,505)**	**2,257**	**7,814**	**12,881**	**16,781**		**40,305**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted										180,182	179,461		
Directly Contracted (DCP)	0	0	0	0	(3,033)	(1,315)	919	(11,498)	(12,582)	(11,985)	(12,386)		(51,880)
Alameda Health System	0	0	0	0	926	1,291	(2,869)	3,243	5,064	6,502	7,863		22,020
	0	0	0	0	(2,107)	(24)	(1,950)	(8,255)	(7,518)	(5,483)	(4,523)		(29,860)
Delegated:													
CFMG	0	0	0	0	1,396	2,060	(956)	932	1,281	2,029	2,859		9,601
CHCN	0	0	0	0	1,672	3,694	(599)	9,580	14,051	16,335	18,445		63,178
Kaiser	0	0	0	0	(452)	(2,162)	0	0	0	0	0		(2,614)
Delegated Subtotal	0	0	0	0	2,616	3,592	(1,555)	10,512	15,332	18,364	21,304		70,165
Total	**0**	**0**	**0**	**0**	**509**	**3,568**	**(3,505)**	**2,257**	**7,814**	**12,881**	**16,781**		**40,305**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED MAY 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:				
$5,126,889	$1,378,470	($3,748,419)	(271.9%)	PCP Capitation	$32,724,940	$13,935,324	($18,789,616)	(134.8%)
6,180,008	6,100,626	(79,382)	(1.3%)	PCP Capitation FQHC	56,517,595	57,627,639	1,110,044	1.9%
381,529	357,867	(23,662)	(6.6%)	Specialty-Capitation	3,687,585	3,605,053	(82,532)	(2.3%)
5,394,049	5,482,855	88,806	1.6%	Specialty-Capitation FQHC	49,247,515	51,089,501	1,841,986	3.6%
709,206	698,738	(10,469)	(1.5%)	Laboratory Capitation	6,764,995	6,620,120	(144,875)	(2.2%)
339,788	323,350	(16,439)	(5.1%)	Vision Cap	3,213,331	3,163,495	(49,836)	(1.6%)
110,996	104,232	(6,764)	(6.5%)	CFMG Capitation	1,072,734	1,049,715	(23,019)	(2.2%)
266,462	267,825	1,362	0.5%	Anc IPA Admin Capitation FQHC	2,438,215	2,511,757	73,542	2.9%
(3,764,475)	0	3,764,475	0.0%	Kaiser Capitation	80,008,718	84,015,590	4,006,872	4.8%
0	0	0	0.0%	BHT Supplemental Expense	4,672	0	(4,672)	0.0%
0	0	0	0.0%	Maternity Supplemental Expense	2,433,101	2,311,103	(121,999)	(5.3%)
878,235	1,020,443	142,208	13.9%	DME Cap	8,684,290	9,542,402	858,112	9.0%
$15,622,688	**$15,734,405**	**$111,717**	**0.7%**	**5 - TOTAL CAPITATED EXPENSES**	**$246,797,691**	**$235,471,698**	**($11,325,994)**	**(4.8%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
(1,274,736)	0	1,274,736	0.0%	IBNR Inpatient Services	21,493,791	(2,306,298)	(23,800,089)	1,032.0%
(38,242)	0	38,242	0.0%	IBNR Settlement (IP)	644,813	(69,188)	(714,001)	1,032.0%
(101,978)	0	101,978	0.0%	IBNR Claims Fluctuation (IP)	756,256	(184,504)	(940,760)	509.9%
44,551,370	48,654,434	4,103,064	8.4%	Inpatient Hospitalization FFS	379,361,569	430,884,284	51,522,715	12.0%
3,286,406	0	(3,286,406)	0.0%	IP OB - Mom & NB	24,640,611	7,462,632	(17,177,978)	(230.2%)
232,762	0	(232,762)	0.0%	IP Behavioral Health	2,166,535	895,483	(1,271,051)	(141.9%)
1,529,039	0	(1,529,039)	0.0%	IP Facility Rehab FFS	11,620,359	4,711,642	(6,908,717)	(146.6%)
$48,184,621	**$48,654,434**	**$469,813**	**1.0%**	**6 - Inpatient Hospital & SNF Expense**	**$440,683,934**	**$441,394,052**	**$710,119**	**0.2%**
4,798	0	(4,798)	0.0%	IBNR PCP	490,670	46,983	(443,687)	(944.4%)
144	0	(144)	0.0%	IBNR Settlement (PCP)	14,719	1,409	(13,310)	(944.6%)
384	0	(384)	0.0%	IBNR Claims Fluctuation (PCP)	49,824	3,759	(46,065)	(1,225.5%)
5,084,736	2,712,746	(2,371,990)	(87.4%)	Primary Care Non-Contracted FF	33,692,593	24,996,213	(8,696,380)	(34.8%)
573,615	321,659	(251,956)	(78.3%)	PCP FQHC FFS	5,005,181	4,126,462	(878,720)	(21.3%)
0	0	0	0.0%	Phys Extended Hours Incentive	3,500	6,000	2,500	41.7%
(2,952,505)	3,593,559	6,546,064	182.2%	Prop 56 Physician	10,121,350	33,948,024	23,826,674	70.2%
16,313	0	(16,313)	0.0%	Prop 56 Hyde	257,700	58,257	(199,443)	(342.3%)
(40,891)	0	40,891	0.0%	Prop 56 Trauma Screening	708,981	316,945	(392,036)	(123.7%)
(71,083)	0	71,083	0.0%	Prop 56 Develop. Screening	776,492	383,782	(392,710)	(102.3%)
(1,545,725)	0	1,545,725	0.0%	Prop 56 Family Planning	5,748,536	2,905,675	(2,842,861)	(97.8%)
(4,007,240)	0	4,007,240	0.0%	Prop 56 VBP	(4,305,646)	7,428	4,313,074	58,062.5%
($2,937,455)	**$6,627,964**	**$9,565,419**	**144.3%**	**7 - Primary Care Physician Expense**	**$52,563,901**	**$66,800,937**	**$14,237,036**	**21.3%**
(1,294,266)	0	1,294,266	0.0%	IBNR Specialist	300,083	(704,271)	(1,004,354)	142.6%
380,899	0	(380,899)	0.0%	Psychiatrist FFS	3,227,730	927,497	(2,300,233)	(248.0%)
4,068,006	7,601,711	3,533,705	46.5%	Specialty Care FFS	28,692,831	57,904,460	29,211,630	50.4%
252,124	0	(252,124)	0.0%	Specialty Anesthesiology	2,095,583	733,088	(1,362,495)	(185.9%)
1,625,959	0	(1,625,959)	0.0%	Specialty Imaging FFS	13,215,085	4,332,553	(8,882,532)	(205.0%)
39,941	0	(39,941)	0.0%	Obstetrics FFS	243,760	71,825	(171,936)	(239.4%)
540,851	0	(540,851)	0.0%	Specialty IP Surgery FFS	3,455,426	1,146,377	(2,309,049)	(201.4%)
1,211,668	0	(1,211,668)	0.0%	Specialty OP Surgery FFS	7,960,190	2,380,160	(5,580,030)	(234.4%)
732,862	0	(732,862)	0.0%	Spec IP Physician	5,587,071	1,804,945	(3,782,127)	(209.5%)
181,070	103,541	(77,530)	(74.9%)	SCP FQHC FFS	1,022,485	917,983	(104,502)	(11.4%)
(38,827)	0	38,827	0.0%	IBNR Settlement (SCP)	9,007	(21,127)	(30,134)	142.6%
(103,541)	0	103,541	0.0%	IBNR Claims Fluctuation (SCP)	64,598	(56,342)	(120,940)	214.7%
$7,596,747	**$7,705,252**	**$108,505**	**1.4%**	**8 - Specialty Care Physician Expense**	**$65,873,849**	**$69,437,148**	**$3,563,298**	**5.1%**
(2,055,027)	0	2,055,027	0.0%	IBNR Ancillary	3,572,848	2,122,555	(1,450,293)	(68.3%)
(61,651)	0	61,651	0.0%	IBNR Settlement (ANC)	107,187	63,677	(43,510)	(68.3%)
(164,402)	0	164,402	0.0%	IBNR Claims Fluctuation (ANC)	224,833	169,805	(55,028)	(32.4%)
12,473	0	(12,473)	0.0%	IBNR Transportation FFS	598,102	45,720	(552,382)	(1,208.2%)
2,059,025	0	(2,059,025)	0.0%	Behavioral Health Therapy FFS	15,080,150	4,951,126	(10,129,023)	(204.6%)
1,961,195	0	(1,961,195)	0.0%	Psychologist & Other MH Prof.	13,533,449	4,215,464	(9,317,985)	(221.0%)
448,362	0	(448,362)	0.0%	Acupuncture/Biofeedback	3,347,492	1,075,338	(2,272,154)	(211.3%)
152,131	0	(152,131)	0.0%	Hearing Devices	1,328,111	381,525	(946,586)	(248.1%)
74,220	0	(74,220)	0.0%	Imaging/MRI/CT Global	535,735	141,544	(394,191)	(278.5%)
85,227	0	(85,227)	0.0%	Vision FFS	640,826	164,593	(476,233)	(289.3%)
20	0	(20)	0.0%	Family Planning	89	30	(59)	(200.0%)
1,554,237	0	(1,554,237)	0.0%	Laboratory-FFS	6,597,507	1,917,612	(4,679,895)	(244.0%)
207,730	0	(207,730)	0.0%	ANC Therapist	1,178,134	395,200	(782,934)	(198.1%)
2,090,815	0	(2,090,815)	0.0%	Transportation (Ambulance)-FFS	13,202,618	3,746,485	(9,456,132)	(252.4%)
2,177,944	0	(2,177,944)	0.0%	Transportation (Other)-FFS	18,599,503	5,929,067	(12,670,436)	(213.7%)
2,102,267	0	(2,102,267)	0.0%	Hospice	16,597,210	5,779,983	(10,817,228)	(187.1%)

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

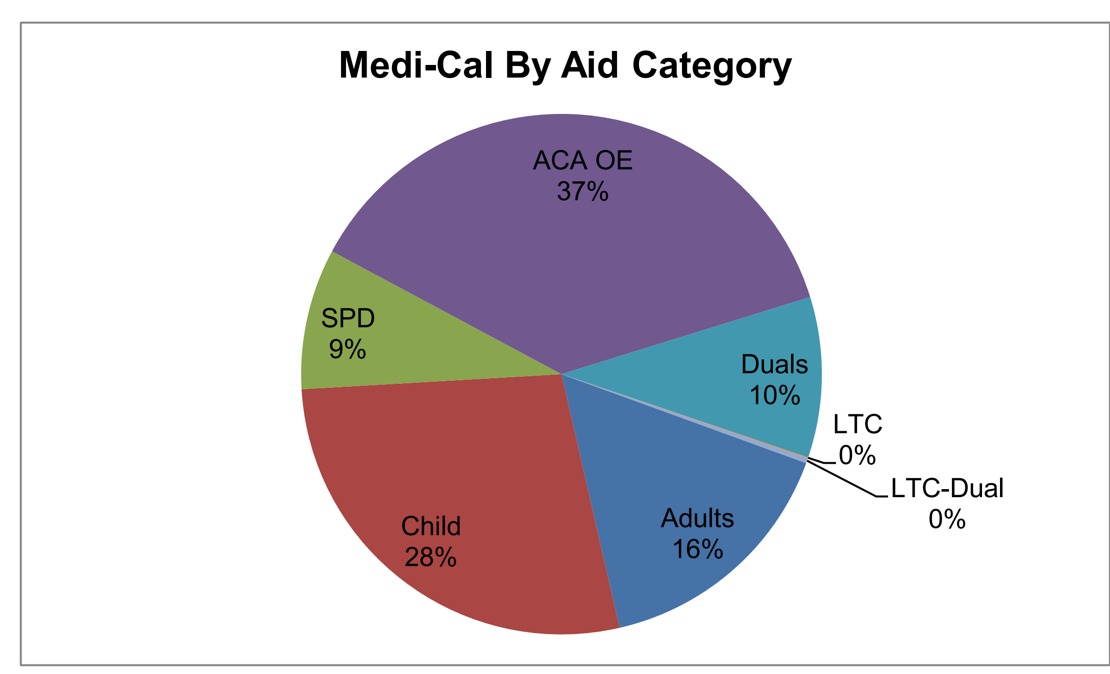
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,805,283	0	(1,805,283)	0.0%	Home Health Services	14,849,808	4,994,036	(9,855,771)	(197.4%)
0	12,444,805	12,444,805	100.0%	Other Medical-FFS	12,077	80,173,389	80,161,312	100.0%
(60,054)	0	60,054	0.0%	Medical Refunds through HMS	(160,659)	(309,963)	(149,303)	48.2%
(83)	0	83	0.0%	Medical Refunds	(768,260)	(565,083)	203,177	(36.0%)
103,790	0	(103,790)	0.0%	DME & Medical Supplies	341,806	116,689	(225,116)	(192.9%)
0	0	0	0.0%	GEMT FFS	(373,988)	(373,988)	0	0.0%
1,752,034	1,812,987	60,953	3.4%	ECM Base/Outreach FFS Anc.	17,488,192	17,237,354	(250,838)	(1.5%)
17,976	0	(17,976)	0.0%	CS Housing Deposits FFS Ancillary	(4,151,737)	135,985	4,287,721	3,153.1%
245,961	0	(245,961)	0.0%	CS Housing Tenancy FFS Ancillary	6,802,916	1,183,089	(5,619,826)	(475.0%)
127,939	0	(127,939)	0.0%	CS Housing Navigation Services FFS Ancillary	160,228	257,647	97,419	37.8%
195,986	0	(195,986)	0.0%	CS Medical Respite FFS Ancillary	2,094,252	377,892	(1,716,360)	(454.2%)
89,981	0	(89,981)	0.0%	CS Medically Tailored Meals FFS Ancillary	(116,733)	128,446	245,179	190.9%
6,126	0	(6,126)	0.0%	CS Asthma Remediation FFS Ancillary	(235,053)	11,648	246,700	2,118.0%
0	10,000	10,000	100.0%	MOT Wrap Around (Non Medical MOT Cost)	0	70,000	70,000	100.0%
153,456	0	(153,456)	0.0%	CS Personal Care & Homemaker Services FFS Ancillary	1,707,850	0	(1,707,850)	0.0%
803	0	(803)	0.0%	CS Caregiver Respite Services FFS Ancillary	12,747	0	(12,747)	0.0%
446,724	0	(446,724)	0.0%	Community Based Adult Services (CBAS)	4,247,406	1,425,263	(2,822,143)	(198.0%)
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	42,815	23,701	(19,114)	(80.6%)
0	0	0	0.0%	Justice Involved Pilot	0	161,111	161,111	100.0%
$15,535,841	**$14,267,792**	**($1,268,049)**	**(8.9%)**	**9 - Ancillary Medical Expense**	**$137,097,463**	**$136,162,232**	**($935,231)**	**(0.7%)**
(1,461,274)	0	1,461,274	0.0%	IBNR Outpatient	3,427,907	422,626	(3,005,281)	(711.1%)
(43,838)	0	43,838	0.0%	IBNR Settlement (OP)	102,836	12,677	(90,159)	(711.2%)
(116,903)	0	116,903	0.0%	IBNR Claims Fluctuation (OP)	268,463	33,811	(234,652)	(694.0%)
2,498,723	12,351,383	9,852,659	79.8%	Out Patient FFS	20,024,953	84,381,191	64,356,238	76.3%
2,500,439	0	(2,500,439)	0.0%	OP Ambul Surgery FFS	20,482,421	6,937,396	(13,545,025)	(195.2%)
2,831,316	0	(2,831,316)	0.0%	OP Fac Imaging Services FFS	20,637,274	6,670,623	(13,966,652)	(209.4%)
23,721	0	(23,721)	0.0%	Behav Health FFS	147,904	(21,966)	(169,870)	773.3%
740,840	0	(740,840)	0.0%	OP Facility Lab FFS	6,505,071	2,081,864	(4,423,207)	(212.5%)
260,474	0	(260,474)	0.0%	OP Facility Cardio FFS	1,877,831	608,098	(1,269,733)	(208.8%)
111,994	0	(111,994)	0.0%	OP Facility PT/OT/ST FFS	1,653,720	270,230	(1,383,489)	(512.0%)
3,576,424	0	(3,576,424)	0.0%	OP Facility Dialysis FFS	25,347,624	8,379,495	(16,968,129)	(202.5%)
$10,921,916	**$12,351,383**	**$1,429,467**	**11.6%**	**10 - Outpatient Medical Expense Medical Expense**	**$100,476,005**	**$109,776,044**	**$9,300,040**	**8.5%**
(2,010,710)	0	2,010,710	0.0%	IBNR Emergency	1,949,394	30,260	(1,919,134)	(6,342.1%)
(60,320)	0	60,320	0.0%	IBNR Settlement (ER)	58,484	910	(57,574)	(6,326.8%)
(160,857)	0	160,857	0.0%	IBNR Claims Fluctuation (ER)	82,033	2,423	(79,610)	(3,285.6%)
1,529,315	0	(1,529,315)	0.0%	Special ER Physician FFS	10,237,472	3,056,795	(7,180,677)	(234.9%)
9,675,482	7,719,500	(1,955,982)	(25.3%)	ER Facility	69,031,029	69,634,046	603,017	0.9%
$8,972,910	**$7,719,500**	**($1,253,410)**	**(16.2%)**	**11 - Emergency Expense**	**$81,358,412**	**$72,724,434**	**($8,633,978)**	**(11.9%)**
(1,644,112)	0	1,644,112	0.0%	IBNR Pharmacy OP	1,328,444	(204,308)	(1,532,752)	750.2%
(49,323)	0	49,323	0.0%	IBNR Settlement (RX) OP	39,850	(6,133)	(45,983)	749.8%
(131,529)	0	131,529	0.0%	IBNR Claims Fluctuation (RX) OP	82,489	(16,345)	(98,834)	604.7%
603,672	372,379	(231,294)	(62.1%)	Pharmacy FFS	5,708,444	4,528,768	(1,179,676)	(26.0%)
249,284	11,985,783	11,736,498	97.9%	Pharmacy Non-PBM FFS-Other Anc	1,444,273	77,580,055	76,135,782	98.1%
10,089,615	0	(10,089,615)	0.0%	Pharmacy Non-PBM FFS-OP FAC	67,992,484	21,975,503	(46,016,981)	(209.4%)
296,965	0	(296,965)	0.0%	Pharmacy Non-PBM FFS-PCP	2,471,764	615,362	(1,856,402)	(301.7%)
2,733,873	0	(2,733,873)	0.0%	Pharmacy Non-PBM FFS-SCP	24,377,589	8,807,902	(15,569,687)	(176.8%)
7,913	0	(7,913)	0.0%	Pharmacy Non-PBM FFS-FQHC	133,887	41,158	(92,728)	(225.3%)
21,788	0	(21,788)	0.0%	Pharmacy Non-PBM FFS-HH	105,368	27,987	(77,381)	(276.5%)
(406)	0	406	0.0%	RX Refunds HMS	(494)	(63)	430	(680.6%)
(54,000)	32,076	86,076	268.3%	Pharmacy Rebate	(568,617)	62,707	631,324	1,006.8%
$12,123,741	**$12,390,238**	**$266,497**	**2.2%**	**12 - Pharmacy Expense**	**$103,115,481**	**$113,412,594**	**$10,297,113**	**9.1%**
(8,310,634)	0	8,310,634	0.0%	IBNR LTC	20,855,446	4,802,539	(16,052,907)	(334.3%)
(249,318)	0	249,318	0.0%	IBNR Settlement (LTC)	625,666	144,077	(481,589)	(334.3%)
(664,851)	0	664,851	0.0%	IBNR Claims Fluctuation (LTC)	1,148,482	384,202	(764,280)	(198.9%)
1,897,201	0	(1,897,201)	0.0%	LTC - ICF/DD	5,394,660	0	(5,394,660)	0.0%
33,729,259	0	(33,729,259)	0.0%	LTC Custodial Care	211,662,033	63,392,176	(148,269,856)	(233.9%)
7,414,296	23,741,966	16,327,670	68.8%	LTC SNF	39,506,976	165,509,829	126,002,853	76.1%
$33,815,954	**$23,741,966**	**($10,073,988)**	**(42.4%)**	**13 - Long Term Care Expense**	**$279,193,263**	**$234,232,824**	**($44,960,439)**	**(19.2%)**
$134,214,275	**$133,458,529**	**($755,746)**	**(0.6%)**	**14 - TOTAL FFS MEDICAL EXPENSES**	**$1,260,362,308**	**$1,243,940,266**	**($16,422,042)**	**(1.3%)**
0	(304,723)	(304,723)	100.0%	Clinical Vacancy Department Total	0	(2,132,798)	(2,132,798)	100.0%
64,346	206,814	142,468	68.9%	Quality Analytics Department Total	884,339	1,621,698	737,360	45.5%
1,167,769	1,515,084	347,315	22.9%	Utilization Management Department Total	9,754,019	11,140,004	1,385,985	12.4%

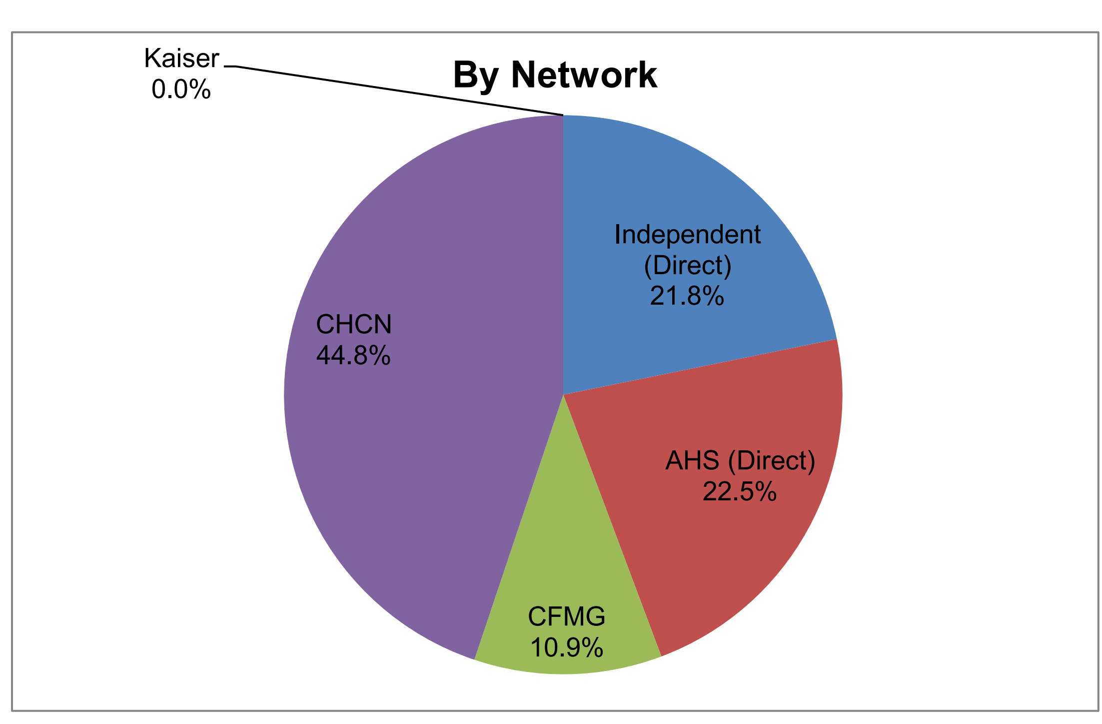
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED MAY 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
742,086	952,028	209,942	22.1%	Case/Disease Management Department Total	6,890,622	7,280,604	389,981	5.4%
(1,815,407)	1,611,614	3,427,021	212.6%	Medical Services Department Total	18,716,922	19,650,302	933,380	4.7%
1,122,497	1,230,686	108,189	8.8%	Quality Management Department Total	9,424,853	12,430,000	3,005,147	24.2%
365,826	448,403	82,577	18.4%	HCS Behavioral Health Department Total	3,148,180	3,413,463	265,283	7.8%
140,840	237,396	96,556	40.7%	Pharmacy Services Department Total	1,548,528	1,698,789	150,261	8.8%
70,681	85,281	14,599	17.1%	Regulatory Readiness Total	687,894	741,654	53,761	7.2%
$1,858,638	**$5,982,582**	**$4,123,945**	**68.9%**	**15 - Other Benefits & Services**	**$51,055,357**	**$55,843,716**	**$4,788,359**	**8.6%**
(3,073,296)	(1,063,796)	2,009,500	(188.9%)	Reinsurance Recoveries	(15,103,607)	(10,685,863)	4,417,744	(41.3%)
1,403,730	1,418,395	14,665	1.0%	Reinsurance Premium	13,352,752	13,362,039	9,287	0.1%
($1,669,566)	**$354,599**	**$2,024,165**	**570.8%**	**16- Reinsurance Expense**	**($1,750,855)**	**$2,676,176**	**$4,427,031**	**165.4%**
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%**
$150,026,034	**$155,530,115**	**$5,504,081**	**3.5%**	**18 - TOTAL MEDICAL EXPENSES**	**$1,559,464,501**	**$1,540,931,856**	**($18,532,645)**	**(1.2%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend							
Category of Aid	**May 2024**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	63,405	16%	13,024	14,537	6	35,838	-
Child	110,561	28%	9,198	13,601	41,127	46,635	-
SPD	34,965	9%	11,319	5,525	1,440	16,681	-
ACA OE	149,427	37%	25,100	53,730	1,506	69,091	-
Duals	39,842	10%	26,119	2,848	4	10,871	-
LTC	220	0%	205	7	-	8	-
LTC-Dual	1,283	0%	1,281	-	-	2	-
Medi-Cal	399,703		86,246	90,248	44,083	179,126	-
Group Care	5,640		2,135	870	-	2,635	-
Total	**405,343**	**100%**	**88,381**	**91,118**	**44,083**	**181,761**	**-**
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	*21.8%*	*22.5%*	*10.9%*	*44.8%*	*0.0%*
			% Direct:	**44%**		**% Delegated:**	**56%**

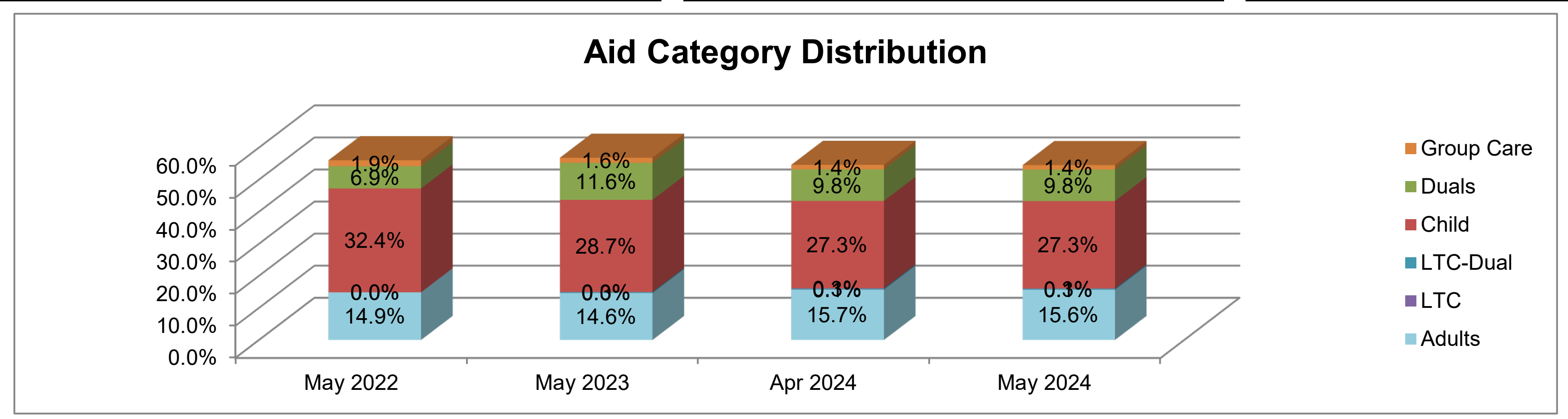




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

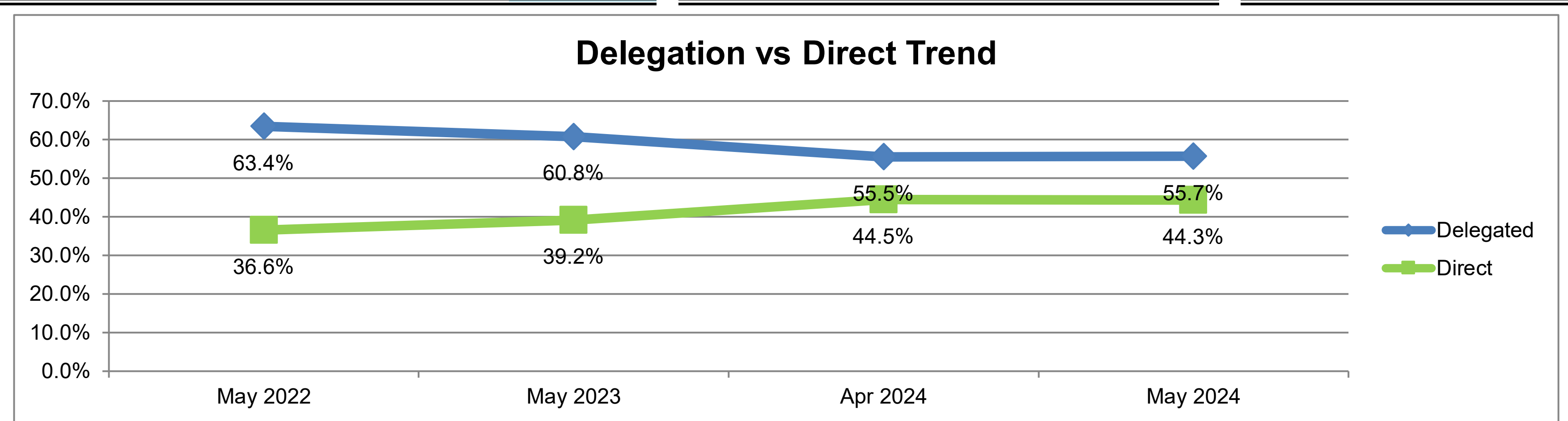
Category of Aid Trend

Category of Aid	Members May 2022	Members May 2023	Members Apr 2024	Members May 2024	% of Total May 2022	% of Total May 2023	% of Total Apr 2024	% of Total May 2024	% Growth May 2022 to May 2023	% Growth May 2023 to May 2024	% Growth Apr 2024 to May 2024
Adults	46,171	52,677	63,551	63,405	14.9%	14.6%	15.7%	15.6%	14.1%	20.4%	-0.2%
Child	100,560	103,434	110,566	110,561	32.4%	28.7%	27.3%	27.3%	2.9%	6.9%	0.0%
SPD	26,958	31,201	34,887	34,965	8.7%	8.7%	8.6%	8.6%	15.7%	12.1%	0.2%
ACA OE	109,734	124,397	149,154	149,427	35.3%	34.5%	36.8%	36.9%	13.4%	20.1%	0.2%
Duals	21,527	41,652	39,912	39,842	6.9%	11.6%	9.8%	9.8%	93.5%	-4.3%	-0.2%
LTC	-	148	223	220	0.0%	0.0%	0.1%	0.1%	0.0%	48.6%	-1.3%
LTC-Dual	-	1,003	1,291	1,283	0.0%	0.3%	0.3%	0.3%	0.0%	27.9%	-0.6%
Medi-Cal Total	304,950	354,512	399,584	399,703	98.1%	98.4%	98.6%	98.6%	16.3%	12.7%	0.0%
Group Care	5,808	5,670	5,643	5,640	1.9%	1.6%	1.4%	1.4%	-2.4%	-0.5%	-0.1%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.9%**	**12.5%**	**0.0%**



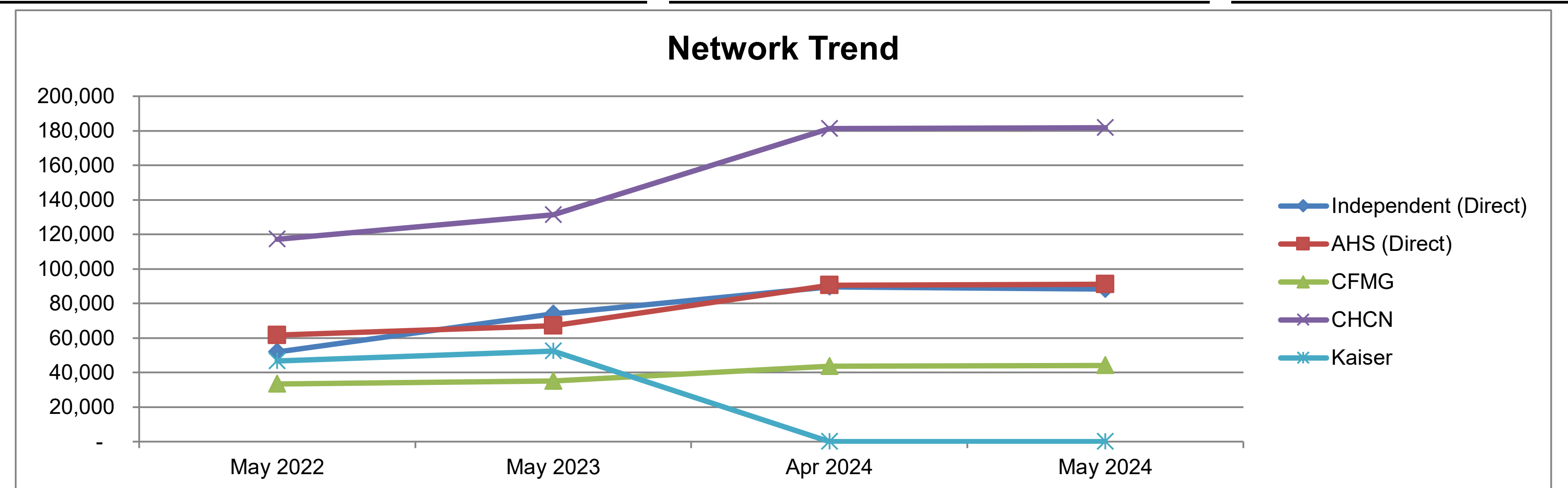
Delegation vs Direct Trend

Members	Members May 2022	Members May 2023	Members Apr 2024	Members May 2024	% of Total May 2022	% of Total May 2023	% of Total Apr 2024	% of Total May 2024	% Growth May 2022 to May 2023	% Growth May 2023 to May 2024	% Growth Apr 2024 to May 2024
Delegated	197,155	219,053	225,002	225,844	63.4%	60.8%	55.5%	55.7%	11.1%	3.1%	0.4%
Direct	113,603	141,129	180,225	179,499	36.6%	39.2%	44.5%	44.3%	24.2%	27.2%	-0.4%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.9%**	**12.5%**	**0.0%**



Network Trend

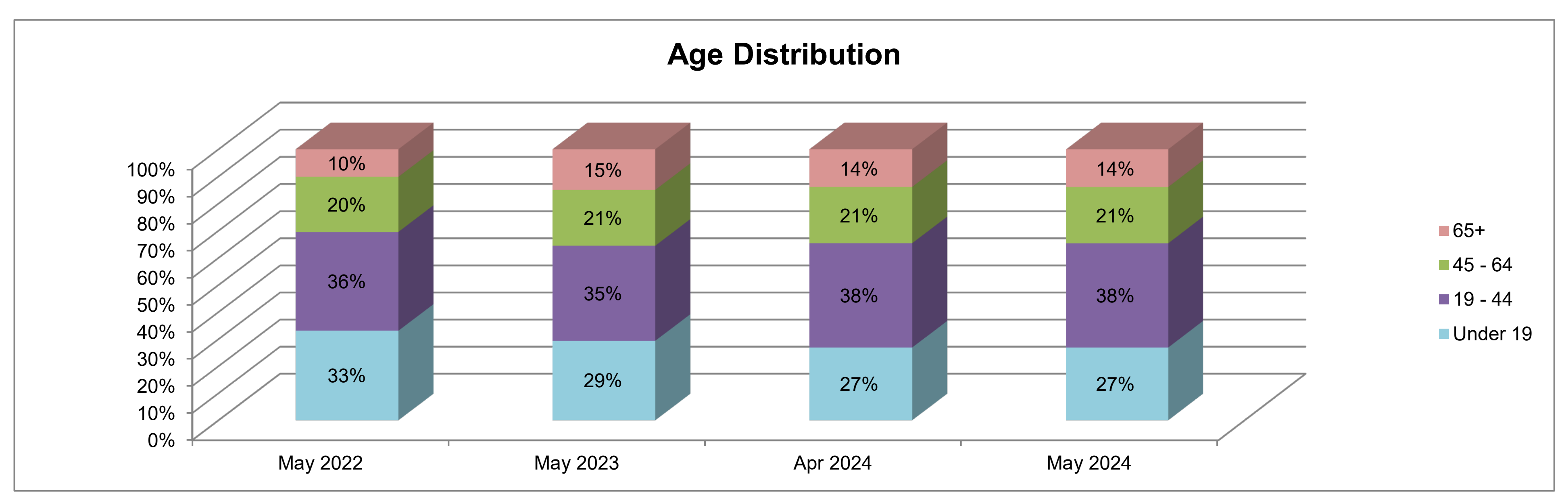
Network	Members May 2022	Members May 2023	Members Apr 2024	Members May 2024	% of Total May 2022	% of Total May 2023	% of Total Apr 2024	% of Total May 2024	% Growth May 2022 to May 2023	% Growth May 2023 to May 2024	% Growth Apr 2024 to May 2024
Independent (Direct)	51,910	74,016	89,595	88,381	16.7%	20.5%	22.1%	21.8%	42.6%	19.4%	-1.4%
AHS (Direct)	61,693	67,113	90,630	91,118	19.9%	18.6%	22.4%	22.5%	8.8%	35.8%	0.5%
CFMG	33,378	35,138	43,702	44,083	10.7%	9.8%	10.8%	10.9%	5.3%	25.5%	0.9%
CHCN	117,163	131,489	181,300	181,761	37.7%	36.5%	44.7%	44.8%	12.2%	38.2%	0.3%
Kaiser	46,614	52,426	-	-	15.0%	14.6%	0.0%	0.0%	12.5%	-100.0%	0.0%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.9%**	**12.5%**	**0.0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

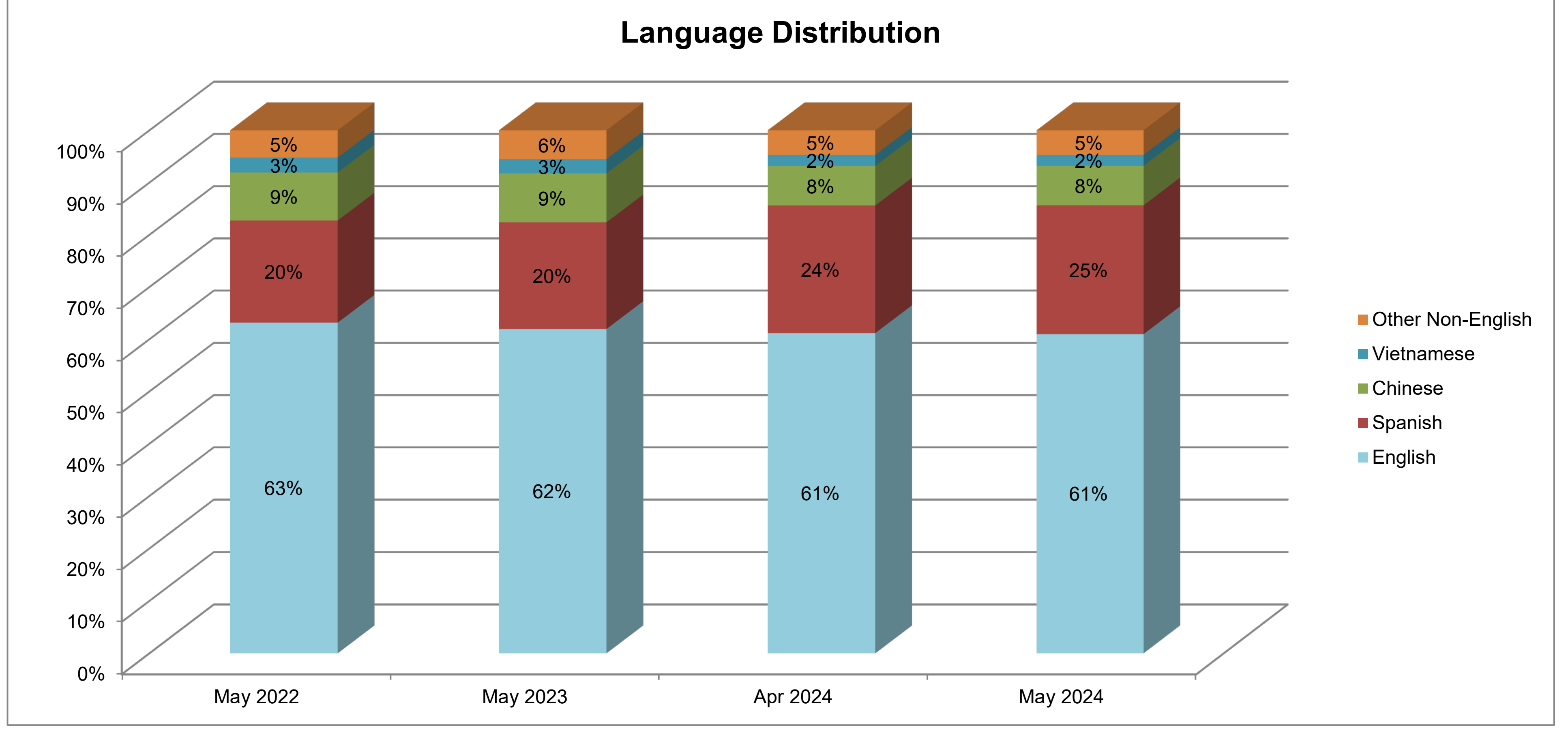
Age Category Trend

Age Category	Members May 2022	Members May 2023	Members Apr 2024	Members May 2024	% of Total (ie.Distribution) May 2022	% of Total May 2023	% of Total Apr 2024	% of Total May 2024	% Growth (Loss) May 2022 to May 2023	% Growth (Loss) May 2023 to May 2024	% Growth (Loss) Apr 2024 to May 2024
Under 19	102,823	105,787	108,917	108,994	33%	29%	27%	27%	3%	3%	0%
19 - 44	113,325	126,401	156,001	155,914	36%	35%	38%	38%	12%	23%	0%
45 - 64	63,061	74,095	84,128	84,121	20%	21%	21%	21%	17%	14%	0%
65+	31,549	53,899	56,181	56,314	10%	15%	14%	14%	71%	4%	0%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



Language Trend

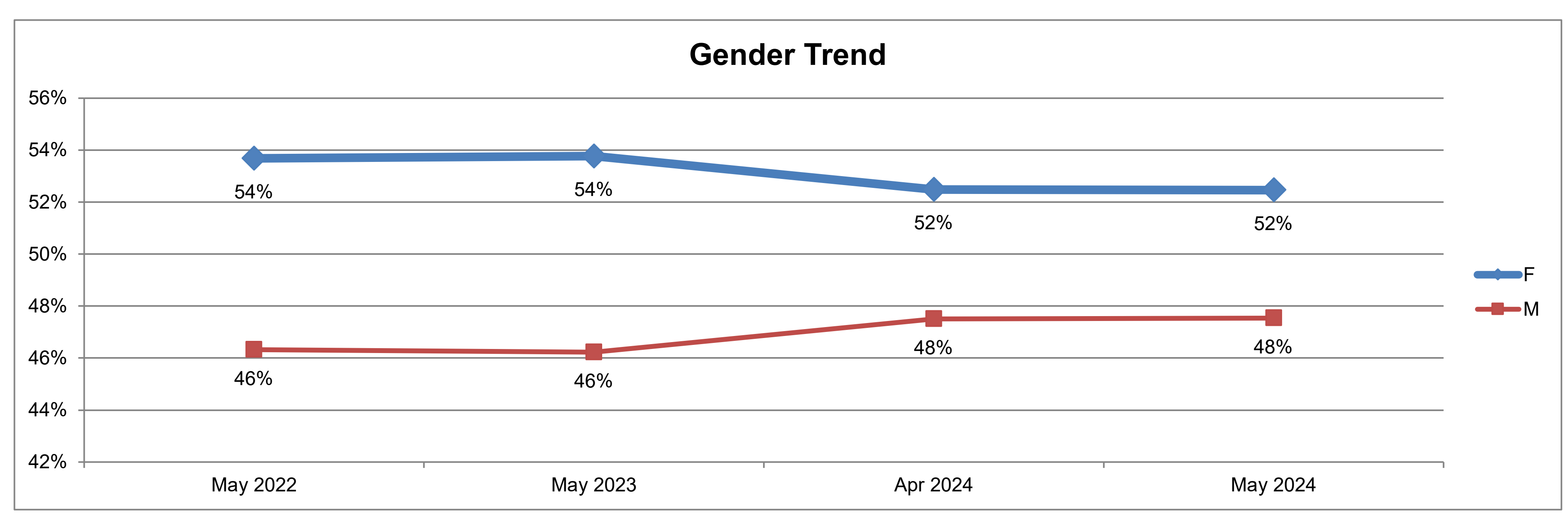
Language	Members May 2022	Members May 2023	Members Apr 2024	Members May 2024	% of Total (ie.Distribution) May 2022	% of Total May 2023	% of Total Apr 2024	% of Total May 2024	% Growth (Loss) May 2022 to May 2023	% Growth (Loss) May 2023 to May 2024	% Growth (Loss) Apr 2024 to May 2024
English	196,309	223,164	247,927	247,134	63%	62%	61%	61%	14%	11%	0%
Spanish	60,778	73,539	98,970	99,964	20%	20%	24%	25%	21%	36%	1%
Chinese	28,583	33,819	30,725	30,741	9%	9%	8%	8%	18%	-9%	0%
Vietnamese	8,868	9,828	8,548	8,461	3%	3%	2%	2%	11%	-14%	-1%
Other Non-English	16,220	19,832	19,057	19,043	5%	6%	5%	5%	22%	-4%	0%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

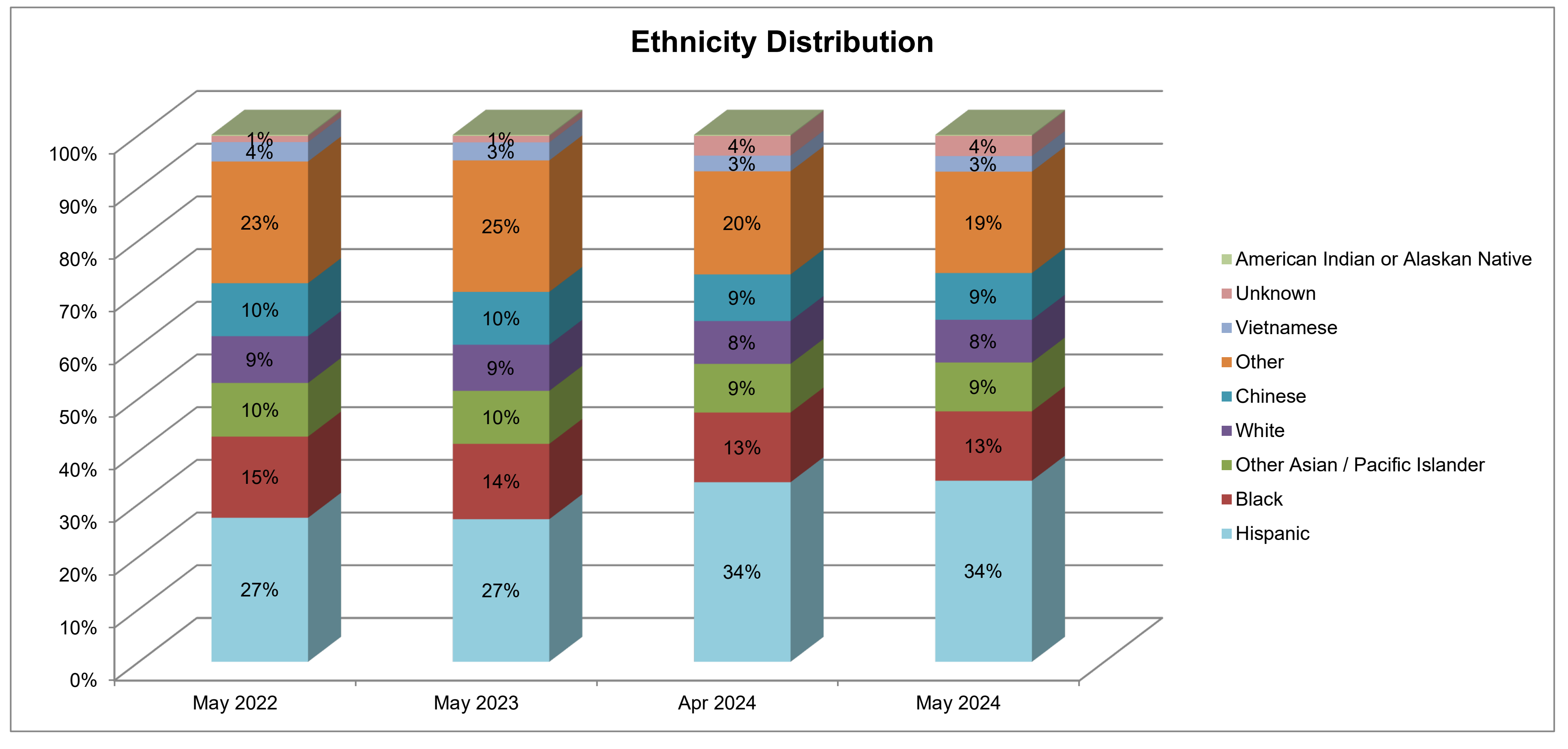
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022 to May 2023**	**May 2023 to May 2024**	**Apr 2024 to May 2024**
F	166,816	193,677	212,693	212,650	54%	54%	52%	52%	16%	10%	0%
M	143,942	166,505	192,534	192,693	46%	46%	48%	48%	16%	16%	0%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022 to May 2023**	**May 2023 to May 2024**	**Apr 2024 to May 2024**
Hispanic	84,892	97,427	138,080	139,254	27%	27%	34%	34%	15%	43%	1%
Black	47,883	51,493	53,580	53,353	15%	14%	13%	13%	8%	4%	0%
Other Asian / Pacific Islander	31,631	36,245	37,409	37,596	10%	10%	9%	9%	15%	4%	0%
White	27,619	31,499	32,949	32,881	9%	9%	8%	8%	14%	4%	0%
Chinese	31,216	36,159	35,847	35,951	10%	10%	9%	9%	16%	-1%	0%
Other	71,778	89,867	79,277	77,966	23%	25%	20%	19%	25%	-13%	-2%
Vietnamese	11,444	12,326	12,050	11,993	4%	3%	3%	3%	8%	-3%	0%
Unknown	3,620	4,425	15,231	15,550	1%	1%	4%	4%	22%	251%	2%
American Indian or Alaskan Native	675	741	804	799	0%	0%	0%	0%	10%	8%	-1%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



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

Medi-Cal By City							
City	May 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	161,449	40%	23,823	42,809	17,574	77,243	-
Hayward	63,710	16%	12,461	17,103	7,515	26,631	-
Fremont	36,699	9%	15,047	6,809	2,088	12,755	-
San Leandro	33,975	8%	8,893	5,712	4,313	15,057	-
Union City	15,521	4%	6,302	2,637	843	5,739	-
Alameda	13,963	3%	3,320	2,527	2,088	6,028	-
Berkeley	15,299	4%	4,105	2,277	1,770	7,147	-
Livermore	12,821	3%	1,901	681	2,241	7,998	-
Newark	9,213	2%	2,676	4,068	498	1,971	-
Castro Valley	9,452	2%	2,462	1,662	1,373	3,955	-
San Lorenzo	7,437	2%	1,598	1,642	839	3,358	-
Pleasanton	7,650	2%	2,045	434	816	4,355	-
Dublin	7,399	2%	1,966	454	890	4,089	-
Emeryville	2,776	1%	596	620	451	1,109	-
Albany	2,544	1%	646	293	569	1,036	-
Piedmont	505	0%	121	203	56	125	-
Sunol	92	0%	31	15	5	41	-
Antioch	22	0%	4	6	5	7	-
Other	1,323	0%	396	296	149	482	-
Total	**401,850**	**100%**	**88,393**	**90,248**	**44,083**	**179,126**	**-**

Group Care By City							
City	May 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,774	31%	353	327	-	1,094	-
Hayward	624	11%	289	145	-	190	-
Fremont	641	11%	439	67	-	135	-
San Leandro	583	10%	234	87	-	262	-
Union City	291	5%	184	47	-	60	-
Alameda	296	5%	95	20	-	181	-
Berkeley	156	3%	49	11	-	96	-
Livermore	103	2%	35	3	-	65	-
Newark	131	2%	79	30	-	22	-
Castro Valley	193	3%	84	28	-	81	-
San Lorenzo	135	2%	41	20	-	74	-
Pleasanton	65	1%	19	3	-	43	-
Dublin	115	2%	39	6	-	70	-
Emeryville	35	1%	13	5	-	17	-
Albany	20	0%	10	2	-	8	-
Piedmont	11	0%	3	1	-	7	-
Sunol	2	0%	2	-	-	-	-
Antioch	26	0%	9	4	-	13	-
Other	439	8%	158	64	-	217	-
Total	**5,640**	**100%**	**2,135**	**870**	**-**	**2,635**	**-**

Total By City							
City	May 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	163,223	40%	24,176	43,136	17,574	78,337	-
Hayward	64,334	16%	12,750	17,248	7,515	26,821	-
Fremont	37,340	9%	15,486	6,876	2,088	12,890	-
San Leandro	34,558	8%	9,127	5,799	4,313	15,319	-
Union City	15,812	4%	6,486	2,684	843	5,799	-
Alameda	14,259	3%	3,415	2,547	2,088	6,209	-
Berkeley	15,455	4%	4,154	2,288	1,770	7,243	-
Livermore	12,924	3%	1,936	684	2,241	8,063	-
Newark	9,344	2%	2,755	4,098	498	1,993	-
Castro Valley	9,645	2%	2,546	1,690	1,373	4,036	-
San Lorenzo	7,572	2%	1,639	1,662	839	3,432	-
Pleasanton	7,715	2%	2,064	437	816	4,398	-
Dublin	7,514	2%	2,005	460	890	4,159	-
Emeryville	2,811	1%	609	625	451	1,126	-
Albany	2,564	1%	656	295	569	1,044	-
Piedmont	516	0%	124	204	56	132	-
Sunol	94	0%	33	15	5	41	-
Antioch	48	0%	13	10	5	20	-
Other	1,762	0%	554	360	149	699	-
Total	**407,490**	**100%**	**90,528**	**91,118**	**44,083**	**181,761**	**-**

Finance

Supporting Documents

Operations

Ruth Watson

To: Alameda Alliance for Health Board of Governors

From: Ruth Watson, Chief Operating Officer

Date: July 12th, 2024

Subject: Operations Report

Member Services

- 12-Month Trend Blended Summary:
  - The Member Services Department received a twenty-one percent (21%) decrease in calls in June 2024, totaling sixteen thousand five hundred twenty-eight (16,528) compared to twenty-one thousand fifty-four (21,054) in June 2023.
  - The abandonment rate for June 2024 was three percent (3%), compared to twenty-two percent (22%) in June 2023.
  - The Department's service level was ninety-four percent (94%) in June 2024, compared to sixty-three percent (63%) in June 2023. The average speed to answer (ASA) was fifteen seconds (00:15) compared to one minute and twenty-nine seconds (01:29) in June 2023. The Department continues to recruit to fill open positions. A Customer Service support service vendor continues to provide overflow call center support.
  - The average talk time (ATT) was six minutes and fifty-five seconds (06:55) for June 2024 compared to six minutes and twenty-one seconds (06:21) for June 2023.
  - One hundred percent (100%) of calls were answered within 10 minutes for June 2024 compared to ninety-seven percent (97%) in June 2023.
  - Outbound calls totaled seven thousand two hundred and nineteen (7,219) in June 2024 compared to seven thousand eight hundred and forty-nine (7,849) in June 2023.
  - The top five call reasons for June 2024 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Benefits, 4). Provider Network, 5). Grievance and Appeals. The top five call reasons for June 2023 were: 1). Eligibility/Enrollment, 2). Change of PCP, 3). Benefits, 4). Kaiser, 5). ID Card Requests.
  - Utilization for the member automated eligibility IVR system totaled one thousand seven hundred thirty-one (1,731) in June 2024 compared to one thousand five hundred fifty-one (1,294) in June 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 one hundred eighty-six (1,186) web-based requests in June 2024 compared to eight hundred eighty-two (882) in June 2023. The top three web reason requests for June 2024 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information. Sixty-one (61) members

were assisted in-person in June 2024 compared to twenty-six (26) in June, 2023.

- Member Services Behavioral Health:

  - The Member Services Behavioral Health Unit received a total of one thousand one hundred eighty-one (1,181) calls in June 2024 compared to one thousand four hundred twenty-four (1,424) in June 2023.
  - The abandonment rate was eight percent (8%) in June 2024 compared to eleven percent (11%) in June 2023.
  - The service level was eighty-three percent (83%) in June 2024 compared to eighty-three percent (83%) in June 2023.
  - The average speed to answer (ASA) was fifty-two seconds. (0:52) compared to forty-eight seconds (0:48) in June 2023.
  - Calls answered in 10 minutes were ninety-nine percent (99%) in June 2024 compared to ninety-nine percent (99%) in June 2023.
  - The Average Talk Time (ATT) was eight minutes and fifty-nine seconds (08:59) in June 2024 compared to nine minutes and twenty-five seconds (09:25) in June 2023. MS BH Team utilizes the DHCS age-appropriate screening tools for Medi-Cal Mental Health Services to determine the appropriate delivery system for members who are not currently receiving mental health services when they contact the plan.
  - One hundred thirty-seven (137) screenings were completed in June 2024.
  - Thirty-four (34) referrals were made to the County (ACCESS) in June 2024.
  - Nine Hundred Seventy-three (973) outbound calls were completed in June 2024.
  - Sixty-three (63) outreach campaigns were completed in June 2024, including ten (10) BH/ABA screenings.
  - Thirty-two (32) members were referred to Center Point for SUD services in June 2024.

<u>Claims</u>

- 12-Month Trend Summary:

  - The Claims Department received 297,267 claims in June 2024 compared to 267,437 in June 2023.
  - The Auto Adjudication was 87.5% in June 2024 compared to 79.3% in June 2023.
  - Claims compliance for the 30-day turn-around time was 89.7% in June 2024 compared to 90% in June 2023. The 45-day turn-around time was 99.8% in June 2024 compared to 99.9% in June 2023.

- Monthly Analysis:

  - In the month of June, we received a total of 297,267 claims in the HEALTHsuite system. This represents a decrease of 20.82% from May

2024, but is higher, by 29,830 claims, than the number of claims received in June 2023. The higher volume of received claims remains attributed to an increased membership.
  - We received 89.4% of claims via EDI and 10.6% of claims via paper.
  - During the month of June, 99.8% of our claims were processed within 45 working days.
  - The Auto Adjudication rate was 87.5% for the month of June.

Provider Services

- 12-Month Trend Summary:
  - The Provider Services department's call volume in June 2024 was 6,825 calls compared to 8,013 calls in June 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 492 calls/visits during June 2024.
  - The Provider Services department answered 5,618 calls for June 2024 and made 829 outbound calls.

Credentialing

- 12-Month Trend Summary:
  - At the Peer Review and Credentialing (PRCC) meeting held on June 11, 2024, there were eighty-seven (87) initial network providers approved; three (3) primary care providers, eight (8) specialists, zero (0) ancillary provider, seven (7) midlevel providers, and sixty-nine (69) behavioral health providers. Additionally, thirty-seven (37) providers were re-credentialed at this meeting; eleven (11) primary care providers, eighteen (18) specialists, zero (0) ancillary providers, and eight (8) midlevel providers.
  - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Provider Dispute Resolution

- 12-Month Trend Summary:
  - In June 2024, the Provider Dispute Resolution (PDR) team received 3,792 PDRs versus 1,453 in June 2023.
  - The PDR team resolved 1,613 cases in June 2024 compared to 1,516 cases in June 2023.

- In June 2024, the PDR team upheld 70% of cases versus 78% in June 2023.
- The PDR team resolved 99.8% of cases in June 2024 compared to 99.8% in June 2023; the compliance standard is 95% within 45 working days.

- Monthly Analysis:
  - AAH received 2,386 PDRs in May 2024.
  - In the month of May, 2,039 PDRs were resolved. Out of the 2,039 PDRs, 1,388 were upheld and 651 were overturned.
  - The overturn rate for PDRs was 32%, which did not meet our goal of 25% or less.
  - The following is a breakdown of the various causes for the 651 overturned PDRs. There were two primary areas that caused the Department to miss their goal of 25% or less:
    - Member OHC corrections – 129 cases that had been denied incorrectly.
    - No authorization denials – 94 cases reviewed for retro/medical necessity.
  - The combined volumes of the two primary reasons for the overturned PDRs this month prevented us from achieving the goal of 25% or less.
    - System Related Issues 28% (183 cases):
      - 99 cases: General configuration issues, like Not Covered, Modifier. (15%)
      - 46 cases: Retro Eligibility changes (7%)
      - 8 cases: LTC SOC Recoupment (1%)
      - 30 cases: CES (5%)
    - OHC Related Issues 20% (129 cases)
      - 129 cases: OHC Member TPL data, incorrect primary EOB not matching, incorrect manual entry. (20%)
    - Authorization Related Issues 28% (187 cases):
      - 61 cases: Processor errors when auth on file. (9%)
      - 17 cases: System (3%)
      - 15 cases: PTPN (2%)
      - 94 cases: UM/retro review (14%)
    - Additional Documentation Provided 5% (32 cases):
      - 24 cases: Duplicate claim documentation that allows for claims to be adjusted. (4%)
      - 8 cases: Timely Filing (1%)
    - Incorrect Rates 5% (31 cases)
      - 24 cases: System (4%)
      - 7 cases: LOA (1%)
    - Claim Processing Errors 14% (89 cases)
      - 36 cases: Duplicate (6%)
      - 20 cases: Incorrect Rate (3%)
      - 33 cases: Various Processor errors. (5%)
  - 2,029 out of 2,039 cases were resolved within 45 working days resulting in a 99.5% compliance rate.
  - The average turnaround time for resolving PDRs in May was 43 days.

There were 3,814 PDRs pending resolution as of 05/31/2024, with no cases older than 45 working days.

Community Relations and Outreach

- 12-Month Trend Summary:
  - In Q4 2023, the Alliance completed 2,997 member orientation outreach calls and 392 member orientations by phone.
  - The C&O Department reached 2,594 people, 55% identified as Alliance members, compared to approximately 794 individuals who identified as Alliance members in Q4 2023.
  - The C&O Department spent a total of $719.75 in donations, fees, and/or sponsorships, compared to $160 in Q4 2023.
  - The C&O Department reached members in 19 cities/unincorporated areas throughout Alameda County, the Bay Area, and the U.S., compared to 13 locations in Q4 2023.

- Quarterly Analysis:
  - In Q4 2024, the C&O Department completed 2,997 member orientation outreach calls and 392 member orientations by phone.
  - Among the 2,594 people reached, 55% identified as Alliance members.
  - In Q4 2024, the C&O Department reached members in 19 locations throughout Alameda County, the Bay Area, and the U.S.

- Monthly Analysis:
  - In June 2024, the C&O Department completed 1,165 member orientation outreach calls and 100 member orientations by phone, and 53 Alliance website inquiries.
  - Among the 840 people reached, 47% identified as Alliance members.
  - In June 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	June 2024
Incoming Calls (R/V)	16,528
Abandoned Rate (R/V)	3%
Answered Calls (R/V)	16,042
Average Speed to Answer (ASA)	0:15
Calls Answered in 30 Seconds (R/V)	94%
Average Talk Time (ATT)	06:55
Calls Answered in 10 minutes	100%
Outbound Calls	7,219

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

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

MSBH	JUNE 2024
Incoming Calls (R/V)	1,181
Abandoned Rate (R/V)	8%
Answered Calls (R/V)	1,083
Average Speed to Answer (ASA)	0:52
Calls Answered in 30 Seconds (R/V)	83%
Average Talk Time (ATT)	08:59
Calls Answered in 10 minutes	99%
Outbound Calls	973
Screenings Completed	136
ACBH Referrals	34
SUD referrals to Center Point	32

Claims Department
May 2024 Final and June 2024 Final

METRICS

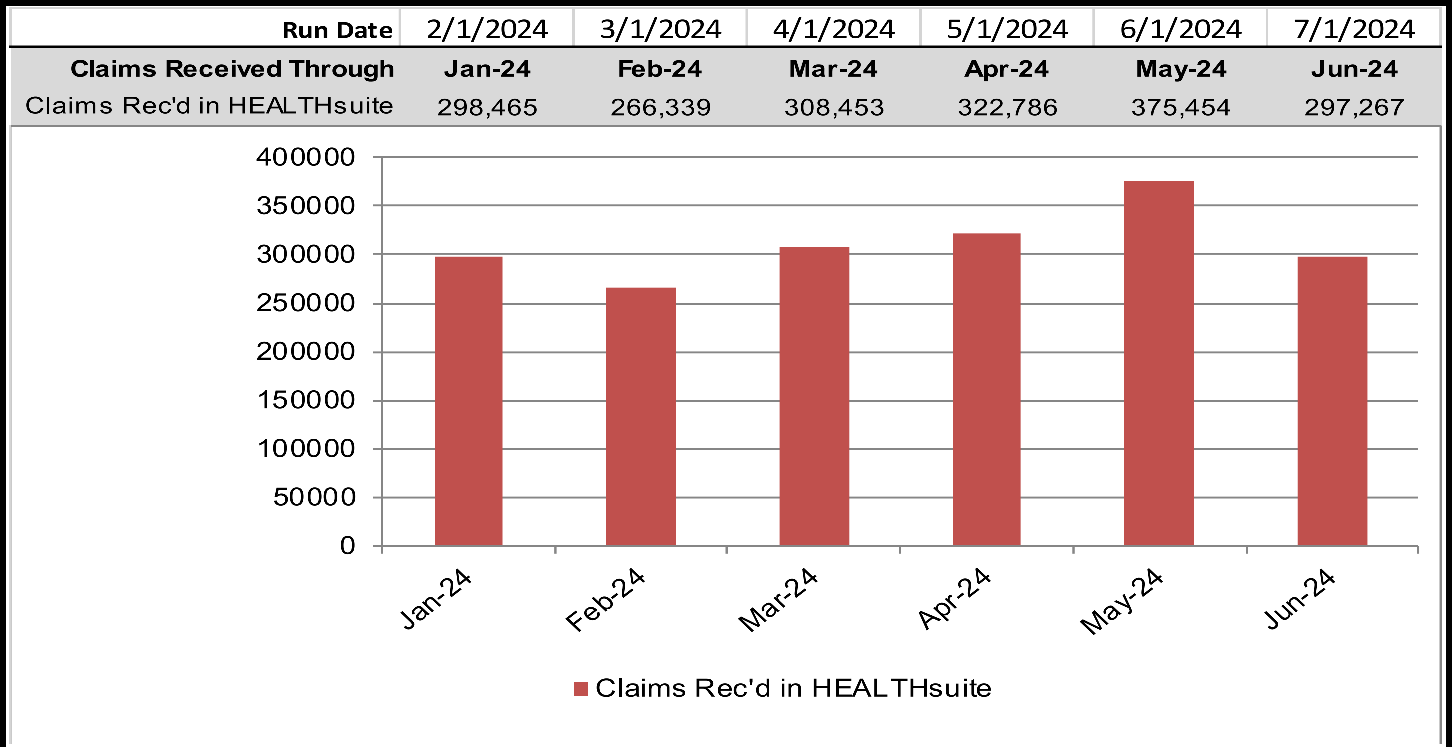
Claims Compliance	May-24	Jun-24
90% of clean claims processed within 30 calendar days	92.3%	89.7%
95% of all claims processed within 45 working days	100.0%	99.8%
Claims Volume (Received)	**May-24**	**Jun-24**
Paper claims	39,268	31,510
EDI claims	336,186	265,757
Claim Volume Total	**375,454**	**297,267**
Percentage of Claims Volume by Submission Method	**May-24**	**Jun-24**
% Paper	10.46%	10.60%
% EDI	89.54%	89.40%
Claims Processed	**May-24**	**Jun-24**
HEALTHsuite Paid (original claims)	280,640	225,484
HEALTHsuite Denied (original claims)	93,493	80,044
HEALTHsuite Original Claims Sub-Total	**374,133**	**305,528**
HEALTHsuite Adjustments	8,263	6,030
HEALTHsuite Total	**382,396**	**311,558**
Claims Expense	**May-24**	**Jun-24**
Medical Claims Paid	$156,841,938	$115,671,347
Interest Paid	$84,769	$84,231
Auto Adjudication	**May-24**	**Jun-24**
Claims Auto Adjudicated	320,197	267,304
% Auto Adjudicated	85.6%	87.5%
Average Days from Receipt to Payment	**May-24**	**Jun-24**
HEALTHsuite	14	14
Pended Claim Age	**May-24**	**Jun-24**
0-29 calendar days	39,193	40,621
HEALTHsuite		
30-59 calendar days	7,841	17,365
HEALTHsuite		
Over 60 calendar days	7	10
HEALTHsuite		
Overall Denial Rate	**May-24**	**Jun-24**
Claims denied in HEALTHsuite	93,493	80,044
% Denied	24.4%	25.7%

Claims Department
May 2024 Final and June 2024 Final

Jun-24

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	25%
No Benefits Found For Dates of Service	15%
Non-Covered Benefit For This Plan	12%
Duplicate Claim	11%
Must Submit Paper Claim With Copy of Primary Payor EOB	8%
% Total of all denials	**71%**

Claims Received By Month



Run Date	2/1/2024	3/1/2024	4/1/2024	5/1/2024	6/1/2024	7/1/2024
Claims Received Through	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**
Claims Rec'd in HEALTHsuite	298,465	266,339	308,453	322,786	375,454	297,267

Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing June 2024 to June 2023 as follows: 30 Days - 89.7% (2024) vs 90% (2023) 45 Days - 99.8% (2024) vs 99.9% (2023) 90 Days - 99.9% (2024) vs 99.9% (2023)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 297,267 claims in June 2024 vs 267,437 in June 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 286,554 in June 2024 (20 working days) vs 218,250 in June 2023 (22 working days).	N/A	N/A
Medical Claims Expense - the amount of paid claims in June 2024 was $115,671,347 (4 check runs) vs $81,756,949 in June 2023 (4 check runs).	N/A	N/A
Interest Expense - the amount of interest paid in June 2024 was $84,231 vs $48,965 in June 2023.	N/A	< $496,000 per fiscal year or $30,000 per month
Auto Adjudication - the AAH rate in June 2024 was 87.5% vs 79.3% in June 2023.	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in June 2024 was 14 days vs 20 days in June 2023.	N/A	<= 25 days

Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Pended Claim Age - comparing June 2024 to June 2023 as follows: 0-30 calendar days - 40,621 (2024) vs 27,955 (2023) 30-59 calendar days - 17,365 (2024) vs 3,259 (2023) Over 60 calendar days - 10 (2024) vs 2 (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 June 2024 to June 2023.	N/A	N/A

Provider Relations Dashboard June 2024

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

Provider Relations Dashboard June 2024

Call Reasons (Medi-Cal and Group Care)

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

Field Visit Activity Details

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

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS						
Practitioners		BH/ABA 1,984	AHP 538	PCP 372	SPEC 721	PCP/SPEC 13
AAH/AHS/CHCN Breakdown			AAH 2,457	AHS 273	CHCN 539	COMBINATION OF GROUPS 359
Facilities	**423**					

VENDOR SUMMARY Credentialing Verification Organization, Symplyr CVO					
	Number	**Average Calendar Days in Process**	**Goal - 25 Business Days**	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	212	26	Y	Y	Y
Recred Files in Process	72	7	Y	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**284**				

June 2024 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	3
SPEC	8
ANCILLARY	0
MIDLEVEL/AHP	7
BH/ABA	69
Sub-total	**87**
Recredentialing	
PCP	11
SPEC	18
ANCILLARY	0
MIDLEVEL/AHP	8
Sub-total	**37**
TOTAL	**124**

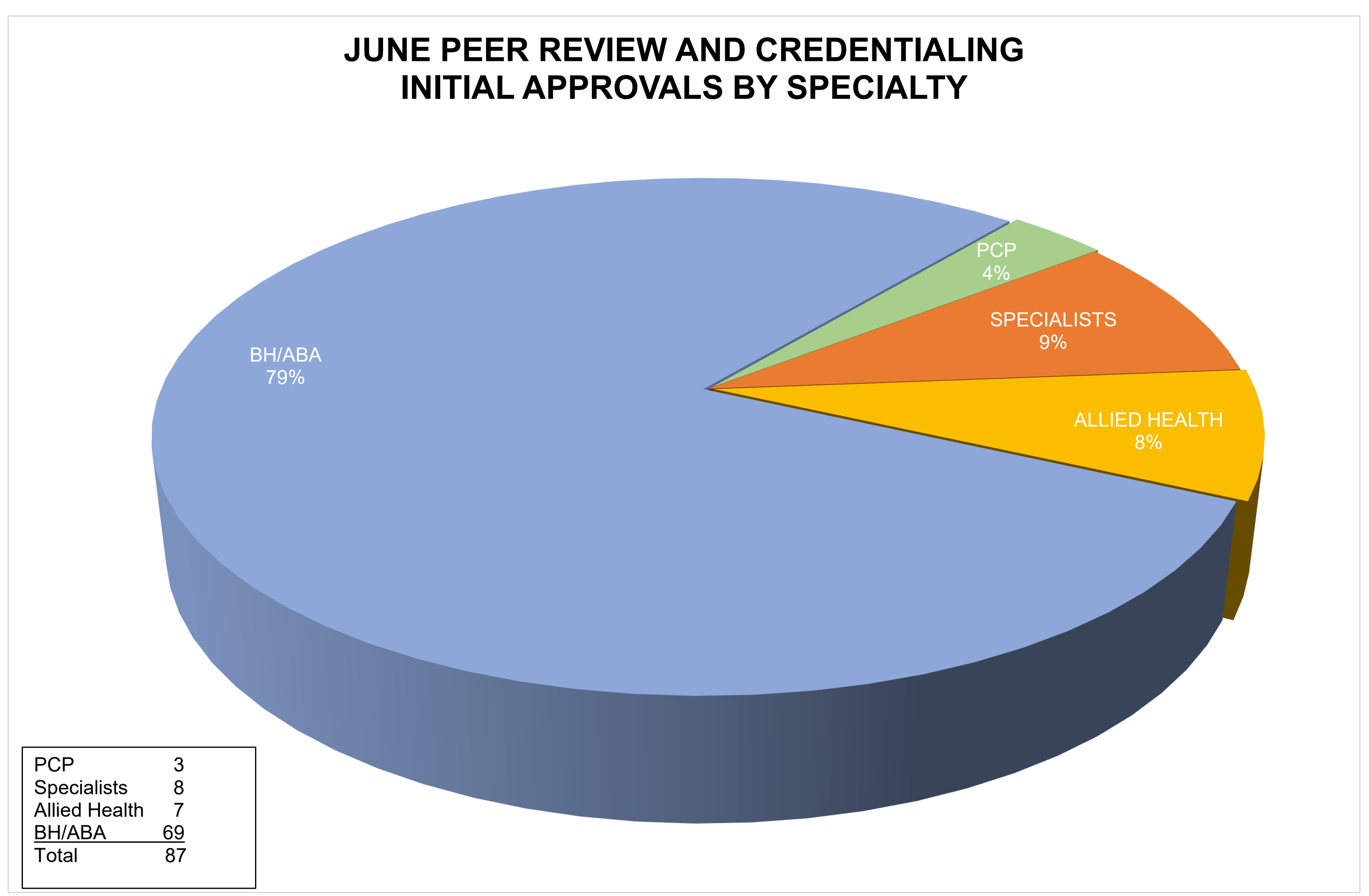
June 2024 Facility Approvals	
Initial Credentialing	**1**
Recredentialing	**6**
Sub-total	**7**
Facility Files in Process	**55**

June 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-CREDS	CRED DATE
Adams	Auther	Specialist	INITIAL	6/13/2024
Aguilar	Rosaura	BH/ABA-Telehealth	INITIAL	6/13/2024
Alajou	Nora	BH/ABA-Telehealth	INITIAL	6/13/2024
Allabadi	Najib	Specialist	INITIAL	6/13/2024
Anaya	Eufemio	BH/ABA-Telehealth	INITIAL	6/13/2024
Ang	Eddy	Primary Care Physician	INITIAL	6/13/2024
Asmuth	Katherine	Allied Health	INITIAL	6/13/2024
Baskerville	Sheaton	BH/ABA	INITIAL	6/13/2024
Belur	Praveen	Specialist	INITIAL	6/13/2024
Benjamin	Vanessa	BH/ABA-Telehealth	INITIAL	6/13/2024
Case	Angela	BH/ABA-Telehealth	INITIAL	6/13/2024
Casey	William	BH/ABA	INITIAL	6/13/2024
Castellanos	Susana	BH/ABA	INITIAL	6/13/2024
Castillo	Celine	BH/ABA	INITIAL	6/13/2024
Comerford	Galen	BH/ABA	INITIAL	6/13/2024
Cruz	Kristine	BH/ABA	INITIAL	6/13/2024
Dabirian	Tannaz	BH/ABA	INITIAL	6/13/2024
Dalautzai	Yusef	BH/ABA	INITIAL	6/13/2024
Ezeofor	Ijeoma	BH/ABA-Telehealth	INITIAL	6/13/2024
Farlow	Tona	BH/ABA	INITIAL	6/13/2024
Favini	Nathan	Primary Care Physician	INITIAL	6/13/2024
Fibrow	Marcy	BH/ABA	INITIAL	6/13/2024
Futterman	Susan	BH/ABA	INITIAL	6/13/2024
Gaffney	Felisa	BH/ABA	INITIAL	6/13/2024
Gephart	Amanda	BH/ABA-Telehealth	INITIAL	6/13/2024
Gonzales Y Tucker	Richard	BH/ABA	INITIAL	6/13/2024
Hansen	Sara	BH/ABA	INITIAL	6/13/2024
Hilp	Lesley	BH/ABA	INITIAL	6/13/2024
Izidoro	India	BH/ABA-Telehealth	INITIAL	6/13/2024
Jimenez	Josephine	Allied Health	INITIAL	6/13/2024
Johnson	Veronica	BH/ABA	INITIAL	6/13/2024
Jones	Alexis	BH/ABA	INITIAL	6/13/2024
Kaufman	Misha	BH/ABA	INITIAL	6/13/2024
Keilman	Ann	BH/ABA	INITIAL	6/13/2024
Khazaeli	Azin	BH/ABA-Telehealth	INITIAL	6/13/2024
Kirkland	Jennifer	BH/ABA-Telehealth	INITIAL	6/13/2024
Krishnan	Brinda	BH/ABA-Telehealth	INITIAL	6/13/2024
Lastie	Shelia	BH/ABA	INITIAL	6/13/2024
Letourneau	Thomas	BH/ABA	INITIAL	6/13/2024
Long	Brittney	BH/ABA-Telehealth	INITIAL	6/13/2024
Madrid	Joseph	BH/ABA-Telehealth	INITIAL	6/13/2024
Maggi	Marco	BH/ABA-Telehealth	INITIAL	6/13/2024
Mahban	Ariana	BH/ABA-Telehealth	INITIAL	6/13/2024
McCullough	Colleen	Allied Health	INITIAL	6/13/2024
McDermott	James	BH/ABA-Telehealth	INITIAL	6/13/2024
Meeks	Dana	BH/ABA	INITIAL	6/13/2024
Melendez	Liana	BH/ABA-Telehealth	INITIAL	6/13/2024
Mori	Amanda	BH/ABA-Telehealth	INITIAL	6/13/2024
Mortensen	Charles	BH/ABA	INITIAL	6/13/2024
Newton	Andrea	BH/ABA-Telehealth	INITIAL	6/13/2024
Okamoto	Annika	BH/ABA	INITIAL	6/13/2024
Omarali	Iqbal	Primary Care Physician	INITIAL	6/13/2024
Partida	Estephanie	BH/ABA-Telehealth	INITIAL	6/13/2024
Pile	Cynthia	BH/ABA	INITIAL	6/13/2024
Ray	Rita	Allied Health	INITIAL	6/13/2024

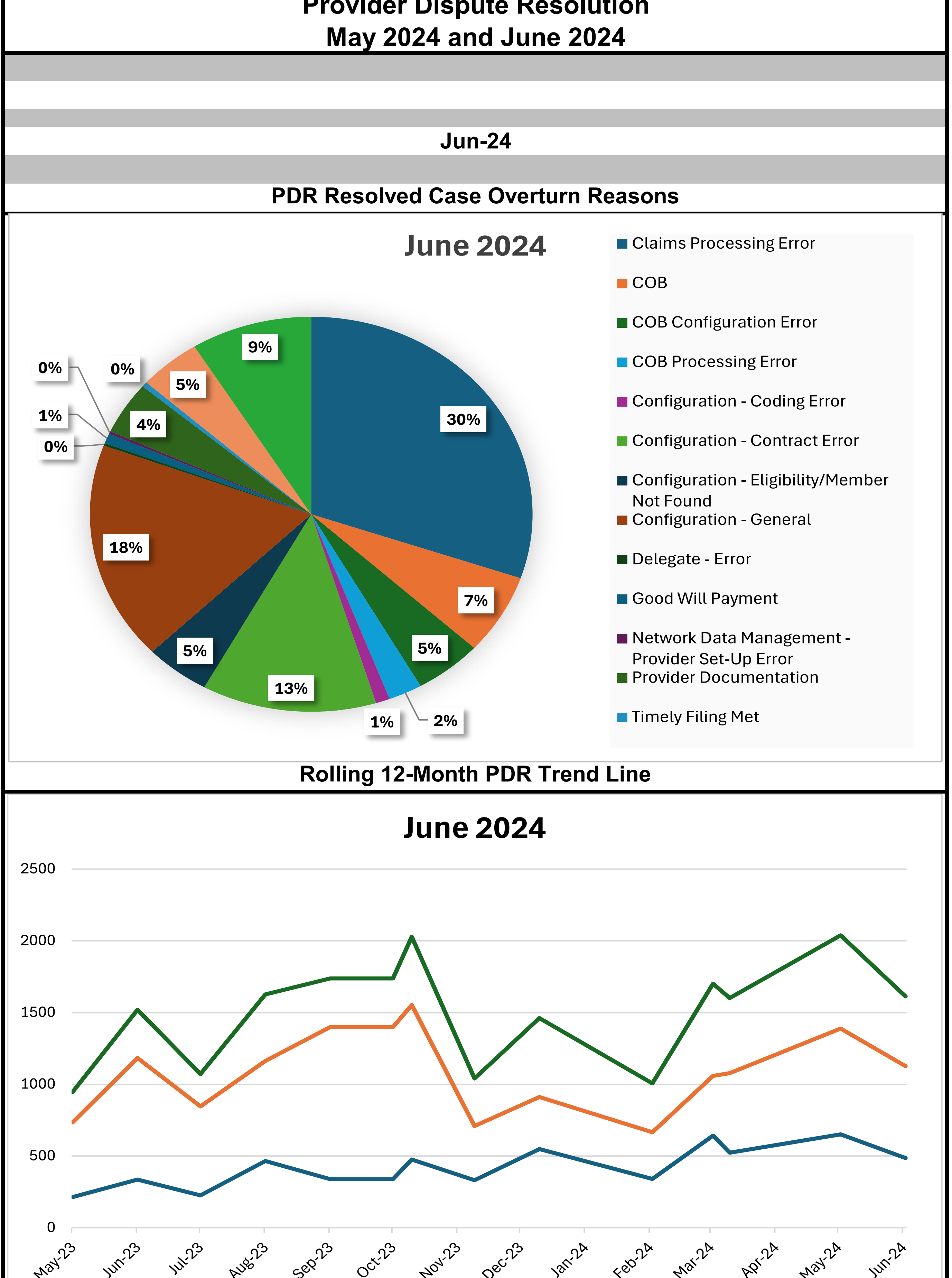
LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CREDS	CRED DATE
Reiter	Mehera	BH/ABA	INITIAL	6/13/2024
Reynolds	William	BH/ABA	INITIAL	6/13/2024
Rice	Torey	BH/ABA	INITIAL	6/13/2024
Rios	Travis	BH/ABA	INITIAL	6/13/2024
Roberts	Craig	Allied Health	INITIAL	6/13/2024
Rodriguez-Jordan	Jazmin	Allied Health	INITIAL	6/13/2024
Samaan	Wasseem	BH/ABA	INITIAL	6/13/2024
Sen	Moushumi	BH/ABA	INITIAL	6/13/2024
Shah	Sarah	BH/ABA	INITIAL	6/13/2024
Shikaloff	Ulyana	Specialist	INITIAL	6/13/2024
Smith	Jackey	BH/ABA	INITIAL	6/13/2024
Smith	Lindsey	BH/ABA-Telehealth	INITIAL	6/13/2024
Smith	Shirley	BH/ABA	INITIAL	6/13/2024
Sohal	Poonam	BH/ABA	INITIAL	6/13/2024
Sparks	Julissa	BH/ABA-Telehealth	INITIAL	6/13/2024
Staples-Foster	Velma	BH/ABA	INITIAL	6/13/2024
Steward-Davis	Jan	BH/ABA-Telehealth	INITIAL	6/13/2024
Sun	Vivian	BH/ABA	INITIAL	6/13/2024
Swartzendruber	Alicia	BH/ABA	INITIAL	6/13/2024
Tanaka	Ted	Specialist	INITIAL	6/13/2024
Towver	Yeni	BH/ABA	INITIAL	6/13/2024
Tran	Hoang-Vu	Specialist	INITIAL	6/13/2024
Vang	Linda	BH/ABA-Telehealth	INITIAL	6/13/2024
Walker	Judianne	Specialist	INITIAL	6/13/2024
Wallace	Jasen	BH/ABA-Telehealth	INITIAL	6/13/2024
Watkins	Jean	BH/ABA-Telehealth	INITIAL	6/13/2024
Williams	Sage	BH/ABA	INITIAL	6/13/2024
Wolfe	Brian	BH/ABA	INITIAL	6/13/2024
Wong	Gordon	Specialist	INITIAL	6/13/2024
Woodman	Asa	BH/ABA-Telehealth	INITIAL	6/13/2024
Yalon	Teaghe	Allied Health	INITIAL	6/13/2024
Yepez	Adriana	BH/ABA-Telehealth	INITIAL	6/13/2024
Bhuket	Taft	Specialist	RE-CRED	6/13/2024
Bullard	Miriam	Specialist	RE-CRED	6/13/2024
Chen	Eric	Specialist	RE-CRED	6/13/2024
Flagg	Kirsten	Allied Health	RE-CRED	6/13/2024
Goswami	Sanjeev	Specialist	RE-CRED	6/13/2024
Hamilton	Jessica	Primary Care Physician	RE-CRED	6/13/2024
Hopkins	Linda	Specialist	RE-CRED	6/13/2024
Huggans-Zapeta	Jennifer	Allied Health	RE-CRED	6/13/2024
Kalra	Jagjeet	Specialist	RE-CRED	6/13/2024
Mallick	Anjum	Primary Care Physician	RE-CRED	6/13/2024
Manjunath	Veena	Specialist	RE-CRED	6/13/2024
Muralidhara	Arti	Specialist	RE-CRED	6/13/2024
Narra	Kishore	Primary Care Physician and Specialist	RE-CRED	6/13/2024
Nguyen	Mychi	Primary Care Physician	RE-CRED	6/13/2024
Palmer	Barnard	Specialist	RE-CRED	6/13/2024
Portnoy	Pamela	Allied Health	RE-CRED	6/13/2024
Powell Hal	Karina	Allied Health	RE-CRED	6/13/2024
Puccini	John	Allied Health	RE-CRED	6/13/2024
Ramchandani	Harsha	Primary Care Physician	RE-CRED	6/13/2024
Safaya	Rakesh	Specialist	RE-CRED	6/13/2024
Shah	Payal	Specialist	RE-CRED	6/13/2024
Shah	Shaily	Specialist	RE-CRED	6/13/2024
Shrivastava	Ankita	Primary Care Physician	RE-CRED	6/13/2024
Singh	Namita	Specialist	RE-CRED	6/13/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CREDS	CRED DATE
Stanten	Russell	Specialist	RE-CRED	6/13/2024
Stanton	Jessica	Primary Care Physician	RE-CRED	6/13/2024
Swift	Upasna	Primary Care Physician	RE-CRED	6/13/2024
Taylor	Briauna	Allied Health	RE-CRED	6/13/2024
Topiol	Lisa	Allied Health	RE-CRED	6/13/2024
Tran	Hanh	Specialist	RE-CRED	6/13/2024
Upadhyay	Ajay	Specialist	RE-CRED	6/13/2024
Van Gompel	Joshua	Specialist	RE-CRED	6/13/2024
Victorino	Gregory	Specialist	RE-CRED	6/13/2024
Wadhwani	Rita	Primary Care Physician	RE-CRED	6/13/2024
Win	Htay	Primary Care Physician	RE-CRED	6/13/2024
Wong-Yap	Sumi	Allied Health	RE-CRED	6/13/2024
Yee	Lisa	Primary Care Physician	RE-CRED	6/13/2024


JUNE PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY
PCP
4%
SPECIALISTS
9%
ALLIED HEALTH
8%
BH/ABA
79%
PCP 3
Specialists 8
Allied Health 7
BH/ABA 69
Total 87

Provider Dispute Resolution
May 2024 and June 2024

METRICS		
PDR Compliance	**May-24**	**Jun-24**
# of PDRs Resolved	2,039	1,613
# Resolved Within 45 Working Days	2,029	1,609
% of PDRs Resolved Within 45 Working Days	99.5%	99.8%
PDRs Received	**May-24**	**Jun-24**
# of PDRs Received	2,386	3,792
PDR Volume Total	**2,386**	**3,792**
PDRs Resolved	**May-24**	**Jun-24**
# of PDRs Upheld	1,388	1,127
% of PDRs Upheld	68%	70%
# of PDRs Overturned	651	486
% of PDRs Overturned	32%	30%
Total # of PDRs Resolved	**2,039**	**1,613**
Average Turnaround Time	**May-24**	**Jun-24**
Average # of Days to Resolve PDRs	43	42
Oldest Resolved PDR in Days	52	61
Unresolved PDR Age	**May-24**	**Jun-24**
0-45 Working Days	3,814	4,505
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**3,814**	**4,505**



Provider Dispute Resolution
May 2024 and June 2024
Jun-24
PDR Resolved Case Overturn Reasons
June 2024
30%
7%
5%
2%
1%
13%
5%
18%
0%
1%
0%
0%
4%
5%
9%
Claims Processing Error
COB
COB Configuration Error
COB Processing Error
Configuration - Coding Error
Configuration - Contract Error
Configuration - Eligibility/Member Not Found
Configuration - General
Delegate - Error
Good Will Payment
Network Data Management - Provider Set-Up Error
Provider Documentation
Timely Filing Met
Rolling 12-Month PDR Trend Line
June 2024
2500
2000
1500
1000
500
0
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Overturned
Upheld
Total

Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Resolved - 1,613 in June 2024 vs 1,519 in June 2023	N/A	N/A
# of PDRs Received - 3,792 in June 2024 vs 1,453 in June 2023	N/A	N/A
# of PDRs Resolved within 45 working days - 1,609 in June 2024 vs 1,516 in June 2023	N/A	N/A
% of PDRs Resolved within 45 working days - 99.8% in June 2024 vs 99.8% in June 2023	95%	95%
Average # of Days to Resolve PDRs - 42 days in June 2024 vs 42 days in June 2023	N/A	30
Oldest Resolved PDR in Days - 61 days in June 2024 vs 45 days June 2023	N/A	N/A
# of PDRs Upheld - 1,127 in June 2024 vs 1,183 in June 2023	N/A	N/A
% of PDRs Upheld - 70% in June 2024 vs 78% in June 2023	N/A	> 75%
# of PDRs Overturned - 486 in June 2024 vs 336 in June 2023	N/A	N/A
% of PDRs Overturned - 30% in June 2024 vs 22% in June 2023	N/A	< 25%

Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
PDR Overturn Reasons: Claims processing errors - 30% (2024) vs 43% (2023) Configuration errors - 36% (2024) vs 31% (2023) COB -14% (2024) vs 16% (2023) Clinical Review/UM Decisions/Medical Necessity Met -14% (2024) vs 9% (2023)	N/A	N/A

Between April 2024 and June 2024, the Alliance completed **2,997** member orientation outreach calls among net new members and non-utilizers and conducted **392** member orientations (**13.1%** member participation rate). In addition, the Outreach team completed **102** Alliance website inquiries, **17** service requests, **2** social media inquiries, **5** community events, **6** member education, and **1** community meeting/presentation events in Q4.

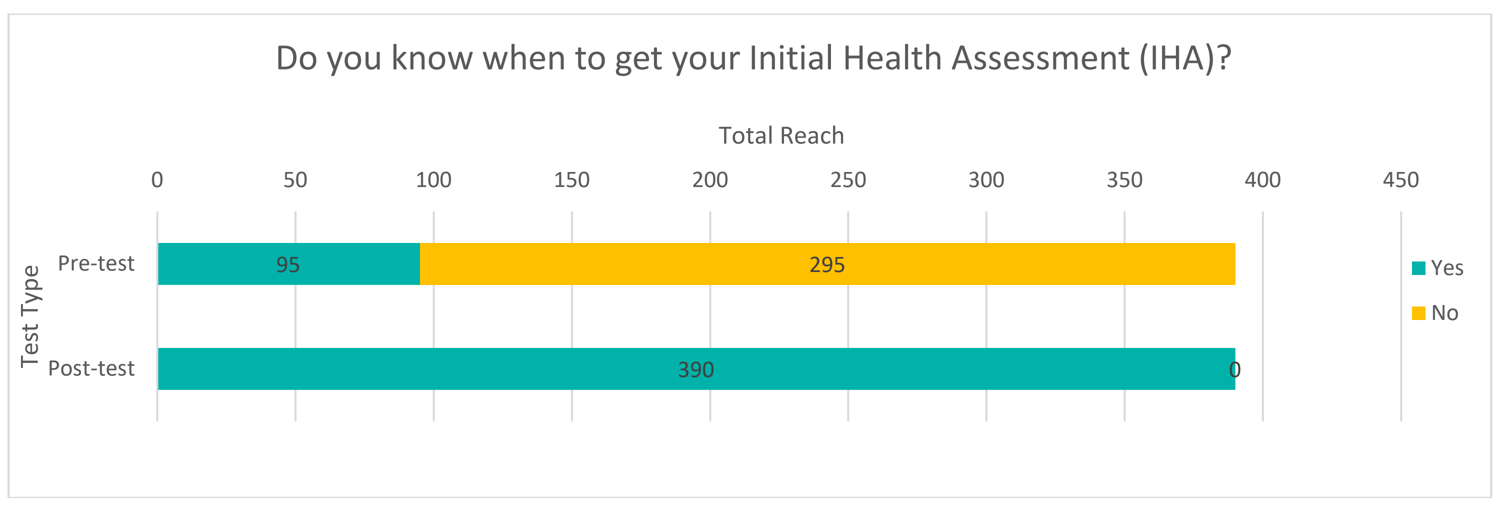
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **33,156** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of **Sunday, June 30, 2024**, the Outreach Team completed **37,503** member orientation outreach calls and conducted **8,622** member orientations (22.9%-member participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18, 2020, through June 30, 2024) – **8,622** members completed our MO and Non-utilizer program by phone.

After completing a MO **100%** of members who completed the post-test survey in Q4 FY 23-24 reported knowing when to get their IHA, compared to only **24.4%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 23-24\Q4\3. June 2024**

Q4 FY 2023-2024 TOTALS

5	COMMUNITY EVENTS	1365	TOTAL REACHED AT VIRTUAL COMMUNITY EVENTS
6	MEMBER EDUCATION EVENTS	804	TOTAL REACHED AT MEMBER EDUCATION EVENTS
392	MEMBER ORIENTATIONS	392	TOTAL REACHED AT MEMBER ORIENTATIONS
1	MEETINGS/ PRESENTATIONS	13	TOTAL REACHED AT MEETINGS/PRESENTATIONS
30	TOTAL INITIATED/INVITED EVENTS	1439	TOTAL MEMBERS REACHED AT EVENTS
404	TOTAL EVENTS	**2594**	TOTAL REACHED AT ALL EVENTS

ALAMEDA
ALBANY
BERKELEY

CASTRO VALLEY
DUBLIN

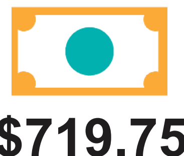
FREMONT
HAYWARD
LIVERMORE

NEWARK
OAKLAND
PLEASANTON

SAN LEANDRO
SAN LORENZO
UNION CITY

TOTAL REACH 19 CITIES

Cities represent the mailing addresses for members who completed a Member Orientation by phone. The italicized cities are outside of Alameda County. The following cities had <1% reach during Q4 2024: Emeryville, *Milpitas, Sacramento, San Mateo, and San Ramon. The C&O Department started including these cities in the Q3 FY21 Outreach Report.*



$719.75

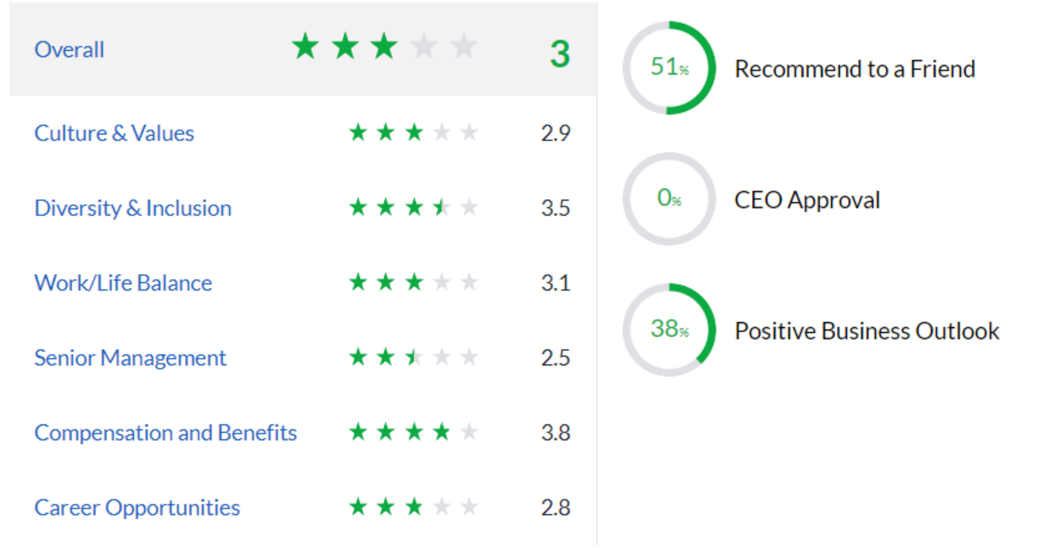
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

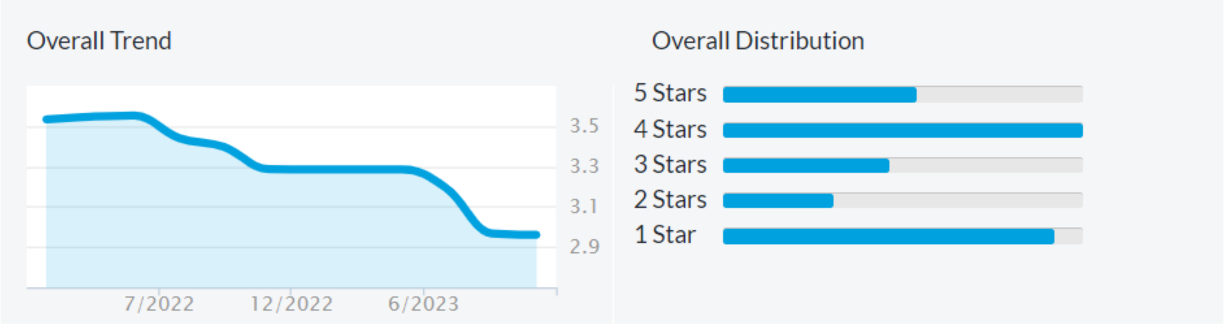
** Includes refundable deposit.*

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 **June 1, 2024**, and **June 30, 2024**:

1. Alliance Website:
    - Received **14,000** unique visits
    - Received **11,000** new user visits
    - The top **10** website page visits were:
        i. Homepage
        ii. Provider Page
        iii. Find a Doctor
        iv. Careers
        v. Benefits and Covered Services
        vi. Contact Us
        vii. Medi-Cal
        viii. Members
        ix. About Us
        x. Get a New ID Card
2. Facebook Page:
    - Maintained Fans at **631**
    - Did not receive any reviews in **June 2024**
3. Glassdoor Page:
    - **3** out of a **5-star** overall rating
    - Received 1 (one) review in **June 2024**
4. Instagram Page:
    - Page debuted **June 10, 2021**
    - Increased in followers from **543** to **554**
5. Twitter Page:
    - Slight Increase in followers from **358** to **360**
6. LinkedIn Page:
    - Increased followers from **5.5k** to **5.6k**
    - Received **286-**page clicks
7. Yelp Page:
    - Page visits **65**
    - Appeared in Yelp searches **84** times
    - Did not receive any reviews in **June 2024**
8. Google Page:
    - **4,061** website clicks made from the business profile
    - **1,300** calls made from the business profile
    - Received **1** (one) review in **June 2024**
    - Received **6** (six) chat messages in **June 2024**

GLASSDOOR OVERVIEW



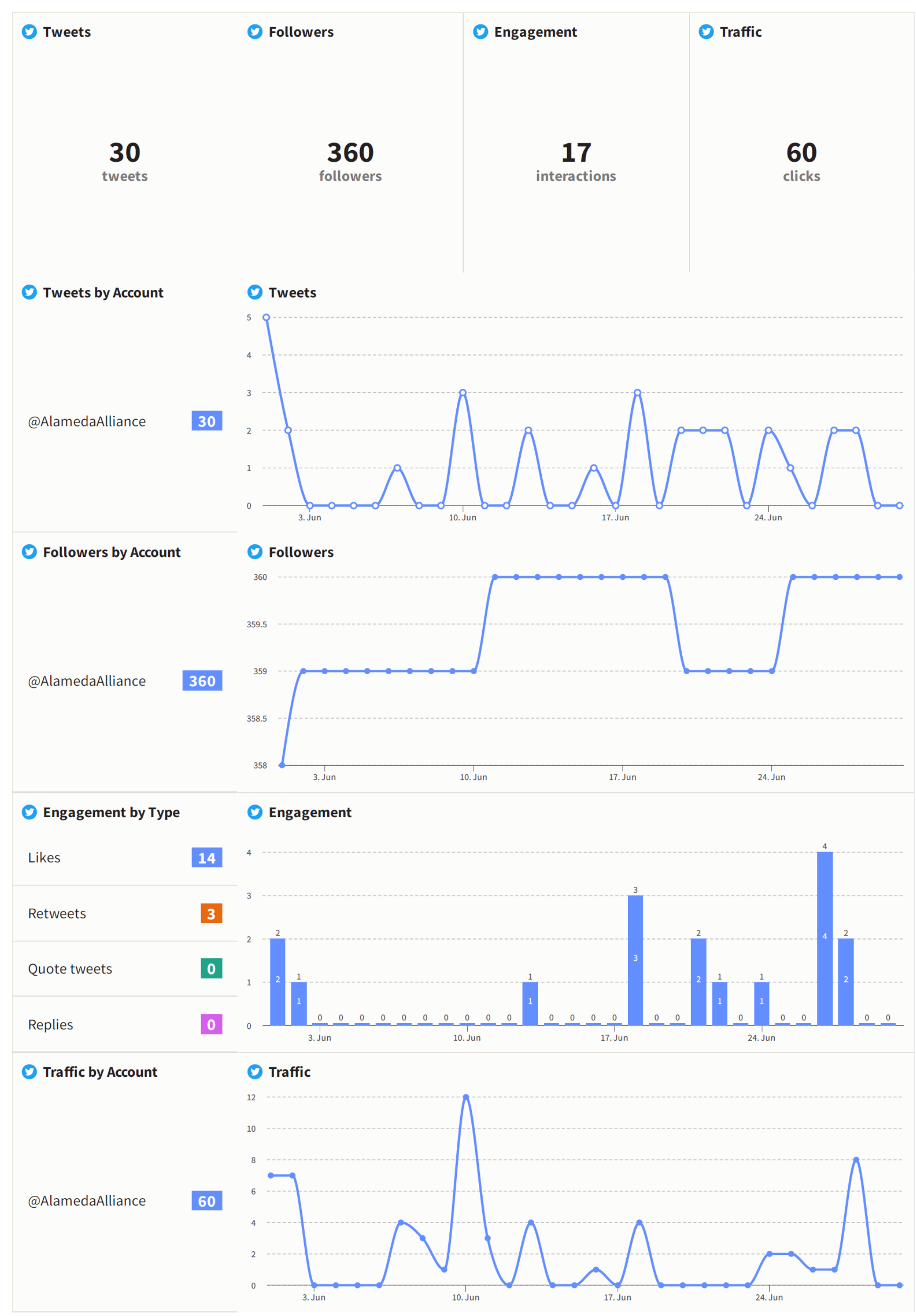


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q4\3. June 2024

FACEBOOK OVERVIEW

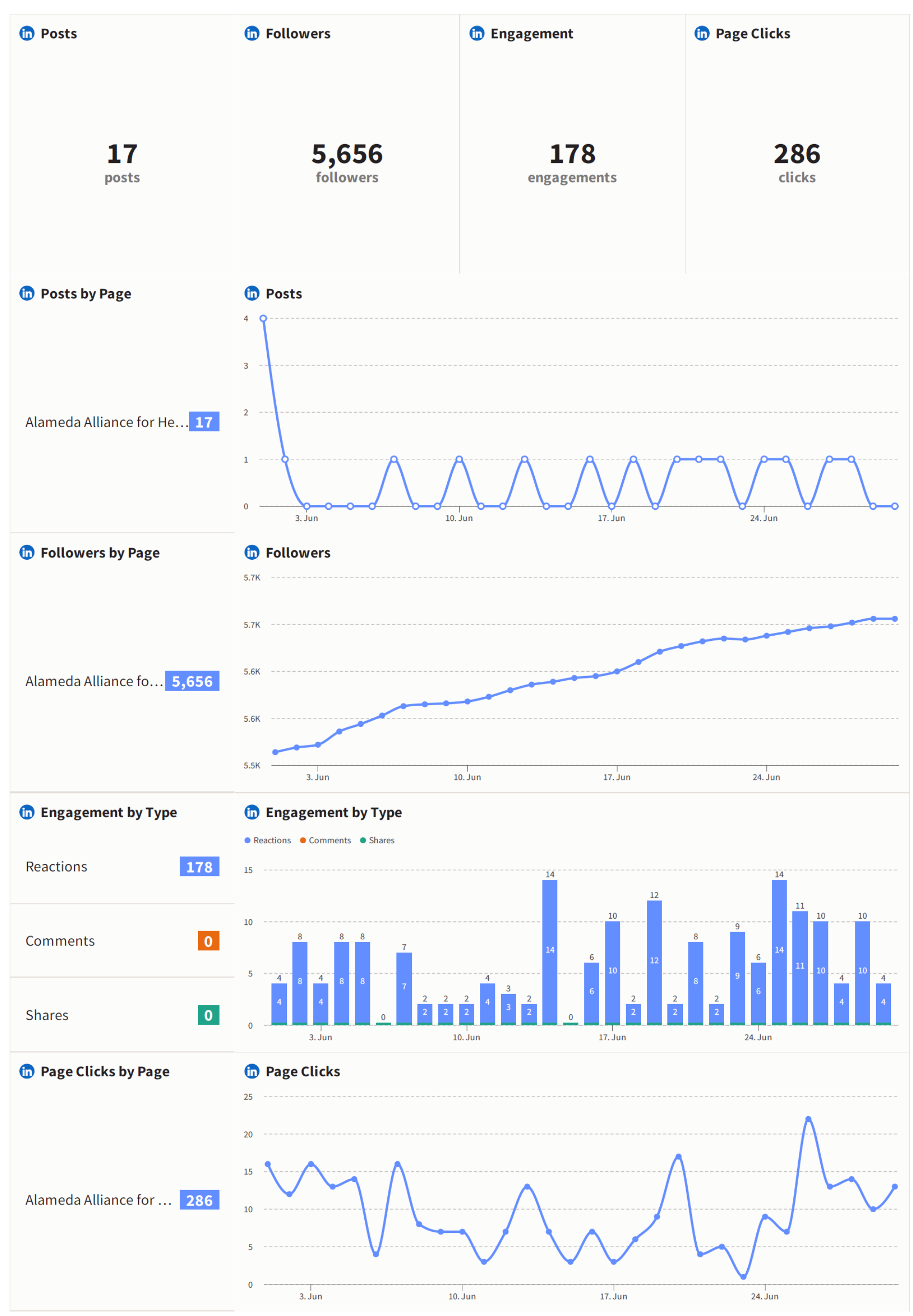
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q4\3. June 2024

TWITTER 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\3. June 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\3. June 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\3. June 2024

ALLIANCE WEBSITE OVERVIEW:

Analytics | Alameda Alliance for Health
Alameda Alliance for Health ...

Go to report

All Users | Add comparison +

Custom Jun 1 - Jun 30, 2024

July 2023

Users	New users	Average engagement time	Total revenue
14K	11K	1m 00s	$0.00

WHERE DO YOUR NEW USERS COME FROM?

New users by First user primary channel group (Default Channel Group)

Direct, Organic Search, Referral, Organic Social

View user acquisition

WHAT ARE YOUR TOP CAMPAIGNS?

Sessions by Session primary channel group

SESSION PRIMARY CHAN...	SESSIONS
Direct	19K
Referral	5K
Organic Search	4K
Organic Social	77
Unassigned	37

View traffic acquisition

Users by Country

COUNTRY	USERS
United States	13K
India	294
Philippines	57
Canada	45
China	39
Germany	30
Pakistan	27

View countries

HOW ARE ACTIVE USERS TRENDING?

User activity over time

- 30 DAYS: 14K
- 7 DAYS: 4K
- 1 DAY: 274

HOW WELL DO YOU RETAIN YOUR USERS?

User activity by cohort
Based on device data only

	Week 0	Week 1	Week 2	Week 3	Week 4	Week 5
All Users	100.0%	6.4%	3.5%	2.6%	1.9%	1.6%

May 19 - May 25; May 26 - Jun 1; Jun 2 - Jun 8; Jun 9 - Jun 15; Jun 16 - Jun 22; Jun 23 - Jun 29

6 weeks ending Jun 29

View retention

WHICH PAGES AND SCREENS GET THE MOST VIEWS?

Views by Page title and screen class

PAGE TITLE AND SCREEN CLASS	VIEWS
Alameda Alliance for Health – Health...	22K
Providers – Alameda Alliance for He...	5.6K
Find a Doctor – Alameda Alliance for...	4.2K
Careers – Alameda Alliance for Health	2.4K
Benefits and Covered Services – Ala...	2.4K
Contact Us – Alameda Alliance for H...	1.7K
Medi-Cal – Alameda Alliance for Hea...	1.7K

View pages and screens

Users by Language

English, Spanish, Chinese, Russian, Ukrainian, Dutch, Korean

View languages

Users by Device category

DESKTOP	MOBILE	TABLET
73.4%	25.7%	0.9%

View device categories

WHERE DOES YOUR LTV COME FROM?

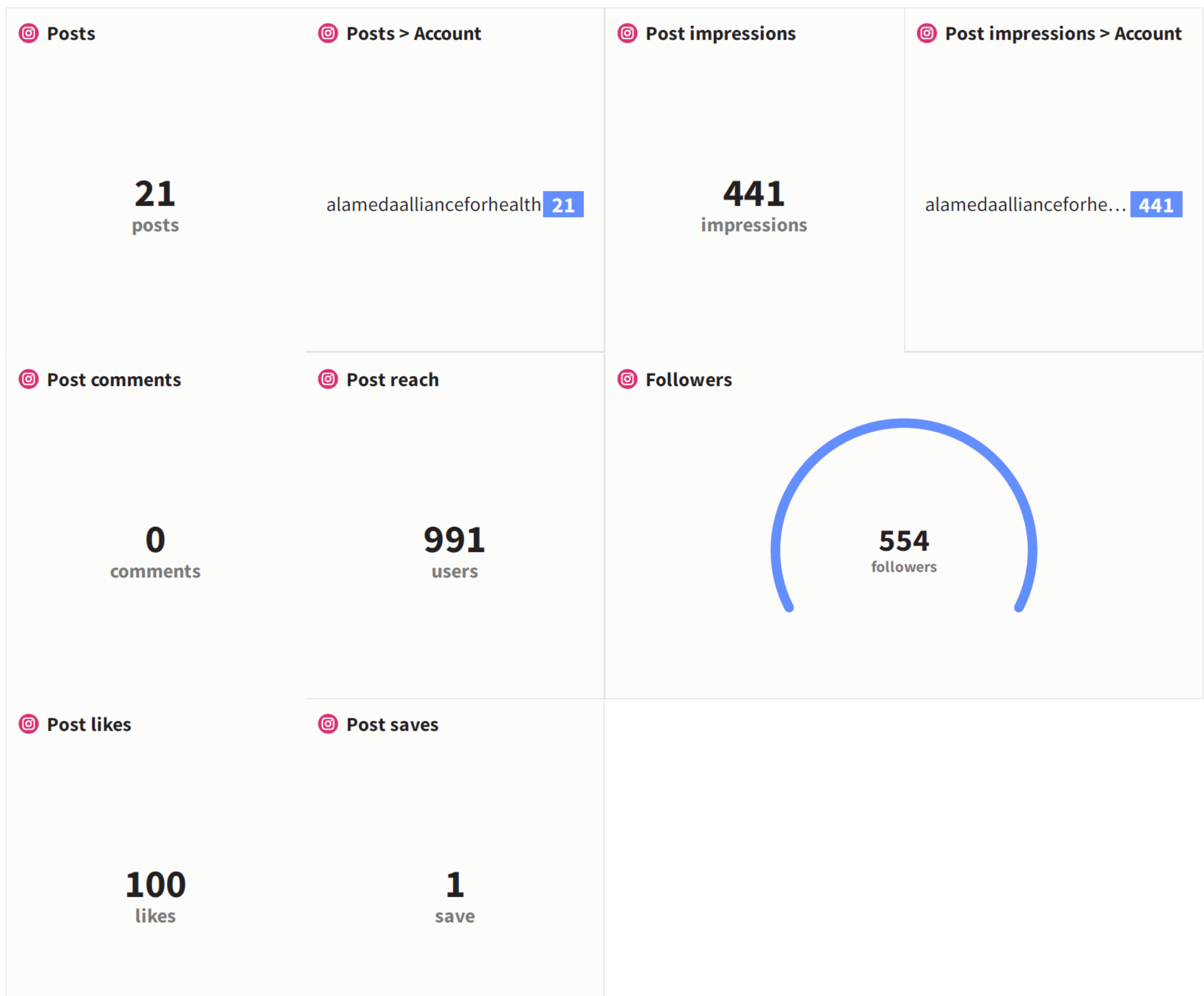
LTV by First user primary channel group (Default...

No data available

View user acquisition cohorts

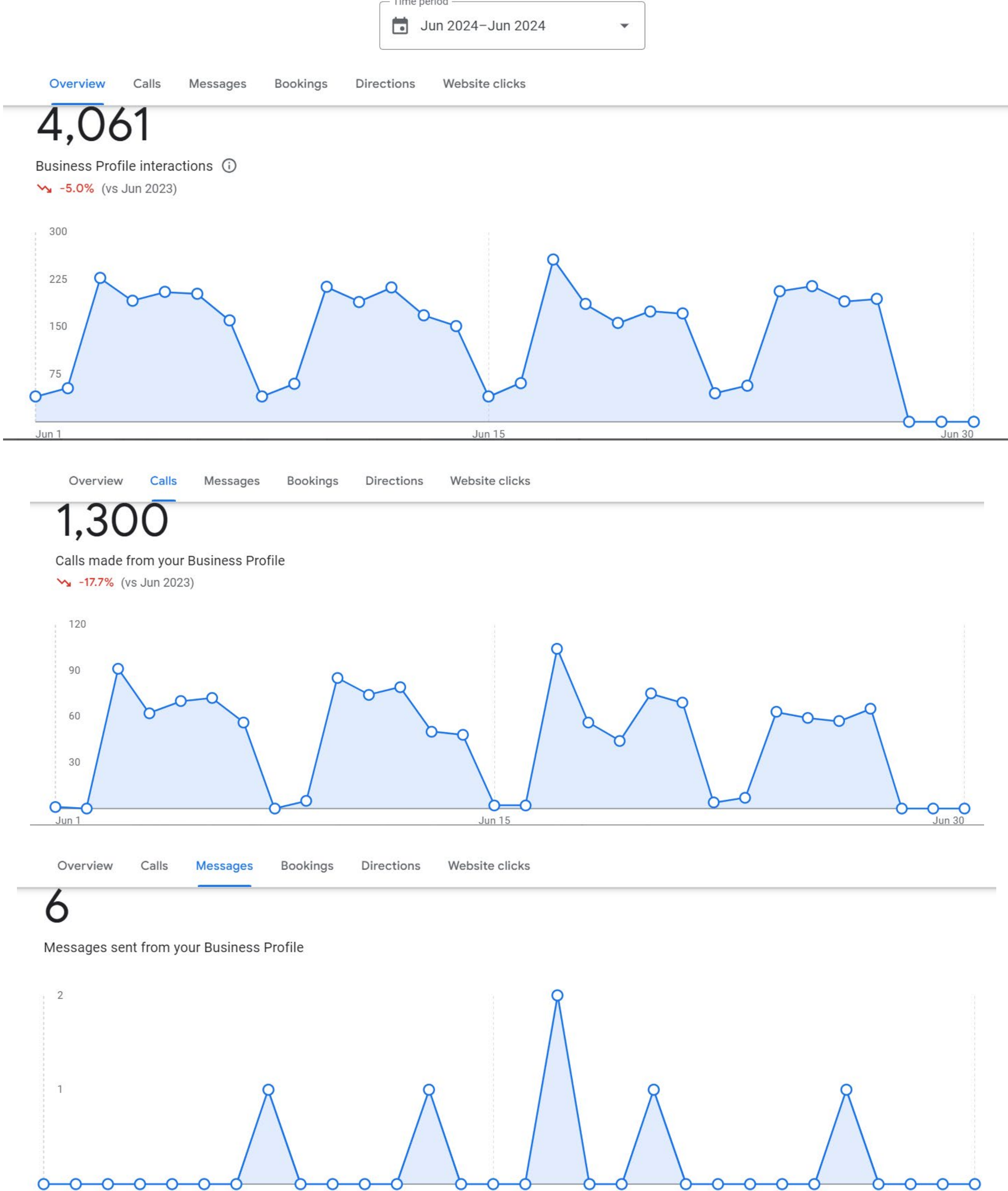
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q4\3. June 2024

Instagram OVERVIEW:

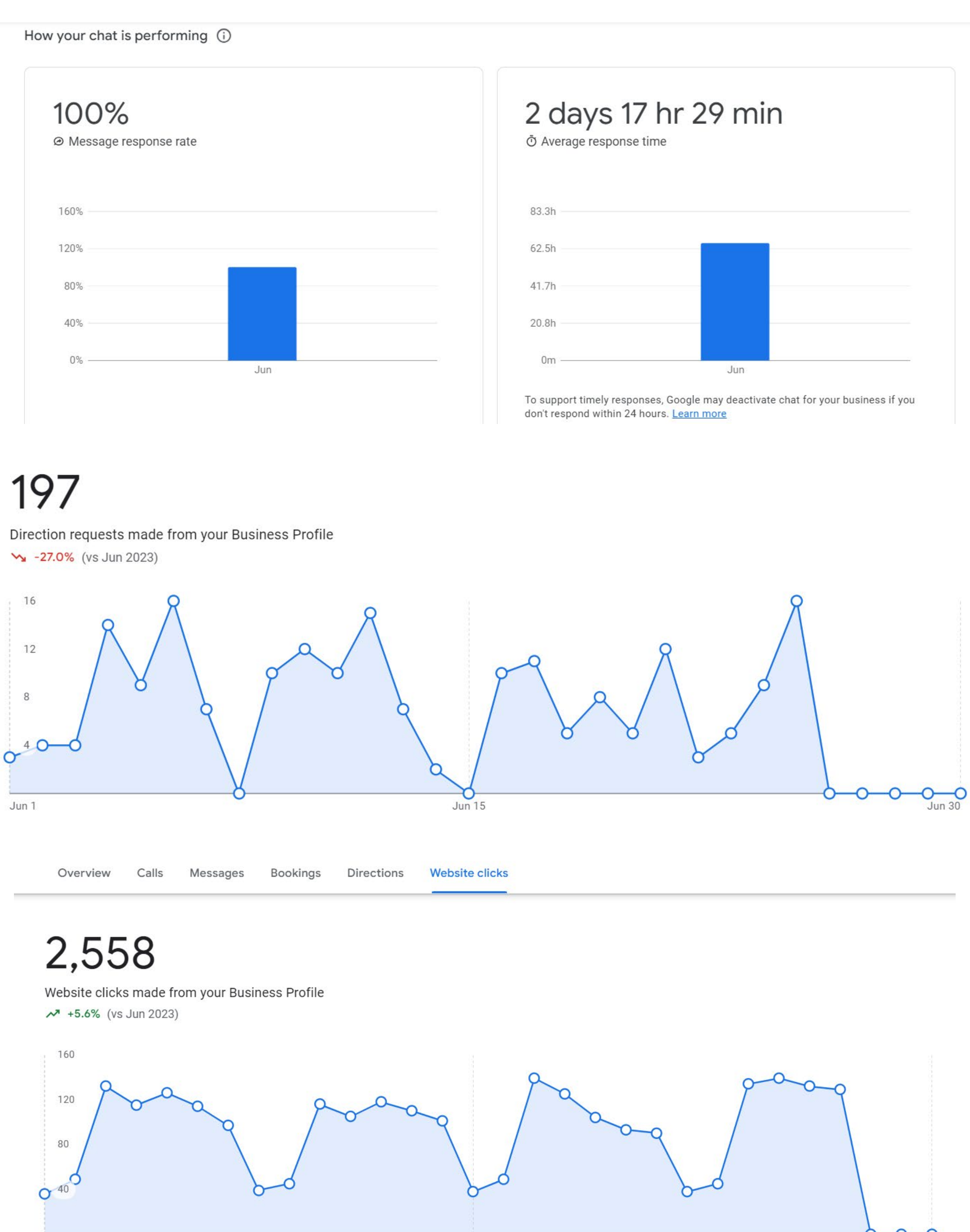


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q4\3. June 2024

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\3. June 2024

Integrated Planning

Ruth Watson

To: Alameda Alliance for Health Board of Governors

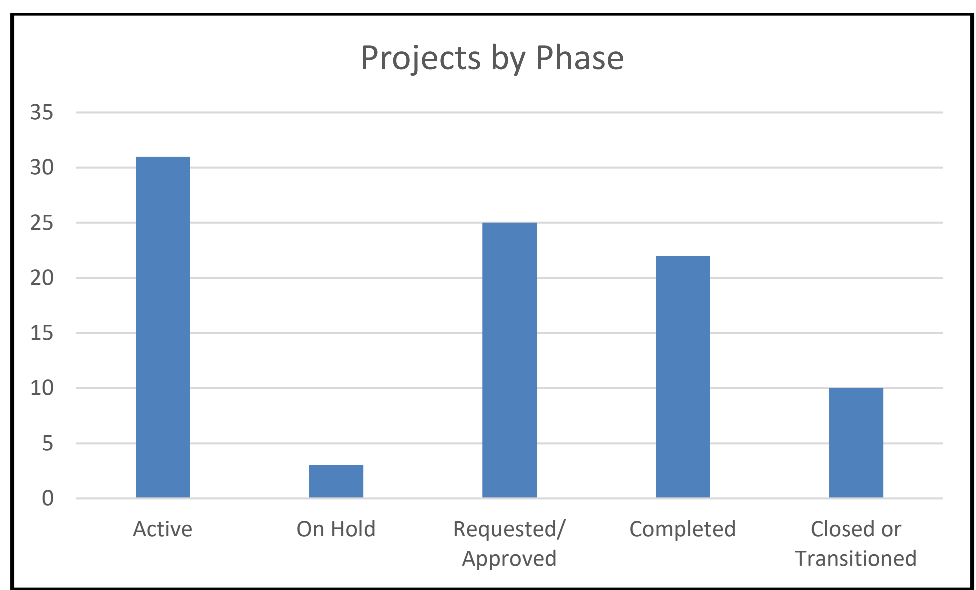
From: Ruth Watson, Chief Operating Officer

Date: July 12, 2024

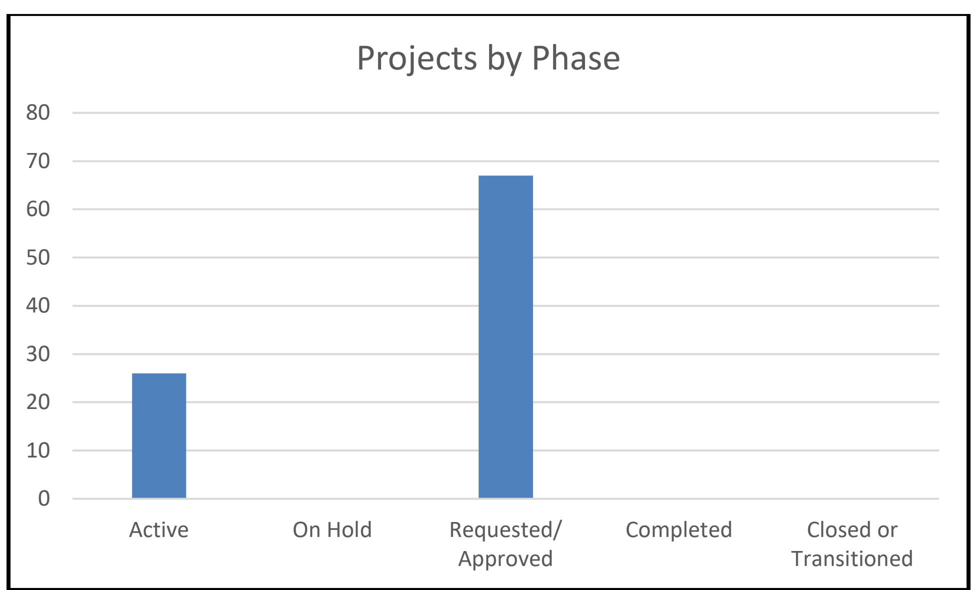
Subject: Integrated Planning Division Report – June 2024 Activities

Integrated Planning Division

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



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



- D-SNP Key Initiatives and Dates
        - DMHC Material Modification Submission – MA Service Area Expansion – March 2024
        - DMHC Material Modification Submission – DSNP Product – August 2024
        - CMS Notice of Intent to Apply – November 2024
        - CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025
        - CMS Formulary & Bid Submission (Benefit Determination) – June 2025
        - CMS SMAC Submission – July 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 – June 2024
        - Medicare Organizational Structure Exercise kick off
        - IT project management plan approach solidified
        - Completed Medicare Branding Demos with 3 agencies
        - Received approval from Administrative Oversite Committee (AOC) on Standard Operating Procedures (SOP) Policy, Template, Example, and Guide
        - Added FluidEdge consulting resources
        - Provider Services & Contracting D-SNP provider amendments supporting Sequestration, Medical Education, Disproportionate Share Hospital, Risk Adjustment (Coding Accuracy, and Stars in review with outside counsel
        - D-SNP provider amendment rates in development
        - Completed Chapman Consulting SOW to support Provider Outreach and Engagement

        - Staffing Update: Posted Two Contract Specialist Positions
            - One open position. Hiring is in process
            - One position hired. Starting July 29, 2024
        - Product
            - RFP of Dental Benefit Services released
            - Medicare Vendor Analysis and Supplemental Benefit Grid in development
            - Development of the First Tier, Downstream or Related Entity (FDR) Oversight Policy
            - Staffing Update:
                - Posted Position(s) - Director, Stars Strategy & Program Management
            - Quality
                - Continued development of Model of Care (MOC) responses for MOC 1, 2, 3, and 4
        - Health Care Services / Quality / Behavioral Health
            - Documenting CMS D-SNP requirements in process
            - Development of the CM Program structure in process
        - Finance
            - Review of CMS D-SNP regulations and development of requirements
        - Compliance
            - Submitted DMHC Material Modification – MA Service Area Expansion Comment Table responses on June 14, 2024
            - DMHC Material Modification – DSNP Product prefiling meeting preparation
        - Pharmacy
            - Pre-delegation tool received and in review
            - Medicare PBM services proposal in review
            - Development of curriculum supporting Pre-delegation audit tool in process
            - Submitted Pharmacy Business Case for temporary Director, Pharmacy

    - 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.
        - Delegate Health Risk Assessment (HRA) to a vendor
        - No member delegation
        - DoFR for CHCN for Capitation
        - One HMO PBP for 1/1/26

CalAIM Initiatives:

- Community Supports (CS):
  - Sobering Centers launch has been delayed due to the extending HCSA contract negotiations
    - The negotiations are expected to last through July, which will delay our July 01 expected launch date
    - DHCS will be notified that we are moving the launch to January 01, 2025, and will be included with the final two CS Services we are launching
  - The final two CS services are expected to launch by January 2025:
    - Day Habilitation Programs
    - Short-Term Post-Hospitalization Housing
  - The CS Model of Care (MOC) was submitted to DHCS on June 28, 2024, in support of the two additional CS services launching January 2025

- 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
  - Alameda County Behavioral Health, Wellpath, and Alameda County Sheriff's office are creating a draft care plan for adults at Santa Rita Jail. They expect to share this draft with AAH by the end of July for MCP review
    - The Youth population will have a separate care plan created by Probation. This work is anticipated to continue into July, with partnership between Probation and Alameda County Behavioral Health.

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

        - 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
            - Roots is proposing an extension to the pilot period. The proposal from Roots is still under review with senior leadership as of July 1, 2024.
        - Monthly check-ins with Roots will continue through the remainder of the pilot

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

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

- Claims may be submitted retroactively back to July 1st, 2024 as long as it is submitted by end of the year

Recruiting and Staffing

- Integrated Planning Open position(s):
  - Backfill for Sr. PM – Position filled - Started June 10, 2024
  - Business Process Analyst – 1 Position filled – Started July 1, 2024; 2nd Position - pending
- Business Analyst – Integrated Planning – Position filled – starting July 15, 2024
- Backfill Business Analyst – Integrated Planning – 1 Position filled - Started June 10, 2024, 2nd Position - Pending

Integrated Planning

Supporting Documents Project Descriptions

Key projects currently in-flight:

- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs
  - Enhanced Care Management (ECM) – ECM will target eight (8) specific populations of vulnerable and high-risk children and adults
    - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022
    - Two (2) additional PoF became effective on January 1st, 2023
      - One (1) PoF became effective on July 1st, 2023
    - Two (2) PoF became effective on January 1st, 2024
  - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays
    - As of January 1st, 2024, AAH will offer twelve (12) of the fourteen (14) DHCS-designated CS services
      - January 1st, 2022 – Six (6) Community Supports were implemented
      - July 1st, 2023 – Three (3) additional CS services went live
      - January 1st, 2024
        - Two (2) CS services that support the LTC PoFs that were effective January 2023 are being piloted in 7/1-12/31/2023 and went live in January
        - One (1) additional CS service is also targeted for implementation in July 2024
  - Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
    - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
      - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024
      - MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by October 1st, 2024
      - Correctional facilities will have two years from 10/1/2024-9/30/2026 to go live based on readiness
  - Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 in order to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary
- Community Health Worker Services Benefit – Community Health Worker (CHW) services became a billable Medi-Cal benefit effective July 1st, 2022. CHW services are

covered as preventive services on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law for individuals who need such services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being

- 2024 Single Plan Model
  - 2024 Managed Care Plan Contract Operational Readiness – new MCP contract developed as part of Procurement RFP; all MCPs must adhere to new contract effective January 1st, 2024
    - Business Continuity Plan required as part of Operational Readiness
    - MOUs with third parties required as part of Operational Readiness
  - MCP Member Transition
    - Anthem members will transition to AAH effective January 1st, 2024
    - Members currently delegated to Kaiser will transition to Kaiser as part of their direct contract with DHCS effective January 1st, 2024
- CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site. CYBHI requires commercial health plans and the Medi-Cal delivery system, as applicable, to reimburse, at or above the published rates, these school-linked providers, regardless of network provider status, for services furnished to students pursuant to the fee schedule. Effective January 1st, 2024, the Alliance is partnering with the Alameda County Office of Education (ACOE) and several Local Education Agencies (LEAs) who were selected to participate in the CYBHI Fee Schedule Cohort 1

To: Alameda Alliance for Health Board of Governors

From: Ruth Watson, Chief Operating Officer

Date: July 12th, 2024

Subject: Incentives & Reporting Board Report – June 2024 Activities

<u>Current Incentive Programs</u>

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

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

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

- Partner meetings continued with the Local Education Agencies (LEAs) regarding project plan activities for successful completion of the milestones; the Alliance worked with LEAs to complete the Bi-Quarterly Report (BQR) submission for the reporting period of January – June 2024; the report was submitted to DHCS on June 27th, 2024
- The Alameda County Office of Education (ACOE) is partnering with the Alliance through SBHIP to build infrastructure to sustain program activities post-SBHIP through regularly scheduled Learning Exchanges and Office Hour sessions
- To date, $7.4M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $6.6M has paid to LEA and SBHIP partners

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

- Total earnable dollars by the Alliance under this program was $44M
- The Alliance received a total of $38M based on submission of deliverables and achievement of DHCS-defined metrics
    - $17.9M has been awarded to our HHIP partners to date
- A HHIP funding opportunity was released earlier this year to SBHIP LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
    - All ten (10) LEA funding applications were approved, totaling $1.3M in funding; LEAs were notified of funding decisions on May 31st, 2024, and development of MOUs is underway
- A program to increase partnerships within the community to support HHIP program goals of reducing and preventing homelessness utilizing funds earned from the S2 report is underway
    - The program application was released on June 3rd, 2024, and five (5) informational sessions were held in June for eleven (11) interested organizations
    - Up to $10M is available to partners through this program

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
- The Legislature and Governor reached a three-party budget deal on Saturday, June 22nd, 2024; the budget for the EPT Directed Payment Program was reduced by $111.3M which will have an impact on this program

New Programs

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

- Expanding the Alameda Alliance Provider network

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

The Alliance finalized program materials, including provider-facing program overview documents, application materials, evaluation criteria, governance structure, and policy and procedures. The program launched on June 1st, 2024, and was announced via a press release on May 29th, 2024. In June, three (3) informational sessions were held for twelve (12) different practices.

Recruiting and Staffing

Incentives & Reporting Open position(s):

- There are currently no open positions

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 into a primary care setting to Medi-Cal members; $200 million of the $650 million will be dedicated to 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 spreading of best practices, practice coaching activities, and achievement of stated quality and equity goals

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

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

Date: **July 12th, 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. The HCSP is responsible for operationalizing the Community Health Worker (CHW) Benefit. 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 members' overall health, wellness, and positive outcomes on a member's social determinants of health.

Housing Program Updates

Program Status:

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

Projects Status:

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

Community Health Worker Program Updates

Program Status:

- Benefit presentations – continued to provide CHW presentations to various stakeholders during June
- Network Building/Provider Recruitment
    - Contracting:
        - Journey Health – contract executed
        - Pair Team – contract executed
        - Roots – expanding existing contract to add CHW services

- Pre-Contracting:
  - On-going meetings with Alameda Health Systems, Alta Bates Medical, Building Futures, Family Resource Navigators, First 5 of California, SAVE DV, and West Oakland Collaborative

Projects Status:

- Developing curriculum for CHW Learning Cohort
- Developing CHW internal referral process
  - Developing strategy with internal stakeholders for compliance with APL 24-006 including CHW Supervising Provider credentialing requirements and oversight for Emergency Department CHW personnel
- Updating CHW Policies and Procedures (P&P) based on APL 24-006 requirements
  - Updated P&P is due to DHCS by 07/31/2024
- Completed the Technology Assessment for CHW Program on 06/05/2024
- Development of a CHW Supervising Provider workflow – In progress
- Development of public website content in partnership with the Communications & Outreach team – in progress

Staffing Updates for Housing & CHW Programs:

- There are currently no open positions; recruitment for FY 2024-25 approved new positions should begin shortly

Compliance

Richard Golfin III

To: Alameda Alliance for Health Board of Governors

From: Richard Golfin III, Chief Compliance & Privacy Officer

Date: July 12, 2024

Subject: Compliance Division Report

Compliance Audit Updates

- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey
  - The 2024 DHCS Routine Full Medical Survey began on June 17th, 2024. The onsite virtual survey ended on June 28th, 2024. During the two (2) week engagement, the Plan received 311 on-site end of day document requests and an additional twelve (12) post-audit requests. This represents a significant increase in document requests YOY and is an indicator that the DHCS seeks to understand Plan documents and interview discussions in greater detail. The Plan expects the DHCS to distribute a draft report in the coming weeks. Once received, the Plan will have fifteen (15) days to respond to the draft report.
- 2023 Department of Health Care Services (DHCS) Focused Medical Survey
  - The Plan received the 2023 DHCS Focused Audit Draft Report and Notice Letter on June 20th, 2024. The 2023 DHCS Focused Audit was conducted concurrently with the 2023 DHCS Routine Survey. The DHCS reviewed the period of April 1, 2022, through March 31, 2023. The focused audit evaluated the areas of performance for Behavioral Health and Transportation services. An exit conference was held on July 3rd, 2024, to discuss the draft report and a timeline for submitting the Plan's response. The Preliminary Report outlined nine (9) findings: four (4) findings under Behavioral Health Services; and five (5) findings under Transportation Services, Non-Medical and Non-Emergent Medical Transportation (NMT/NEMT). The Plan's response to the draft report is due on July 19th, 2024.

- 2024 Health Services Advisory Group, Inc. (HSAG) Network Adequacy Validation Audit (NAV)
    - On March 15th, 2024, HSAG informed the Plan of its intent to conduct the State's NAV Audit. HSAG is a third-party contractor of DHCS, an External Quality Review Organization (EQRO). The NAV Audit will evaluate the Plan's data, systems and methods used to calculate results for each network adequacy indicator outlined by the State. Impacted departments include Analytics, IT, QI, Provider Services and Compliance. HSAG has made 51 separate requests, with additional requests made to a key delegate. A virtual walkthrough and interviews are scheduled for July 15th, 2024, and July 17th, 2024. The Compliance Division will hold internal walkthrough sessions to prepare audit participants for this audit.

<u>Compliance Activity Updates</u>

- DMHC Medicare Filings – 2026 Medicare Launch
    - 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 by January 1, 2026. The DMHC issued an Order of Postponement on March 28th, 2024. Based on the substance of the DMHC's most recent comments, the Plan expects that the filing will be approved in the coming months.
    - D-SNP Product Filing: In preparation for submitting a second Material Modification (proposed E-Filing) to add a D-SNP product to the Plan's current State License, the Plan scheduled a pre-filing meeting with DMHC to be held on Wednesday, July 24th, 2024. The purpose of the meeting is to receive DMHC's guidance related to structuring the filing and outlining timelines and key plan personnel to be involved in the filing.
- California Department of Managed Health Care (DMHC) Material Modification – 2024 RFP Readiness, County Model Transition Submission:
    - The DMHC requested status of DHCS' post-transition monitoring of the Plan, including a description of the monitoring reports and other closing documents. The Plan is compiling a report that will clearly outline the Plan's post-transition activities and will submit to DMHC by July 17th, 2024.

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

  - Effective January 1st, 2024, the Plan is contractually required to cover LTC-ICF/DD Services. To demonstrate its readiness to provide services at this level of care, the Plan must attempt to contract with *all* California Department of Public Health (CDPH) licensed and certified LTC-ICF/DDs within California and specific care-homes within its county. The Plan is also required to contract with at least one statewide facility. To demonstrate its compliance with this requirement, the Plan submitted evidence of its attempts to contract with providers meeting the State's specifications. However, due to barriers experienced during the contracting process, e.g.: provider non-responsiveness, and; provider's refusing to contract with the Plan; the Plan has been unable to successfully contract with a facility outside of Alameda County. As a result, the Plan is out of compliance with the statewide contracting requirement. DHCS requires monthly contracting reports of Plan progress towards meeting this requirement and a CAP will remain in place until met.

- Alameda Alliance for Health - Kaiser Behavioral Health Comparison Audit (BHCA)

  - As a part of it's Corporate Internal Audit Plan, the Plan has leveraged the DMHC settlement agreement findings with Kaiser Foundation Health Plan to mitigate internal risks and effectuate greater compliance adherence by comparing Plan operations to the Kaiser-DMHC settlement agreement. The settlement agreement primarily involves Kaiser's violation of timely access and clinical standards surrounding Behavioral Health services and appointments. During its preliminary review of the Settlement Agreement, the Plan found sixty-six (66) points of interest to review against Plan Operations.

  - Phase 1 of the BHCA commenced on March 19th, 2024. To date, Plan Internal Auditors have reviewed: policies; procedures; internal data; and, held interviews with internal leads. The Compliance Division has begun to prepare its preliminary findings for presentation to the Board of Governor's later in the year.

- 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. One Undertaking remains outstanding, listed below.

Undertaking Compliance Chart			
Undertaking No.	**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.	July 22nd, 2024	The DMHC responded with additional comments to the Plan's updated Non-Quantitative Treatment Limitations (NQTL) Tables submitted on April 30th, 2024. The responses were initially due to DMHC on June 28th, 2024. However, due to most of the SMEs being preoccupied by the DHCS audits, the Plan received an extension to submit its responses by July 22nd, 2024. With support from outside counsel, the Plan will provide substantive responses by July 22nd, 2024, and anticipates closing this filing within the next 90 days.

Compliance

Supporting Documents

COMPLIANCE DASHBOARD SUMMARY

	Resource	Type	2018	2019	2020	2021	2022	2023	2024	TOTAL	% Completed
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	24	TBD	145	
		Total Self-Identified Issues	12	0	0	2	0	2	23	39	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**23**	**184**	
		Total In Progress	0	0	0	0	0	9	23	32	
		Total Completed	50	28	7	35	15	17	0	152	**94%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**23**	**161**	
	DMHC	Total State Audit Findings			5	6	8			19	
		Total Self-Identified Issues			3	0	0			3	
		Total Findings			**8**	**6**	**8**			**22**	
		Total In Progress			0	0	1			1	
		Total Completed			8	6	7			21	**95%**
		Total Findings	**NA**	**NA**	**8**	**6**	**8**	**NA**		**22**	
	DMHC Financial Services	Total State Audit Findings		5			4			9	
		Total Self-Identified Issues		0			0			0	
		Total Findings		**5**			**4**			**9**	
		Total In Progress		0			0			0	
		Total Completed		5			4			9	**100%**
		Total Findings	**NA**	**5**	**NA**	**NA**	**4**	**NA**		**9**	
STATE AUDIT FINDINGS		In Progress	0	0	0	0	1	9	0	10	
		Completed	38	33	12	39	26	15	0	163	**94%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**24**	**0**	**173**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	23	23	
		Completed	12	0	3	2	0	2	0	19	**45%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**23**	**42**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**26**	**23**	**215**	

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

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

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

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

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

	Total Findings	2	

2022 DMHC RBO Audit: Delegate

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

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

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

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

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

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

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

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

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
R = Repeat Observation

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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2023 DHCS Focused Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 ***Audit Onsite Dates - April 17, 2023 - April 28, 2023***			
#	**Category**	**Deficiency**	**Department Responsible**
1	UM	(2.1) Case Management and Care Coordination The Plan did not ensure the provision of coordination of care to deliver mental health care services to its members.	UM Provider Services
2	BH	(2.2) Information Exchange with the County Mental Health Plan (MHP) The Plan did not follow the written policies and procedures in its MOU for the timely sharing of medical information with the MHP.	UM Privacy IT
3	BHT	(2.3) Confirmation of Referred Treatments for Substance Use Disorder (SUD) The Plan did not make good faith efforts to confirm whether members received referred treatment for SUD and document when and where treatment was received, and any next steps following treatment.	UM Continuity of Care Behavioral Health
4	BH	(2.4) Follow Up for Referred Substance Use Disorder Treatments The Plan did not follow up with members who did not receive referred treatments to understand barriers and make subsequent adjustments to referrals.	UM Case Management Behavioral Health
5	NMT & NEMT	(3.1) Door-to-Door Assistance The Plan did not have a process in place to ensure that door-to-door assistance was provided for all members receiving NEMT services.	Vendor Management
6	NMT & NEMT	(3.2) Monitoring of Door-to-Door Assistance The Plan did not conduct monitoring activities to verify NEMT providers were providing door-to-door assistance for members receiving NEMT services, per APL 22-008	Vendor Management
7	NMT & NEMT	(3.3) Transportation Liaison The Plan did not have a direct line to the transportation liaison that it provided to providers and members, and the transportation liaison did not process authorizations after business hours.	UM

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2023 DHCS Focused Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 ***Audit Onsite Dates - April 17, 2023 - April 28, 2023***			
#	**Category**	**Deficiency**	**Department Responsible**
8	NMT & NEMT	(3.4) **R** Physician Certification Statement Forms The Plan did not ensure that members had the required PCS forms for NEMT services, nor did the Plan ensure that PCS forms contained all required components. A verification study of 14 samples revealed ten NEMT trips did not include the required PCS forms. The verification study also revealed for three samples that required the PCS form, there was not a place for start and end dates for NEMT services. The Plan updated the PCS form in March 2023; however, the start and end dates still were not included. Instead, the form had boxes for the prescriber to check off for durations of time; 3, 6, 9, and 12 months.	UM
9	Member Rights	(3.5) Ambulatory Door-to-Door The Plan did not ensure its delegate, provided the appropriate level of service for members requiring ambulatory door-to-door service.	UM Continuity of Care Vendor Management

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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 members and that outreach was completed to confirm that services approved or had denial modification authorizations were utilized by members. The delegate also developed workflows to detect and mitigate failures. The CAP includes the delegate's implementation of a remediation plan. The remediation plan includes updates in their workflow, training, and an internal monthly audit- with results submitted to The Alliance for review. The Plan reviewed and evaluated the delegate's CAP implementation and progress during the interim and provided guidance. The CAP was approved and closed on 09/25/2023. (Completed) The delegate is expected to continue its internal monthly audit for the NOA letters and fax confirmation. The Plan will continue to monitor the audit results for compliance. Please see document 1.5.1_AAH Response for full details. (On Track) Additionally, the Plan will review the UM delegates' P&P's to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation and these will be evaluated annually at minimum. (On Track) 1a. Monitoring of the delegate's monthly internal audit is ongoing. (On Track) 2. Review the UM delegates' policies and procedures to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation. (On Track) Update 3/8/2024 P&P review complete and P&P deemed adequate. Review of the delegate's P&P regarding NOAs is ongoing and The Alliance will continue to meet with the delegate to have P&P appropriately updated. **Update 4/5/2024** The delegates have submitted all requested policies for review. The policies have been reviewed and the delegates have made all necessary revisions.	**3/31/2024**	Completed	Compliance UM	State	DHCS	2023

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

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

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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**
9	Member Rights	(4.1.1) **R** Grievance Acknowledgement and Resolution Letter Timeframes The Plan did not send acknowledgement and resolution letters within the required timeframes.	A grievance processing timeline was created to outline the grievance 30 calendar day process, day by day. The timeline outlines that by day 5, acknowledgement letters will be sent out. We will continue to monitor the daily aging report to ensure that acknowledgement letters are sent in a timely manner. The timeline also outlines that on Day 20, "If response is not received, after at least two follow-up attempts, task to a Medical Director in Quality Suite." Complying with this process will ensure that the Medical Director has sufficient time to reach out to the provider or facility to assist in obtaining a response. The Grievance and Appeals staff were trained on the new timeline on 8/1/2023, copies of the timeline were distributed to the department. (Completed and Ongoing)	8/1/2023	Completed	G&A	State	DHCS	2023
10	Member Rights	(4.1.2) **R** Grievance Letters in Threshold Languages The Plan did not send acknowledgement, resolution delay, and resolution letters in threshold languages.	The Plan's Grievance and Appeals Department has created a reporting mechanism in our daily aging reports to monitor what cases are still pending translation and when was the request for translation sent out, this was implemented on 4/12/2023. We have then assigned one specific team member to be responsible for following up on translation letters to ensure that they are getting the attention that they need to be completed in a timely manner. The Grievance Processing Timeline will be updated to include when a request for translation needs to be sent out and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted on 10/10/2023. (Completed and ongoing)	10/10/2023	Completed	G&A	State	DHCS	2023
11	Member Rights	(4.1.3) **R** Written Notification of Grievance Resolution Delays The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days and did not resolve grievances by the estimated resolution date in the delay letters.	The Plan's Grievance and Appeals Department will be updating our system, Quality Suite, to better capture data on if and/or when a delay letter is sent out. Once the system is updated, we will be able to create a reporting mechanism in our daily aging reports to monitor for when a case needs a delay letter and if the letter was sent out. The Grievance Processing Timeline will also be updated to include the process for sending out a delay letter and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted. (Completed and Ongoing)	12/1/2023	Completed	G&A	State	DHCS	2023
12	Member Rights	(4.1.4) Grievance Delay Timeframes The Plan inappropriately utilized a 14 calendar day delay timeframe for grievance resolutions.	In review of our current policy and procedures, and workflows; they were in line with the APL requirements. There was miscommunication in the staff training to use 14 calendar days instead of an estimated resolution date in the delay letters. There was a refresher training for the Grievance and Appeals staff held on 4/18/2023, the staff was provided the requirement and were reminded to provide an estimated resolution date in the delay letters if a resolution is not reached within 30 calendar days. (Completed)	4/18/2023	Completed	G&A	State	DHCS	2023
13	Member Rights	(4.1.5) Exempt Grievance Resolution The Plan did not resolve exempt grievances by close of the next business day.	In conjunction with the Grievance Department, the Member Services Grievance Guide was revised on 10/9/2023. (Completed) Training was provided to all Member Services staff on these revisions by 11/1/2023. (Completed)	11/1/2023	Completed	Member Services	State	DHCS	2023
14	Member Rights	(4.1.6) Grievance Identification The Plan did not process and resolve all member expressions of dissatisfaction as grievances.	Member Services has implemented a process to identify expressions of dissatisfaction that were not classified appropriately. (Completed) A Member Services Supervisor works with the agent to ensure the case is classified accurately and resolved in a timely manner. (Completed)	3/15/2023	Completed	Member Services	State	DHCS	2023
15	State Supported Services	(SSS.1) Minimum Proposition 56 Payments The Plan did not distribute minimum payments for a State Supported Services claim as described in APL 19-013.	The claims system configuration team has corrected the fee schedule for the provider and adjusted the impacted claims to pay the correct rate. (Completed)	4/26/2023	Completed	Claims	State	DHCS	2023
16	CM	(2.2) PCP and members are not consistently notified of Case Management case closures	Configuration made in TruCare to ensure consistent notification	4/26/2023	Completed	Case Management	Self	DHCS	2023

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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**
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 2023 Update 03/10/2023: Delegate has submitted an updated form and delegate is currently working toward completion of the form for submission to the Plan. Provider Services and Compliance will review to validate all fields are complete once all forms are received. Update 4/15/2023: The other delegate's form received on 3/2/2023, and two levels of review completed 3/10/2023.	3/10/2023	Completed	Provider Relations		State	DHCS	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
4	QI	(2.1.1) The Plan did not document attempts to contact members and schedule the IHA.	1. The plan will continue to inform members of the IHA through the EOC, welcome letters to all new members, and videos. - In addition, all members are eligible for a new member orientation (including a financial incentive). - Information regarding the IHA will be included in the member newsletter. The Alliance will initiate a new phone campaign where all new members will receive a phone call encouraging the member to receive an IHA. This phone log will be appropriately documented. The Alliance will create a call script for new member phone calls. 2. The plan will create a report to identify new plan members. Update 5/12/2023: Fulfillment Report created to track mailing of member Orientation reports that contain reminder to schedule IHA to new members. Member Orientation Service Request tracking report tracks outreach attempts to members to complete new member orientation, which includes communication about scheduling IHAs 3. The plan will create workflows for informing members of the IHA. Update 5/12/2023: Clinical QI Program Coordinator will review IVR reports to determine all new members have received an outreach call. 4. The plan will update the IHA P&P to reflect the updated workflows. Update 3/10/2023: Draft policy QI-124 completed, IVR outreach is pending DHCS approval of script. Upon DHCS approval we will continue to develop the process for IVR outreach and develop desktop procedures. Update 4/15/2023: The updated P&P was approved at Compliance Committee 3/21/2023 5. The plan will create a phone call campaign, create a script, and work with the state for approval. Update 3/10/2023: Awaiting DHCS approval of script. Update 6/9/2023: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreach attempts via providers, by reviewing documentation as part of FSRs.	9/8/2023	Completed	QI		State	DHCS	2022
5	CM	**R** (2.5.1) The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.	1. The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with the MHP to review redline changes to the MOU. The MHP is currently under review of the redline changes and will notify the Alliance when they can move forward with signing the MOU. The MHP MOU vetting process includes County Board of Supervisor (BOS) approval. Therefore, the Alliance is hoping to execute the MOU by the end of 2022.	12/31/2023	Completed	Provider Relations		State	DHCS	2022
6	Provider Relations	**R** (3.1.1) The Plan did not monitor the network providers' compliance with requirements for when appointments were extended.	1. The Provider Manual was edited to update the requirements, providers were advised in the Quarterly Provider Packet, and The Alliance Provider Representatives advised providers during PCP visits. Additionally, fax blasts were sent to providers regarding the updated requirements, and the Provider Education document was updated to reflect the requirements. 2. Edit P&P and Quality of Access Workflow to ensure all cases are reviewed by a QI Nurse. If a case is determined to be related to access, QI / A&A staff will review data for ED / Inpatient Stays as a result of delay in appointment. If the member does have an ED / IP Claim, the QI RN will then work the case up as a PQI / Quality of Care. This will be reviewed by the Medical Director and follow the PQI process. Finally, all QOA cases with available MRs will be reviewed to ensure the appropriate provider documentation. Update 03/10/2023: Policy QI-114 has been updated and is awaiting approval at committee Update 4/14/2023: P&P Q1-114 was approved at Compliance Committee 3/21/2023	3/21/2023	Completed	Provider Relations QI		State	DHCS	2022

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

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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
9	Member Rights	**R** (4.1.1) The Plan did not send acknowledgement and resolution letters within the required timeframes.	1. The G & A Department Leadership and Quality Assurance Specialist will reference the daily reports to ensure the acknowledgment and resolution letters are sent timely 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement and resolution letters. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/20222	Completed	G&A		State	DHCS	2022
10	Member Rights	**R** (4.1.2) The Plan did not send acknowledgement and resolution letters in threshold languages.	1. Updated our system of record to capture the dates the resolution letter was submitted for translation and the date it was mailed to the member. 2. The Plan provided training to the Grievance & Appeals staff on the updates made to the system of record. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	9/20/2022	Completed	G&A		State	DHCS	2022
11	Member Rights	(4.1.3) The Plan was not compliant with grievance extension letter timeframes; in some cases, it did not send extension letters for grievances that were not resolved within 30 calendar days and in other cases it did not resolve grievances by the estimated completion date specified in the extension letter	1. The Plan provided training to the Grievance & Appeals staff on the system updates to capture extension letters. 2. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month. 3. Updated Policy & Procedure G&A- 003: Grievance and Appeals, Receipt, Review and Resolution. The policy will be sent to Committee for approval. Update 03/10/2023: Draft policy updated and awaiting approval at committee. Update 4/15/2023: P&P G&A-003 was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022
12	Member Rights	**R** (4.1.4) The Plan did not thoroughly investigate and resolve grievances prior to sending resolution letters.	1. The Alliance will review resolution letters prior to mailing to the member. 2. The Alliance provided training to the Grievance & Appeals staff to ensure the resolution letter clearly addresses all of the member's concerns 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/2022	Completed	G&A		State	DHCS	2022
13	Member Rights	**R** (4.3.1) The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes.	The Plan has created an interdepartmental team to work in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify HIPAA and FWA incidents and the method for immediate reporting to compliance. Update 03/10/2023: Training created and provided to The Alliance staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022
14	Member Rights	(4.3.2) The Plan did not notify the DHCS Program Contract Manager and DHCS ISO of suspected security incidents or unauthorized disclosure of PHI or PI.	Due to human error, reporting to the three (3) entities at DHCS; DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer was not completed for all possible HIPAA incidents. Reporting Policy CMP-013 has been updated to reflect the current reporting email address for possible HIPAA incidents to DHCS incidents@dhcs.ca.gov. This change was reviewed and approved by the Compliance Committee on 11/23/2021.	11/23/2021	Completed	Compliance		State	DHCS	2022

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#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
15	Fraud and Abuse	**R** (6.2.1) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness. Update 03/10/2023: Training created and provided to The Alliance staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022

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

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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
COMPLIANCE DASHBOARD

2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
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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#	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.

2	DMHC	24-001	1/12/2024	Amendment to Rule 1300.71.31 regarding calculation of the "Average Contracted Rate" for AB 72 (2016) purposes	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-001 to provide guidance to plans on the Amendment to section 1300.71.31 of title 28 of the California Code of Regulations (Rule 1300.71.31).

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

16	DHCS	24-006	5/13/2024	Community Health Worker Services Benefit	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the qualifications for becoming a Community Health Worker (CHW), the definitions of eligible populations for CHW services, and descriptions of applicable conditions for the CHW benefit.
17	DMHC	24-010	6/13/2024	Coverage of Ground Ambulance Services Provided by a Noncontracted Provider	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-010 to provide additional guidance regarding Assembly Bill 716.
18	DMHC	24-011	6/17/2024	Request for Health Plan Information and Addendum Revisions	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-011 to notify health care service plans the Department has revised the attached, Request for Health Plan Information (RHPI) and RHPI Addendum forms.
19	DHCS	24-007	6/20/2024	Targeted Provider Rate Increases	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on Network Provider payment requirements applicable to Medi-Cal Targeted Rate Increases (TRI), as defined herein, effective for dates of service on or after January 1, 2024.
20	DHCS	24-008	6/21/2024	Immunization Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify requirements related to the provision of immunization services.
21	DHCS	20-016	6/24/2024	Blood Lead Screening of Young Children (TECHNICAL CHANGE)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements for blood lead screening tests and associated monitoring and reporting for Medi-Cal managed care plans (MCPs).
22	DMHC	24-012	6/25/2024	Single Point of Contact for Hospitals to Request Authorization for Poststabilization Care	MEDI-CAL & GROUP CARE	This All Plan Letter (APL) reminds plans they may not require a hospital to make more than one telephone call to request authorization to provide poststabilization care to plan enrollees.
23	DMHC	24-013	6/28/2024	Health Equity and Quality Program Policies and Requirements	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-013 to inform all health care service plans (health plans) of the DMHC Health Equity and Quality (HEQ) program policies and requirements. The instructions provided herein supersede those previously published in APL 22-028 and REVISED APL 23-029.

Health Care Services

Donna Carey, MD

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

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

Date: **July 12th, 2024**

Subject: **Health Care Services Report**

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

There was a month-over-month decrease in total authorization volume from May to June 2024.

Total Authorization Volume (Medical Services)			
Authorization Type	**April 2024**	**May 2024**	**June 2024**
Inpatient	2,244	2,150	1,980
Outpatient	4,407	4,192	3,669
Long-Term Care	978	868	745
Total	**7,629**	**7,210**	**6,394**

***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 3,578 authorizations in the month of June, which is a decrease from the past 2 months. The top 5 categories remain radiology, OP Rehab, TQ, Home Health and Outpatient facility.

Total Outpatient Authorization Volume			
Authorization Status	**April 2024**	**May 2024**	**June 2024**
Approvals	4,239	4,044	3,587
Partial Approvals	9	9	7
Denials	159	139	75
Total	**4,407**	**4,192**	**3,669**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**April 2024**	**May 2024**	**June 2024**
Overall Denial Rate	**3.0%**	**3.0%**	**2.5%**
Denial Rate Excluding Partial Denials	**2.8%**	**2.9%**	**2.3%**
Partial Denial Rate	**0.2%**	**0.2%**	**0.2%**

***Source**: #03690_Executive_Dashboard*

Outpatient Turn Around Time Compliance			
Line of Business	**April 2024**	**May 2024**	**June 2024**
Overall	**100%**	**100%**	**100%**
Medi-Cal	**100%**	**100%**	**100%**
IHSS	**100%**	**100%**	**100%**
Benchmark	*95%*	*95%*	*95%*

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- Total inpatient auth volume decreased slightly from May to June, while there was a slight increase in denials from May to June.

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

- Inpatient denial rate decreased slightly from 3.0% in May to 2.8% in June.

- IP Auth TAT compliance continues to surpass benchmark of 95%: 97% in April, and 98% in May, and 98% in June.

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

- IP UM team continues to identify members eligible for care management services who are currently admitted to a hospital, conducts inpatient discharge risk assessment, provides the name of Care Manager for inclusion in the discharge summary, and refers to Case Management department for follow up. 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 offer support in terms of ECM, Community Supports services, and other opportunities for supporting throughput and appropriate discharge.

Total Inpatient Authorization Volume			
Authorization Status	**April 2024**	**May 2024**	**June 2024**
Approvals	2,176	2,106	1,920
Partial Approvals	0	0	0
Denials	68	44	60
Total	**2,244**	**2,150**	**1,980**

***Source**: #02569_AuthTAT_Summary*

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**March 2024**	**April 2024**	**May 2024**
Authorized LOS	**6.1**	**5.8**	**5.1**
Admits/1,000	**51.9**	**50.5**	**53.7**
Days/1,000	**316.1**	**292.2**	**274.9**

***Source**: #01034_AuthUtilizationStatistics*

Inpatient Authorization Denial Rates			
Denial Rate Type	**March 2024**	**April 2024**	**May 2024**
Full Denials Rate	**1.3%**	**0.7%**	**0.6%**
Partial Denials	**1.3%**	**1.2%**	**0.8%**
All Types of Denials Rate	**2.5%**	**1.9%**	**1.4%**

***Source**: #01292_AllAuthDenialsRates*

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

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Long-Term Care

- Transition of the long-term care staff to the new manager will be effective 8/1/24.
- LTC census during June 2024 was 2,827 members. This is a decrease of 2% from May 2024.
- Month to Month, the admissions, days and readmissions are decreasing. From March to May the admissions decreased by 46.72%, the days decreased by 63.2% and the readmissions decreased by 58.22%. Some of this could be due to a lag in claims, but we are seeing a decrease, overall.

Totals	March 2024	April 2024	May 2024
Admissions	137	122	73
Days	1,000	775	368
Readmissions	34	35	14

***Source**: #14236_LTC_Dashboard*

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

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

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

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

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

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

- Authorization volume had a slight decrease in June by 14.17% compared to May 2024.

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

Total LTC Authorization Volume			
Authorization Status	**April 2024**	**May 2024**	**June 2024**
Approvals	947	844	717
Partial Approvals	0	0	0
Denials	31	24	28
Total	**978**	**868**	**745**

Source: *#02569_AuthTAT_Summary*

LTC Turn Around Time Compliance			
Line of Business	**March 2024**	**April 2024**	**May 2024**
Medi-Cal	**98%**	**97%**	**96%**
Benchmark	*95%*	*95%*	*95%*

Source: *#02569_AuthTAT_Summary*

Behavioral Health

- In June, Behavioral Health processed 440 authorizations, 308 Care Coordination referrals, and completed 231 Medi-Cal Mental Health Screenings and continued to maintain a turnaround time performance level above 95%.

Total BH Authorization Volume			
	24-Apr	**24-May**	**24-June**
Approvals	486	469	339
Partial Approvals	0	1	0
Denials	0	1	1
Total	486	471	440

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
**Goal ≥95%*	**24-Apr**	**24-May**	**24-June**
Determination TAT%	98%	97%	98%
Notification TAT%	89%	95%	98%

Source: 14939_BH_AuthTAT

Behavioral Health Treatment Turnaround Times

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

Source: 14939_BH_AuthTAT

Behavioral Health Denial Rates

**Goal ≤ 5%* BH Denial Rates		
24-Apr	**24-May**	**24-June**
0	0.01%	0.01%

Source: 14939_BH_AuthTAT

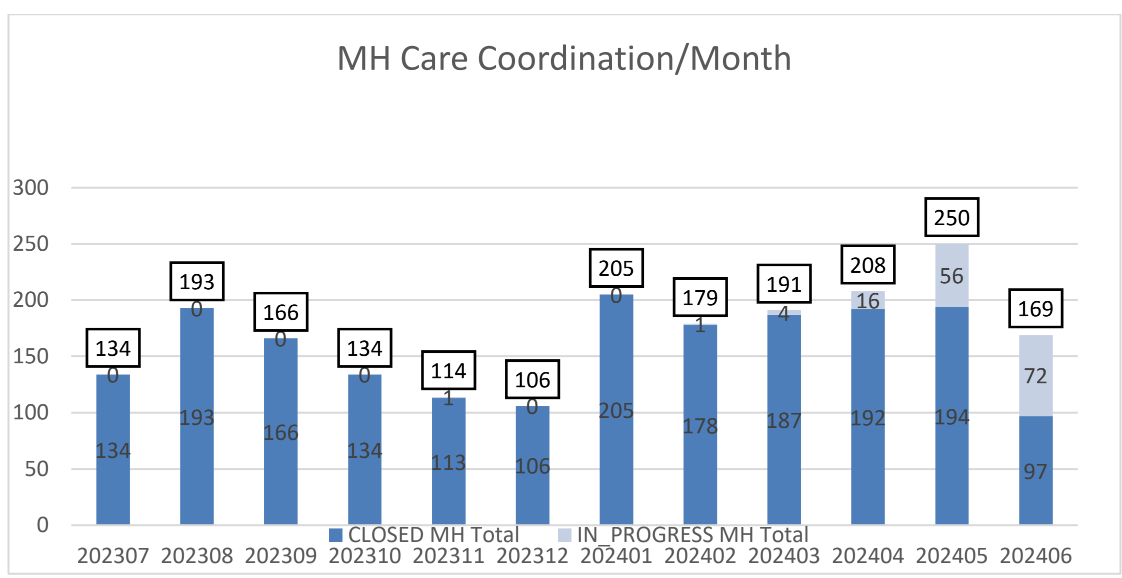
Mental Health Care Coordination

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

Total # Medi-Cal Screening Tools			
	24-Apr	24-May	24-June
Youth Screenings	46	57	77
Adults Screenings	119	118	154

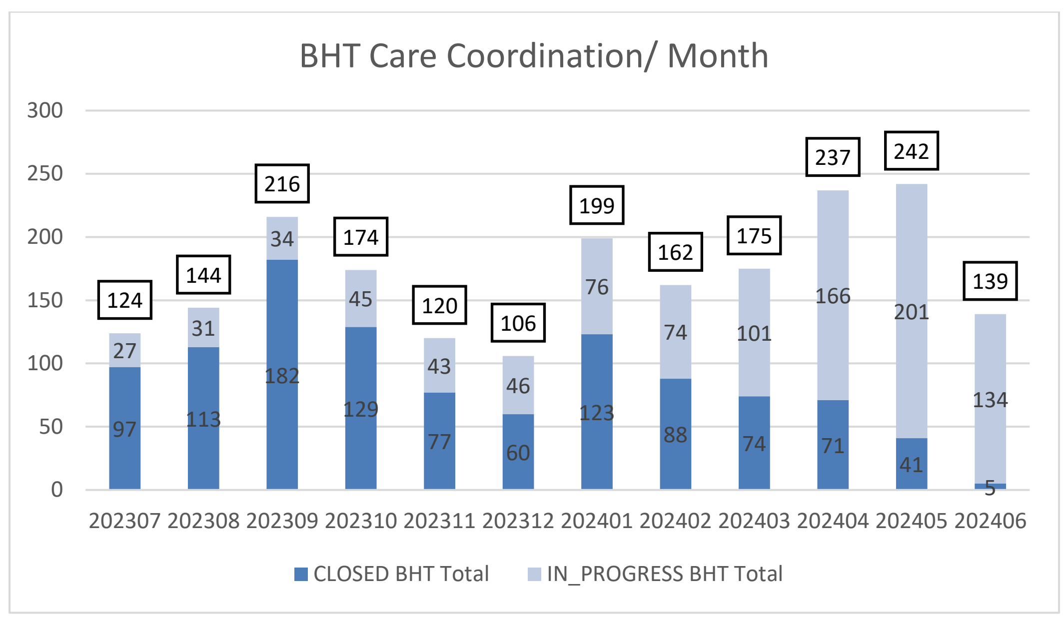
Source: PBI_14460 – MLS BH TruCare Assessments

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



Behavioral Health Treatment (BHT)

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

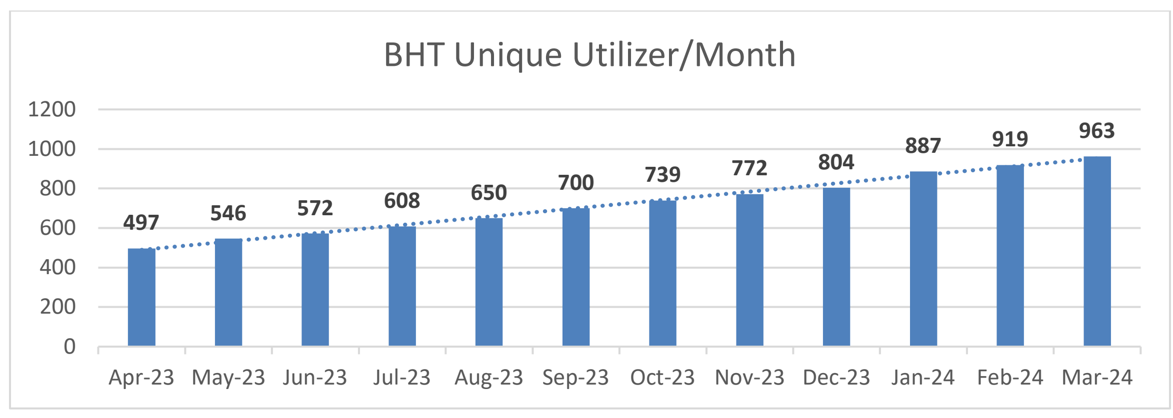


Source: 14665_BH_Cases

Behavioral Health Utilization

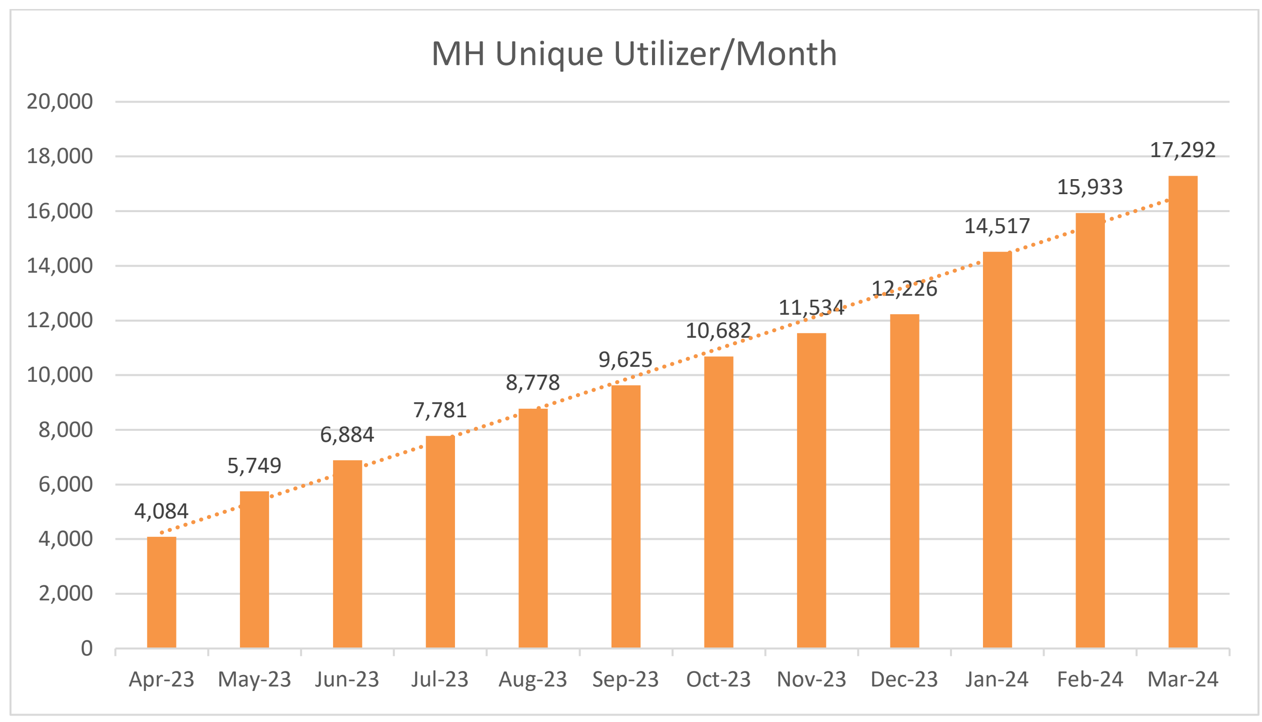
- Removing barriers to access Behavioral Health services remains a primary goal for the Alliance Behavioral Health team.

- We observed a consistent rise in unique utilizers of BHT/ABA services, with a 4.8% increase from February 2024 to March 2024.



Source: PBI 14621 BH Utilization Report

- The utilization of mental health services has steadily risen, showing an 8.5% increase in unique utilizers from February 2024 to March 2024.



Source: PBI 14637 BH12M Report

Pharmacy

- Pharmacy Services process outpatient pharmacy claims, and pharmacy prior authorization (PA) has met turn-around time compliance for GroupCare line of business (LOB) for Q2, 2024:

LOB	Quarterly Number of Outpatient PAs Processed	Quarterly Turn Around Rate Compliance (%)
GroupCare	519	100%

Decisions	Number of PAs Processed in June
Approved	36
Denied	55
Closed	95
Total	**186**

- Medications for weight management, nerve pain, dry eyes, hepatitis B, asthma, eczema, migraines, colon cleanse and diabetes are in the top ten categories for denials.

June Ranking	Drug Name	Common Use	Common Denial Reason
1	WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML	Weight Management	Criteria for approval not met
2	ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 2.5 MG/0.5ML	Weight Management	Criteria for approval not met
3	LIDOCAINE EXTERNAL PATCH 5%	Nerve Pain	Criteria for approval not met
4	CEQUA OPHTHALMIC SOLUTION 0.09%	Dry Eyes	Criteria for approval not met
5	VEMLIDY ORAL TABLET 25 MG	Hepatitis B	Criteria for approval not met
6	DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2 ML	Asthma & Eczema	Criteria for approval not met
7	EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML	Migraines	Criteria for approval not met
8	XIIDRA OPTHALMIC SOLUTION 5%	Dry Eyes	Criteria for approval not met
9	SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML	Colon Cleanse	Criteria for approval not met
10	VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML	Diabetes	Criteria for approval not met

- The AAH Pharmacy Department has re-launched its Transition of Care pilot program as of 4/1/2024, with a focus on members with Congestive Heart Failure. Recently, additional high-risk diagnoses have been added as well such as sepsis and end stage renal disease (ESRD). Alliance pharmacists work with some of these members after hospital discharge to help decrease hospital readmission through education to the members as well as filling potential gaps between providers and their patients. AAH Pharmacy is focusing on helping lower volume but higher risk members that may benefit from pharmacy outreach.

Case and Disease Management

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

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

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

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

Case Type	Cases Opened in May 2024	Total Open Cases as of May 2024	Cases Opened in June 2024	Total Open Cases as of June 2024
Care Coordination	779	1,462	615	1,317
Complex Case Management	2	22	7	21
Transitions of Care (TCS)	1,212	2,333	992	2,084

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

CalAIM

Enhanced Case Management

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

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

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

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

- AAH continues to collaborate with Alameda County (AC) Health (formerly known as 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 staff are participating in DHCS Foster Care Youth Transition Stakeholder meetings, to prepare for the mandatory transition of Foster Care Youth on 1/1/2025

ECM Outreach in March 2024	Total Open Cases as of March 2024	ECM Outreach in April 2024	Total Open Cases as of April 2024	ECM Outreach in May 2024	Total Open Cases as of May 2024
2,393	2,653	1,202	2,896	648	3,052

Source*: #13360 ECM Dashboard*

Community Supports (CS)

- AAH CS team is working on notifying members that are receiving services from non-contracted providers, that they need to start transitioning to in-network providers as their Continuity of Care comes to an end.

- 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 Jan 2025)
    - Short term Post Hospitalization Housing (coming Jan 2025)
    - Day Habilitation (coming Jan 2025)

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

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

- The CS leadership team submitted the Model of Care to DHCS to bring the last 3 Community Supports services live on 1/1/25:
    - Sobering Centers
    - Short-Term Post-Hospitalization Housing
    - Day Habilitation Program

Community Supports	Services Authorized in March 2024	Services Authorized in April 2024	Services Authorized in May 2024
Housing Navigation	1,172	1,186	1,188
Housing Deposits	229	252	260
Housing Tenancy	1,619	1,426	1,390
Asthma Remediation	7	12	12
Meals	1,255	1,290	1,261
Medical Respite	112	121	124
Transition to Home	3	9	10
Nursing Facility Diversion	13	17	19
Home Modifications	3	3	6
Homemaker Services	284	276	256
Caregiver Respite	5	8	9

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

Grievances & Appeals

- All cases were resolved within the goal of 95% of regulatory timeframes.
- Total Unique grievances resolved in June were 7.17 complaints per 1,000 members.

June 2024 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,541	30 Calendar Days	95% compliance within standard	1,540	99.9%	3.81
Expedited Grievance	2	72 Hours	95% compliance within standard	2	100.0%	0.004
Exempt Grievance	1,698	Next Business Day	95% compliance within standard	1,698	100.0%	4.19
Standard Appeal	35	30 Calendar Days	95% compliance within standard	35	100.0%	0.08
Expedited Appeal	1	72 Hours	95% compliance within standard	1	100.0%	0.002
Total Cases:	3,277		95% compliance within standard	3,276	99.9%	9.13

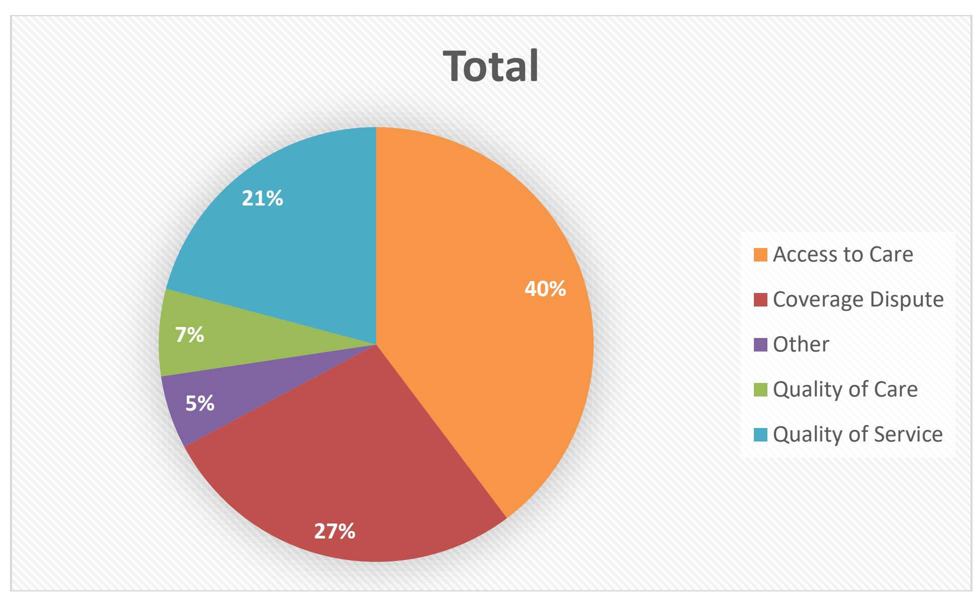
*Calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1000.

Grievances

- 613 of 1,543 (39%) cases were related to Access to Care, the top 3 grievance categories are:
    - (306) Timely Access
    - (138) Technology/Telephone
    - (306) Provider Availability

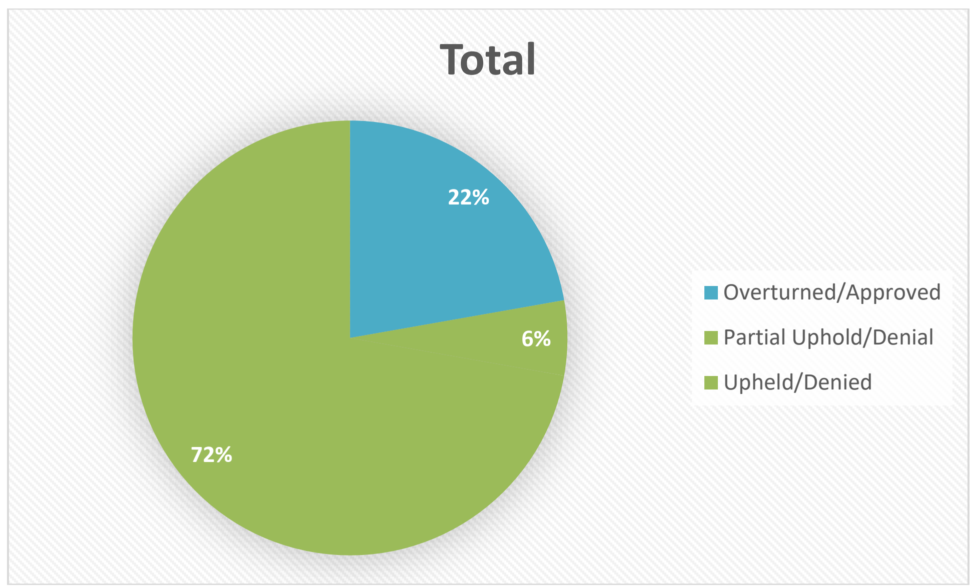
- 424 of 1,543 (27%) cases were related to Coverage Dispute, the top 3 grievance categories are:
    - (203) Provider Direct Member Billing
    - (138) Provider Balance Billing
    - (42) Benefit

- 322 of 1,543 (20%) cases were related to Quality of Service, the top 3 categories are:
    - (87) Plan Customer Service
    - (68) Transportation
    - (49) Provider/Staff Attitude



Appeals:

- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of June 2024; we met our goal at 22% overturn rate.



- 8 out of 36 (22%) cases were overturned for the month of June 2024:
    - (4) Out of network
    - (2) Disputes Involving Medical Necessity
    - (2) Coverage Disputes

Quality

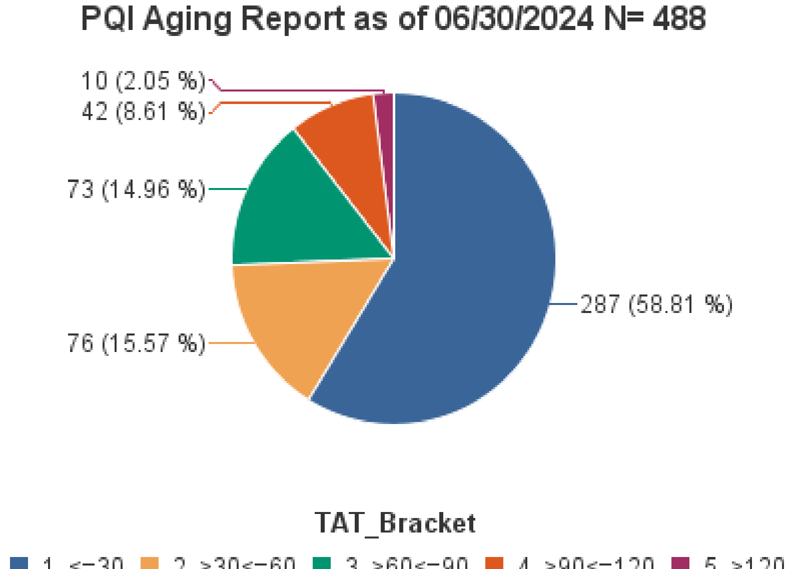
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

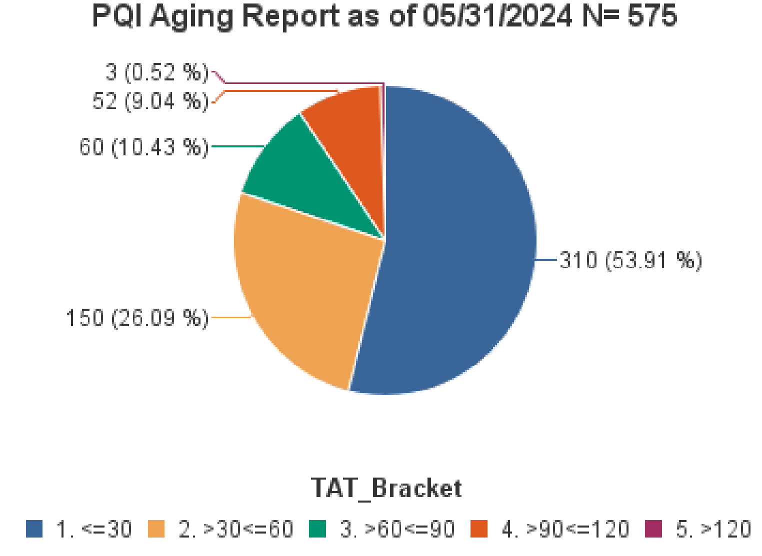
- As part of an effort to streamline the PQI review process, Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics team after they are triaged by the QI Clinical team. Quality of Care and Service issues continue to be reviewed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

- 0.52% cases in May and 2.05% in June were still open past the 120-day TAT. Therefore, turnaround times for case review and closure remain well within the benchmark of 95% per PQI P&P QI-104 for this lookback period.

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

- Total number of PQIs from all categories decreased by 87 from May to June. TATs are closely monitored to ensure timely closure of cases within the standard 95%.

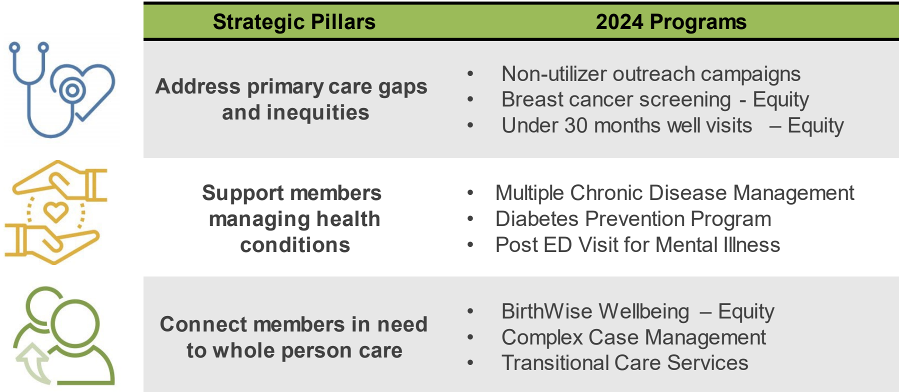




Quality Improvement: Population Health Management (PHM)

- The Alliance Population Health Management program follows the DHCS PHM Policy Guide and National Committee for Quality Assurance (NCQA) standards with the aim of improved health outcomes for all members through assessment of member needs and equitable access to necessary wellness and prevention services, care coordination and care management.

- Completed annual update of the Alliance population health assessment, evaluation of 2023 PHM strategy, and NCQA compliant PHM Strategy in May 2024. The 2024 PHM Strategy includes the core programs listed in the table below. The programs address disparities and gaps in services identified in the population health assessment.



Strategic Pillars	2024 Programs
Address primary care gaps and inequities	• Non-utilizer outreach campaigns • Breast cancer screening - Equity • Under 30 months well visits – Equity
Support members managing health conditions	• Multiple Chronic Disease Management • Diabetes Prevention Program • Post ED Visit for Mental Illness
Connect members in need to whole person care	• BirthWise Wellbeing – Equity • Complex Case Management • Transitional Care Services

- The Alliance submitted timely quarterly PHM DHCS-required Key Performance Indicators (KPIs) in August and November of 2023. Metrics include ED versus PCP, primary care, and Complex Case Management utilization and Transitional Care Services engagement. These submissions were put on hold from February 2024 until further notice. DHCS collected feedback from MCPs about the KPIs and will be reviewing the specifications.

- Continued meetings with Alameda County Health, City of Berkeley, and Kaiser to discuss Community Health Assessment and Improvement Plan (CHA/CHIP) collaborations.
  - Participated in Alameda County CHIP Kickoff Meeting on May 1st with three Alliance Community Advisory Committee (CAC) members also in attendance.
  - Discussing partnerships with two Alameda County CHIP signature programs, Immunization Program and EmbraceHer. Alliance staff will also participate in Alameda County CHIP focus area workgroup meetings.
  - Attended Alameda County CHA planning meeting on June 25th. The Alliance is planning to assist with Alameda County and City of Berkeley CHA efforts this summer through recruitment for community member surveys and/or focus groups and possible data sharing.

Health Equity

Lao Paul Vang

To: Alameda Alliance for Health Board of Governors

From: Lao Paul Vang, Chief Health Equity Officer

Date: July 12th, 2024

Subject: Health Equity Report

Staffing Update

- The Health Equity Department would like to introduce Dr. Yen Ang, our Director of Health Equity, who started on July 8th.

Internal Collaboration

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

External Collaboration

- **Introduction Meeting with Rev. Rhina Ramos,** Of the Ministerio Latino, Plymouth United Church of Christ, as part of our efforts to reach out to faith-based organizations to discuss possible collaboration on community engagement and outreach activities.
- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update**
  - Discussed the DEI training development process for MCPs, including a selection of providers for the pilot training process as required by APL23-025 to ensure the success and completion of this process.
  - We continue to seek clarity with DHCS on APL–23–025.
- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**
  - DHCS CHEO and MCPs CHEOs met to collaborate on Health Equity and DEI initiatives.
  - The meeting consisted of DHCS updates and a DHCS presentation

by Sarah Lahidji on Managed Care Advancing Quality and Equity Portfolio. The meeting ended with Policy Guides and an Intersection of CMO/CHEO Work, which was presented by Alex Li.

- **Quality and Population Health Management**

    - Attended the DHCA–MCP Quality & Health Equity Think Tank held in Sacramento.
    - The meeting was a deep dive into – MCAS
        - Principles for selecting/adding/removing measures
        - Draft MCAS measures (for MY 2025/RY 2026)
        - MCAS sanctions policy (for MY 2023)
        - Auto-Assignment & AQFS (for PY20/2025)
        - Quality Withhold (for MY 2025)
    - Strategic Planning: Comprehensive Quality Strategy 2025-28

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

- **Alliance Strategic Roadmap Update**

    - The second session took place in June.
    - The next two Committee meeting sessions are scheduled for July and August.

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

    DEI Curriculum Development

    - A meeting is set up with the Senior Leadership to review the 'storyboarding' for the HE DEI modules.
    - We are in the process of the final meetings with community members to discuss curriculum content specifics and meet APL requirements pertaining to the members served.
    - Continued work with the Vendor Management team to review the identified vendors' DEI/Health Equity training curriculum and to 'brand' the attestation form to be utilized by Alliance vendors.

    DEI Training Curriculum Timeline

        - Mid-July 2024 - First draft
        - Mid-August - Final draft
        - Mid-September - Submission to DHCS for approval.
        - Mid-November - Select a provider for the pilot training process.
        - January 2025 – Launch pilot training process.
        - April – June, completion of pilot training and launch all training to all providers and downstream subcontractors.

- **Communications Update**

  - The HE Department is working with Communications and Outreach to brand the attestation form.
  - A communication from the CEO introducing the DEI Training Curriculum is also being prepared in July for staff.

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

- **DEIB Committee Update**

  - The June DEIB Committee was canceled due to the absence of agenda items.

- **VIA Committee Update**

  - The VIA Committee discussed the upcoming Summer Social Event. More vegetarian and vegan options will be available. There will be a photo booth and music entertainment. Facilities will supply more tents for shade from the summer sun.

Information Technology

Sasikumar Karaiyan

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

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

Date: **July 12th, 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 June 2024 despite supporting 97% of staff working remotely.

Encounter Data

- In the month of June 2024, the Alliance submitted 180 encounter files to the Department of Health Care Services (DHCS) with a total of 359,662 encounters.

Enrollment

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

HealthSuite

- The Alliance received 297,217 claims in the month of June 2024.

- A total of 305,528 claims were finalized during the month of June, out of which 267,304 claims auto adjudicated. This sets the auto-adjudication rate for this period to 87.5%.

- HEALTHsuite application did not encounter any outages in June 2024. This sets the uptime to 99.9% for the application.

TruCare

- A total of 16,316 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.99%.

IT Security Program

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

    - **Key initiatives include:**

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

- The Annual Security Penetration testing report has been delivered by our vendor and the project team is currently prioritizing the critical items from the report which will be addressed immediately.

- Completed the server patches gaps identified in our quarterly report.

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 in the process of interviewing the subject matter experts and updating the recovery runbook.

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. In the process of contract extension to implement the data retention to all structured data.

Information Technology

Supporting Documents

Enrollment

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

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
June	403,889	7,144	8,985	5,657	137	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 June 2024

Auto-Assignments	Member Count
Auto-assignments MC	2,427
Auto-assignments Expansion	2,253
Auto-assignments GC	67
PCP Changes (PCP Change Tool) Total	4,747

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of June 2024”.
- There were 16,316 authorizations processed within the TruCare application.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

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

Transaction Type	Inbound automated Auths	Errored	Total Auths Loaded in TruCare
Paper Fax to Scan (DocuStream)	2,589	2,110	1,452
Provider Portal Requests (Zipari)	4,874	982	4,813
EDI (CHCN)	5,045	1,456	4,902
Provider Portal to AAH Online (Long Term Care)	32	15	27
ADT	1,168	634	693
Behavioral Health COC Update - Online	57	46	51
Behavioral initial evaluation - Online	46	19	43
HCSA (Health Care Service Agencies)	N/A	N/A	N/A
Manual Entry (all other not automated or faxed vs portal use)	N/A	N/A	2,343
Total			14,324

Key: EDI – Electronic Data Interchange

Web Portal Consumer Platform

- The following table 3-1 is a supporting document from the Web Portal summary section. (Portal reports always one month behind current month)

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

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	7,477	5,486	418,958	667
MCAL	112,638	3832	9157	1,307
IHSS	3,723	81	186	28
Total	123,838	9,399	428,301	2,002

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

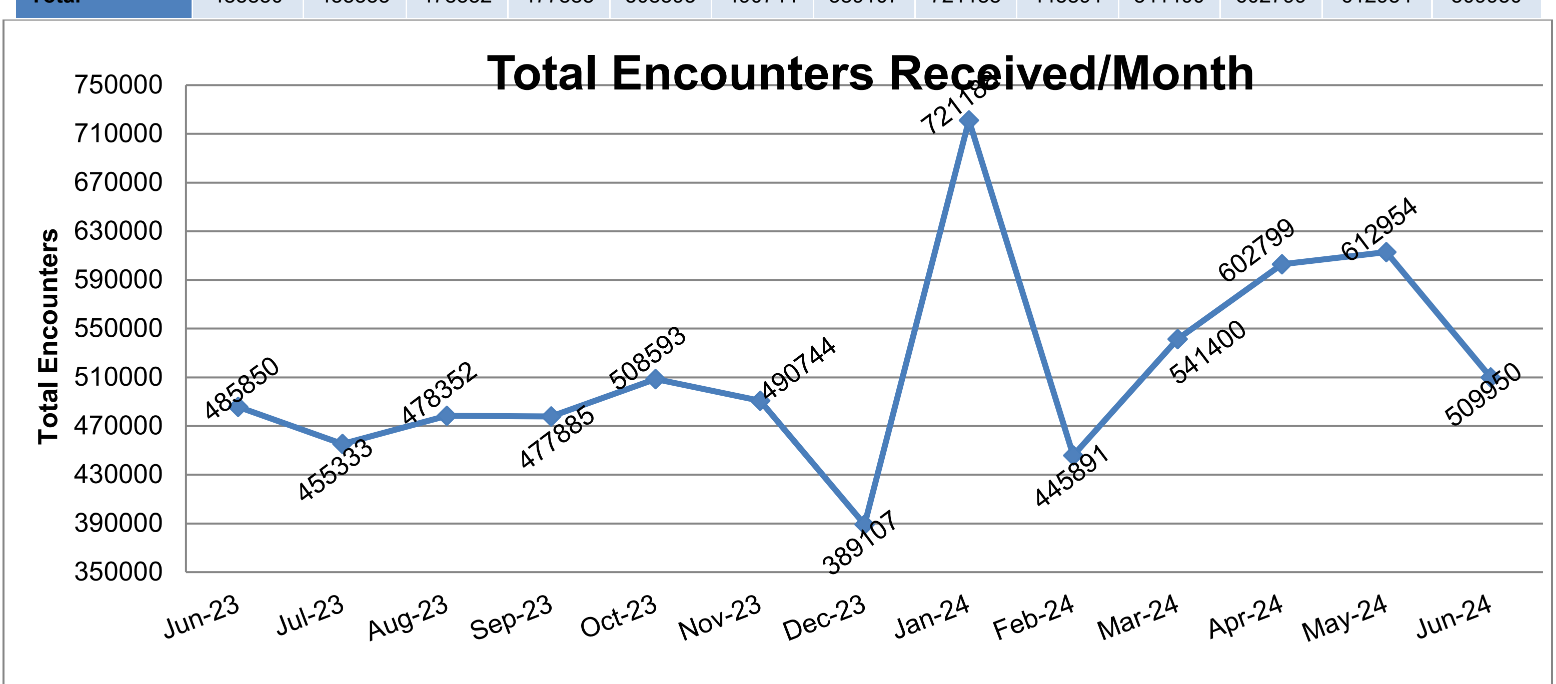
Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1,502,730
Provider - Claims	Claim Status	241,475
Provider - eligibility/claim	Claim Status	29,042
Provider - authorizations	Auth Submit	17,202
Provider - authorizations	Auth Search	8,608
Member Config	Provider Directory	8,259
Provider - Claims	Submit professional claims	4,979
Directory Config	Provider Directory	4,951
Member My Care	Member Eligibility	4,646
Member Help Resources	Find a Doctor or Hospital	3,143
Member Help Resources	ID Card	2,397
Member Help Resources	Select or Change Your PCP	1,926
Provider - eligibility/claim	Member Roster	1,921
Member Home	MC ID Card	1,421
Member My Care	My Claims Services	1,301
Provider - Provider Directory	Provider Directory 2019	1,210
Member My Care	Authorization	956
Provider - reports	Reports	926
Provider - Home	Forms	449
Member My Care	My Pharmacy Medication Benefits	422
Provider - Home	Behavior Health Forms SSO	396
Member Help Resources	Forms Resources	311
Member Help Resources	FAQs	298
Provider - Provider Directory	Manual	293
Member My Care	Member Benefits Materials	289
Member Help Resources	Authorizations Referrals	270
Provider - Provider Directory	Instruction Guide	269
Member Help Resources	Contact Us	263

Encounter Data From Trading Partners 2024

- **AHS**: June weekly files (13,316 records) were received on time.
- **BAC**: June monthly files (77 records) were received on time.
- **Beacon**: June weekly files (0 records)
    - No longer receiving encounter files.
- **CHCN**: June weekly files (110,650 records) were received on time.
- **CHME**: June monthly files (7,449 records) were received on time.
- **CFMG**: June weekly files (21,143 records) were received on time.
- **Docustream**: June monthly files (748 records) were received on time.
- **EBI**: June monthly files (2,043 records) were received on time.
- **FULLCIR**: June monthly files (2,842 records) were received on time.
- **HCSA**: June monthly files (3,663 records) were received on time.
- **IOA**: June monthly files (1,280 records) were received on time.
- **Kaiser**: June bi-weekly files (1,079 records) were received on time.
- **LAFAM**: June monthly files (86 records) were received on time.
- **LIFE**: June monthly files (1,694 records) were received on time
- **LogistiCare**: June weekly files (16,205 records) were received on time.
- **March Vision**: June monthly files (7,092 records) were received on time.
- **MED**: June monthly files (744 records) were received on time.
- **OMATOCHI**: June monthly files (0 records) were not received on time.
- **PAIRTEAM**: June monthly files (0 records) were not received on time.
- **Quest Diagnostics**: June weekly files (22,500 records) were received on time.
- **SENECA**: June monthly files (71 records) were received on time.
- **TITANIUM**: June monthly files (0 records) were not received on time.
- **Magellan**: June monthly files (409,433 records) were received on time.

Trading Partner Encounter Inbound Submission History

Trading Partners	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Health Suite	267437	224540	244907	247423	241298	247537	215246	298465	266339	308453	322786	375454	297267
AHS	6250	4363	4380	5479	5371	5243	6284	4570	7736	7005	6573	8412	13316
BAC	37	39	38	38	57	73	55	59	57	55	64	70	77
Beacon	4559	620											
CHCN	90418	102081	85836	77060	111275	87839	58566	96124	103674	122217	170653	122445	110650
CHME	5692	5706	5704	6212	7609	6445	5694	5843	5560	6022	7969	7107	7449
Claimsnet	9986	12379	8946	12302	12167	11670	18995	12043	10557	12651	16394	15934	21143
Docustream	607	567	744	562	400	705	476	930	814	698	302	1589	749
EBI	910	1664	814	867	718	823	811	1047	2903	1625	1700	184	2043
FULLCIR					888	598	177	828	1586	213	2261	8478	2842
HCSA	5573	3824	3466	2490	1913	2403	2087	2223	2097	2822	7118	5535	3663
IOA	974	424	673	1086	967	1073	1250	1453	1233	1054	1925	1163	1280
Kaiser	53820	56673	76278	79751	81985	87005	26208	77407	3725	9966	2286	886	1079
LAFAM					24				60	39	105	116	86
LIFE													1694
LogistiCare	20859	22235	27129	22456	25509	20781	32181	182822	20774	35600	32632	27531	16205
March Vision	5101	4468	4563	4933	4427	4428	4562	9693		6183	3633	8546	7092
MED		9	11	144	194	523	532	535	742	683	633	722	744
OMATOCHI											29		
PAIRTEAM											5344	7582	
Quest	13627	15741	14859	17008	13712	13077	15834	27022	17658	22306	18000	18001	22500
SENECA			4	74	79	56	52	124	222	112	159	113	71
TITANIUM						465	97		154	3696	2233	3086	
Total	485850	455333	478352	477885	508593	490744	389107	721188	445891	541400	602799	612954	509950



Outbound Encounter Submission

Trading Partners	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Health Suite	126674	147199	170751	127465	163149	134823	136233	172386	177658	147776	250835	198595	204068
AHS	5070	5318	4251	4253	6355	5147	4936	5667	7497	6968	6524	7002	10684
BAC	37	39	37	38	52	67	53	55	55	47	59	66	72
Beacon	2233	318											
CHCN	65595	56593	74313	55365	62962	73866	39846	67063	74336	80498	104625	107577	77200
CHME	5577	5595	5546	6063	7475	6321	5588	5703	5470	5889	7558	6749	7310
Claimsnet	7445	8849	6386	7075	7452	8031	11581	10145	7730	6757	13467	11561	11506
Docustream	378	347	529	441	270	573	404	387	600	377	267	839	570
EBI	872	1574	804	855	710	794	802	987	1347	1002	1589	60	1835
FULLCIR					806	516	124	653	540	116	1636	5401	2410
HCSA	1781	3778	3405	2349	1876	2342	1991	2142	2013	2769	4710	5363	3493
IOA	751	410	654	984	65	934	1228	1378	1156	1000	1868	1029	1221
Kaiser	68887	55988	75591	78162	81165	85807	26113	76335	3542	9650	1905	1292	812
LAFAM					2					16	92	103	58
LIFE													28
LogistiCare	20787	21686	26670	22142	24497	25951	31546	157548	40529	34931	32247	27487	16221
March Vision	3408	2720	2737	2992	2863	2661	2752	2700	2616	3736	2407	5719	4553
MED		9	11	126	145	438	428	446	624	528	518	579	654
OMATOCHI											56		
PAIRTEAM											4279	4422	
Quest	12642	14634	13788	12456	16082	3655	8394	28299	16589	16333	20983	16912	16898
SENECA			4	73	78	52	48	114	14	199	140	109	69
TITANIUM						438	75			3261	1911	2789	
Total	322137	325057	385477	320839	376004	352416	272142	532008	342316	321853	457676	403654	359662

Total Outbound Encounter/Month

Total Encounters

550000
510000
470000
430000
390000
350000
310000
270000
230000

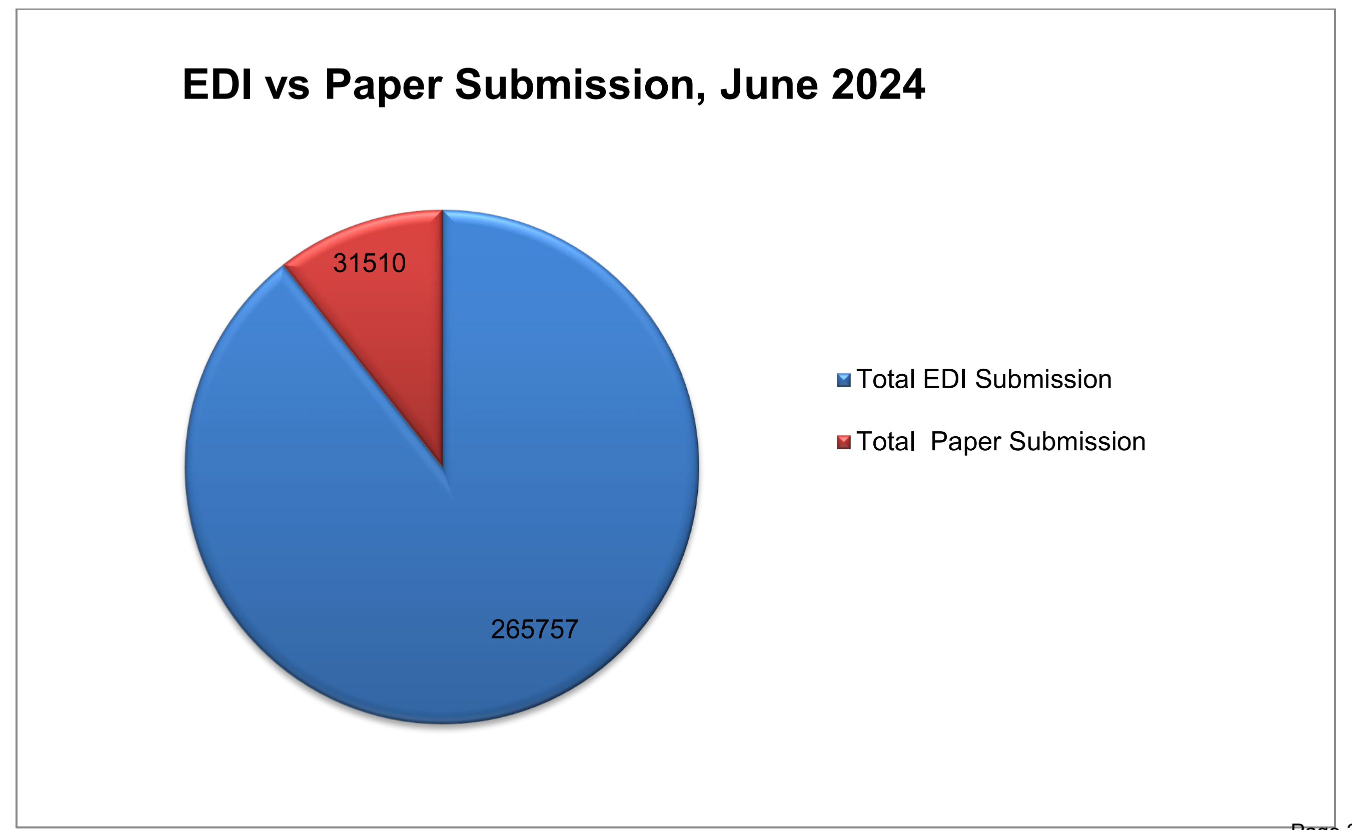
322137
325057
385477
320839
376004
352416
272142
532008
342316
321853
457676
403654
359662

June-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 June-24

HealthSuite Paper vs EDI Claims Submission Breakdown

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

Key: EDI – Electronic Data Interchange

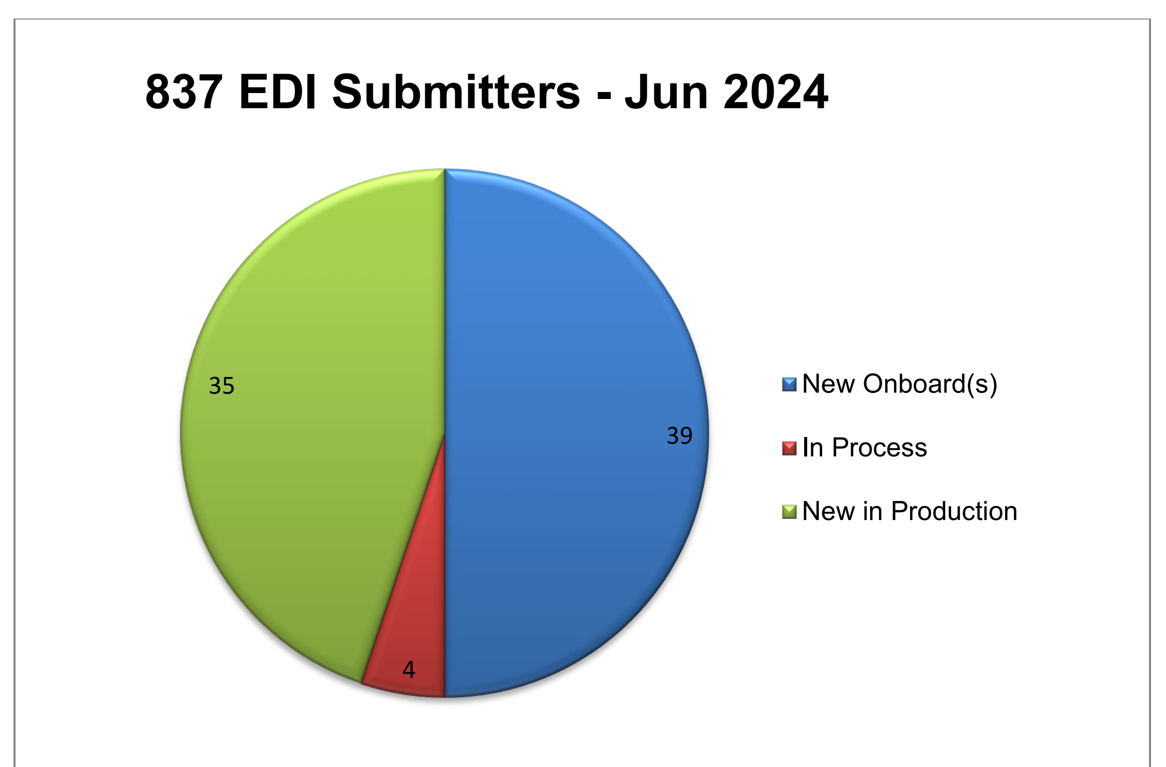


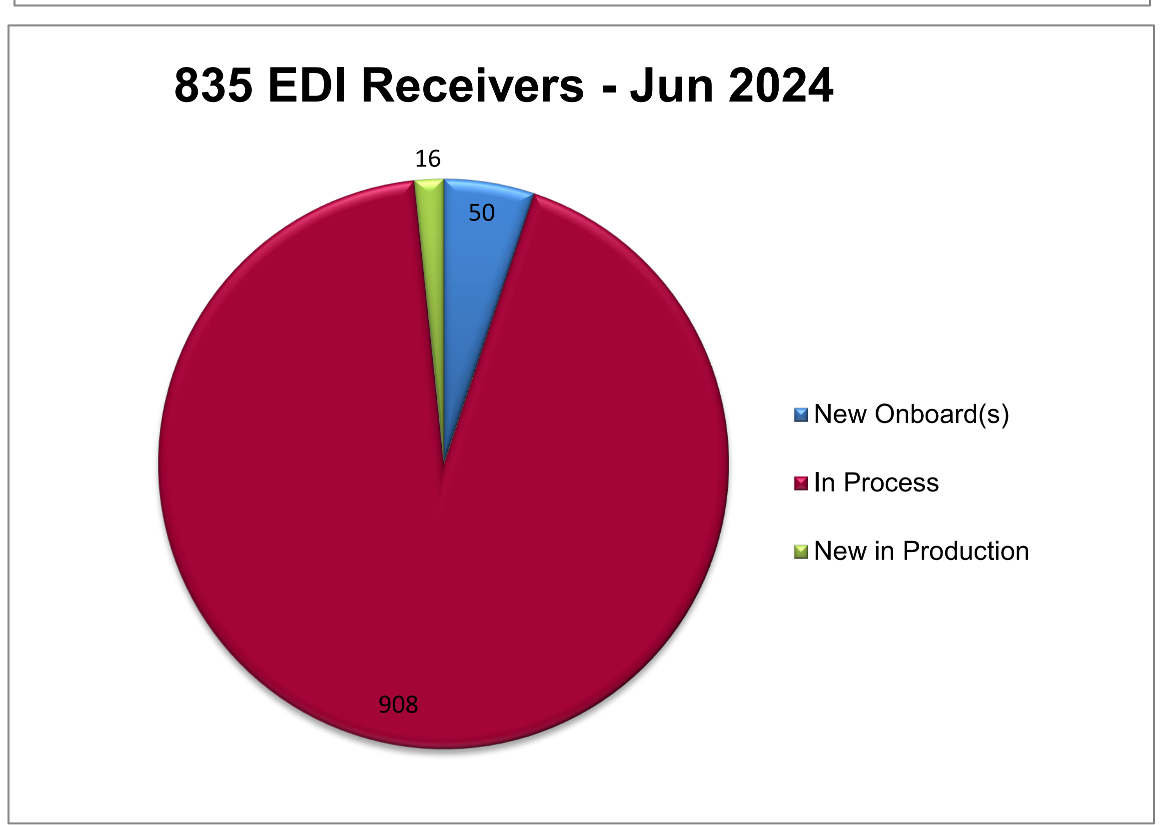
Onboarding EDI Providers – Updates

- June 2024 EDI Claims:
  - A total of 2380 new EDI submitters have been added since October 2015, with 35 added in June 2024.
  - The total number of EDI submitters is 3120 providers.

- June 2024 EDI Remittances (ERA):
  - A total of 1052 new ERA receivers have been added since October 2015, with 16 added in June 2024.
  - The total number of ERA receivers is 1068 providers.

	837				835			
	New on Boards	In Process	New In Production	Total in Production	New on Boards	In Process	New In Production	Total in Production
Jul-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
May-24	81	13	68	3085	63	874	40	1052
Jun-24	39	4	35	3120	50	908	16	1068


837 EDI Submitters - Jun 2024
35
39
4
New Onboard(s)
In Process
New in Production


835 EDI Receivers - Jun 2024
16
50
908
New Onboard(s)
In Process
New in Production

Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

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

File Type	Jun-24
837 I Files	39
837 P Files	141
Total Files	180

Lag-time Metrics/Key Performance Indicators (KPI)

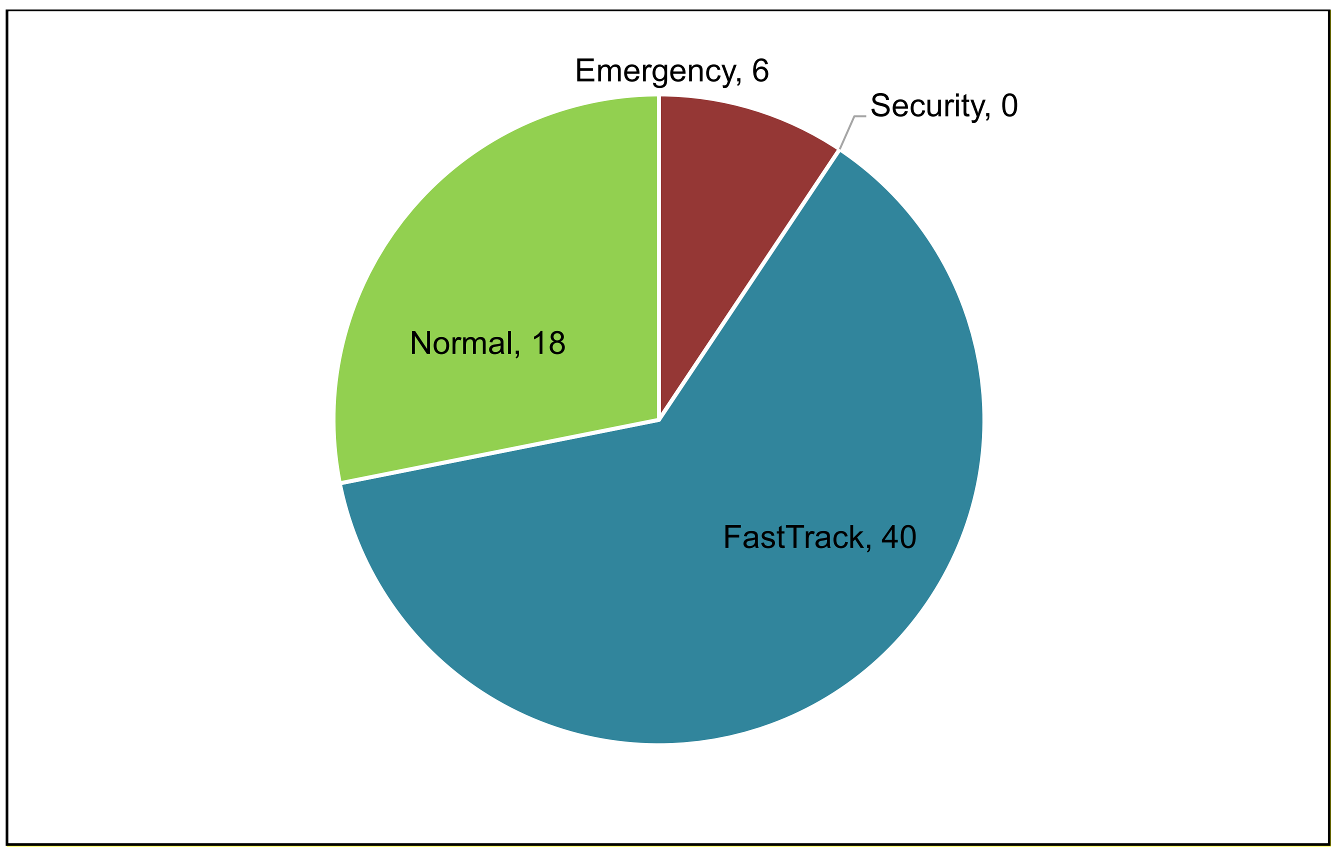
AAH Encounters: Outbound 837	Jun-24	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	92%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	91%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

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

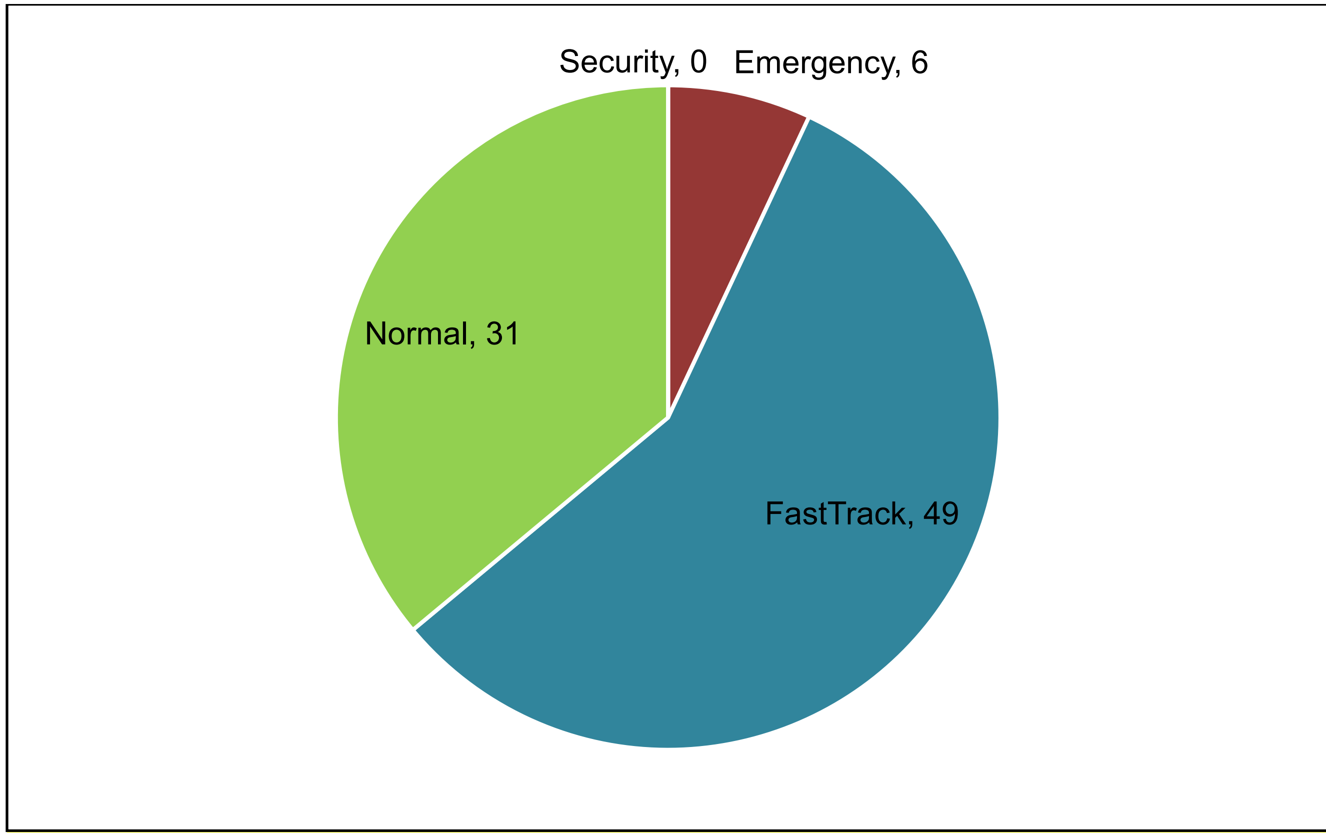
Change Management Key Performance Indicator (KPI)

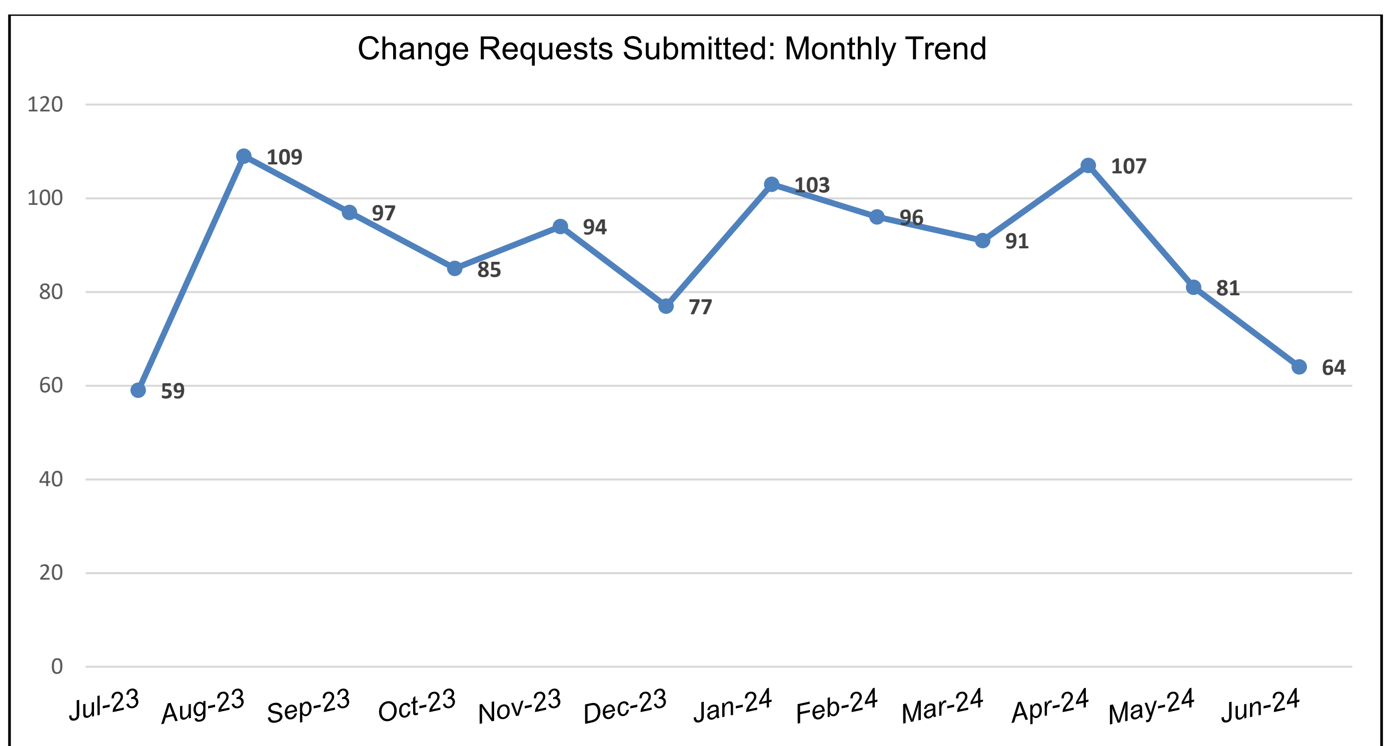
- Change Request Overall Summary in the month of June 2024 KPI:
  - 64 Changes Submitted.
  - 86 Changes Completed and Closed.
  - 148 Active Change Requests in pipeline.
  - 3 Change Requests Cancelled or Rejected.

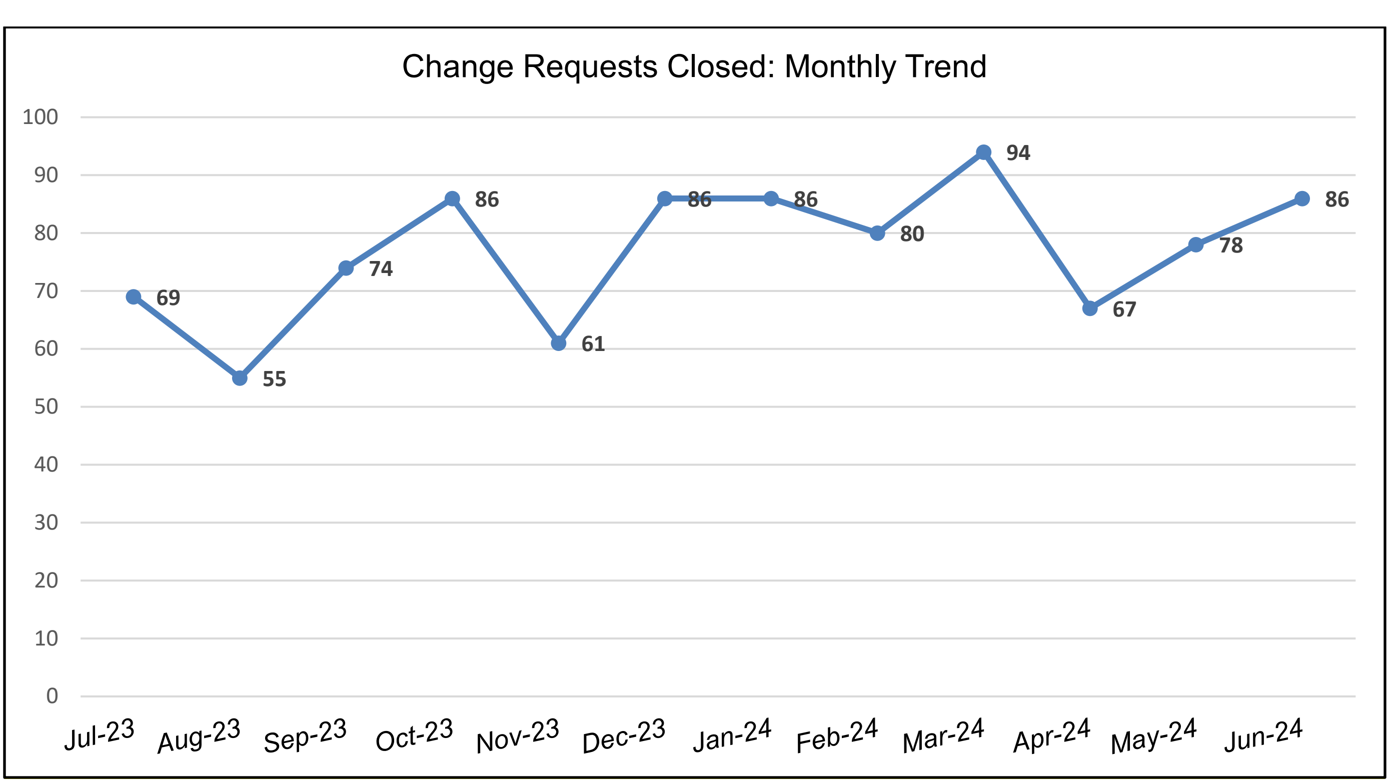
- 64 Change Requests Submitted/Logged in the month of June 2024



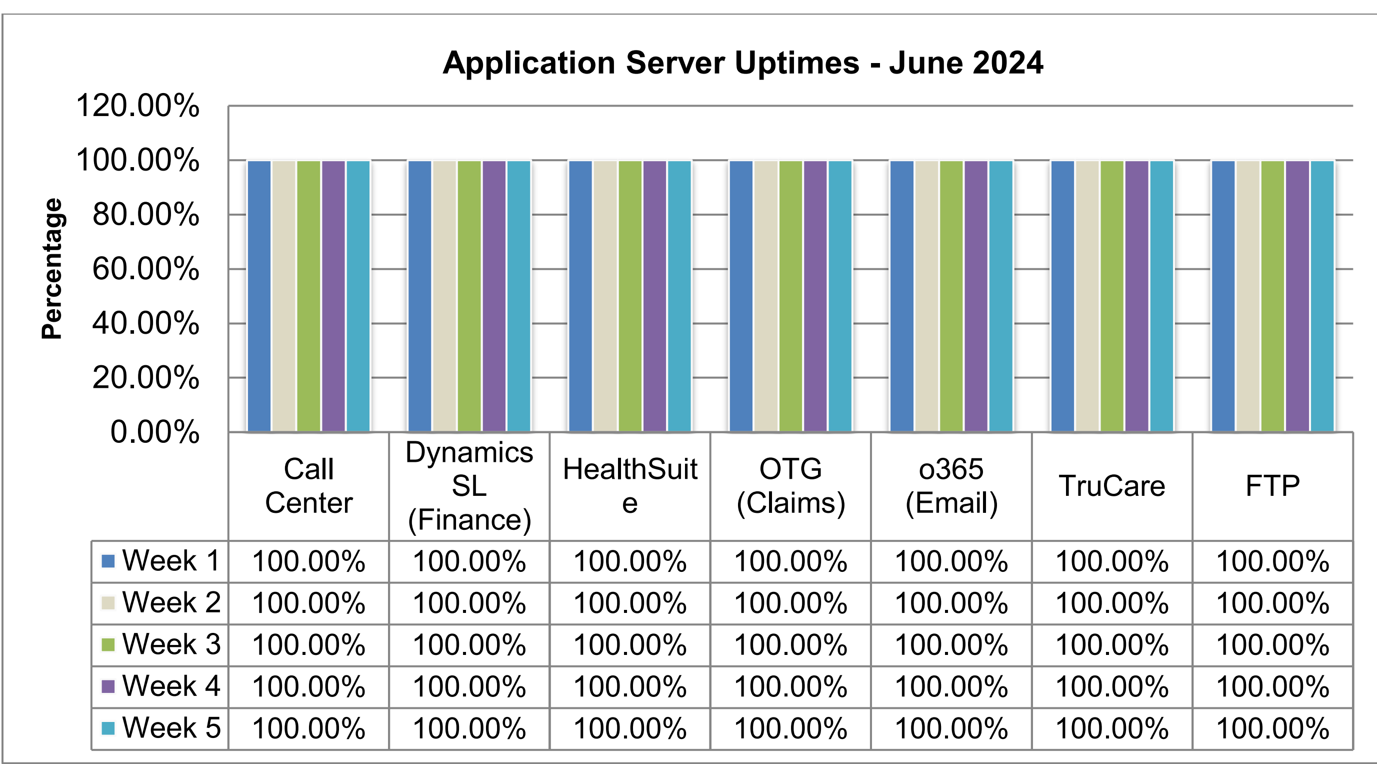
- 86 Change Requests Closed in the month of June 2024




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
59
109
97
85
94
77
103
96
91
107
81
64
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24

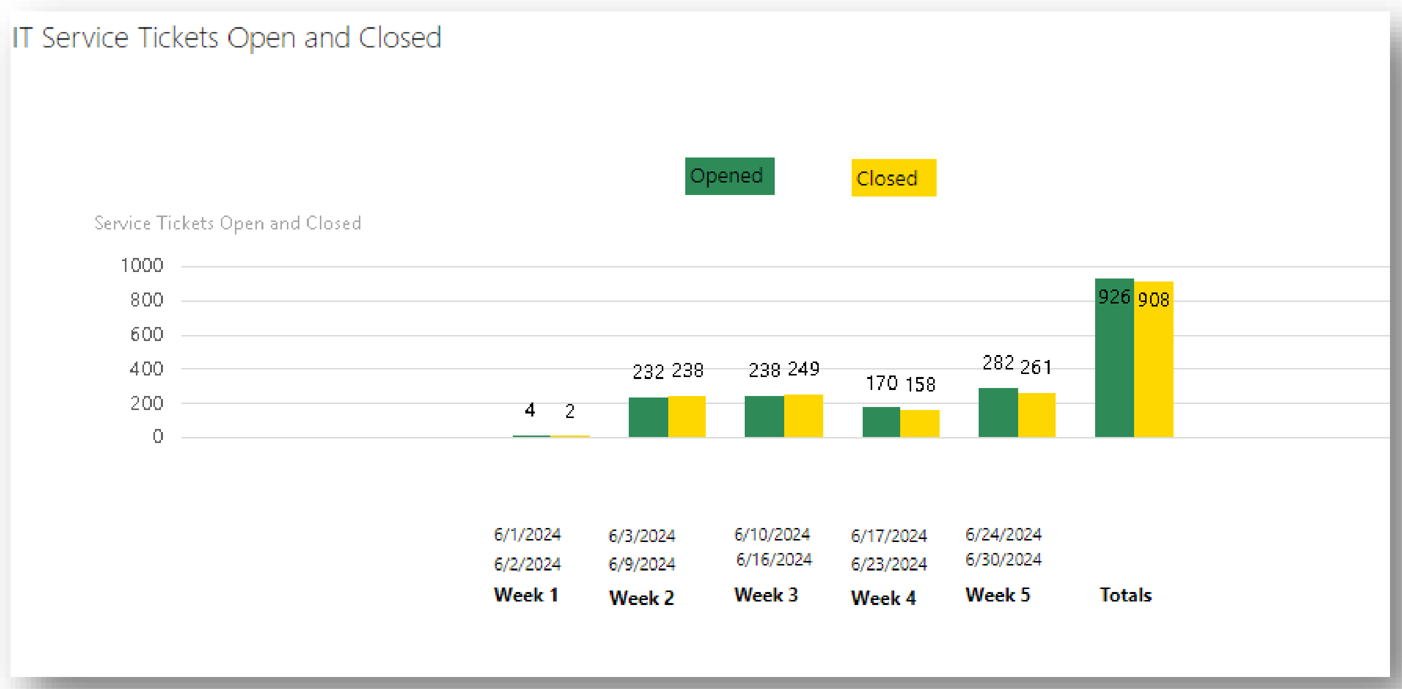

Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
69
55
74
86
61
86
86
80
94
67
78
86
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24

IT Stats: Infrastructure



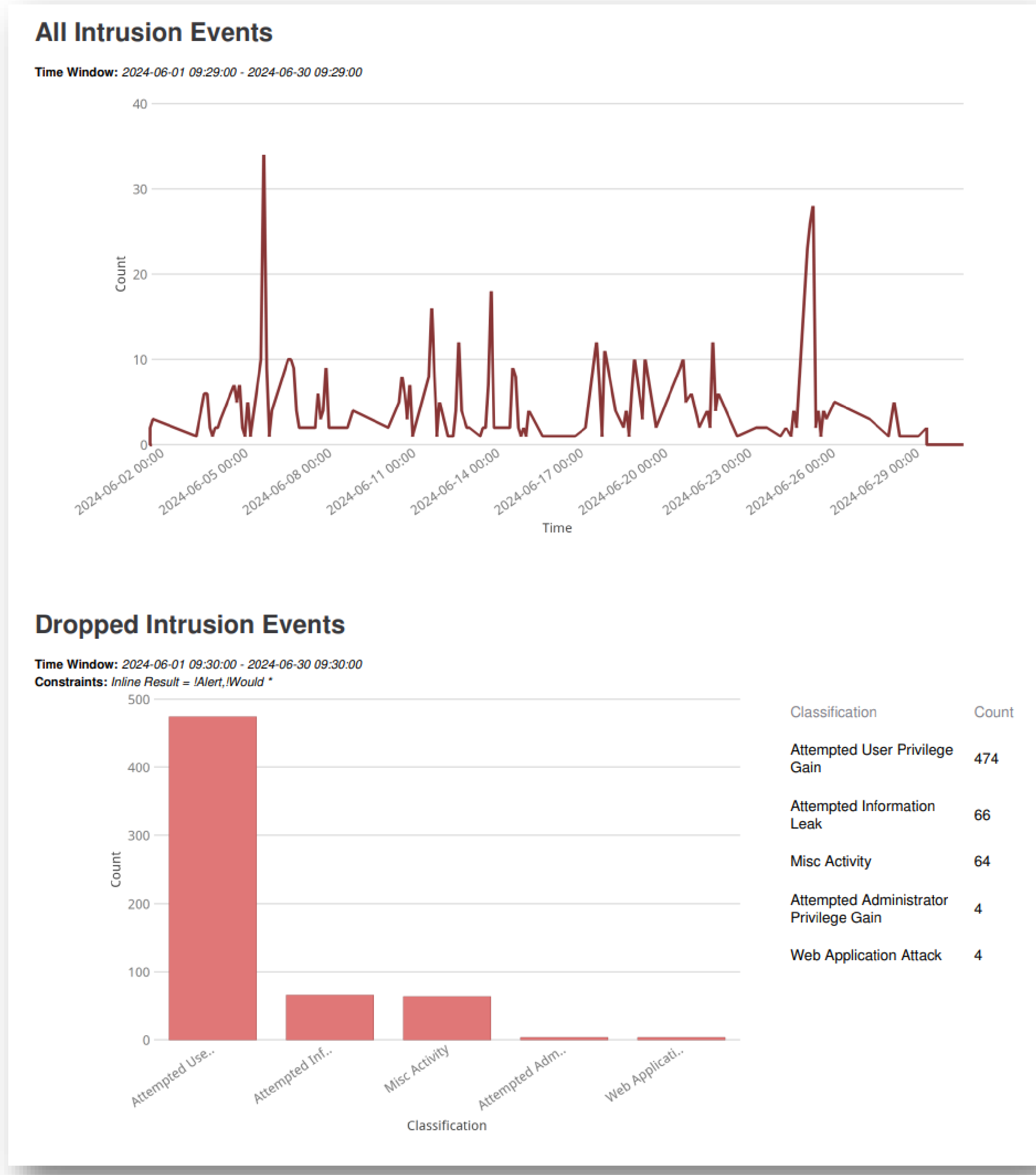
	Call Center	Dynamics SL (Finance)	HealthSuite	OTG (Claims)	o365 (Email)	TruCare	FTP
Week 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 2	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 3	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 4	100.00%	100.00%	100.00%	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.
- There were no outages in the month of June 2024



- 926 Service Desk tickets were opened in the month of June 2024, which is 5.02% lower than the previous month (975) and 8.86% lower than the previous 3-month average of 1016.
- 908 Service Desk tickets were closed in the month of June 2024, which is 4.22% lower than the previous month (948) and 11.59% lower than the previous 3-month average of 1027.

June 2024



Classification	Count
Attempted User Privilege Gain	474
Attempted Information Leak	66
Misc Activity	64
Attempted Administrator Privilege Gain	4
Web Application Attack	4

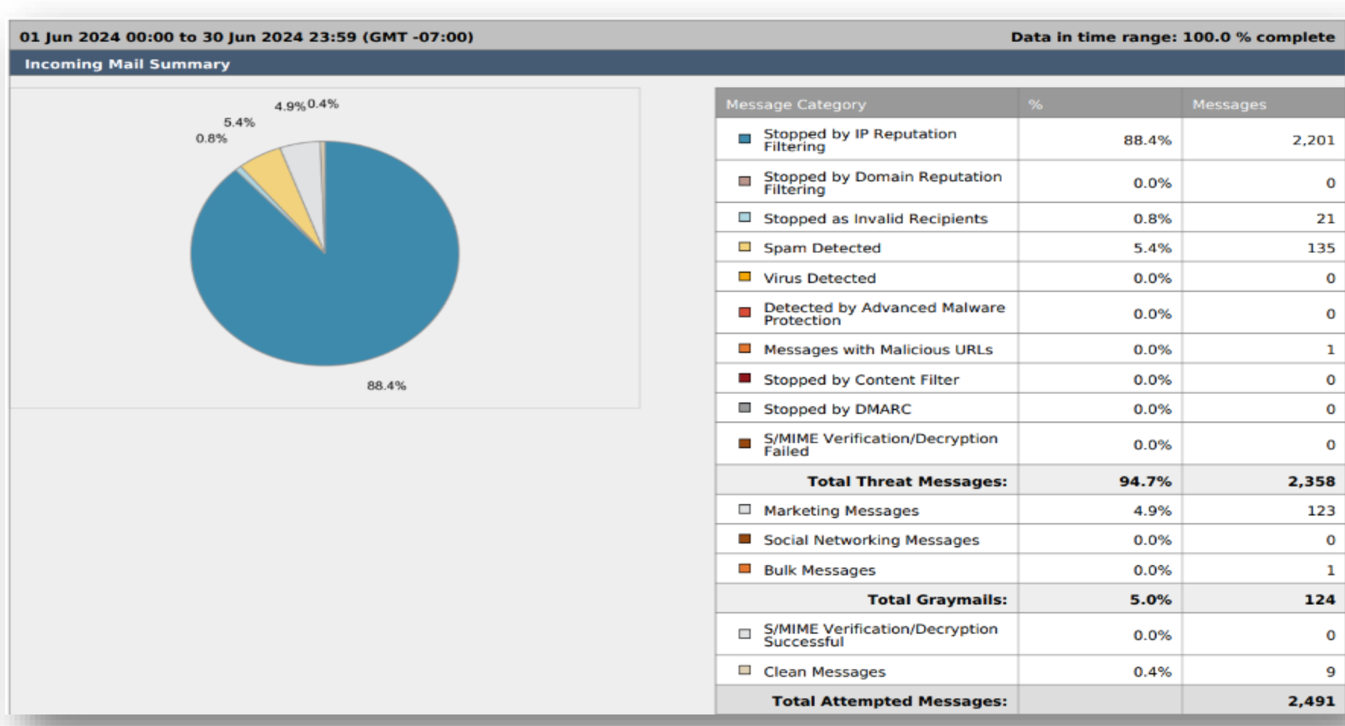
IronPort Email Security Gateways

Email Filters

June 2024

MX4

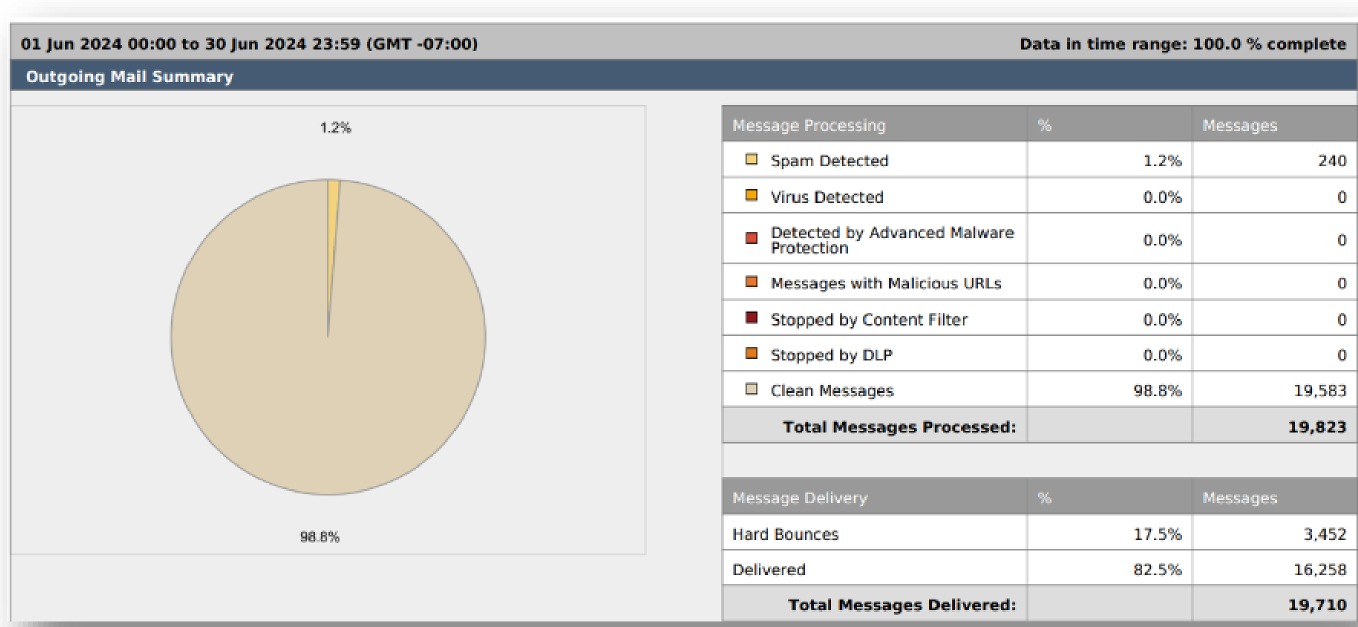
Inbound Mail


01 Jun 2024 00:00 to 30 Jun 2024 23:59 (GMT -07:00) — Data in time range: 100.0 % complete

Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	88.4%	2,201
Stopped by Domain Reputation Filtering	0.0%	0
Stopped as Invalid Recipients	0.8%	21
Spam Detected	5.4%	135
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	1
Stopped by Content Filter	0.0%	0
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**94.7%**	**2,358**
Marketing Messages	4.9%	123
Social Networking Messages	0.0%	0
Bulk Messages	0.0%	1
Total Graymails:	**5.0%**	**124**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	0.4%	9
Total Attempted Messages:		**2,491**

Outbound Mail


01 Jun 2024 00:00 to 30 Jun 2024 23:59 (GMT -07:00) — Data in time range: 100.0 % complete

Outgoing Mail Summary

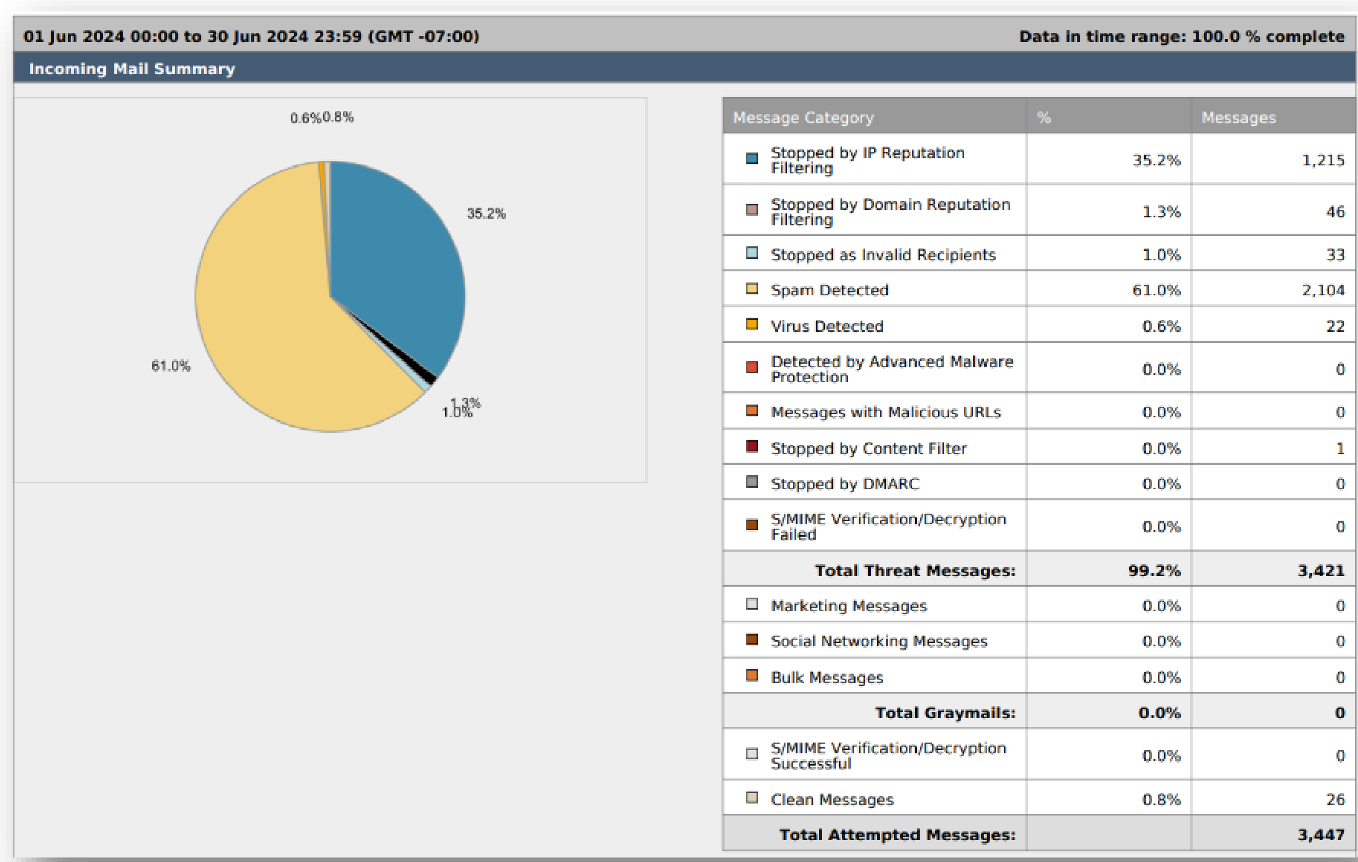
Message Processing	%	Messages
Spam Detected	1.2%	240
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	0
Stopped by Content Filter	0.0%	0
Stopped by DLP	0.0%	0
Clean Messages	98.8%	19,583
Total Messages Processed:		**19,823**

Message Delivery	%	Messages
Hard Bounces	17.5%	3,452
Delivered	82.5%	16,258
Total Messages Delivered:		**19,710**

June 2024

MX9

Inbound Mail

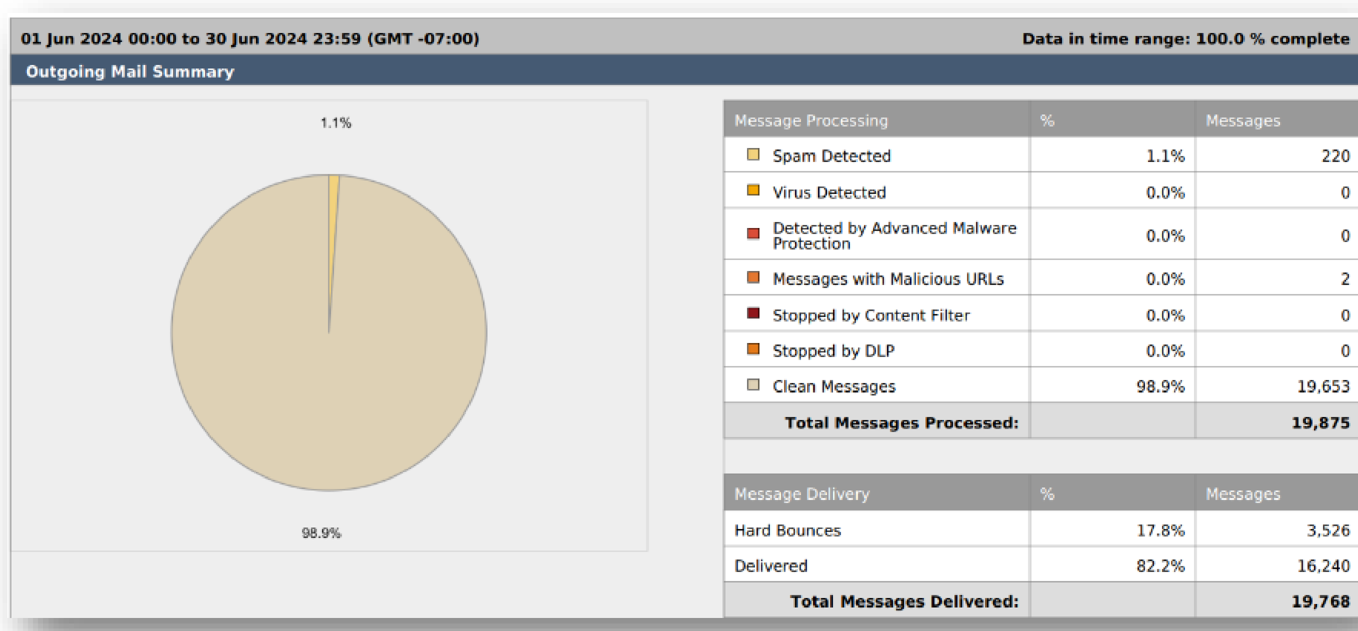


01 Jun 2024 00:00 to 30 Jun 2024 23:59 (GMT -07:00) — Data in time range: 100.0 % complete

Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	35.2%	1,215
Stopped by Domain Reputation Filtering	1.3%	46
Stopped as Invalid Recipients	1.0%	33
Spam Detected	61.0%	2,104
Virus Detected	0.6%	22
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	0
Stopped by Content Filter	0.0%	1
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**99.2%**	**3,421**
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	0.8%	26
Total Attempted Messages:		**3,447**

Outbound Mail



01 Jun 2024 00:00 to 30 Jun 2024 23:59 (GMT -07:00) — Data in time range: 100.0 % complete

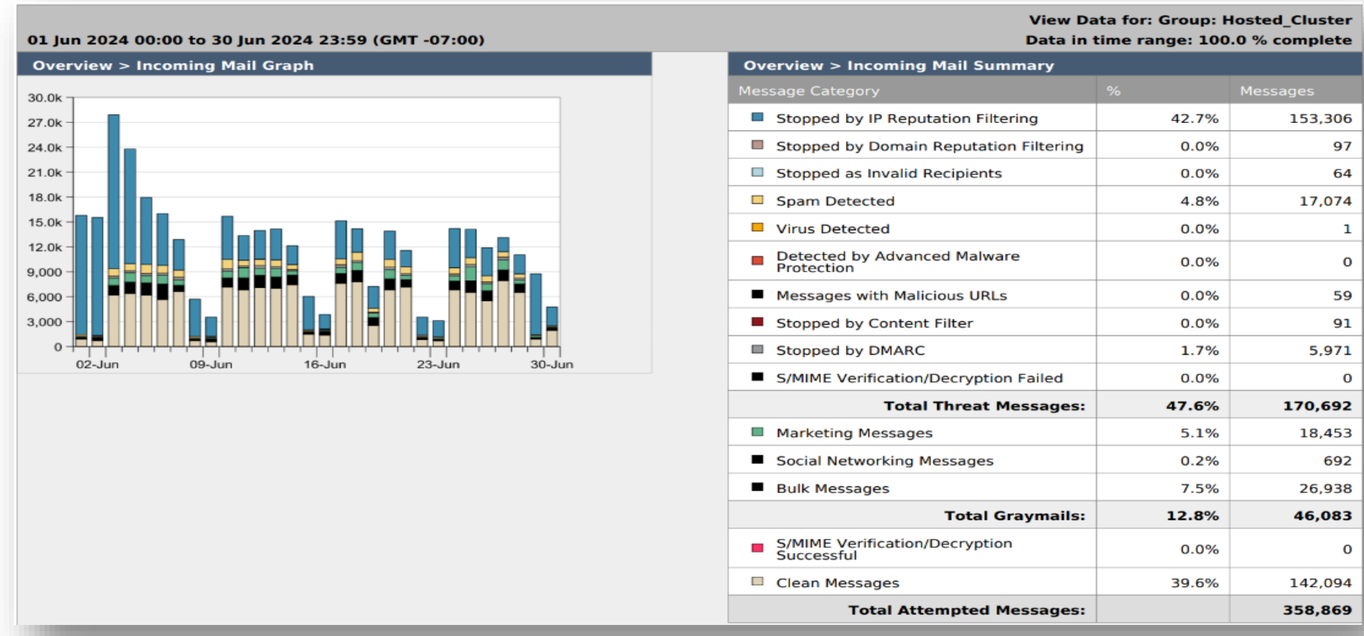
Outgoing Mail Summary

Message Processing	%	Messages
Spam Detected	1.1%	220
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	2
Stopped by Content Filter	0.0%	0
Stopped by DLP	0.0%	0
Clean Messages	98.9%	19,653
Total Messages Processed:		**19,875**

Message Delivery	%	Messages
Hard Bounces	17.8%	3,526
Delivered	82.2%	16,240
Total Messages Delivered:		**19,768**

June 2024

Cloud



01 Jun 2024 00:00 to 30 Jun 2024 23:59 (GMT -07:00)

View Data for: Group: Hosted_Cluster
Data in time range: 100.0 % complete

Overview > Incoming Mail Graph

Overview > Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	42.7%	153,306
Stopped by Domain Reputation Filtering	0.0%	97
Stopped as Invalid Recipients	0.0%	64
Spam Detected	4.8%	17,074
Virus Detected	0.0%	1
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	59
Stopped by Content Filter	0.0%	91
Stopped by DMARC	1.7%	5,971
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**47.6%**	**170,692**
Marketing Messages	5.1%	18,453
Social Networking Messages	0.2%	692
Bulk Messages	7.5%	26,938
Total Graymails:	**12.8%**	**46,083**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	39.6%	142,094
Total Attempted Messages:		**358,869**

Item / Date	Jun-23	Jul-23	Aug-23	*Sep-23*	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	*May-24*	*Jun-24*
Stopped By Reputation	27.1k	30.4k	59.1k	*99.7k*	74k	74.1k	58k	91.9k	51k	84.7k	63.5k	27.5k	***2.7k***
Invalid Recipients	92	82	79	*98*	86	88	73	81	87	185	83	93	***54***
Spam Detected	14.1k	12.5k	27.9k	*33.1*	28.7k	25.8k	20.6k	26.9k	22.6k	27.6k	23.4k	15.1k	***2.2k***
Virus Detected	1	5	3	*22*	10	29	6	11	9	12	5	13	***22***
Advanced Malware	1	0	1	*55*	37	78	24	29	8	4	2	9	***0***
Malicious URLs	233	170	6	*50*	97	11	57	57	43	33	205	209	***1***
Content Filter	162	56	39	*110*	114	333	66	108	376	116	133	100	***1***
Marketing Messages	16.1k	15.7k	16.2k	*8.4k*	9.5k	8.9k	8.1k	9.4k	10.1k	10.1k	12.5k	8.4k	***18.4k***
Attempted Admin Privilege Gain	50	173	51	*250*	6	0	1	7	4	48	3	1	***4***
Attempted User Privilege Gain	66	162	47	*329*	146	48	48	69	330	526	569	554	***474***
Attempted Information Leak	1	18	53	*118*	71	51	50	65	51	72	57	46	***66***
Potential Corp Policy Violation	2	0	0	*0*	0	0	0	0	3	4	0	0	***0***
Network Scans Detected	0	0	0	*0*	0	0	0	0	0	0	0	0	***0***
Web Application Attack	1	8	0	*15*	7	4	4	1	0	0	5	3	***4***
Attempted Denial of Service	0	1	0	*4*	0	0	0	0	0	0	0	1	***0***
Misc. Attack	3	1,862	151	*2,901*	1,023	347	2,146	1	424	332	795	145	***64***

- 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 27.5k.
- Attempted information leaks detected and blocked at the firewall is at 66 for the month of **June 2024.**
- Network scans returned a value of 0, which is in line with previous month's data.
- Attempted User Privilege Gain is at 474 from a previous six-month average of 420.

Projects and Programs

Supporting Documents

Analytics

Tiffany Cheang

To: Alameda Alliance for Health Board of Governors

From: Tiffany Cheang, Chief Analytics Officer

Date: July 12, 2024

Subject: Performance & Analytics Report

Member Cost Analysis

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

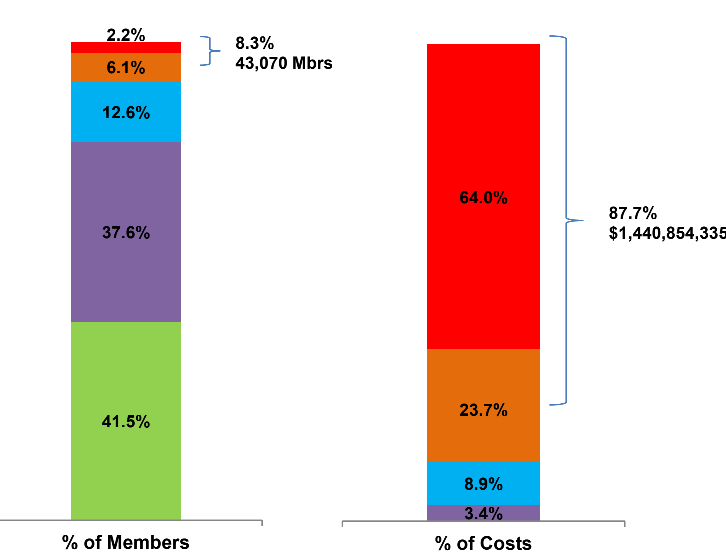
Current reporting period: April 2023 – March 2024 dates of service
Prior reporting period: April 2022 – March 2023 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 8.3% of members account for 87.7% of total costs.
- In comparison, the Prior reporting period was lower at 9.6% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
  - The SPD (non duals) and ACA OE categories of aid decreased to account for 54.0% of the members, with SPDs accounting for 22.1% and ACA OE's at 31.9%.
  - The percent of members with costs >= $30K saw no change from 2.2% to 2.2%.
  - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.6%.
    - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 33.5%.
  - Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
  - However, the age distribution of the top 8.3% is more concentrated in the 45-66 year old category (37.3%) compared to the overall population (20.8%).

Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Apr 2023 - Mar 2024
Note: Data incomplete due to claims lag
Run Date: 06/28/2024



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	11,318	2.2%	$ 1,051,281,025	64.0%
$5K - $30K	31,752	6.1%	$ 389,573,310	23.7%
$1K - $5K	65,640	12.6%	$ 146,433,189	8.9%
< $1K	196,045	37.6%	$ 56,362,129	3.4%
$0	216,574	41.5%	$ -	0.0%
Totals	**521,329**	**100.0%**	**$ 1,643,649,653**	**100.0%**

Top 8.3% of Members = 87.7% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	3,112	0.6%	$ 610,537,337	37.1%
$75K to $100K	1,484	0.3%	$ 129,095,667	7.9%
$50K to $75K	2,388	0.5%	$ 145,656,206	8.9%
$40K to $50K	1,638	0.3%	$ 73,023,425	4.4%
$30K to $40K	2,696	0.5%	$ 92,968,390	5.7%
SubTotal	***11,318***	***2.2%***	***$ 1,051,281,025***	***64.0%***
$20K to $30K	4,729	0.9%	$ 115,923,032	7.1%
$10K to $20K	11,790	2.3%	$ 165,370,332	10.1%
$5K to $10K	15,233	2.9%	$ 108,279,946	6.6%
SubTotal	***31,752***	***6.1%***	***$ 389,573,310***	***23.7%***
Total	**43,070**	***8.3%***	**$ 1,440,854,335**	***87.7%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Mar 2024	405,035	$ 1,440,735,842
Dis-Enrolled During Year	116,294	$ 202,913,811
Totals	**521,329**	**$ 1,643,649,653**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
8.3% of Members = 87.7% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Apr 2023 - Mar 2024
Note: Data incomplete due to claims lag
Run Date: 06/28/2024

8.3% of Members = 87.7% of Costs
22.1% of members are SPDs and account for 27.0% of costs.
31.9% of members are ACA OE and account for 31.1% of costs.
11.1% of members disenrolled as of Mar 2024 and account for 12.6% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	158	730	888	2.1%
MCAL	MCAL - ADULT	929	5,301	6,230	14.5%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	435	2,718	3,153	7.3%
	MCAL - ACA OE	3,262	10,464	13,726	31.9%
	MCAL - SPD	3,229	6,296	9,525	22.1%
	MCAL - DUALS	754	2,692	3,446	8.0%
	MCAL - LTC	152	36	188	0.4%
	MCAL - LTC-DUAL	834	299	1,133	2.6%
Not Eligible	Not Eligible	1,565	3,216	4,781	11.1%
Total		**11,318**	**31,752**	**43,070**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 11,602,401	$ 8,419,662	$ 20,022,062	1.4%
MCAL	MCAL - ADULT	$ 82,909,856	$ 62,487,585	$ 145,397,441	10.1%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 31,414,915	$ 30,664,863	$ 62,079,778	4.3%
	MCAL - ACA OE	$ 321,326,491	$ 127,152,524	$ 448,479,014	31.1%
	MCAL - SPD	$ 307,699,667	$ 81,611,852	$ 389,311,519	27.0%
	MCAL - DUALS	$ 60,800,675	$ 33,059,089	$ 93,859,765	6.5%
	MCAL - LTC	$ 19,189,286	$ 836,837	$ 20,026,123	1.4%
	MCAL - LTC-DUAL	$ 74,196,827	$ 6,641,803	$ 80,838,630	5.6%
Not Eligible	Not Eligible	$ 142,140,907	$ 38,699,097	$ 180,840,004	12.6%
Total		**$ 1,051,281,025**	**$ 389,573,310**	**$ 1,440,854,335**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
29.1% of members are SPDs and account for 30.0% of costs.
27.9% of members are ACA OE and account for 32.4% of costs.
11.7% of members disenrolled as of Mar 2024 and account for 12.1% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	34	1.1%
MCAL	MCAL - ADULT	204	6.6%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	61	2.0%
	MCAL - ACA OE	867	27.9%
	MCAL - SPD	906	29.1%
	MCAL - DUALS	244	7.8%
	MCAL - LTC	97	3.1%
	MCAL - LTC-DUAL	335	10.8%
Not Eligible	Not Eligible	364	11.7%
Total		**3,112**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 5,280,633	0.9%
MCAL	MCAL - ADULT	$ 46,180,748	7.6%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 13,692,648	2.2%
	MCAL - ACA OE	$ 198,013,034	32.4%
	MCAL - SPD	$ 183,087,138	30.0%
	MCAL - DUALS	$ 32,632,245	5.3%
	MCAL - LTC	$ 16,190,333	2.7%
	MCAL - LTC-DUAL	$ 41,480,211	6.8%
Not Eligible	Not Eligible	$ 73,980,346	12.1%
Total		**$ 610,537,337**	**100.0%**

% of Total Costs By Service Type

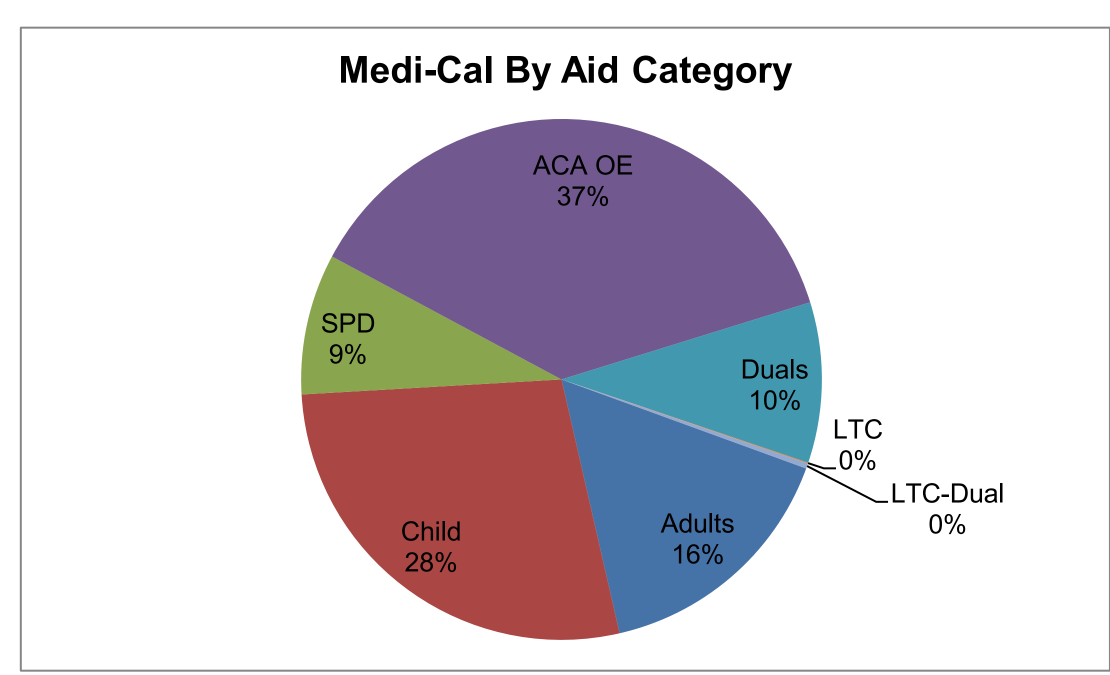
				Breakout by Service Type/Location						
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	7%	0%	1%	0%	41%	1%	11%	3%	2%	26%
$75K to $100K	3%	0%	1%	0%	24%	2%	5%	3%	4%	44%
$50K to $75K	4%	0%	2%	0%	27%	3%	6%	5%	4%	33%
$40K to $50K	5%	0%	1%	1%	29%	6%	5%	6%	1%	19%
$30K to $40K	9%	0%	2%	0%	20%	11%	5%	5%	1%	26%
$20K to $30K	2%	1%	4%	0%	22%	6%	7%	6%	1%	24%
$10K to $20K	0%	0%	10%	1%	25%	5%	9%	8%	2%	15%
$5K to $10K	0%	0%	6%	1%	14%	9%	12%	13%	0%	17%
Total	**5%**	**0%**	**3%**	**0%**	**31%**	**4%**	**9%**	**5%**	**2%**	**26%**

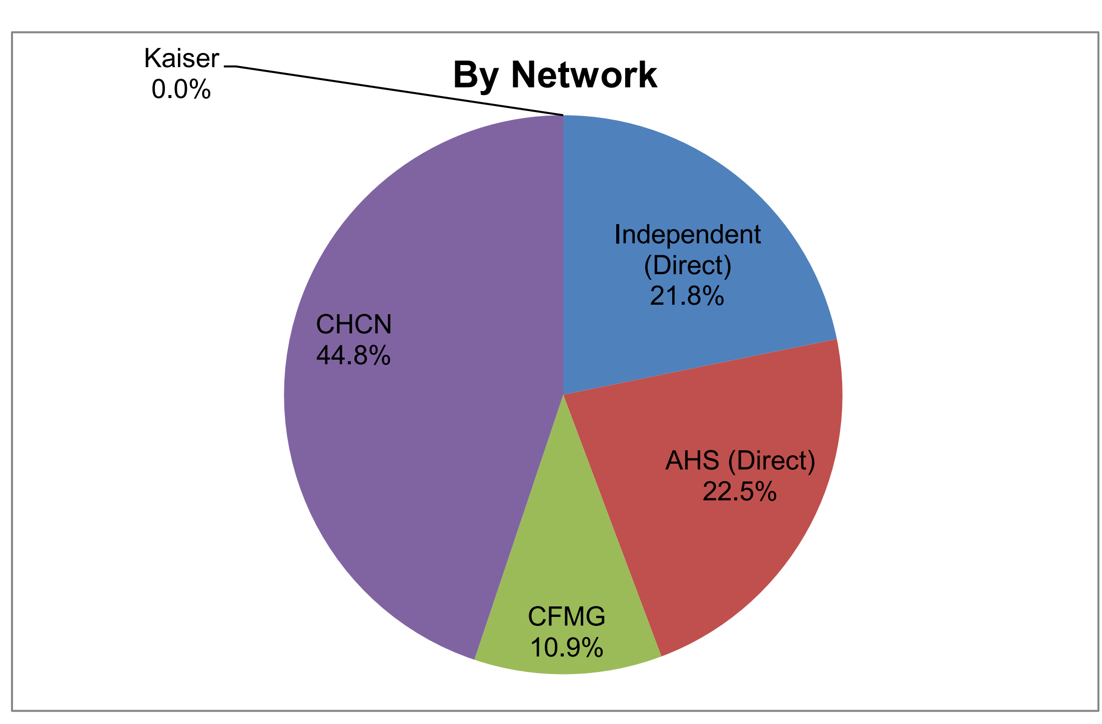
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	May 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	63,405	16%	13,024	14,537	6	35,838	-
Child	110,561	28%	9,198	13,601	41,127	46,635	-
SPD	34,965	9%	11,319	5,525	1,440	16,681	-
ACA OE	149,427	37%	25,100	53,730	1,506	69,091	-
Duals	39,842	10%	26,119	2,848	4	10,871	-
LTC	220	0%	205	7	-	8	-
LTC-Dual	1,283	0%	1,281	-	-	2	-
Medi-Cal	399,703		86,246	90,248	44,083	179,126	-
Group Care	5,640		2,135	870	-	2,635	-
Total	**405,343**	**100%**	**88,381**	**91,118**	**44,083**	**181,761**	**-**
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	*21.8%*	*22.5%*	*10.9%*	*44.8%*	*0.0%*
			% Direct:	**44%**		**% Delegated:**	**56%**

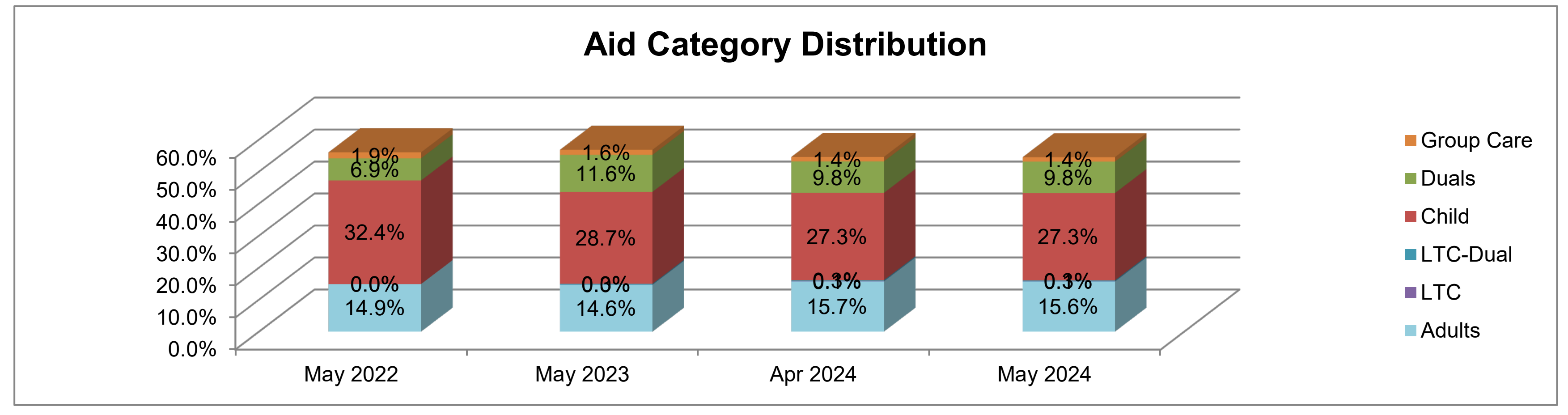




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

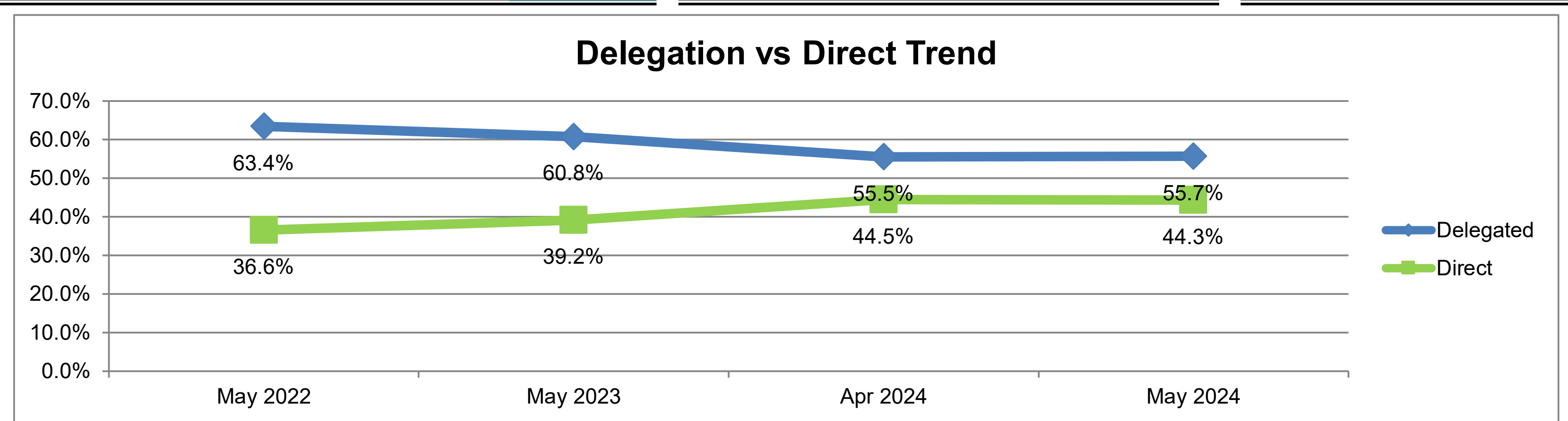
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022 to May 2023**	**May 2023 to May 2024**	**Apr 2024 to May 2024**
Adults	46,171	52,677	63,551	63,405	14.9%	14.6%	15.7%	15.6%	14.1%	20.4%	-0.2%
Child	100,560	103,434	110,566	110,561	32.4%	28.7%	27.3%	27.3%	2.9%	6.9%	0.0%
SPD	26,958	31,201	34,887	34,965	8.7%	8.7%	8.6%	8.6%	15.7%	12.1%	0.2%
ACA OE	109,734	124,397	149,154	149,427	35.3%	34.5%	36.8%	36.9%	13.4%	20.1%	0.2%
Duals	21,527	41,652	39,912	39,842	6.9%	11.6%	9.8%	9.8%	93.5%	-4.3%	-0.2%
LTC	-	148	223	220	0.0%	0.0%	0.1%	0.1%	0.0%	48.6%	-1.3%
LTC-Dual	-	1,003	1,291	1,283	0.0%	0.3%	0.3%	0.3%	0.0%	27.9%	-0.6%
Medi-Cal Total	304,950	354,512	399,584	399,703	98.1%	98.4%	98.6%	98.6%	16.3%	12.7%	0.0%
Group Care	5,808	5,670	5,643	5,640	1.9%	1.6%	1.4%	1.4%	-2.4%	-0.5%	-0.1%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.9%**	**12.5%**	**0.0%**



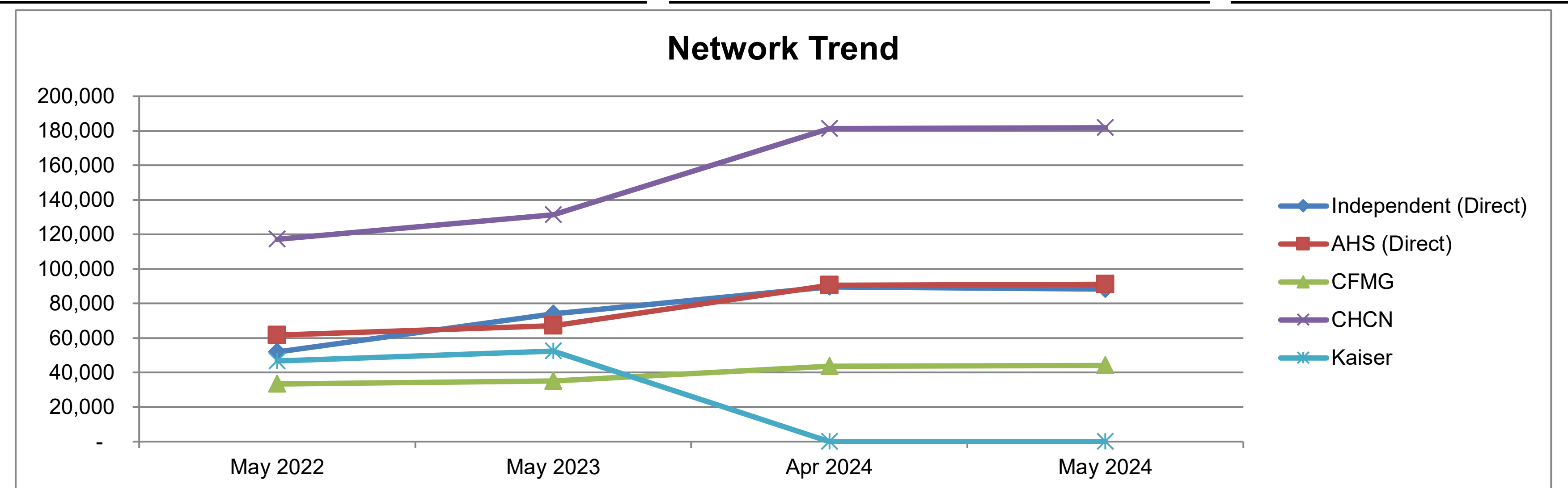
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022 to May 2023**	**May 2023 to May 2024**	**Apr 2024 to May 2024**
Delegated	197,155	219,053	225,002	225,844	63.4%	60.8%	55.5%	55.7%	11.1%	3.1%	0.4%
Direct	113,603	141,129	180,225	179,499	36.6%	39.2%	44.5%	44.3%	24.2%	27.2%	-0.4%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.9%**	**12.5%**	**0.0%**



Network Trend

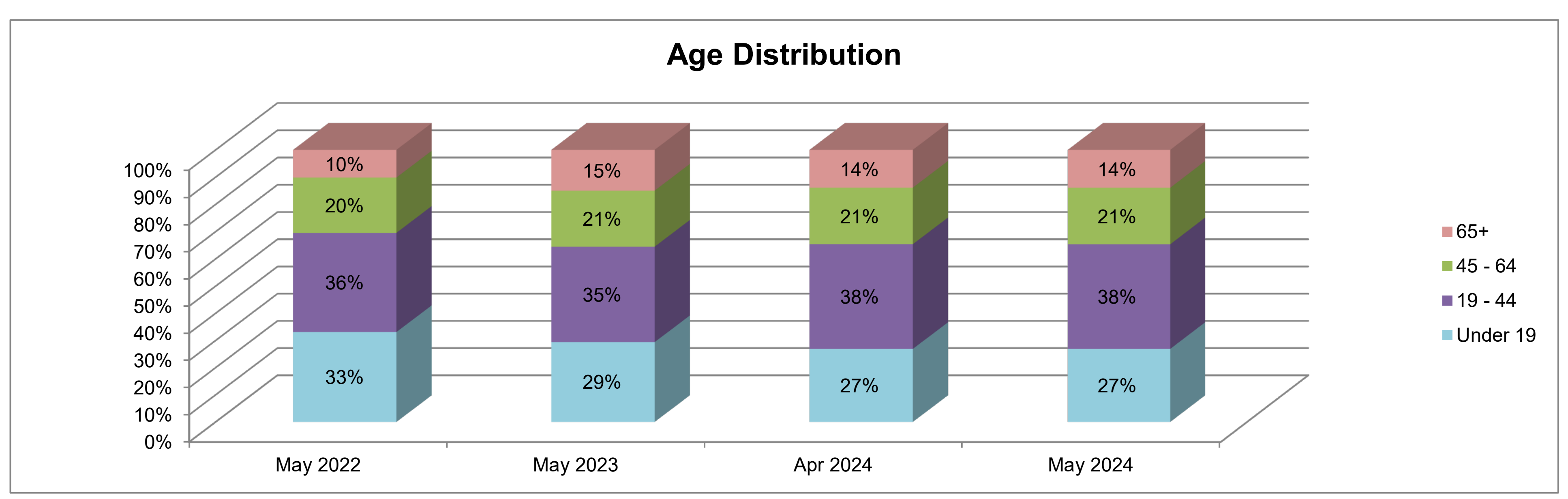
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022 to May 2023**	**May 2023 to May 2024**	**Apr 2024 to May 2024**
Independent (Direct)	51,910	74,016	89,595	88,381	16.7%	20.5%	22.1%	21.8%	42.6%	19.4%	-1.4%
AHS (Direct)	61,693	67,113	90,630	91,118	19.9%	18.6%	22.4%	22.5%	8.8%	35.8%	0.5%
CFMG	33,378	35,138	43,702	44,083	10.7%	9.8%	10.8%	10.9%	5.3%	25.5%	0.9%
CHCN	117,163	131,489	181,300	181,761	37.7%	36.5%	44.7%	44.8%	12.2%	38.2%	0.3%
Kaiser	46,614	52,426	-	-	15.0%	14.6%	0.0%	0.0%	12.5%	-100.0%	0.0%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.9%**	**12.5%**	**0.0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

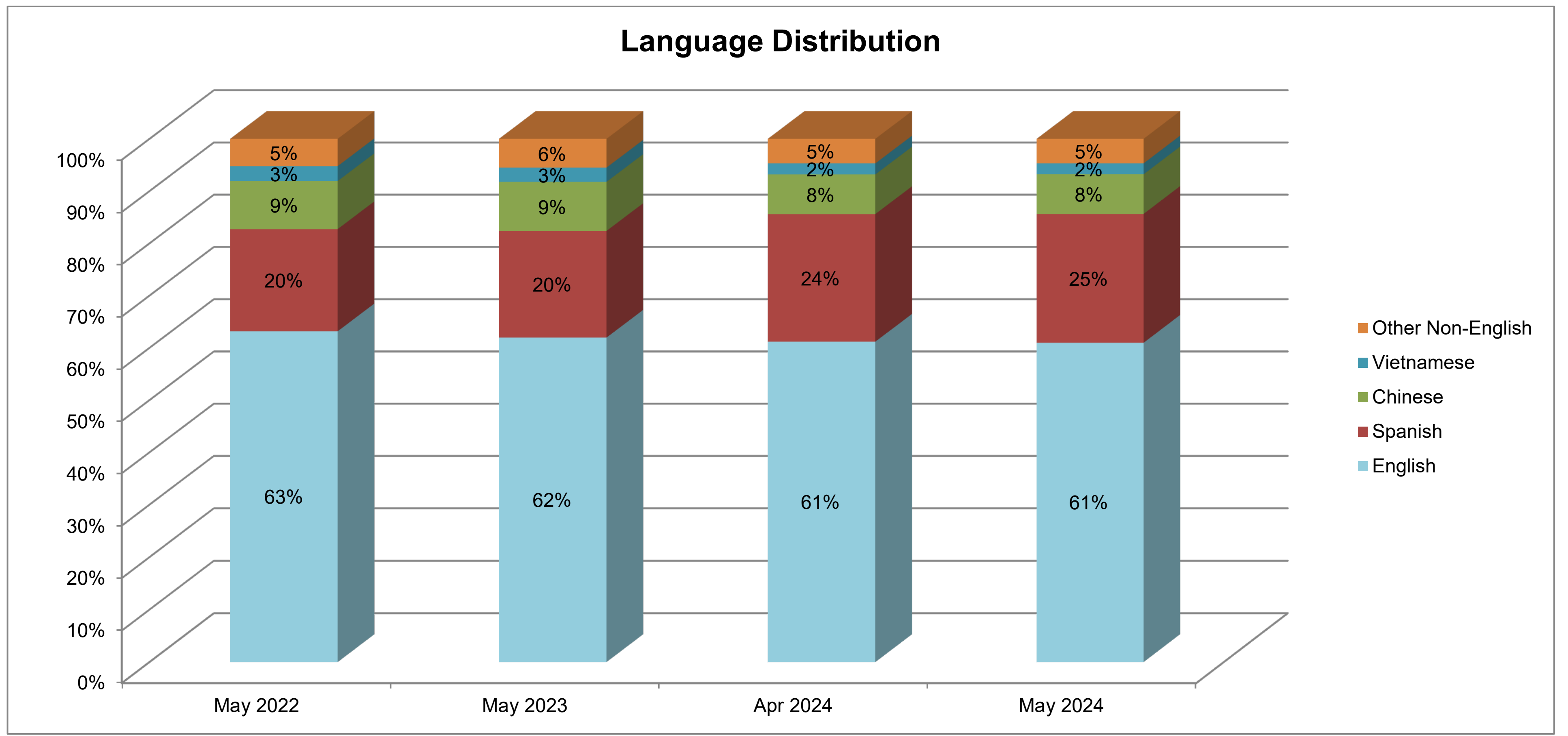
Age Category Trend

Age Category	Members May 2022	Members May 2023	Members Apr 2024	Members May 2024	% of Total (ie.Distribution) May 2022	% of Total May 2023	% of Total Apr 2024	% of Total May 2024	% Growth (Loss) May 2022 to May 2023	% Growth (Loss) May 2023 to May 2024	% Growth (Loss) Apr 2024 to May 2024
Under 19	102,823	105,787	108,917	108,994	33%	29%	27%	27%	3%	3%	0%
19 - 44	113,325	126,401	156,001	155,914	36%	35%	38%	38%	12%	23%	0%
45 - 64	63,061	74,095	84,128	84,121	20%	21%	21%	21%	17%	14%	0%
65+	31,549	53,899	56,181	56,314	10%	15%	14%	14%	71%	4%	0%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



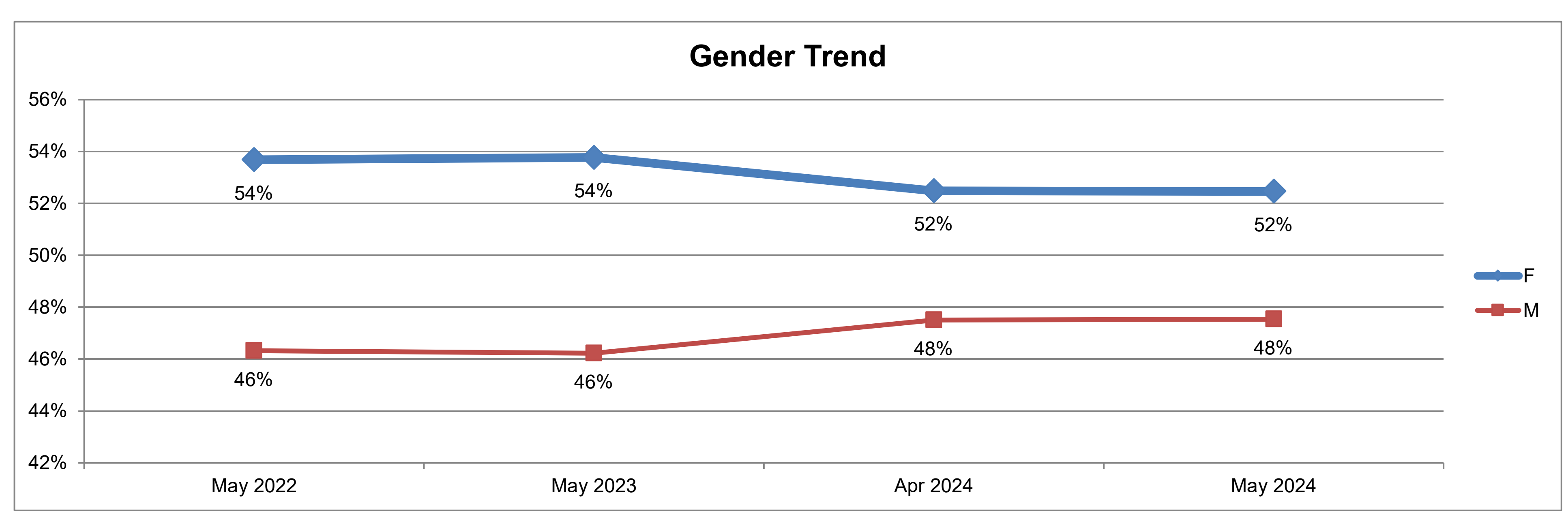
Language Trend

Language	Members May 2022	Members May 2023	Members Apr 2024	Members May 2024	% of Total (ie.Distribution) May 2022	% of Total May 2023	% of Total Apr 2024	% of Total May 2024	% Growth (Loss) May 2022 to May 2023	% Growth (Loss) May 2023 to May 2024	% Growth (Loss) Apr 2024 to May 2024
English	196,309	223,164	247,927	247,134	63%	62%	61%	61%	14%	11%	0%
Spanish	60,778	73,539	98,970	99,964	20%	20%	24%	25%	21%	36%	1%
Chinese	28,583	33,819	30,725	30,741	9%	9%	8%	8%	18%	-9%	0%
Vietnamese	8,868	9,828	8,548	8,461	3%	3%	2%	2%	11%	-14%	-1%
Other Non-English	16,220	19,832	19,057	19,043	5%	6%	5%	5%	22%	-4%	0%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**

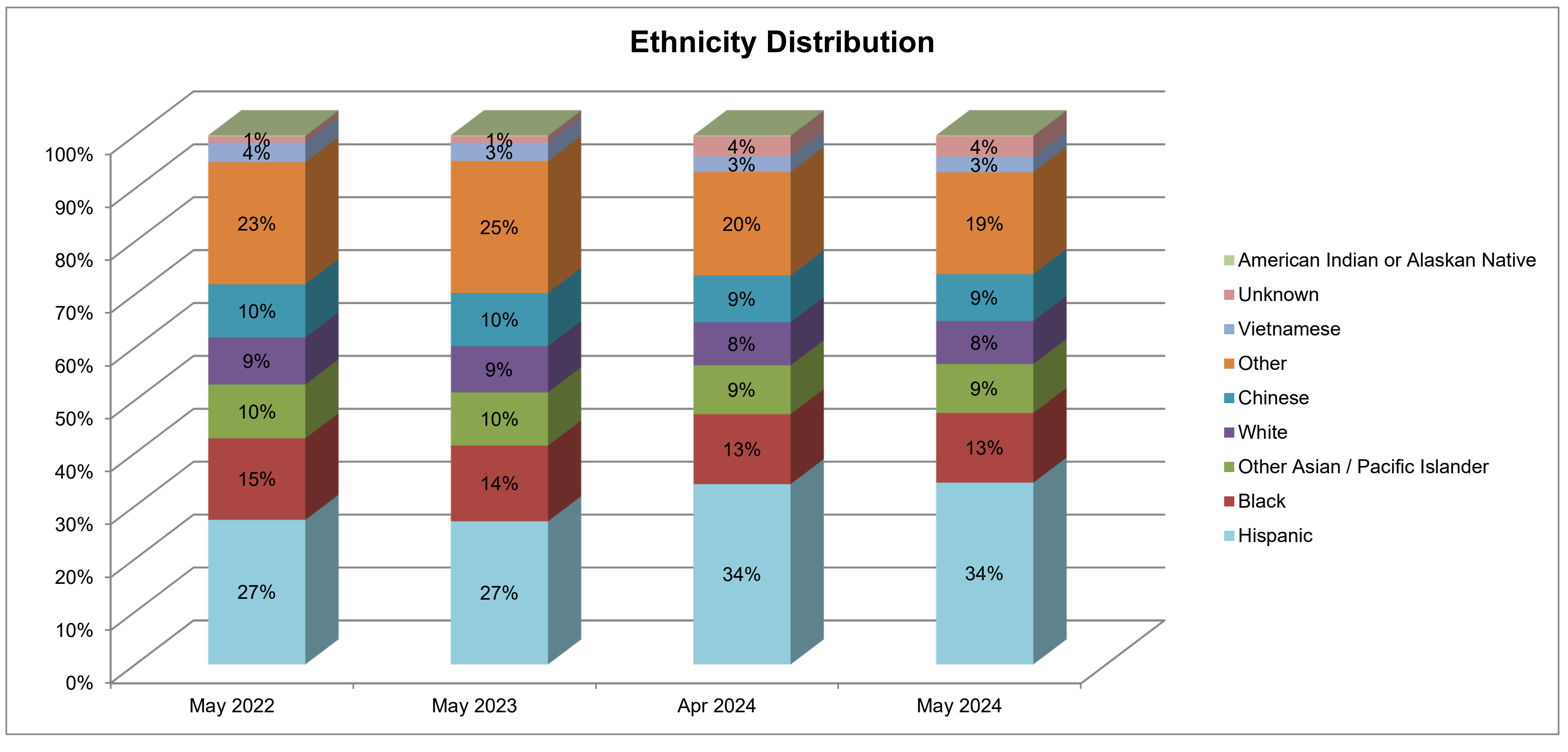


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Gender Trend											
	Members				**% of Total (ie.Distribution)**				**% Growth (Loss)**		
Gender	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022 to May 2023**	**May 2023 to May 2024**	**Apr 2024 to May 2024**
F	166,816	193,677	212,693	212,650	54%	54%	52%	52%	16%	10%	0%
M	143,942	166,505	192,534	192,693	46%	46%	48%	48%	16%	16%	0%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



Ethnicity Trend											
	Members				**% of Total (ie.Distribution)**				**% Growth (Loss)**		
Ethnicity	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022**	**May 2023**	**Apr 2024**	**May 2024**	**May 2022 to May 2023**	**May 2023 to May 2024**	**Apr 2024 to May 2024**
Hispanic	84,892	97,427	138,080	139,254	27%	27%	34%	34%	15%	43%	1%
Black	47,883	51,493	53,580	53,353	15%	14%	13%	13%	8%	4%	0%
Other Asian / Pacific Islander	31,631	36,245	37,409	37,596	10%	10%	9%	9%	15%	4%	0%
White	27,619	31,499	32,949	32,881	9%	9%	8%	8%	14%	4%	0%
Chinese	31,216	36,159	35,847	35,951	10%	10%	9%	9%	16%	-1%	0%
Other	71,778	89,867	79,277	77,966	23%	25%	20%	19%	25%	-13%	-2%
Vietnamese	11,444	12,326	12,050	11,993	4%	3%	3%	3%	8%	-3%	0%
Unknown	3,620	4,425	15,231	15,550	1%	1%	4%	4%	22%	251%	2%
American Indian or Alaskan Native	675	741	804	799	0%	0%	0%	0%	10%	8%	-1%
Total	**310,758**	**360,182**	**405,227**	**405,343**	**100%**	**100%**	**100%**	**100%**	**16%**	**13%**	**0%**



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

Medi-Cal By City

City	May 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	161,449	40%	23,823	42,809	17,574	77,243	-
Hayward	63,710	16%	12,461	17,103	7,515	26,631	-
Fremont	36,699	9%	15,047	6,809	2,088	12,755	-
San Leandro	33,975	8%	8,893	5,712	4,313	15,057	-
Union City	15,521	4%	6,302	2,637	843	5,739	-
Alameda	13,963	3%	3,320	2,527	2,088	6,028	-
Berkeley	15,299	4%	4,105	2,277	1,770	7,147	-
Livermore	12,821	3%	1,901	681	2,241	7,998	-
Newark	9,213	2%	2,676	4,068	498	1,971	-
Castro Valley	9,452	2%	2,462	1,662	1,373	3,955	-
San Lorenzo	7,437	2%	1,598	1,642	839	3,358	-
Pleasanton	7,650	2%	2,045	434	816	4,355	-
Dublin	7,399	2%	1,966	454	890	4,089	-
Emeryville	2,776	1%	596	620	451	1,109	-
Albany	2,544	1%	646	293	569	1,036	-
Piedmont	505	0%	121	203	56	125	-
Sunol	92	0%	31	15	5	41	-
Antioch	22	0%	4	6	5	7	-
Other	1,323	0%	396	296	149	482	-
Total	**401,850**	**100%**	**88,393**	**90,248**	**44,083**	**179,126**	**-**

Group Care By City

City	May 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,774	31%	353	327	-	1,094	-
Hayward	624	11%	289	145	-	190	-
Fremont	641	11%	439	67	-	135	-
San Leandro	583	10%	234	87	-	262	-
Union City	291	5%	184	47	-	60	-
Alameda	296	5%	95	20	-	181	-
Berkeley	156	3%	49	11	-	96	-
Livermore	103	2%	35	3	-	65	-
Newark	131	2%	79	30	-	22	-
Castro Valley	193	3%	84	28	-	81	-
San Lorenzo	135	2%	41	20	-	74	-
Pleasanton	65	1%	19	3	-	43	-
Dublin	115	2%	39	6	-	70	-
Emeryville	35	1%	13	5	-	17	-
Albany	20	0%	10	2	-	8	-
Piedmont	11	0%	3	1	-	7	-
Sunol	2	0%	2	-	-	-	-
Antioch	26	0%	9	4	-	13	-
Other	439	8%	158	64	-	217	-
Total	**5,640**	**100%**	**2,135**	**870**	**-**	**2,635**	**-**

Total By City

City	May 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	163,223	40%	24,176	43,136	17,574	78,337	-
Hayward	64,334	16%	12,750	17,248	7,515	26,821	-
Fremont	37,340	9%	15,486	6,876	2,088	12,890	-
San Leandro	34,558	8%	9,127	5,799	4,313	15,319	-
Union City	15,812	4%	6,486	2,684	843	5,799	-
Alameda	14,259	3%	3,415	2,547	2,088	6,209	-
Berkeley	15,455	4%	4,154	2,288	1,770	7,243	-
Livermore	12,924	3%	1,936	684	2,241	8,063	-
Newark	9,344	2%	2,755	4,098	498	1,993	-
Castro Valley	9,645	2%	2,546	1,690	1,373	4,036	-
San Lorenzo	7,572	2%	1,639	1,662	839	3,432	-
Pleasanton	7,715	2%	2,064	437	816	4,398	-
Dublin	7,514	2%	2,005	460	890	4,159	-
Emeryville	2,811	1%	609	625	451	1,126	-
Albany	2,564	1%	656	295	569	1,044	-
Piedmont	516	0%	124	204	56	132	-
Sunol	94	0%	33	15	5	41	-
Antioch	48	0%	13	10	5	20	-
Other	1,762	0%	554	360	149	699	-
Total	**407,490**	**100%**	**90,528**	**91,118**	**44,083**	**181,761**	**-**

Human Resources

Anastacia Swift

To: Alameda Alliance for Health Board of Governors

From: Anastacia Swift, Chief Human Resources Officer

Date: July 12th, 2024

Subject: Human Resources Report

Staffing

- As of July 1st, 2024, the Alliance had 607 full time employees and 1-part time employee.
- On July 1st, 2024, the Alliance had 60 open positions in which 15 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 45 positions open to date. The Alliance is actively recruiting for the remaining 45 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by division:

Division	Open Position July 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	10	2	8
Operations	31	7	24
Healthcare Analytics	2	1	1
Information Technology	5	1	4
Finance	3	2	1
Compliance	3	0	3
Human Resources	3	1	2
Health Equity	1	1	0
Executive	2	0	2
Total	60	15	45

- Our current recruitment rate is 9%.

Employee Recognition

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

  5 years:
    - Katherine Godwin (Privacy & SIU)
    - Rosa Sanchez (Provider Services)
    - Harinath Pottam (Apps Management, IT Quality & Process Improvement)
    - Lily Hunter (Case/ Disease Management)

  7 years:
    - Brittany Nielsen (Healthcare Analytics)
    - Judith Foster (Member Services)

  8 years:
    - Sherry Roces (Utilization Management)

  9 years:
    - Jeanette Murray (Health Equity)
    - Latrice Allen (Claims)
    - Tiana Rivas (Provider Services)

  12 years:
    - Thuan Le (Claims)
    - Marcie Sperling-Bullock (Claims)

  13 years:
    - Elisea Toscano Cochrane (Case/ Disease Management)
    - Eileen Ahn (Regulatory Readiness)

  17 years:
    - Cindy Brazil (Quality Management)

  16 years:
    - Annie Wong (Healthcare Analytics)

  27 years:
    - Monina Rayo (Claims)

  28 years:
    - Angie Vaziri (Member Services)