ALAMEDA Alliance FOR HEALTH

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Board of Governors

Regular Meeting

Friday, October 11th, 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, October 11th, 2024
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

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 922927764#. 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 October 11th, 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) SEPTEMBER 10th, 2024, FINANCE COMMITTEE MEETING MINUTES

b) SEPTEMBER 13th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

c) SEPTEMBER 13th, 2024, BOARD OF GOVERNORS MEETING MINUTES

d) REVIEW AND APPROVE RESOLUTION RE-APPOINTING YEON PARK TO DESIGNATED BOARD OF GOVERNORS SEAT (AT-LARGE LABOR)

e) REVIEW AND APPROVE RESOLUTION RE-APPOINTING AARON BASRAI TO DESIGNATED BOARD OF GOVERNORS SEAT (AT-LARGE PHARMACIST)

f) REVIEW AND APPROVE RESOLUTION RE-APPOINTING DR. ROLLINGTON FERGUSON TO DESIGNATED BOARD OF GOVERNORS SEAT (ACCMA/SMMA PHYSICIAN)

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

b) FINANCE COMMITTEE

7. REVIEW AND APPROVE MOSS ADAMS FINANCIAL AUDIT REVIEW

8. CEO UPDATE

9. BOARD BUSINESS

a) REVIEW AND APPROVE AUGUST 2024 MONTHLY FINANCIAL STATEMENTS

b) APPROVE TO ADD NOVEMBER FINANCE SUBCOMMITTEE MEETING ON NOVEMBER 12, 2024

c) APPROVE RESOLUTION ADDING REBECCA GEBHART TO THE FINANCE COMMITTEE

d) BEHAVIORAL HEALTH UPDATE

e) CYBER SECURITY UPDATE

f) REPORT OUT OF BEHAVIORAL HEALTH AUDIT

10. STANDING COMMITTEE UPDATES

a) **PEER REVIEW AND CREDENTIALING COMMITTEE**

b) **PHARMACY & THERAPEUTICS COMMITTEE**

c) **STRATEGIC PLANNING COMMITTEE**

11. STAFF UPDATES

12. UNFINISHED BUSINESS

13. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

14. PUBLIC COMMENT (NON-AGENDA ITEMS)

15. 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.

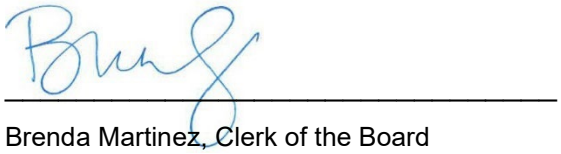
Supplemental Material Received After the Posting of the Agenda: Any supplemental materials or documents distributed to a majority of the Board regarding any item on this agenda after the posting of the

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 October 8th, 2024, by 12:00 p.m.



Brenda Martinez, Clerk of the Board

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EXECUTIVE SUMMARY APPENDIX

ALAMEDA Alliance FOR HEALTH

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PRESENTATIONS APPENDIX

ALAMEDA Alliance FOR HEALTH

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SUPPORTING MATERIALS APPENDIX

ALAMEDA Alliance FOR HEALTH

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Consent Calendar

ALAMEDA Alliance FOR HEALTH

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Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

September 10th, 2024
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted in-person and by Teleconference.

Committee Members in-person: Dr. Rollington Ferguson, Yeon Park, Gil Riojas
Committee Members by Teleconference: James Jackson
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, Yen Ang, Brett Kish, Shulin Lin, Jeanette Murray, Carol van Oosterwijk, Linda Ly, Brenda Martinez, Renan Ramirez, Felix Rodriguez, Danube Serri, Michelle Valles, Christine Corpus, James Zhong Xu

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.

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 Finance committee on several key topics which included:

Long-term care:
In July, there was a loss of $7 million primarily due to inpatient costs, emergency room and long-term care issues.

Financial Restatement:
June and year-end financials are being restated due to retroactivity, with auditors currently reviewing the changes.

Claims Timeliness:
In August, there was a missed regulatory metric regarding claims timeliness, achieving 87% against the State standard of 90%.

Recoupments:
A recent review discovered double payments for retroactive claims, resulting in approximately $2.5 million in recoupments. Efforts are underway to address this issue.

b) REVIEW AND APPROVE JUNE AND JULY MONTHLY FINANCIAL STATEMENTS

JUNE 2024 Financial Statement Summary

Enrollment:

Enrollment decreased by 1,289 members since May and an overall increase from the year of 42,305 members since June 2023. Significant growth was related to moving to a single plan model and offset by the move away from Kaiser and redetermination.

Net Income:

For the month ending June 30th, 2024, the Alliance reported a Net Loss of $60.6 million (versus budgeted Net Loss of $1.8 million). The unfavorable variance is attributed primarily to acuity adjustments related to long-term care and long-term care expense trends. For the year-to-date, the Alliance recorded a Net Loss of $68.6 million versus a budgeted Net Income of $9.3 million. The most significant factor was the acuity adjustment for long-term care that the state made back to calendar year 2023.

Premium Revenue:

For the month ending June 30th, 2024, actual Revenue was $138.2 million vs. our budgeted amount of $157.7 million. This was as a result of the acuity adjustments that were made.

Medical Expense:

Actual Medical Expenses for the month were $192.3 million, vs. budgeted amount of $152.3 million. For the year-to-date, actual, and budgeted Medical Expenses were $1.8 billion, overall unfavorable in terms of the revenue number. Drivers leading to the unfavorable variance is related to long-term care specifically duplicate claims payments, facility type and bed hold days. Further details can be seen on the tables on pages 11 and 12.

Question: Dr. Ferguson asked if we are taking steps to transfer the patients from a high acuity ward to a lower acuity ward. What actions are being taken to deal with this?

Answer: Dr. Carey mentioned that we are currently assessing our partner facilities and determining the number of members in each facility. We need to figure out if it's suitable for them to be moved to a different facility. We are identifying available facilities and evaluating the needs of our members to determine if a transfer is appropriate.

Question: Yeon Park inquired about the possibility of recovering the double payments we made.

Answer: Gil mentioned that we have a limited time frame within which to recoup those funds, typically around twelve months. After this period, the opportunity to recoup the funds may no longer be available.

Question: Rebecca requested clarification on whether the duplicate claims payment was related to retroactivity. Specifically, she wanted to know if we were supposed to pay a retroactive differential, increase or decrease the payment, but ended up paying the full claim amount again, along with the delta.

Answer: Ruth pointed out several issues with the current situation. Many long-term care facilities changed their NPIs, which caused the system to treat the new identifiers as duplicates. This led to denied claims being duplicated and mistakenly paid. The sudden surge in claims from long-term care also overwhelmed the system, necessitating adjustments dating back to January. As a result, new processes have been implemented, which may temporarily slow down claim processing. The IT and claims teams are dedicating significant time to prevent future occurrences.

Question: Rebecca inquired whether distinct part facilities are a provider group or a classification of facilities.

Answer: Gil and Dr. Carey explained that it is the categorization of a facility, representing the way a facility is connected with a hospital.

Question: Rebecca requested clarification on the definition of a bed hold.

Answer: Dr. Carey explained that if a person is in a skilled nursing facility and needs to be hospitalized, their bed in the nursing facility is held for up to seven days. However, if they stay in the hospital for more than seven days, they may lose their bed in the facility. This is a way for the facilities to ensure that the person can return and for the facility to maintain bed occupancy. James Jackson explained that in an acute care facility, when a patient no longer needs acute care, the facility can't charge the full rate. Instead, they have to charge for an admin day at a much lower rate. This is why it's important for them to manage their bed space effectively and transition patients to the appropriate level of care. From a financial perspective, they are penalized for keeping patients in the acute care setting when they no longer require it.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 139.2%. The year-to-date MLR was 100.1%. Normally, we aim to be between 90-95%. Thus, we are significantly higher than our target range.

Administrative Expense:

Actual Administrative Expenses for the month ending June 30th, 2024 were $9.5 million vs. our budgeted amount of $9.7 million. Our Administrative Loss Ratio (ALR) is 6.9% of our Revenue for the month, and 5.6% of Net Revenue for year-to-date.

Other Income / (Expense):

As of June 30th, 2024, our YTD interest income from investments show a gain of $31.7 million.

YTD claims interest expense is $865,000.

Managed Care Organization (MCO) Provider Tax:

For the month ending June 30th, 2024, we reported $114.8 million unbudgeted MCO Tax Revenue, and $114.8 million unbudgeted MCO Tax Expense.

Tangible Net Equity (TNE):

For June, the DMHC requires that we have $63.4 million in TNE, and we reported $255.4 million, leaving an excess of $192.0 million. As a percentage we are at 403%, which remains well above the minimum required.

Cash and Cash Equivalents:

We reported $640.3 million in cash; $282.9 million is uncommitted. Our current ratio is above the minimum required at 1.26 compared to regulatory minimum of 1.0.

Capital Investments:

We have spent $415,000 on Capital Assets year-to-date. Our annual capital budget is $1.6 million.

Question: Dr. Ferguson asked Matt what the plan is for stopping the slide since our numbers are going in the wrong direction.

Answer: We must address the necessary corrections within our systems, particularly the accuracy of claims payment and the authorization process within the healthcare services team. These initiatives must be completed by the end of the month, following our focused efforts over the past three weeks on the developments in September. It is imperative that we rectify all outstanding matters, circulate recruitment letters, and ensure the accuracy of all authorizations within this time frame.

JULY 2024 Financial Statement Summary

Enrollment:

Enrollment increased by 518 members since June.

Net Income:

For the month ending July 31st, 2024, the Alliance reported a Net Loss of $7.0 million (versus budgeted Net Loss of $2.4 million).

Premium Revenue:

For the month ending July 31st, 2024, actual Revenue was $164.3 million vs. our budgeted amount of $166.0 million.

Medical Expense:

Actual Medical Expenses for the month were $164.5 million, vs. budgeted amount of $162.2 million. The negative impact is a result of the revenue issue with the acuity.

Medical Loss Ratio:

Our MLR ratio for this month and fiscal year-to-date was reported at 100.1%.

Administrative Expense:

Actual Administrative Expenses for the month ending July 31st, 2024 were $10.8 million vs. our budgeted amount of $8.7 million. Our Administrative Loss Ratio (ALR) is 6.6% of our Revenue for the month and year-to-date. Most of this is related to timing of licensing fees.

Other Income / (Expense):

Fiscal YTD net investments show a gain of $4.0 million.

YTD claims interest expense is $184,000.

Managed Care Organization (MCO) Provider Tax:

For the month and FYTD ending July 31st, 2024, we reported actual revenue of $46.9 million and budgeted $47.0 million for both revenue and expense.

Tangible Net Equity (TNE):

For July, the DMHC requires that we have $68.8 million in TNE, and we reported $248.4 million, leaving an excess of $179.6 million. As a percentage we are at 361%, which remains well above the minimum required. TNE continues to decline; however, we are optimistic that once we achieve stability in our long-term care expenses and certain administrative costs, our TNE will plateau.

Cash and Cash Equivalents:

We reported $527.2 million in cash; $355.8 million is uncommitted. Our current ratio is above the minimum required at 1.25 compared to regulatory minimum of 1.0.

Capital Investments:

We have spent $692,000 on Capital Assets year-to-date. Our annual capital budget is $1.7 million.

Motion: A motion was made by Yeon Park, and seconded by James Jackson, to accept and approve the June and July 2024 Financial Statements.

Motion Passed

No opposed or abstained.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 8:58 a.m.

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Compliance Advisory Committee Meeting Minutes

COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes
Friday, September 13th, 2024
10:30 a.m. – 11:30 a.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

CALL TO ORDER

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

Remote: None

Committee Members Excused: None

1. CALL TO ORDER

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

2. ROLL CALL

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

3. AGENDA APPROVAL OR MODIFICATIONS

Rebecc Gebhart requested an agenda modification to add item 6.a Brown Act Violation

Motion: A motion was made by Richard Golfin III and seconded by Byron Lopez to add agenda item 6.a. Brown Act Violation to the agenda.

Vote: The motion was passed unanimously

Ayes: Byron Lopez, Richard Golfin III, Dr. Kelley Meade, Rebecca Gebhart

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

None

5. CONSENT CALENDAR

a) July 12th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

Motion: A motion was made by Richard Golfin III and seconded by Byron Lopez to approve Consent Calendar Agenda Items.

Vote: The motion was passed unanimously

Ayes: Byron Lopez, Richard Golfin III, Dr. Kelley Meade, Rebecca Gebhart

6. COMPLIANCE MEMBER REPORTS

a) Brown Act Violation

i Board Chair Rebecca Gerhart: Note to the Compliance Committee. At the June Board of Governors (Board) meeting there was a Brown Act Violation. During closed session at the end of the meeting there were some technical issues with remote permitted board members. After the closed session the meeting was mistakenly adjourned. The Board meeting should have been re-opened to finish discussion and report out any reportable actions. This action will be corrected at today's Board of Governors meeting by reporting the reportable actions.

b) Compliance Activity Report

i Plan Audits and State Regulatory Oversight

1. Compliance Dashboard
    - There are a total of 231 findings being tracked on the Compliance Dashboard, 49 of these findings are still in progress
    - Nine of these findings were added from the recently received 2023 DHCS Focused Audit
    - There are also 16 self-identified observations from the 2024 DHCS Routine Full Medical Survey. These are in addition to the twenty three potential findings DHCS discussed during the exit conference.

Question: Can you clarify the math of the open finding?
Answer: Nine are from 2023 the remainder are from 2024.

a. 2023 Focused Medical Survey Report

This audit focused on behavioral health and transportation services.

The audit occurred in April 2023, with a review period from April 2022 through March 2023.

This audit ran concurrently with our 2023 routine survey.

The final audit report and corrective action plan (CAP) were received on September 4, 2024, and our CAP response is due on October 4, 2024.

Finding 1: Behavioral Health Case Management and Care Coordination

- The Plan did not ensure the provision of coordination of care to deliver mental health care services to its members. Recommendation: Revise and

implement policies and procedures to ensure the Plan coordinates care with the MHP.

- The DHCS 2023 lookback audit was for the period when we still had Beacon Health Services as our vendor delivering behavioral services.
- We have since brought these services in house. During that process these deficiencies were identified and actions have already been taken to correct them.
- Deficiencies in case management and care coordination have continued to be a focus this year.
- The backlog of Behavioral Health Therapy (BHT) and Applied Behavior Analysis (ABA) services was discovered when we brought the services in house, and so we've been diligently working on putting in place systems to make sure that we are touching members, touching families, and overcoming barriers to services.

Finding 2: Behavioral Health Information Exchange with the County Mental Health Plan (MHP)

- The Plan did not follow the written policies and procedures in its MOU for the timely sharing of medical information with the MHP. Recommendation: Implement policies and procedures to ensure the Plan follows agreed upon written policies and procedures in its MOU for the timely exchange of medical information with the MHP.
  - We are Working with the county on an information exchange.
  - The county system is Smart Care. It has had problems throughout the year which has prevented us from completing the actual data exchange, however we are tracking closely with the county to see when the systems will come back online.
  - Once we activate the data exchange it will enable a closed loop of referrals and care coordination between the Alliance and the county.

Finding 3: Behavioral Health Confirmation of Referred Treatments for Substance Use Disorder (SUD)

- The Plan did not make good faith efforts to confirm whether members received referred treatment for SUD and document when and where treatment was received, and any next steps following treatment. Recommendation: Revise and implement policies and procedures to ensure the Plan makes good faith efforts to confirm whether members received referred SUD treatment and document when and where treatment was received, and any next steps following treatment.

Finding 4: Behavioral Health Follow Up for Referred Substance Use Disorder (SUD) Treatments

- The Plan did not follow up with members who did not receive referred treatments to understand barriers and make subsequent adjustments to referrals. Recommendation: Revise and implement policies and

procedures to ensure the Plan awareness of members who did not receive referred SUD treatments, to understand barriers and make subsequent adjustment to referrals, if warranted.

- The two findings around SUDs is a challenge that is continuing to be worked on.
- Substance use disorder is governed by a federal statute, 42 CFR, which requires more rigorous privacy constraints, particularly requiring signed release of information from patients.
- The Alliance currently does not have in place satisfactory care coordination or data exchange around SUD treatment, which for our Medi-Cal population is the responsibility of the County, which is a top priority for the Alliance to continue to address with the County and look for solutions.
- There is a continued barrier with the county around 42 CFR, which prevents the County from sending the Alliance information due to privacy issues. The Alliance is continuing to address this barrier with the County.

Question: Do other plans face the same 42 CFR privacy issue with their County Behavioral Health Plans?

Answer: Yes, it has been a perpetual problem for many years. The difficulty is that DHCS in the APL gives us responsibility to be compliant with 42 CFR and it does not give us guidance on how Counties and Plans are to actually able to overcome this barrier. We have to work with Alameda County to find a solution to overcome this barrier.

Question: Going back to the data exchange process. Are there other loops with other entities that are not covered with the data exchange that are a concern?

Answer: We have completed a parallel exchange process with our CHCN partners. They represent about 50% or more of our mental health network that are delivering care to our members. That was completed and first leg of that operates. The Alliance gets a daily update from the EPIC system which is the EHR CNCN uses. We are working with the Alliance IT team to complete the loop. Currently we are receiving the data, but the data is not then going anywhere yet. Estimated completion by end of year to push out treatment reports to member's primary care doctors and connecting co-treating providers.

Finding 5: Non-Medical Transport (NMT) and Non-Emergency Medical Transport (NEMT) Door-to-Door Assistance

- The Plan did not have a process in place to ensure that door-to-door assistance was provided for all members receiving NEMT services. Recommendation: Revise and implement policies and procedures to ensure door-to-door assistance is being provided for all members receiving NEMT services.
  - There are multiple levels of service, for door to door service, these are members who need assistance from the car to their appointment, and then back again to the car.
  - In partnership with our transportation vendor, we have taken the

following steps to modify this:

- Updated policies
- Ensured the transportation vendor is providing additional training for their broker staff and their transportation vendors. This training has already been implemented
- This was also reviewed in our 2024 routine audit, were they did not find these same findings.

Finding 6: NMT and NEMT 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.
  - The big difference with this finding is the monitoring.
  - We oversee our transportation providers via our transportation vendor, and so we have to demonstrate that we are monitoring our vendor's monitoring of the transportation providers.
- 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.
  - The Plan monitors the transportation vendor through physical in person monitoring in the field, reviewing the trips ourselves instead of relying on the vendor's reporting– five door to door trips per quarter.

Finding 7: NMT and NEMT 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.
  - The vendor has a 24-hour call center for contact, however members still need to be able to get rides after hours, and a health plan staff member needs to be designated as a liaison for this work.
  - The Plan also has a designated Transportation Liaison, a specific person has been designated for this, however their information needs to be better published.
  - Handbook and Health Plan website for easy accessibility.

Question: This is an on-call position 24 hours? Is there a special designation?

Answer: Yes, working on a solution and options. The individual is working salary not hourly from the HR designation. Phone number is available, but it has never been called. Currently a trial and error process to see how it will work out in the end.

Finding 8: NMT and NEMT Physician Certification Statement Forms

- This is a repeat finding.
- The Plan did not ensure that members had the required PCS forms for

NEMT services, nor did the Plan ensure that PCS forms contained all required components. Recommendation: Implement policies and procedures to ensure PCS forms are on file for all members receiving NEMT services and that the forms contain all the required components. Working with Motive Care to streamline the processes.

- This is a known problem that we have identified and has been insourced at the Plan.
- Work lists of members who need rides to ensure PCS forms are on file, and if none on file, actively calling providers to get the active PCS forms.
- This is an issue with most Medi-Cal plans across the State.
- Currently at 92% compliance with the forms.
    - This has been independently audited by the Plan Internal Audit to confirm.
    - This was also not identified as an issue at the 2024 DHCS audit.

Finding 9: NMT and NEMT 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.
    - The same issue as the first door to door.
    - Will need to do audits and spot checks at the Plan level.

Question: Treating them all as one bucket, is there concern that they will be a repeat finding when the final 2024 comes out?
Answer: As Elizabeth pointed out, they asked us for the documentation to prove that we were performing this oversight and we were able to provide it to them. They didn't have a lot of questioning.

b. 2024 Routine Full Medical Survey (RMS) - Potential Findings

Last month we reviewed the potential findings that came out of our audit exit conference with DHCS, of which there were 23.

We are still waiting for the official preliminary audit findings from DHCS, which are expected very soon. Once we receive them, we will have fifteen days to respond, and then they will send us the final report.

In addition to the potential findings that were discussed at the exit conference, we have identified 16 other areas of concern. These were identified based upon our observations of lines of questioning during the audit interview sessions, as well as the additional document requests we received after the virtual onsite audit. Our observations of what was being asked, as well as the answers we gave, let us see potential areas where we could approve our processes. We have added those to our dashboard in order to work on improving.

Compliance will be working with the various departments identified in these areas to strategize on the next steps.

1. The discrimination grievance workflow needs to be updated to include timeliness and tracking.
    - When grievances alleging discrimination are received, G&A works with Compliance to obtain a resolution. There is a common system used for tracking grievances, however, the Compliance piece of discrimination grievances was being tracked on an excel spreadsheet, so we are updating our workflows to track this in the G&A system as well, which will help with analytics monitoring, as well as ensuring both teams are on the same page with the status of cases.
2. Consultants and independent contractors are not consistently trained, and the training is not tracked per our policy on Compliance Training and Education
    - Consultants and independent contractors who have member data access are required to complete compliance trainings and we need to ensure we are consistently tracking to ensure this is done.
3. Similarly, the Board of Governors does not consistently complete compliance trainings, per regulations and contract requirements.
    - We will need to put a process in place to ensure this is done consistently and timely as well.
4. The Privacy Reporting Desktop Procedure should be updated to include the steps regarding educating internal stake holders on timely referrals and correct categorization in Health Suite
    - Since there is a 24-hour turnaround time from when a potential privacy incident is identified, to when it must be reported to the State, it is imperative that the incident be reported as quickly as possible to the Privacy Office. Part of the way we ensure this happens is with constant and consistent training. While we do this training, it is not necessarily reflected in the desktop procedures, so those need to be updated.
5. The Privacy office should update workflows for timely investigation of referrals sent to the incorrect inbox.
    - There is a specific inbox for privacy incident referrals, however, sometimes, the referrals are sent to other Compliance related inboxes. Workflows need to be updated to ensure those other inboxes are checked regularly as well so that nothing is missed.
6. Updates should be made to the Compliance Plan on an annual basis, and the Code of Conduct should be updated to reflect the new CEO.
    - We have talked about this one before, however for a long time we did not have a Compliance Plan. Last year we created one with the plan to be updated every other year, however during the audit session the State questioned this, so we will be updating it yearly. Also, the Code of

Conduct had not been updated to reflect the change in CEO, so we are working on our workflows to ensure when we have changes like this going forward, the updates are made timely

7. Timeliness of reporting of the Chief Medical Officer transition.
    - Again, this is about updating our workflows to ensure, when we have changes like this, they are reported timely
8. Changes to transportation liaisons should be communicated to Compliance in a reasonable time with updated lists of liaisons provided to the State regularly.
    - This was discussed as part of our 2023 DHCS focused audit, however, this finding is specific to the need to ensure that any changes to liaisons are communicated to Compliance.
9. There are no separate California Children's Services and Early Periodic Screening, Detection, and Treatment services reviews during the annual UM delegation audit.
    - The audit tools for the audit of our UM delegates does not include reviews specific to CCS and EPSDT services, so these will need to be updated to ensure our delegates are meeting the requirements.
10. There is no separate review of Prop 56 claims during annual delegation oversight audits
    - We have not specifically been pulling claims related to Prop 56 when we perform our annual delegation oversight audits, so we will be updating the audit tools to ensure these are reviewed going forward, instead of just relying on some to come up in selection of overall claims to audit
11. The virtual care provider had two involuntary terminations during the audit period. The Plan did not report provider terminations to DHCS.
    - The provider, Teladoc, had two provider terminations during the audit period. We are required to report all provider terminations to the state, however we had not been consistently including Teladoc in this, so we need to update the process to ensure these provider terminations are reported as well.
12. A delegate reported terminations under quality of care in error.
    - There was an error with one of our delegates (CFMG) in how they reported provider terminations. When reporting terminations to the state, we must list the reason why the providers were terminated, and the delegate accidently listed the reason as quality of care. We need to work with the delegate to ensure these are reported correctly going forward. (APL 21-003)
    - The reason for termination can affect a providers standing, and also affects our reporting requirements

13. UM Policy UM-063 for Gender Affirmation Surgery Services did not include the most recent World Professional Association of Transgender Health 8 Guidelines

    - The World Professional Association of Transgender Health periodically puts out guidelines for transgender healthcare, to help guide how we provide services to these members. When the guidelines are updated we need to ensure we are updating out policies timely to reflect these guidelines

14. The transportation provider conducts spot checks, the resulting reports are available to the Plan but the Plan has not requested or reviewed them.

    - Our transportation provider does their own reviews of their services, however we had not been asking them to provide these reports to us.

    - This was discussed as part of their response to findings from the 2023 DHCS focused audit.

15. Confirmation of minor consent forms collected by the transportation provider for transport of minor.

    - When transporting members who are minors, they must have a minor consent form. Our transportation provider is responsible for collecting these, and we need to set up a process to check that this is being done.

16. Ownership and Disclosure forms are not collected and reviewed from all subcontractors per contract requirements.

    - We are continuing to work to improve our ownership and disclosure for process. We have been collecting these for our delegates, however, we need to make sure we are collecting them for all of our subcontractors consistently and reviewing them to ensure all information that is reported is correct This came up during the delegation of UM session, forms missing from some subcontractors.

Question: Is this a fairly typical annual event that self-identified, with discussions with the state that we identify for example 16 more or an unusual thing?

Answer: All the information was not available to us and we did not have the opportunity to collect all the findings.

Discussion: The plan is doing a very good job at self-reflection going through these processes. We are waiting for the September preliminary finding report. We are building a whole new division called Enterprise Risk Management. Which is all about self-reflection. We will be managing these risks. IT compliance, key performing indicators, and other metrics. It will be managed in house. Interviews begin next week.

Follow Up Question: Instead of every year it is every other year to update the plan. What is the timing and process if that happens? Is it another to do item?

Answer: Rules require compliance to be updated every year. In almost 30 years we have not had a compliance plan. The state has never had issue with that. It's taken two years to get the compliance plan done. The decision was made to do it every other year. Fortunately, we were

able to bring on Compliance knowledgeable Director Stephen Smythe. Professionals that manage this process which we didn't have prior. The compliance plan has been updated for this year, incorporates Medicare and 2026 with all of our active licenses.

Follow Up Question: How can this committee help in the process?

Answer: We will bring the approved Compliance to the Compliance Advisory Committee. That would be appropriate.

2024 DHCS Audit

- We are in the process of scheduling meetings with the SME to go over those potential findings and the self-identified that were just discussed. Still waiting to receive the preliminary findings from DHCS. Once received we have 15 days to respond.
- 2023 DHCS focus medical survey we received the audit report. They are working on their CAPS which are due to Compliance on September 23rd. Compliance will review. Our deadline is October 4th.
- 2025 Surveys DMHC and DHCS joint audit will be March of 2025. Health Equity Audit we are planning for June of 2025 and the NCQA survey will be July 2025. Prep work will begin soon for upcoming audits.

b) MEDI-CAL PROGRAM UPDATES

i 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

a) Dr. Kelley Meade adjourned the meeting at 11:29 am.

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Board of Governors Meeting Minutes

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, September 13th, 2024
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

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

Board of Governors Remote: Andrea Ford ('Traditional Brown Act')

Board of Governors Excused: Aaron Basrai, Yeon Park, Dr. Evan Seevak

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

Chair Gebhart called the regular Board of Governors meeting to order at 12:04 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

The new board members, Tosan Boyo and Wendy Peterson, were formally introduced. Additionally, Stephen Smythe was introduced as the new Director of Compliance, Dr. Donna Carey as the new Chief Medical Officer, and Troy Szabo, who is serving as the external General Counsel to Alameda Alliance.

5. CONSENT CALENDAR

a) JULY 9th, 2024, FINANCE COMMITTEE MEETING MINUTES

b) JULY 12th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

c) JULY 12th, 2024, BOARD OF GOVERNORS MEETING MINUTES

d) REVIEW AND APPROVE RESOLUTION RE-APPOINTING JAMES JACKSON TO DESIGNATED BOARD OF GOVERNORS SEAT (ALAMEDA HEALTH SYSTEM)

e) REVIEW AND APPROVE RESOLUTION RE-APPOINTING DR. EVAN SEEVAK TO DESIGNATED BOARD OF GOVERNORS SEAT (AT-LARGE SUBJECT KNOWLEDGE EXPERTISE)

Motion: A motion was proposed by Dr. Marty Lynch and seconded by Dr. Kelley Meade to approve the Consent Calendar Agenda Items 5a through 5e, with a modification to the BOG July 12th, 2024, minutes. The Finance Committee section under section 6b should state, "The TNE has decreased to 540%".

Vote: The motion was passed unanimously.

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

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) ANNOUNCEMENT REGARDING JUNE CLOSED SESSION

Chair Rebecca Gebhart issued a statement of a potential Brown Act violation. It had come to the board's attention that during the June 14th, 2024, board meeting, an oversight resulted in the board's closed session report not being publicly reported. As a result, the recorded minutes do not reflect the actions taken by the board in the closed session. The following reportable action from the June 14th, 2024, closed session should have been disclosed at the conclusion of the meeting:

“During the closed session, the Board reported on the process of the CEO's performance review and reviewed the CEO's performance, and there was a consensus to increase the CEO's compensation to $500,011. This amount aligns with the CEO compensation of the CEO managed care plan salary survey of Northern California Region, 2023 median for CEO salaries.”

The Board also thanked CEO Matthew Woodruff for his leadership and diligence in directing the Alliance’s operation and the mission to serve our members.

b) COMPLIANCE ADVISORY COMMITTEE

Dr. Kelley Meade provided an update on the Compliance Advisory Committee meeting held on September 13th. The committee thoroughly reviewed the compliance dashboard and addressed nine open items from the 2023 Focus Medical Survey report. Notably, about half of them were related to behavioral health, with the remaining items focusing on the audit and compliance with transportation and our transport vendor. Additionally, the committee discussed the 2024 routine full medical survey, highlighting twenty-three self-identified findings and sixteen new self-identified findings, bringing the total to thirty-nine.

c) FINANCE COMMITTEE

Dr. Ferguson provided an update on the Finance Committee meeting that took place on September 10th. During the meeting, the committee discussed the financial performance for June and July. In June, we incurred a net loss of $60.6 million, contributing to a total year loss of $68.6 million. The TNE (Total Net Expenditure) for the year declined to 403%. Moving into the new fiscal year, we continued to experience losses, with a net loss of $7 million in July. The TNE was reported to be 361%, indicating an ongoing decline. The MLR (Medical Loss Ratio) for June was 139. The state's recoupment of $59 million significantly contributed to the loss. Long-term care and ER services also posed challenges in terms of spending. The committee extensively discussed the challenges related to long-term care, recognizing the need to address the current trends. Double payments and potential overpayments for hold stays were also identified as issues, with an estimated $3-5 million impact. Further discussions on these matters are planned.

Question: Where has the $59 million recoupment been allocated?

Answer: The transition of long-term care members to the Alliance from January to March who were previously with Anthem revealed a significant disparity in the proportion of long-term members between Alliance and Anthem. At that time, our organization had 300,000 lives, including 1,400 long-term care members, while Anthem had 81,000 lives with 1,000 long-term care members. This indicates a substantial imbalance and a higher demand for care within Anthem's membership. Despite now serving the former Anthem members, the financial resources were allocated to Anthem.

7. CEO UPDATE

In the CEO update, Matt Woodruff discussed the following key points:

Financials

- Revenue was $164.3 million in July 2024 and Year-to-Date (YTD).
- Tangible Net Equity (TNE): Financial reserves are 361% of the required DMHC minimum, representing $179.6 million in excess TNE.
- Total enrollment in July 2024 was 404,508, an increase of 518 Medi-Cal members compared to June.

Key Performance Indicators

- The Alliance did not meet our claims timeliness payment. According to the state metric, which stands at 90%, our score of 87% indicates that our claim fell slightly below the state standard.
- The Alliance missed an internal metric on system availability. Our goal is 100%, and we averaged 99.9%.

Alliance Updates

- The Alliance Health Equity plan starting in 2025, and Provider Training is due to DHCS in December 2024. The Alliance will send these documents for Board review in October 2024.

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.

Long Term Care

- Recoupments – The system paid the full claim, not just a retroactive delta of $2.5 million.
- Case Management – Our social workers visit the facilities monthly to meet with the staff, check on the members, and ensure all their case management needs are met. We aim to prevent unnecessary emergency room or hospital visits by closely monitoring these facilities and members. If a facility has 6-20 of our members, we meet with them quarterly. We conduct phone check-ins for facilities with fewer than five members. Our team focuses on prioritizing facilities with the highest number of members to ensure they receive proper care.

Question: How do we ensure those members meet the requirements to stay in those facilities?

Answer: We continually monitor our utilization, track emergency room visits and hospital admissions, and follow up with members.

Question: What happens if you find a diminished quality of care? What are the plans of action to increase it?

Answer: We have a quality-of-care process in place. If there is a grievance or concern about the quality of care, we conduct an investigation. This involves looking at the facility, asking questions, and reviewing medical records to ensure the quality of care. Depending on the investigation's findings, we take the appropriate next steps.

Question: Do we have data on ER utilization by different delegated groups or provider types so that we can focus interventions on them?

Answer: We have a report that will help us categorize emergency room visits as necessary or potentially avoidable. We plan to use the Johns Hopkins algorithm to assist us.

Comment: Due to significant interest, Chair Gebhart suggests considering a comprehensive long-term care report for an upcoming board meeting.

Informational item only.

8. BOARD BUSINESS

a) REVIEW AND APPROVE JUNE AND JULY 2024 MONTHLY FINANCIAL STATEMENTS

Gil Riojas, the Chief Financial Officer, presented an overview of the financial statements for June and July 2024. The complete packet, containing all the details, had already been presented to the Finance Committee earlier in the week.

June 2024 Financials

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

Net Income – For the month ended June 30th, 2024, the actual Net Loss was $60.6 million vs. the budgeted Net Loss of $1.8 million. The fiscal year-to-date actual Net Loss was $68.6 million vs. the Budgeted Net Income of $9.3 million.

Medical Loss Ratio (MLR) - The Medical Loss Ratio was 139.2% for the month and 100.1% for the fiscal year-to-date.

Tangible Net Equity (TNE) – DMHC required $63.4 million in reserves; we reported $192.0 million. Our overall TNE remains above the required levels at 403%.

Question: Dr. Ferguson inquired about the plan to halt the decline, expressing concern about the possibility of ending up with negative numbers if the trend persists.

Answer: Matt mentioned that we will recoup the money and improve the system. We are also making improvements in case management. We are currently focusing on these two areas: the operational side of claims and the operational side of healthcare services. We believe that improving case management will have the most long-term impact on our members, and we will provide monthly updates.

July 2024 Financials

Enrollment – Total enrollment increased by 518 members since June 2024.

Net Income – For the month and fiscal YTD ended July 31st, 2024, the actual Net Loss was $7.0 million vs. the budgeted Net Loss of $2.4 million. For the month and fiscal YTD, Premium Revenue was slightly unfavorable to budget, actual Revenue was $164.3 million vs. budgeted Revenue of $166.0 million.

Medical Loss Ratio (MLR) – The Medical Loss Ratio was 100.1% for the month.

Tangible Net Equity (TNE) – DMHC required $68.8 million in reserves; we reported $179.6 million. Our overall TNE remains above DMHC requirements at 361%.

We are currently undergoing our Moss Adams audit and are in the final stages of completing it. We expect to have the audit report ready for the board at the October board meeting. We do not anticipate any findings from the audit.

Question: Dr. Aboelata asked if we should conduct further analysis to determine what additional facilities we might need.

Answer: Matt mentioned that the Alliance has a solid urgent care network. Over the years, we have conducted various outreach campaigns for urgent care. Additionally, our network is quite extensive. In the future, we will focus on ensuring that our members receive the appropriate care at the right location and time.

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Natalie Williams to approve the June and July 2024 monthly financial statements.

Vote: The motion was passed unanimously.

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

No opposition or abstentions.

b) MEDICARE UPDATE

Tome Meyers presented an update on Medicare, covering D-SNP Organizational Projects, technology updates, vendor management, sales model overview, stars measures overview, provider networks, challenges & risks, and next steps.

Key highlights:

- D-SNP Program: 39 active projects and 55 reviewed/approved projects, projecting approximately 150.
- RFP's:
    - Dental – finalizing vendor selection
    - Hearing – Released on August 30th, 2024
    - Vision – Released on August 8th, 2024
- Completed first series (of three webinars) for Medicare provider contracting education with Chapman Consulting.
- Completed D-SNP readiness meeting with DMHC, DHCS, and CMS on August 19th, 2024.
- Will conduct a pre-delegation audit for Pharmacy Benefits Manager (PBM) on October 21st, 2024.
- Claim system optimization and D-SMP core systems upgrades started on July 31st, 2024.

Question: Chair Gebhart asked about the concierge-like sales model and the high touch aspect, specifically inquiring whether there is a component of health navigation that aids individuals in accessing care or if the focus is solely on providing educational information. Furthermore, Chair Gebhart sought clarification on whether there is any hands-on navigation involved in the process.

Answer: Tome mentioned that there's navigation involved not only within our health plan but also with services in the community and within the hospital. When an individual is identified as qualifying for case management, the sales individual would refer them to the case management team and ensure that the individual is partnered with Dr. Carey and her group. This involves navigating not only within our organization but also within the hospital.

Question: James Jackson inquired about the protocol regarding the low percentage of provider contracts received back. Is there a specific threshold for the return percentage needed to deem the process viable?

Answer: Tome stated that we aim to achieve the target by December. Upon reviewing LHPC's timeline, we see we are currently on track with the contracting process. The goal is to have 33% completed by the end of the month, another 33% shortly after, and to be fully prepared to proceed in December. Despite feeling like we should be further ahead; we are on schedule according to the timeline.

Question: Dr. Lynch asked if we have seen a budget for the annual expenses of implementing the plan.

Answer: Matt mentioned that the overall budget was shared with the board in December and filed with the state. He also expressed willingness to share the updated budget at a future meeting.

Question: Jody inquired about the defining characteristics of palliative care for an individual.

Answer: Dr. Carey explained that palliative care focuses more on managing the level of a patient's condition rather than providing a specific diagnosis. Palliative care aims to relieve symptoms and ensure that individuals with chronic illnesses effectively manage their symptoms. If a person meets the criteria for palliative care, they can receive this type of care.

Informational item only.

c) BEHAVIORAL HEALTH UPDATE

Due to time constraints, the Behavioral Health Presentation has been rescheduled for the October 11th, 2024, Board meeting.

Motion: A motion was made by James Jackson and seconded by Natalie Williams to postpone the Behavioral Health Update to the October 11th, 2024, board meeting.

Vote: The motion was passed unanimously.

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

9. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE

Dr. Carey provided an update on the Peer Review and Credentialing Committee's meeting held in July. A total of 128 initial providers were credentialed, with 107 of them in behavioral health. Additionally, 18 providers were recredentialed, bringing the total number of credentialed to 146. Furthermore, 65 facilities were approved during the meeting.

b) PHARMACY & THERAPEUTICS COMMITTEE

Dr. Carey provided an update on the Pharmacy & Therapeutics committee meeting that took place on June 11th. This was the final meeting for the Senior Director of Pharmacy, Dr. Helen Lee. In the meeting, eight therapeutic categories and drug monographs were updated, eight formulary modifications were made, five drugs were updated to non-formulary status, two new medications were added to their formulary, and one medication was added to their formulary without prior authorization. Additionally, they updated eight prior authorization guidelines and reviewed 22 prior authorization guidelines with no updates.

c) QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE

Dr. Carey gave an overview of the Quality Improvement Health Equity Committee meeting that took place on August 16th. During the meeting, CHCN, a community partner, presented a QI measure strategy for updating chronic disease. Work plans for UM and quality departments were approved, and there was also an update on behavioral health.

10. STAFF UPDATES

There were no staff updates.

11. UNFINISHED BUSINESS

None.

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

At a future board meeting, there will be a comprehensive analysis of long-term care and emergency room services in relation to primary care, as well as strategies to increase urgent care utilization. The behavioral health update will also be presented at the next board meeting.

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

14. ADJOURNMENT

Chair Gebhart adjourned the meeting at 1:55 p.m.

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RESOLUTION RE-APPOINTING YEON PARK TO THE AT-LARGE LABOR SEAT

RESOLUTION NO. 2024-

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS REAPPOINT YEON PARK TO THE REGULAR #4 AT LARGE LABOR SEAT TO THE ALAMEDA ALLIANCE FOR HEALTH BOARD OF GOVERNORS

WHEREAS, Ms. Yeon Park's current term as an Alameda Alliance for Health (Alliance) Board of Governors member, in the At-Large Labor Seat (Regular #4), expires November 21, 2024; and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors nominate Ms. Yeon Park for reappointment to the At-Large Labor Seat (Regular #4), pursuant to Section 3.D.8 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. Yeon Park for reappointment to the Alliance Board of Governors (Regular #4); 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. Yeon Park for reappointment to the At-Large Labor Seat (Regular #4), 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. Yeon Park to the At-Large Labor Seat (Regular #4), 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 11th day of October 2024.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

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RESOLUTION RE-APPOINTING AARON BASRAI TO AT-LARGE PHARMACY SEAT

RESOLUTION NO. 2024-

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS REAPPOINT MR. AARON BASRAI, PHARMD, TO THE REGULAR #12 AT LARGE PHARMACIST SEAT TO THE ALAMEDA ALLIANCE FOR HEALTH BOARD OF GOVERNORS

WHEREAS, Mr. Aaron Basrai's current term as an Alameda Alliance for Health (Alliance) Board of Governors member, in the At-Large Pharmacist Seat (Regular #12), expires November 21, 2024; and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors nominate Mr. Aaron Basrai for reappointment to the At-Large Pharmacist Seat (Regular #12), pursuant to Section 3.D.8 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. Aaron Basrai for reappointment to the Alliance Board of Governors (Regular #12); 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. Aaron Basrai to the At-Large Pharmacist Seat (Regular #12), 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 Mr. Aaron Basrai to the At-Large Pharmacist Seat (Regular #12), 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 11th day of October 2024.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

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RESOLUTION RE-APPOINTING DR. ROLLINGTON FERGUSON TO DESIGNATED ALAMEDA-CONTRA COSTA MEDICAL ASSOCIATION AND SINKLER-MILLER MEDICAL ASSOCIATION SEAT

RESOLUTION NO. 2024-

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS REAPPOINT DR. ROLLINGTON FERGUSON TO THE REGULAR #11 AT DESIGNATED ALAMEDA-CONTRA COSTA MEDICAL ASSOCIATION AND SINKLER-MILLER MEDICAL ASSOCIATION SEAT TO THE ALAMEDA ALLIANCE FOR HEALTH BOARD OF GOVERNORS

WHEREAS, Dr. Rollington Ferguson's current term as an Alameda Alliance for Health (Alliance) Board of Governors member, in the Designated ACCMA/SMMA physician seat (Regular #11), expires November 21, 2024; and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors nominate Dr. Rollington Ferguson for reappointment to the Designated ACCMA/SMMA physician seat (Regular #11), pursuant to Section 3.D.2 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 Dr. Rollington Ferguson for reappointment to the Alliance Board of Governors (Regular #11); 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 Dr. Rollington Ferguson for reappointment to the Designated ACCMA/SMMA physician seat (Regular #11), on the Alliance Board of Governors, as created pursuant to Section 3.D.2 of the Alliance *Bylaws*.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors reappoint by majority vote Dr. Rollington Ferguson

for reappointment to the Designated ACCMA/SMMA physician seat (Regular #11), 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 11th day of October 2024.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

ALAMEDA Alliance FOR HEALTH

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

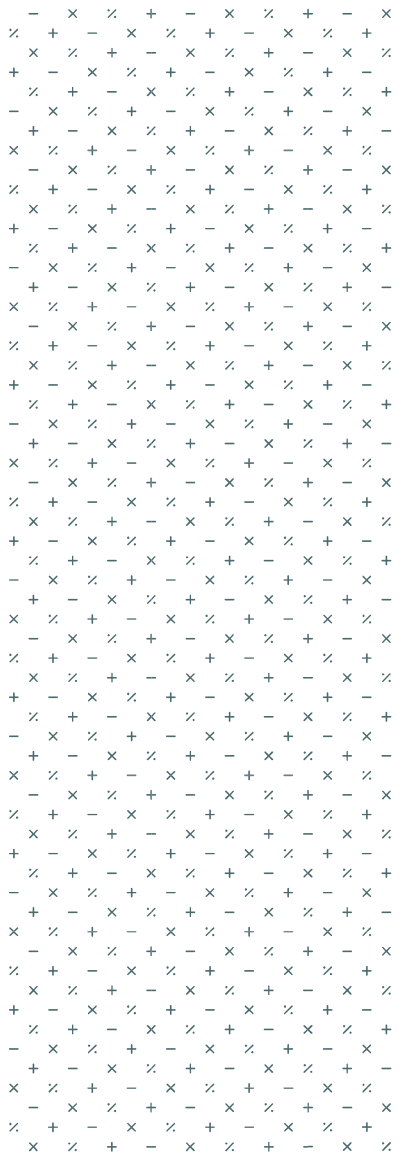
MOSS ADAMS FINANCIAL AUDIT REVIEW

MOSSADAMS

2024 Audit Results: Alameda Alliance for Health

Chris Pritchard
Health Care and Insurance Services Partner

Rianne Suico
Health Care and Insurance Services Partner



2024 Audit Objectives

- Opinion on whether the financial statements are reasonably stated and free of material misstatement in accordance with generally accepted accounting principles.
- Consideration of internal controls and compliance.

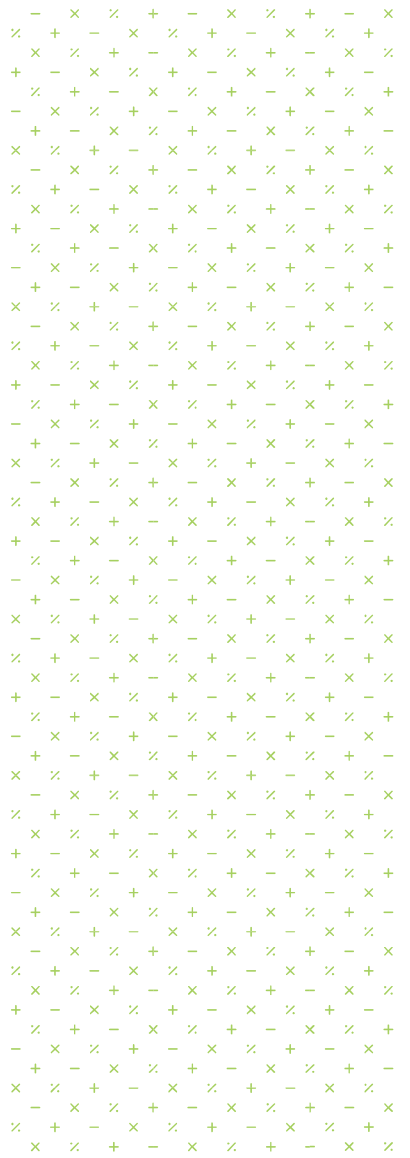
Report of Independent Auditors

Unmodified Opinion

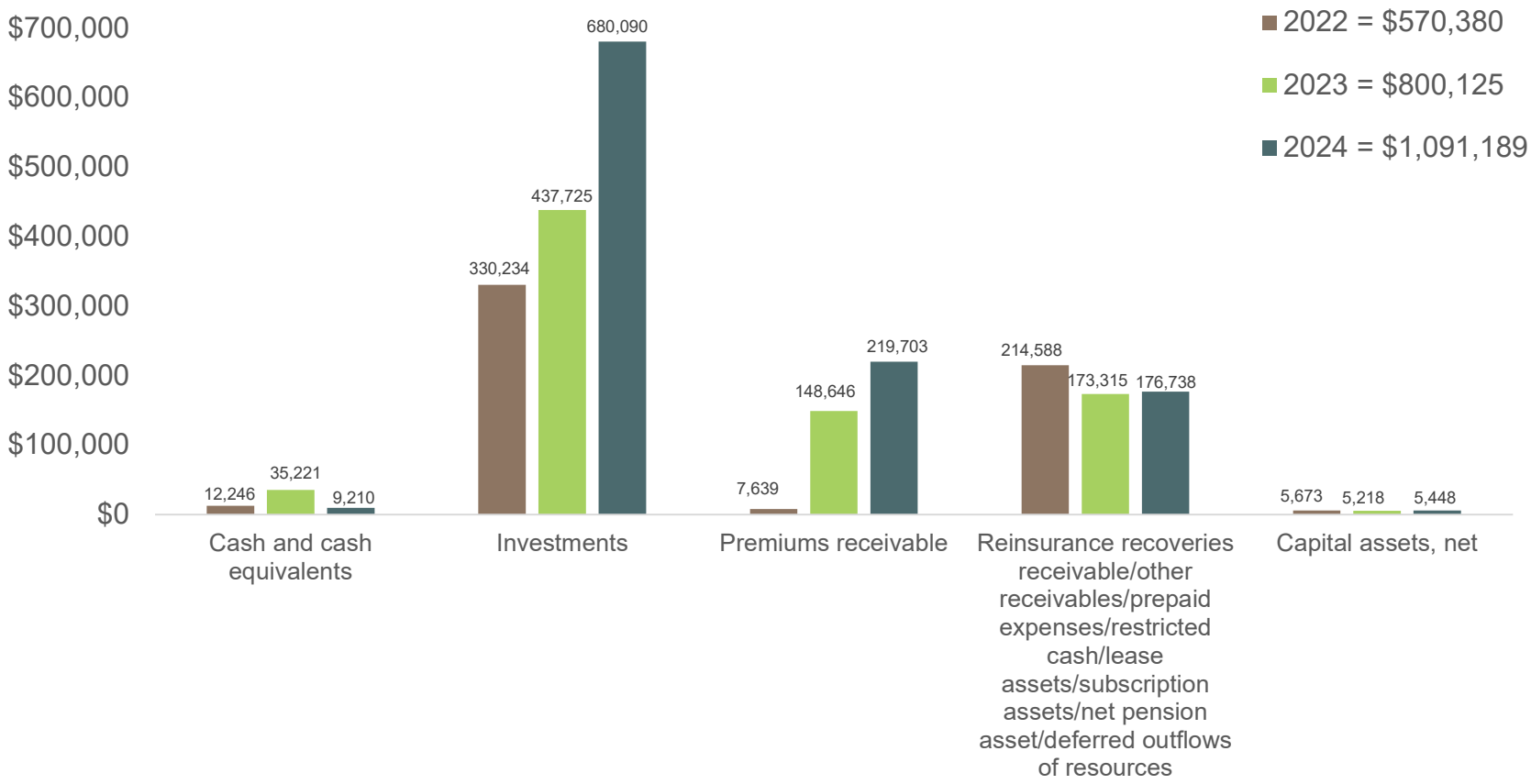
Financial statements are presented fairly and in accordance with generally accepted accounting principles.

MOSSADAMS

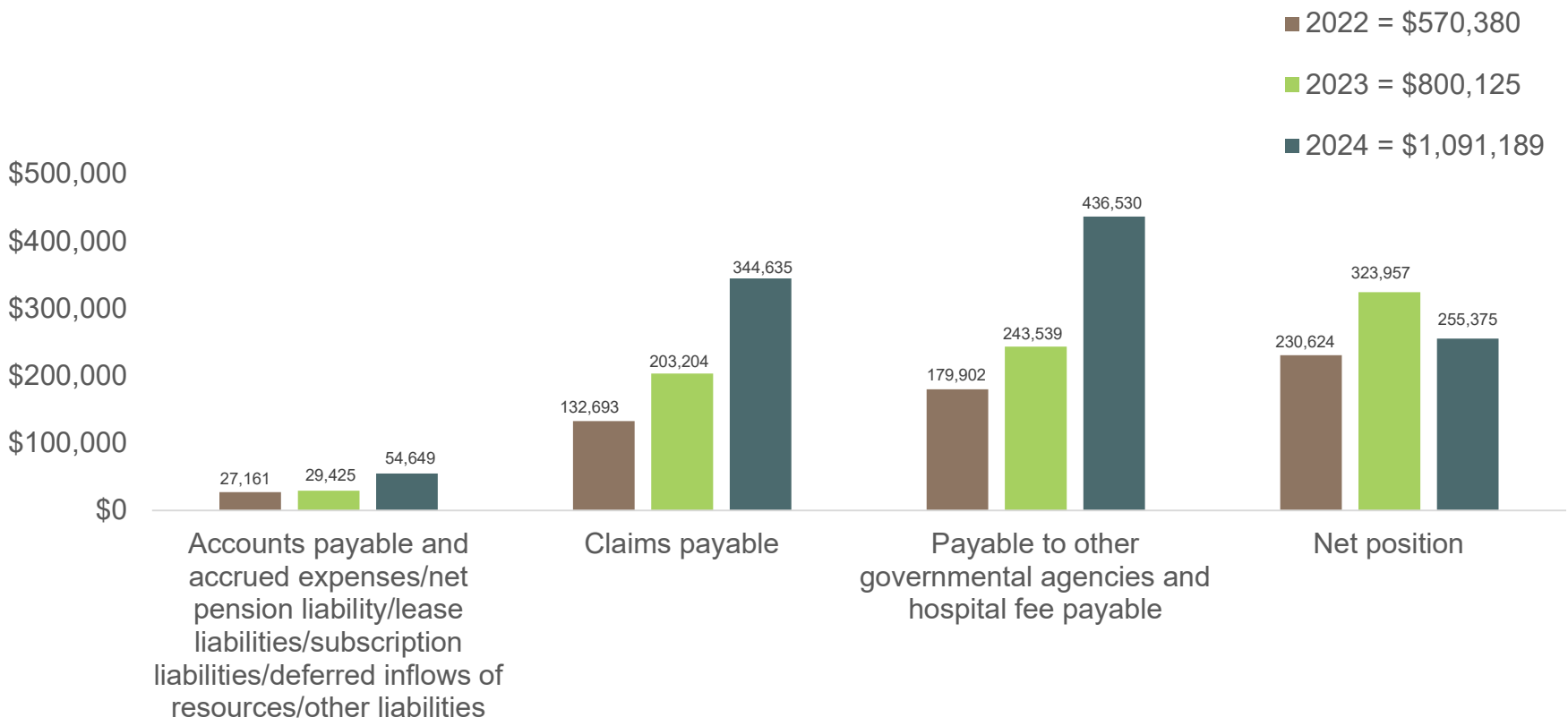
Statements of Net Positions



Assets and Deferred Outflows of Resources Composition (in thousands)



Liabilities, Deferred Inflows of Resources, and Net Position Balance (in thousands)



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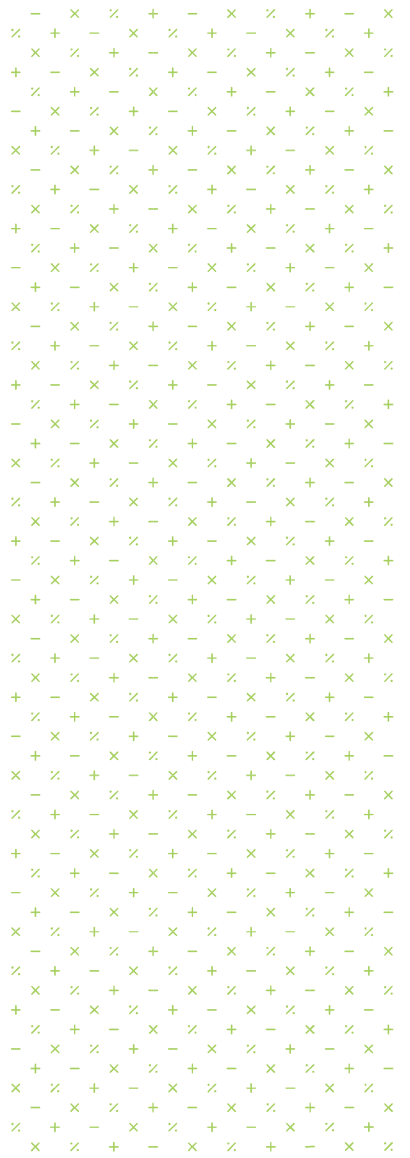
Operations

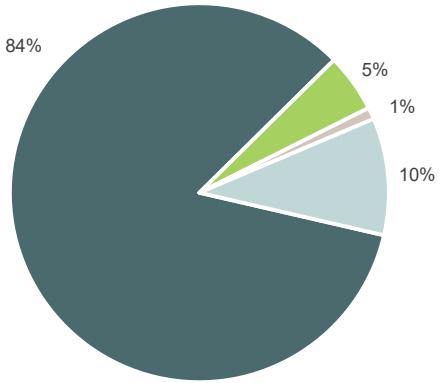


Operating Expenses (in thousands)

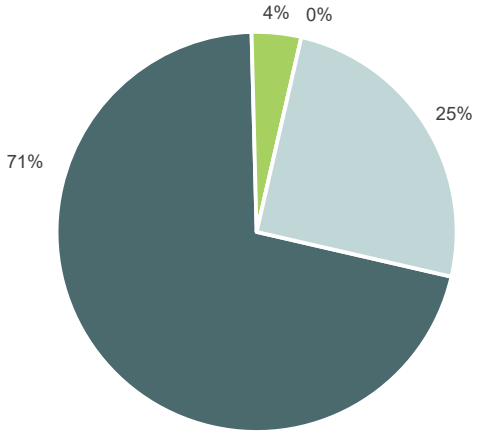
June 30, 2023
$1,437,067

- Medical services
- Marketing, general, and administrative expenses
- Depreciation and amortization expense
- Premium tax

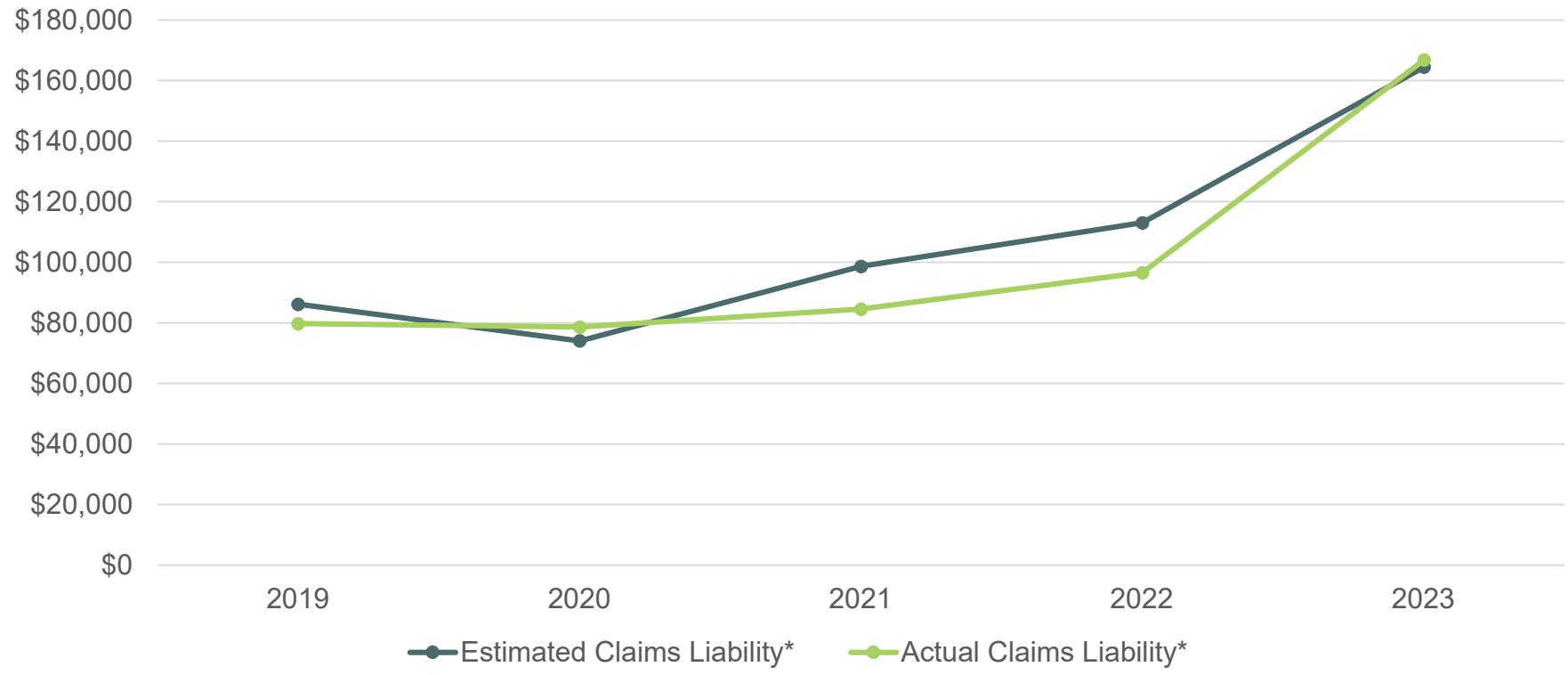
June 30, 2022
$1,294,271



June 30, 2024
$2,456,087



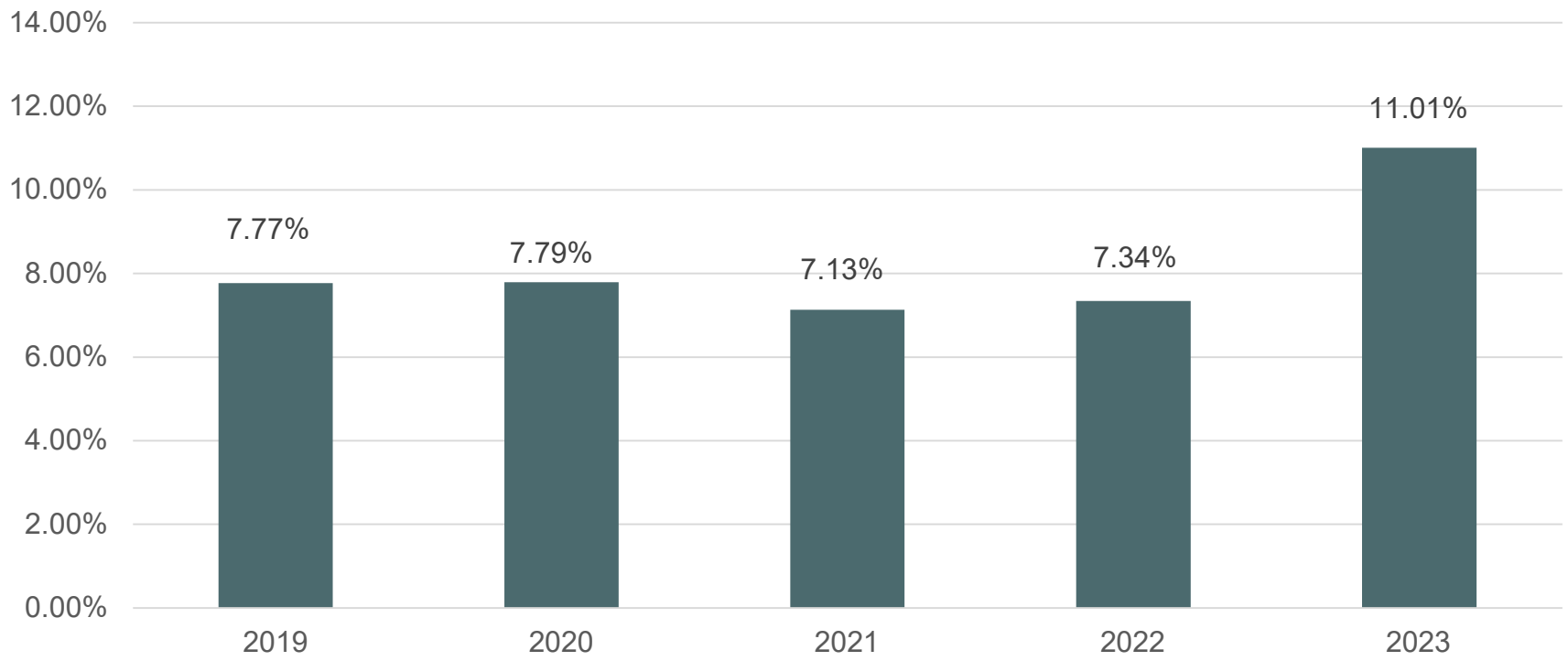
Historic Estimated Claims Liability and Historic Actual Claims Liability (in thousands)



* Estimated claims liability and actual claims liability excludes non-hospital claims.

Source: Alliance's internal reports

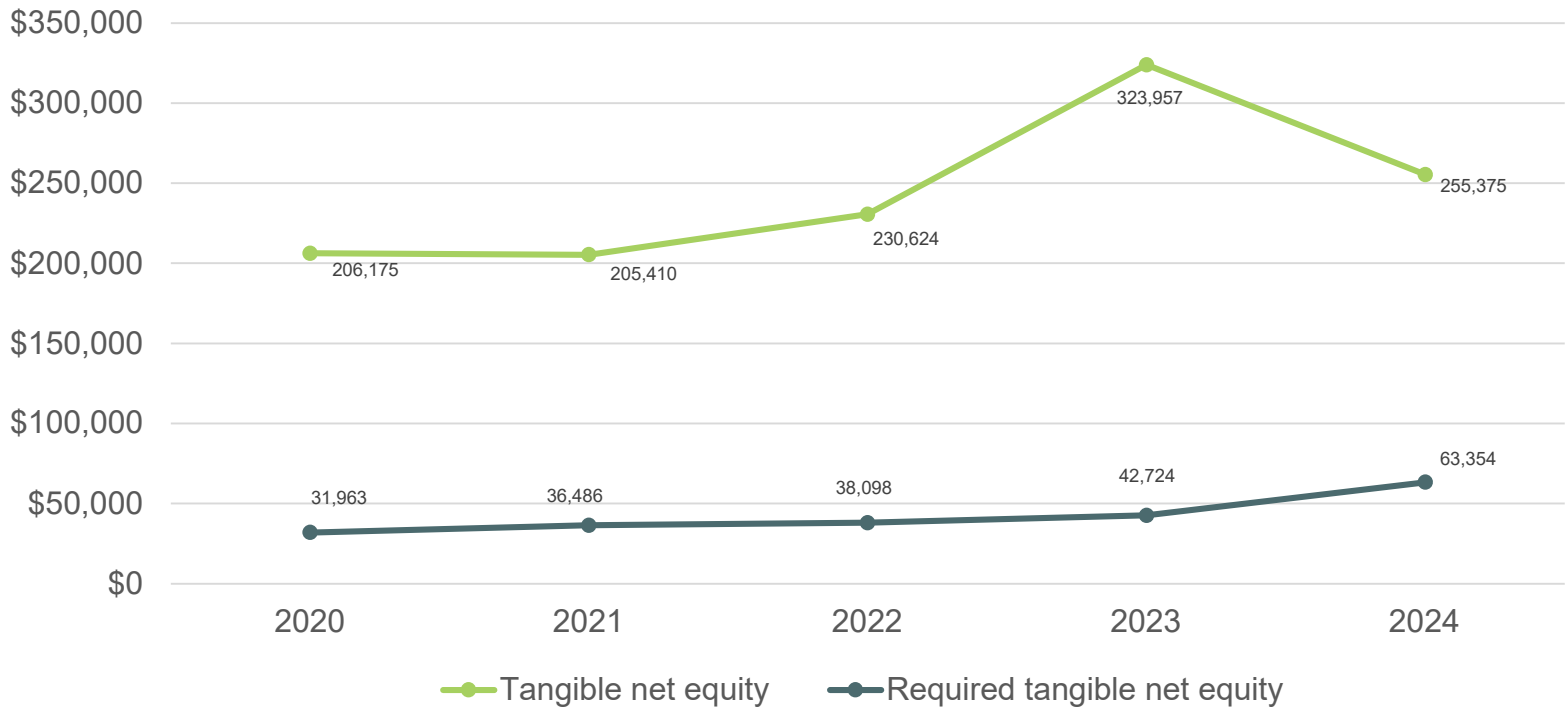
Historic Actual Claims Liability* as a % of Capitation and Premium Revenues



* Actual claims liability excludes non-hospital claims.

Source: Alliance's internal reports

Tangible Net Equity (in thousands)



Source: Annual Department of Managed Health Care Filing

Important Board Communications

- AU-C Section 260 – *The Auditor's Communication with Those Charged with Governance*
- Significant accounting policies
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No awareness of material instances of fraud or noncompliance with laws and regulations

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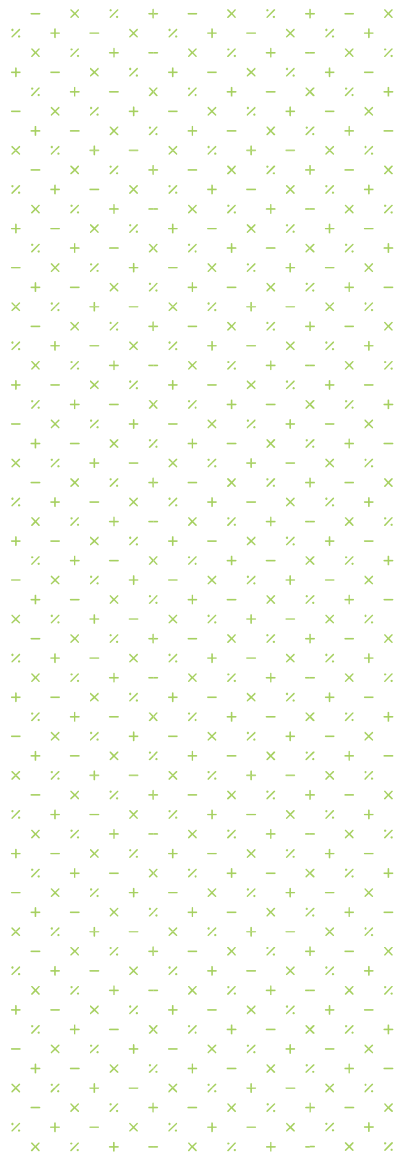
Questions?



ALAMEDA Alliance FOR HEALTH

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CEO Update

Matthew Woodruff

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

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

Date: **October 11th, 2024**

Subject: **CEO Report**

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

	August	YTD
Medi-Cal	($17.8M)	($24.9M)
Group Care	($401K)	($215K)
Total	($18.4M)	($25.3M)

  - **Revenue was $175.8 million in August 2024 and $340.1 Year-to-Date (YTD)**.
    - Medical expenses were $187.9 million in August and $352.4 million for the fiscal year-to-date; the medical loss ratio is 106.8% for the month and 103.6% for the fiscal year-to-date.
    - Administrative expenses were $9.5 million in August and $20.3 million for the year-to-date; the administrative loss ratio is 5.4% of net revenue for the month and 6.0% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 322% of the required DMHC minimum, representing $158.5 million in excess TNE.
  - **Total enrollment in August 2024 was 405,267**, an increase of 759 Medi-Cal members compared to July.
- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - The Alliance missed our claims timeliness of payment. The State metric is 90% in 30 days, and we scored 84%. Please note we did score 100% of the claims paid in 45 days.
  - **Non-Regulatory Metrics:**
    - Nothing to report
- **Alliance Updates:**
  - **Demographics**
    - Please see attached power point describing the demographics of the Alliance employees.

- **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.
    - On 9/19, AAH received DMHC material modification approval for service area expansion of license (filling #20241128).
    - 140 Medicare Provider Amendments have been returned with 88 (estimated 20%) counting towards CMS network adequacy. 3 LOI have also been received / verbal confirmation.
    - For RFQs, Flex Card was released on 9/16, Medication Therapy Management (MTM) was released on 9/16, and Health Risk Assessment (HRA) was released on 9/27.
    - Campaign 2 (of 3) are webinars scheduled with Chapman Consulting on October 24th, October 31st, and November 1st.
    - Director, Stars Strategy & Program Management and Interim Director, Pharmacy both started on 9/23.
  - **Financial Review**
    - Net increase in rates of 0.1%. This is only a $1.2M increase for the entire year.
    - LTC rate decreased 0.5%. Impacted by DHCS removal of temporary COVID-19 rate increase, out of our control.
    - The TRI rate decreased by 0.6%. Based on data from our supplemental data request the State reduced our rate to reflect higher rates we are already paying to providers. We will be asking for a better understanding of this to ensure they provided adequate funds for us to cover our FFS and Capitation payments related to TRI.
    - Population acuity decreased by 0.8%. We are going to push this for CY25 by showing them our current experience, which shows higher costs.
    - Risk Adjustment increased by 1.9%. Our risk scores increased, primarily in the LTC category. This could be in part due to our messaging and data we shared and in part due to Mercer updating the study period of data they were looking at.
    - Steps taken:

      What have we done about the losses:

      1. In July, our CFO Gil, a few Board Members and I visited the DHCS to request a review of our current payments from the DHCS compared to our cost.

      2. The Alliance froze all travel effective July 1st, with limited exceptions.

3. We removed provider grants and board grants from the fiscal year budget.

What are we doing this fiscal year to stop the losses:

1. Gil and I are in the process of setting up another meeting with the DHCS for CY25 rates to review the financial information that our Finance team has supplied.
2. Hiring Freeze - I have decided to freeze hiring of all positions that are not currently open.
4. Contract Changes – Upcoming hospital/provider contract increases will be minimal and pushed to future periods.
5. Community Supports/ECM - We will not move forward with the three previously planned CS services (day habilitation, short-term post-hospitalization housing, and sobering centers), and the Alliance will not move forward with the transitional rent pilot program in 2025. ECM and CS will continue for now, with the caveat that new providers will be put on hold. We will have to review existing CS services to determine if we need to scale back on any existing offerings.
6. Claims Overpayment and IBNP – How much and when will the money be recouped by our internal team and when will the system and/or procedure changes be completed?
7. Operational Efficiency – We started our operational efficiency early in 2024. We have many changes coming that will hopefully make the Alliance more efficient. A few examples include automation and pushing out non-regulatory work.
8. If the calendar year 2025 rates do not reflect our current cost for service categories, then the next steps will be:
    a. Freezing open positions.
    b. Discussions with the Board and DHCS about moving Medicare out one year.
    c. Delaying budgeted projects to another fiscal year.
    d. Layoffs as a last resort.
    e. Decisions will be made once draft final calendar year 2025 rates are received from DHCS but no later than our December Board meeting.

- **Incentive Programs**

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.

- 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 $14.8 million 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 $4.56 million, 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.

  The Submission 5 report, reflecting the lookback period of 1/1/2024-06/30/2024, was submitted to DHCS on September 9th, 2024; the Alliance is still awaiting feedback from DHCS.

Program #2 – Student Behavioral Health Incentive Program

- Description & Purpose:

  Statewide, $389 million is designated over a three-year period (January 1st, 2022-December 31st, 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, and 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; DHCS notified the Alliance on September 18th, 2024, that we had earned 100% of eligible funds tied to the reporting period ($1.1M). The dollars earned are anticipated to be received from DHCS in October 2024. Additionally, DHCS reallocated Alameda County SBHIP funds between the Alliance and Kaiser following Anthem's exit from the county. The Alliance Re-Allocation increase in funding is $66K.

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 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: $**18.7 million**
- State Guidance: DHCS APL 22-007

- Current Status:

  The Alliance has issued $13.6 million 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.

  On May 31st, the Alliance announced the approval of ten (10) newly funded projects, totaling $1.3 million, 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. To-date, $221K has been paid to SBHIP LEA partners for newly developed HHIP projects.

  In September, the Alliance announced funding decisions for the HHIP funding application that was released to the community in June. The Alliance awarded a total of $11.2 million in funding to ten (10) organizations for projects ranging from training support to funding for space acquisition to expand medical respite units in the community. Development of MOUs is underway to outline the scope of work and deliverables for the various projects.

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

Program #5 – COVID-19 Vaccine Incentive Program (Completed)

- Description & Purpose:

The incentive program began in October 2021 and ended on February 28th, 2022. The vaccine program targeted children and adults enrolled in Medi-Cal managed care, ages 12 and older. During the vaccination campaign, the vaccination rates for Medi-Cal beneficiaries increased by 13.2%, from 62.2% to 75.4%. The Alliance was awarded $2.2 million, or 26% of the available funding.

This incentive program ended on February 28th, 2022.

- Program Years: **10/1/2021 – 2/28/2022**
- Maximum allocation to Alameda Alliance: $**8.4 million**
- Earned incentive dollars: $**3.0 million**
- Payments issued to Providers: **$1.4 million awarded** to approximately nineteen (19) organizations across Alameda County. Member incentives continue to be paid for eligible members receiving COVID-19 vaccinations.

Program #6 - Equity and Practice Transformation (EPT) Payments Program

The Department of Health Care Services (DHCS) implemented a one-time $700 million primary care provider practice transformation program called the Equity and Practice Transformation (EPT) Payments Program. The program is designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment models.

The EPT program 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. The funding was to be allocated in three separate pathways throughout the phases of the program year(s):

1) 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 using standardized assessment tools to support these practices as they develop practice transformation plans and applications to the larger EPT Provider Directed Payment Program. AAH supported practices in preparing to submit their applications to DHCS on October 23rd, 2023. Subsequently, AAH evaluated all submitted applications for the larger EPT program and submitted fourteen (14) participation recommendations to DHCS on November 21st, 2023, of which DHCS identified six small/medium sized practices that would count towards the outlined MCP milestones. AAH was notified on March 18th, 2024, that our submitted deliverables were reviewed and approved; the associated payment of $442K was received on April 22nd, 2024.

2) EPT Provider Directed Payment Program

   $650 million ($325 million General Fund) over five (5) years to support delivery system transformation, specifically targeting primary care

practices that provide primary care pediatrics, family medicine, internal medicine, primary care OB/GYN services, or behavioral health services that are integrated in a primary care setting to Medi-Cal members. $200 million of the $650 million will be dedicated to preparing practices for value-based care. This includes implementing practice infrastructure, such as electronic health record systems, data collection, recording capabilities, improved data exchange, and implementation of care management systems.

AAH will not receive incentive dollars for this program; however, the Plan will be expected to transmit payments from DHCS to participating providers that earn dollars. DHCS announced final selections on January 12th, 2024, and only one of the 14 practices that applied and identified the Alliance as their MCP was selected by DHCS to participate in the program. DHCS noted that 719 practices were applied to participate in the program, and 211 were selected.

3) The Statewide Learning Collaborative

$25 million over five (5) years to support participants in the Provider Directed Payment Program in implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of stated quality and equity goals. On January 3rd, 2024, DHCS announced they were partnering with the Population Health Learning Center to run the EPT Learning Collaborative. The Population Health Learning Center will serve as the program office for the Provider Directed Payment Program, working closely with DHCS, participating practices, and Medi-Cal managed care plans. All practices in the Provider Directed Payment Program must participate in Population Health Learning Center activities.

Program #7 - Providing Access and Transforming Health (PATH)

Providing Access and Transforming Health (PATH): Comprising 5 initiatives, PATH funding supports Enhanced Care Management (ECM) and Community Support (CS) providers. $1.85 billion will be available statewide. Initiatives include:

- **WPC Services & Transition to Managed Care Mitigation Initiative**: Direct funding for WPC Pilot Lead Entities to sustain existing WPC Pilot services that “map to” ECM/Community Supports until an MCP covers the service. Services that will not continue under CalAIM—either because they are not included in CalAIM or will not be picked up by any MCP in the future—are not eligible for this funding.
- **Technical Assistance Initiative**: Providers will have access to a statewide marketplace for ECM/Community Supports related technical assistance.
- **Collaborative Planning & Implementation Initiative**: Support for regional collaborative planning and implementation efforts across

entities essential to the success of CalAIM. BluePath Health was selected by DHCS as the facilitator for Alameda County and the initial kick-off meeting was held on January 27th, 2023. BluePath Health is conducting monthly meetings with all Collaborative participants. BluePath Health also conducted two informational meetings with AAH in January and February. Health Care Services continues to represent Alameda Alliance in the monthly collaborative meetings.

- **Capacity & Infrastructure Transition, Expansion, and Development Initiative (CITED)**: Funding for providers, community-based organizations, counties, Lead Entities, tribes and others for capacity and infrastructure development activities that support the implementation of ECM and Community Supports. Round 1A CITED recipients were announced by DHCS on January 31st, 2023, and Round 1B CITED recipients were announced on March 24th, 2023; a total of $207 million was awarded to 139 recipients during Round 1. The CITED Round 2 application period closed on May 31st, 2023, and DHCS announced the recipients on October 30th, awarding $144 million to 145 providers across California. The CITED Round 3 application period closed on February 15th, 2024, and DHCS announced the recipients on August 30th, awarding $146.6 million to 133 providers across California.
- **Justice-Involved Capacity Building**: Funding to maintain and build pre-release and post-release services to support the implementation of the CalAIM justice-involved population, including capacity and infrastructure to support services, including EHR systems. Round 1 grants in the amount of $4.55 million were awarded statewide in November 2022. The application period for Round 2 closed on March 31st, 2023; grants in the amount of $64.5 million were awarded in January 2024. The application period for Round 3 opened on May 1st, 2023, and closed on July 31st, 2023; awards have yet to be announced.

Alameda County Health Care Services Agency has applied for the PATH Mitigation funds to continue the following WPC services under CalAIM:

- **Sobering Center services**
- **Street Health Outreach**

Program #8 - New Programs

Provider Recruitment Initiative

The Alliance Provider Recruitment Initiative (PRI) was launched in June 2024. The program 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, as well as provide training scholarships for community health workers and housing grants for providers relocating to the area. The PRI aims to grow the Alliance provider network and support our community partners' ability to supply culturally and linguistically competent care to increase accessibility and reflect the diversity of Alliance members. Program goals include:

- Expanding the Alameda Alliance Provider network

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

Up to two million ($2 million) in funding is available for the fiscal year 2024-2025. 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 September, a multi-disciplinary team started the evaluation of 15 applications totaling $6 million in funding requests. Funding decisions and recommendations are anticipated to be made by the end of October.

ALAMEDA Alliance FOR HEALTH

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Executive Dashboard

OPERATIONS DASHBOARD

OCTOBER 2024

10/4/2024 11:38:30 AM

Financials

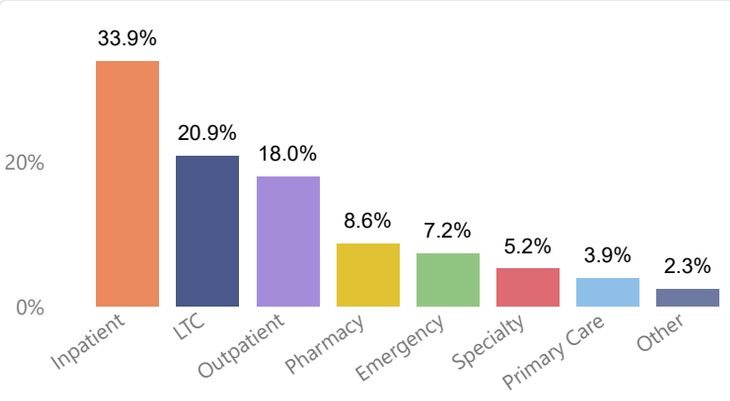
Income & Expenses

	AUGUST 2024	FISCAL YTD
REVENUE	$ 222.8 M	$ 434.1 M
MEDICAL EXPENSE	$ (187.9) M	$ (352.4) M
ADMIN EXPENSE	$ (9.5) M	$ (20.3) M
OTHER/TAX	$ (43.8) M	$ (86.8) M
NET INCOME	$ (18.4) M	$ (25.3) M

Medical Loss % (Fiscal YTD)

103.6%

Medical Expenses



Liquid Reserves

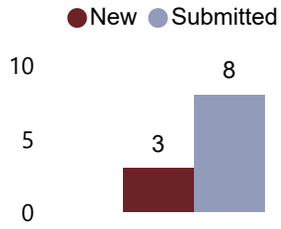
TNE %

321.7%

TNE $

$230.0M

Reinsurance Cases



Balance Sheet

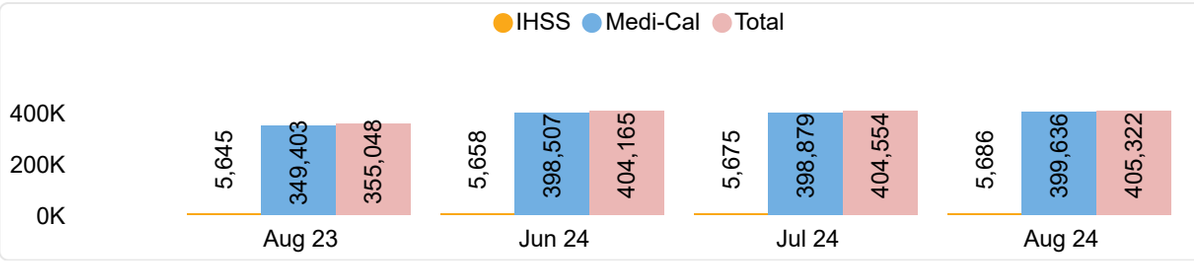
Cash Equivalents	$549.4M
Pass-Through Liabilities	$171.6M
Uncommitted Cash	$377.8M
Working Capital	$158.5M

Current Ratio

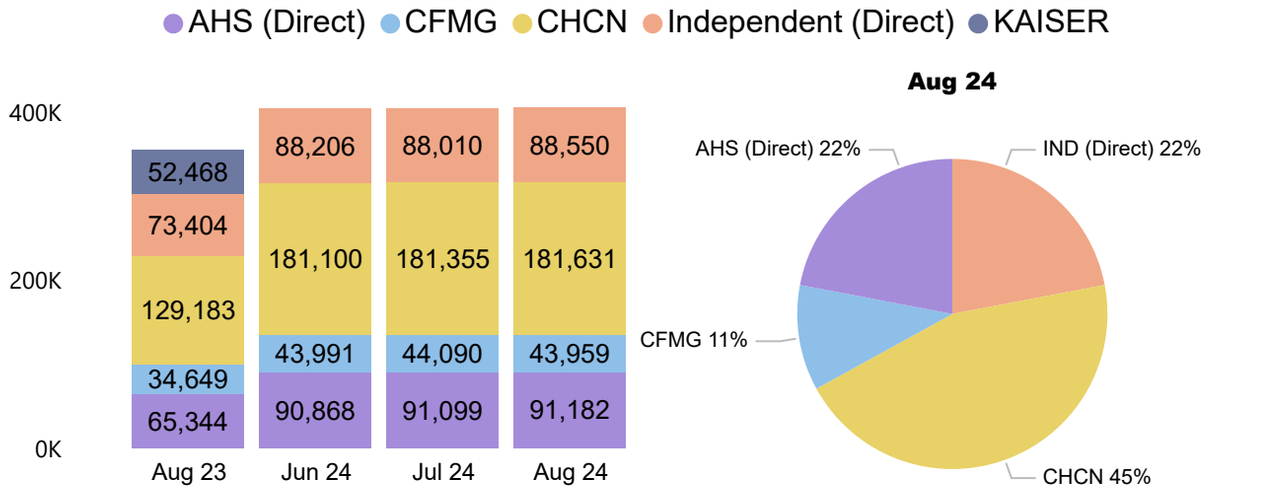
1.20

Membership

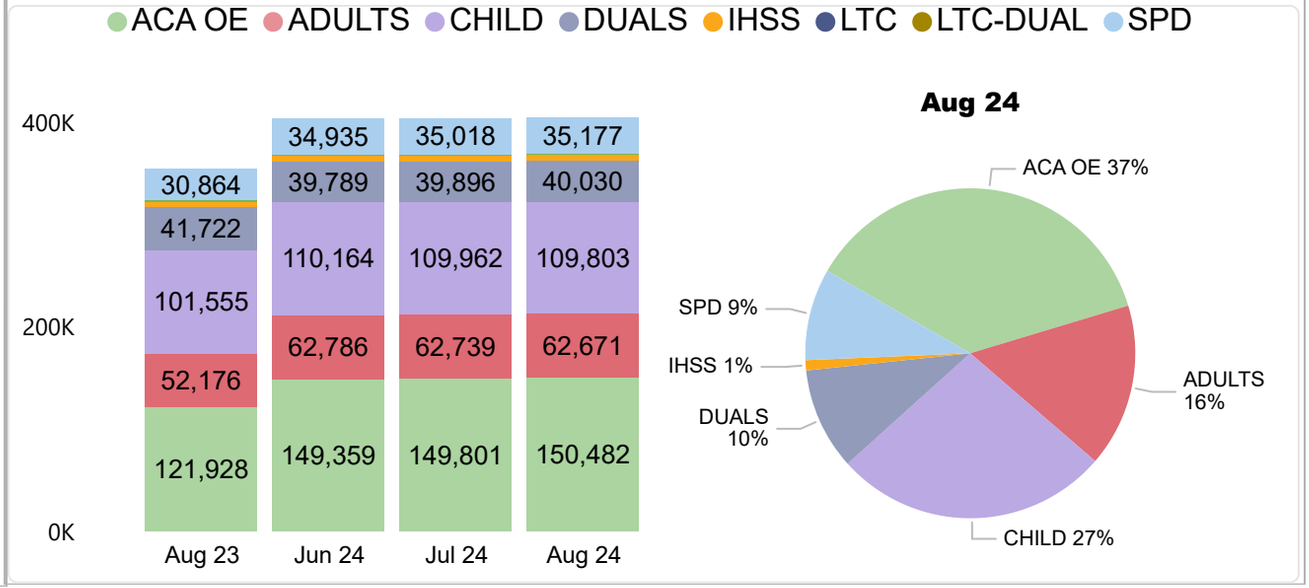
By Plan



By Network



By Category



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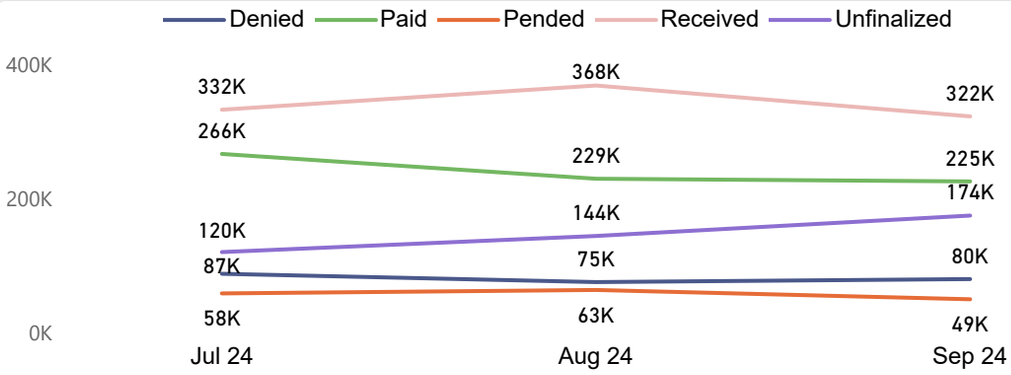
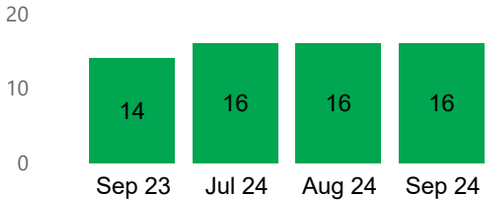
Claims

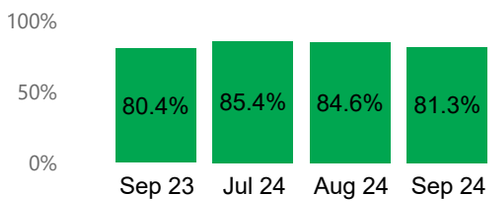
Claims Processing



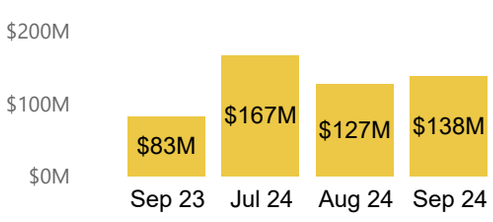
Average Payment TAT (Days)



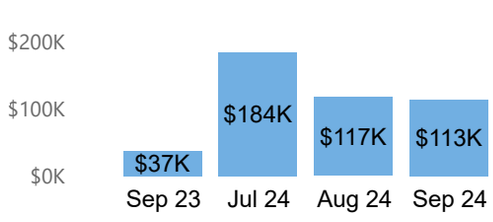
Auto Adjudication Rate (%)



Claims Paid ($)

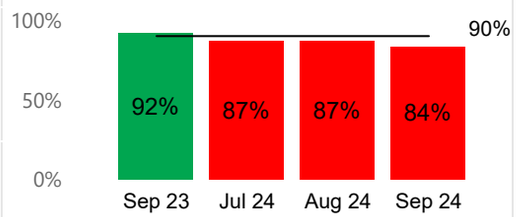


Interest Paid ($)

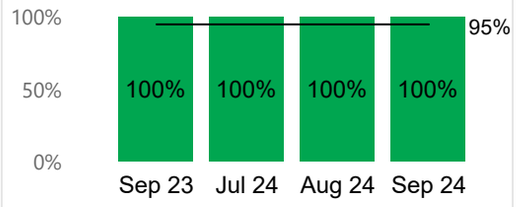


Claims Compliance

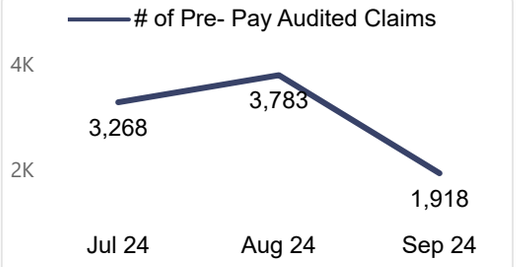
Processed 30 Cal Days (%)



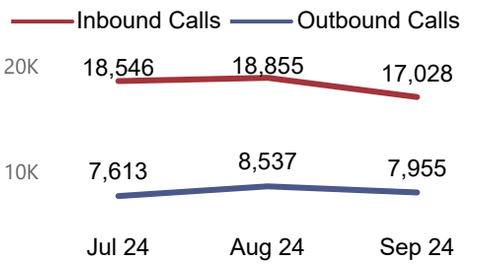
Processed 45 Work Days (%)



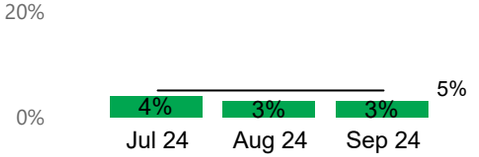
Claims Auditing



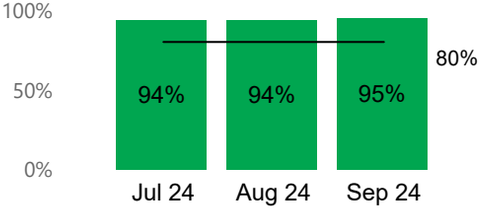
Member Services



Abandoned Call Rate (%)

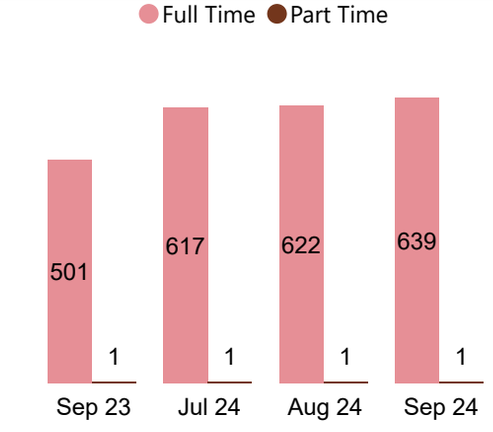


Calls Answered in 30 Seconds (%)

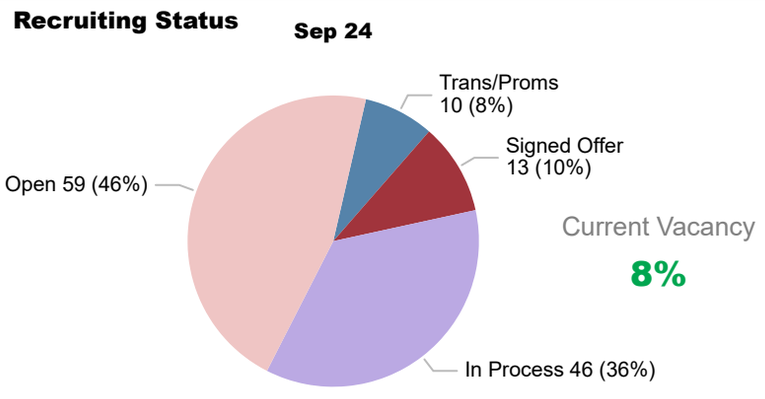


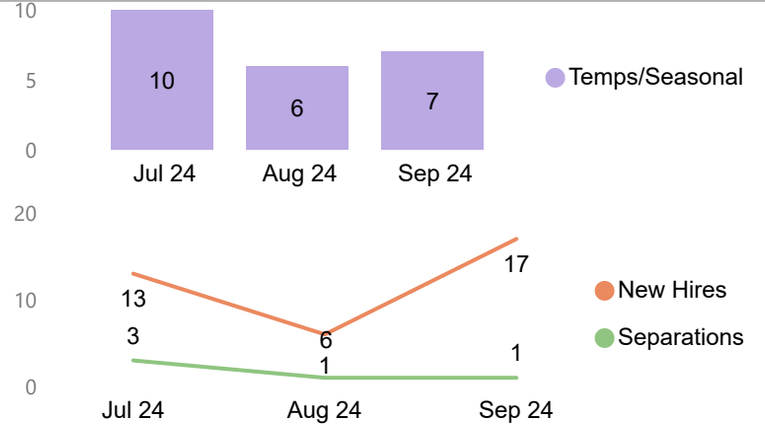
Average Call Times	Jul 24	Aug 24	Sep 24
Wait Time	00:14	00:13	00:14
Call Duration	06:58	07:10	07:11

Human Resources



Recruiting Status Sep 24





OPERATIONS DASHBOARD

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Provider Services

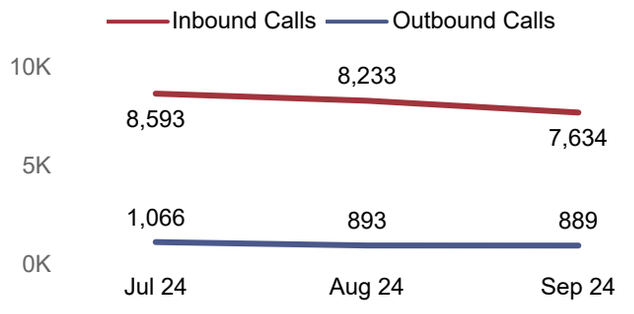
Provider Network

Hospital	17
Specialist	11,108
Primary Care Physician	759
Skilled Nursing Facility	107
Urgent Care	15
Health Centers (FQHCs and Non-FQHCs)	83
TOTAL	**12,089**

Provider Credentialing

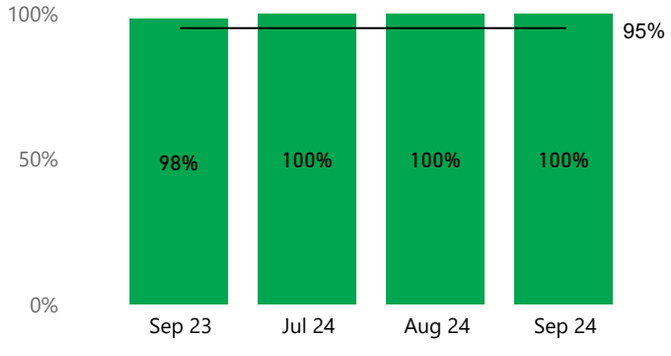
3,985

Provider Call Center



Provider Disputes & Resolutions

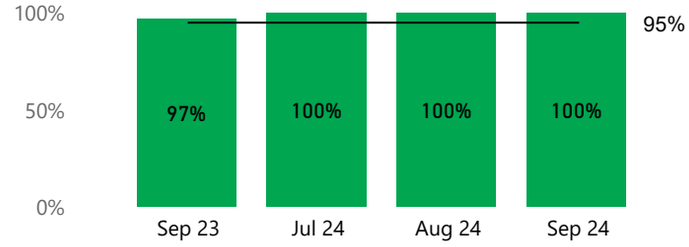
Turnaround Compliance (45 business days)



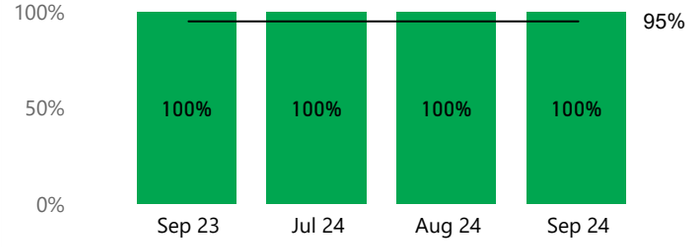
Compliance

Member Grievances

Standard (30 calendar days)

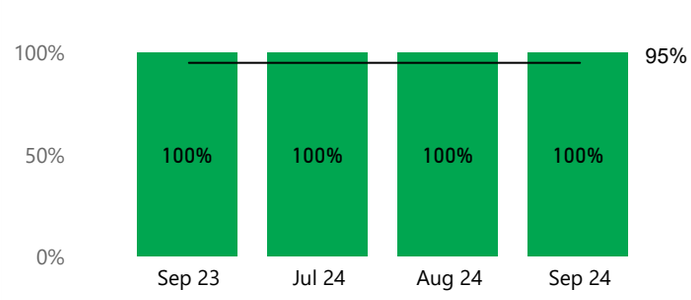


Expedited (3 calendar days)

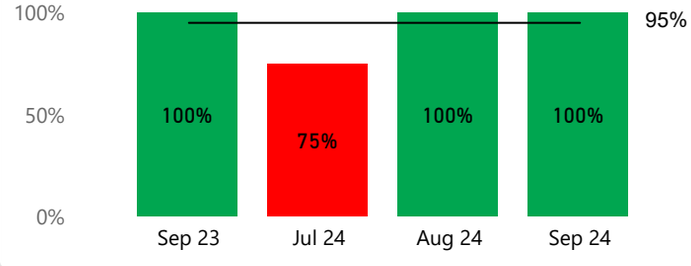


Member Appeals

Standard (30 calendar days)

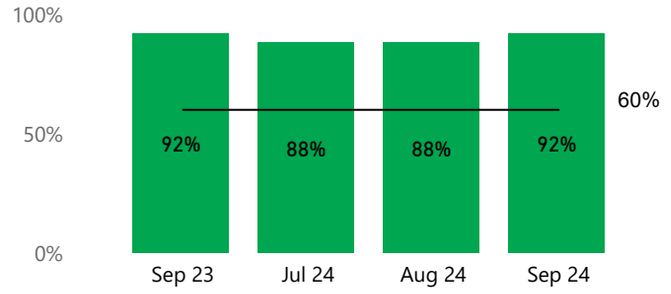


Expedited (3 calendar days)

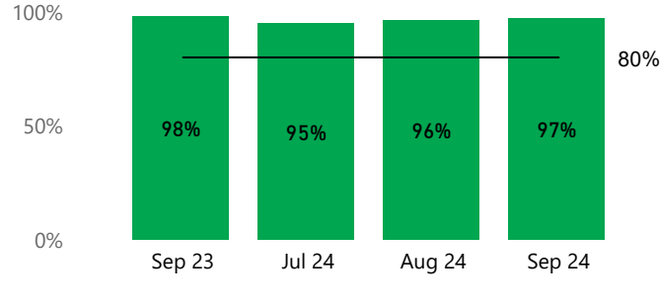


Encounter Data

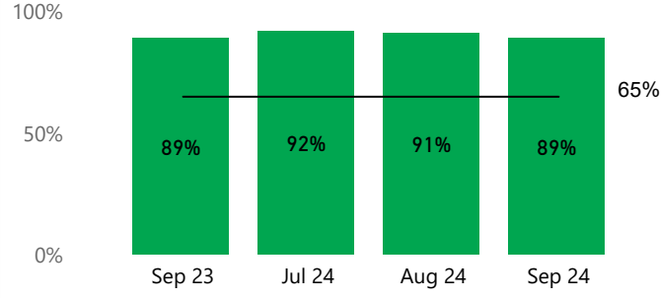
Institutional 0-90 days



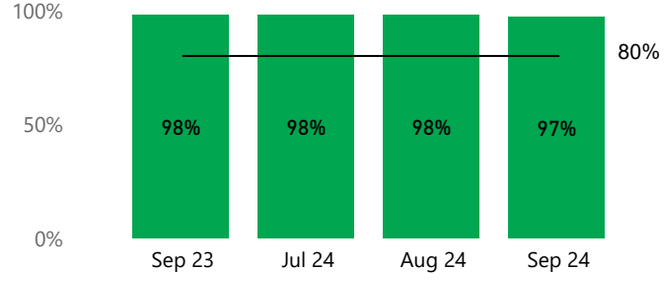
Institutional 0-180 days



Professional 0-90 days



Professional 0-180 days



OPERATIONS DASHBOARD

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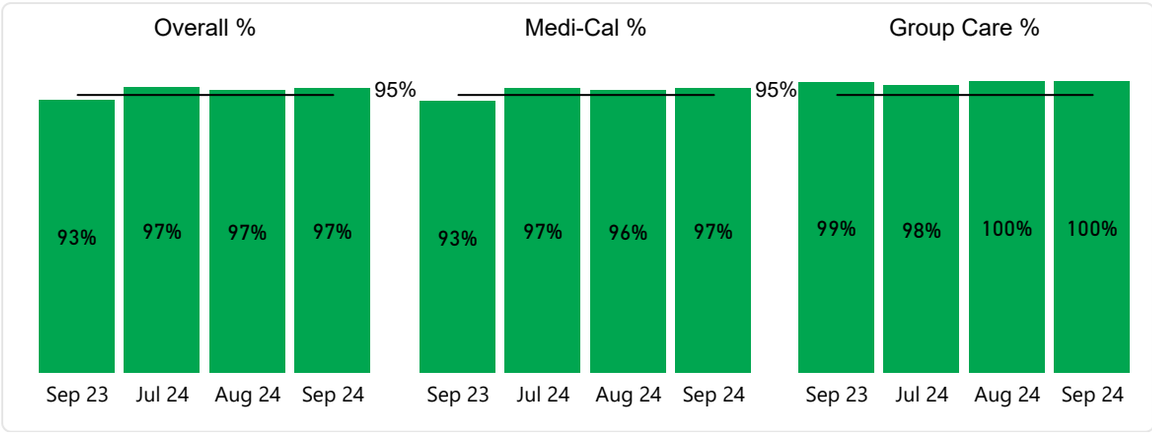
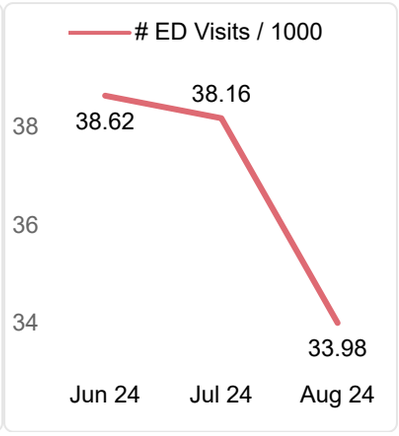
Health Care Services

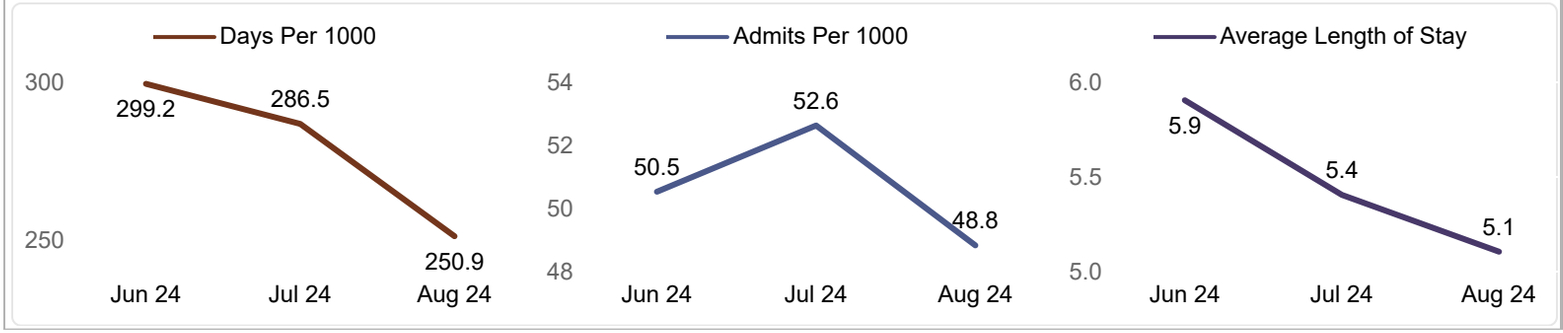
Authorization Turnaround



ED Utilization

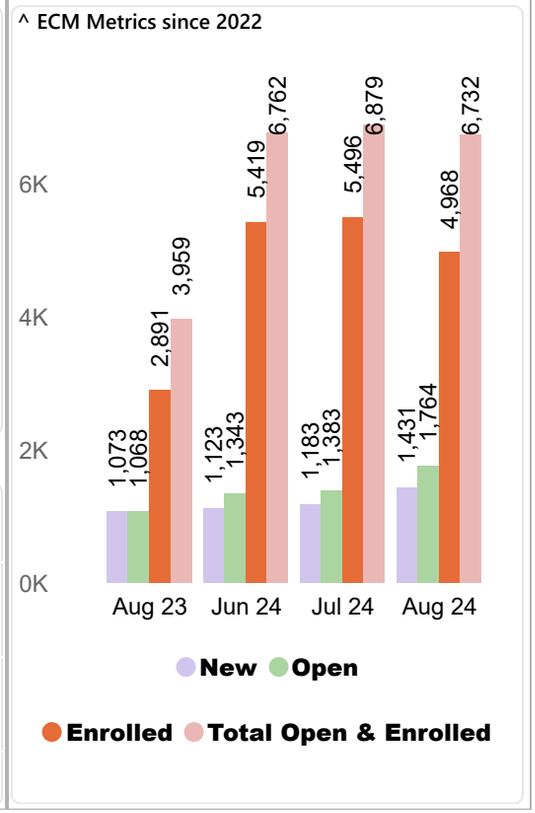


Inpatient Utilization

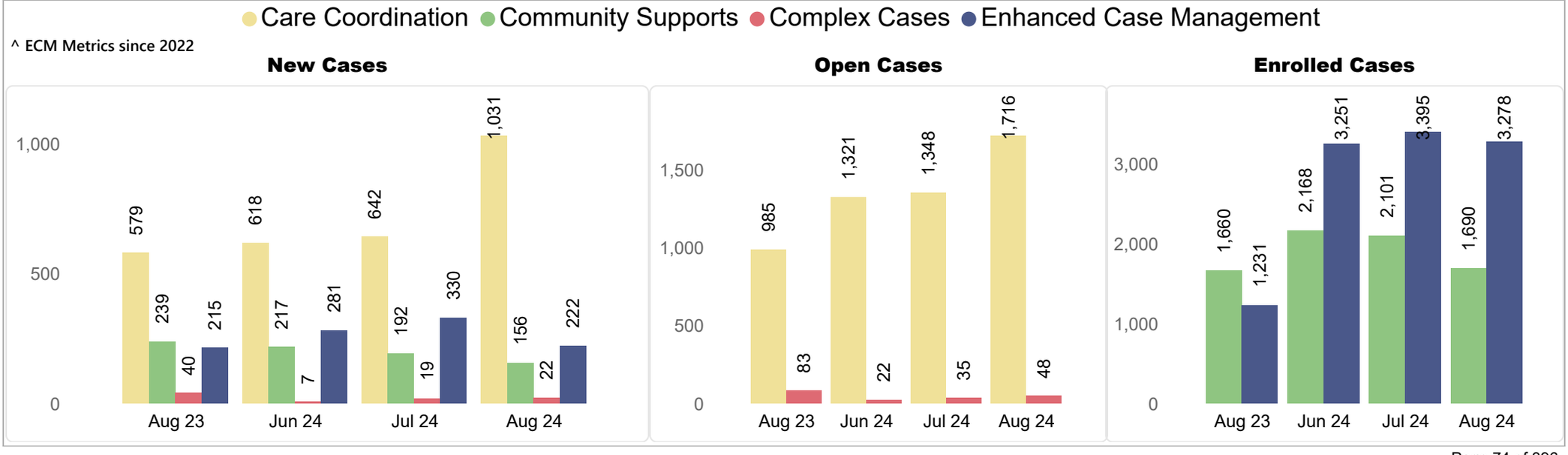


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Sep 23	Jul 24	Aug 24	Sep 24
HEALTHsuite System	99.9%	99.6%	99.9%	100.0%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Sep 23	Jul 24	Aug 24	Sep 24
Denial Rate Excluding Partial Denials (%)	3.8%	2.4%	2.9%	2.5%
Overall Denial Rate (%)	4.1%	2.5%	3.1%	2.7%
Partial Denial Rate (%)	0.2%	0.1%	0.1%	0.1%

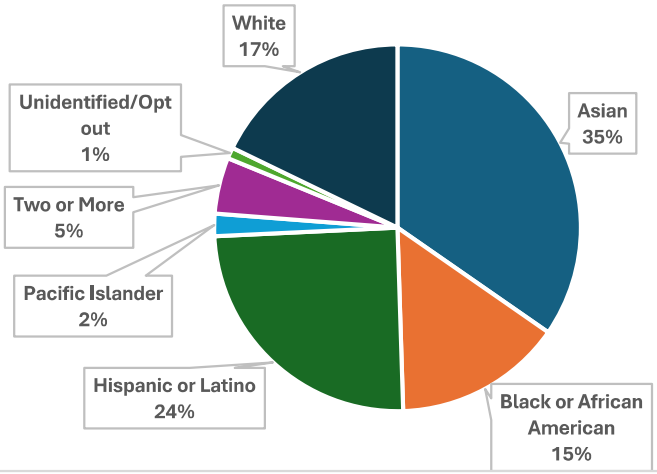
*** IHSS and Medi-Cal Line Of Business**

Pharmacy Authorizations

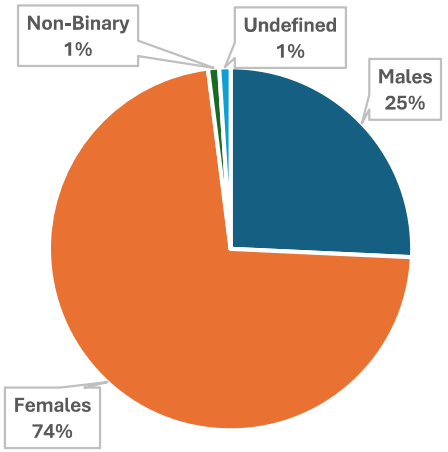
Authorizations	Sep 23	Jul 24	Aug 24	Sep 24
Approved Prior Authorizations	29	43	46	39
Closed Prior Authorizations	92	89	97	74
Denied Prior Authorizations	28	51	51	57
Total Prior Authorizations	149	183	194	170

AAH Employee Demographics Data Report September 2024

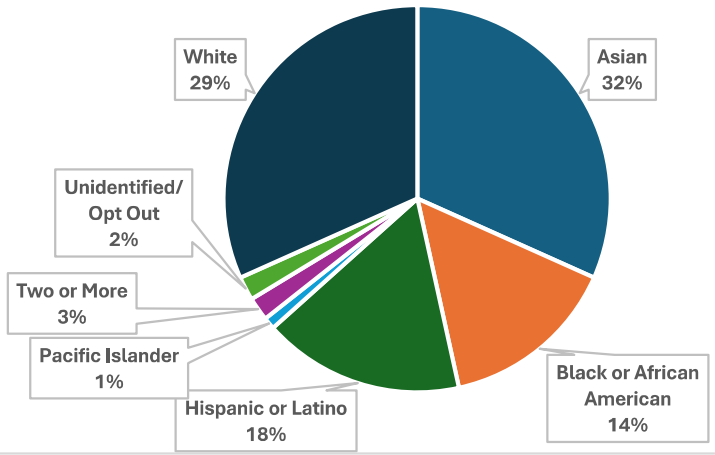
Employee Ethnicity - 639
September 2024



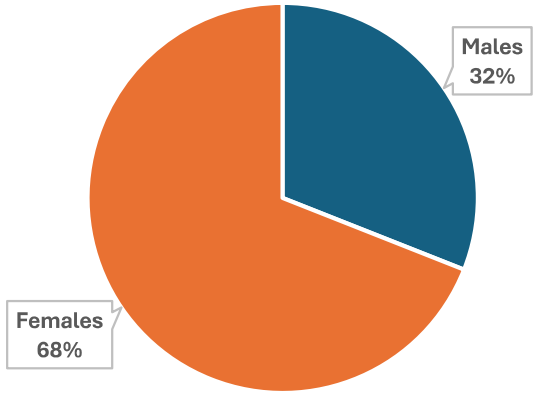
Employee Gender - 639
September 2024

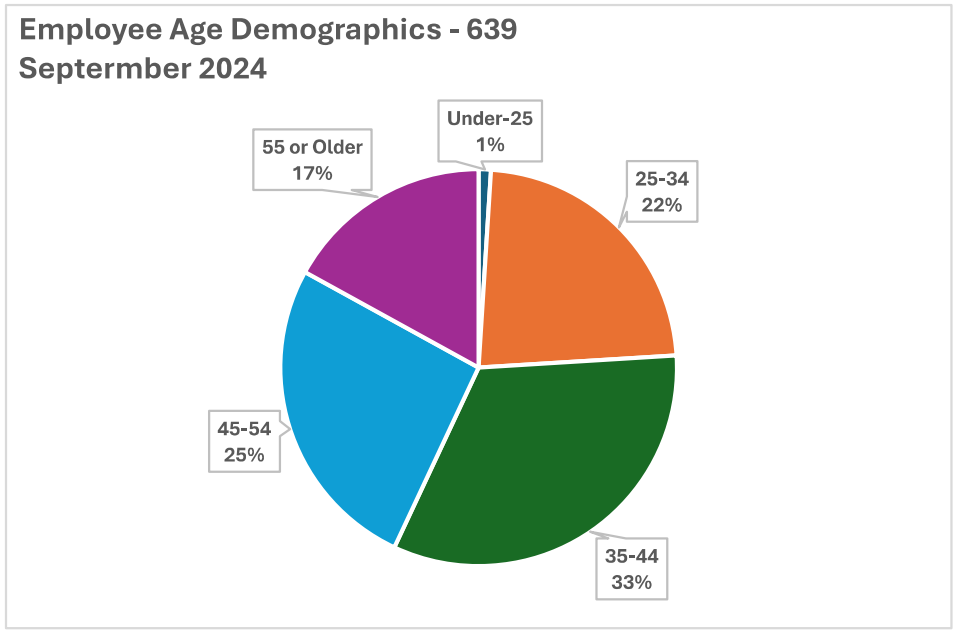


Managers Ethnicity - 128
Septermber 2024



Managers Gender - 128
Septermber 2024




Employee Age Demographics - 639
Septermber 2024
Under-25
1%
25-34
22%
35-44
33%
45-54
25%
55 or Older
17%

ALAMEDA Alliance FOR HEALTH

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

Legislative Tracking

2024 Legislative Tracking List

On September 30th, Governor Newsom wrapped up the 2023-2024 legislative by acting on 1,206 bills that state legislators sent to his desk where he signed 1,017 bills and vetoed 189 bills.

The following is a list of state bills tracked by the Public Affairs and Compliance Departments. This list of 131 bills includes 37 bills that were signed by the Governor, 7 that were vetoed and the remainder which died along the legislative session. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership.

Public Affairs will provide a final legislative report focused on signed and vetoed bills in the next Board of Governors meeting packet.

AB 4 **(Arambula D) Covered California: expansion.**
Current Text: Amended: 8/6/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/12/2024)
Location: 8/15/2024-S. DEAD

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

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, no sooner than January 1, 2026, and upon appropriation by the Legislature for this purpose, to administer a program to allow persons otherwise not able to obtain coverage by reason of immigration status to enroll in health insurance coverage in a manner as substantially similar to other Californians as feasible, consistent with federal guidance and given existing federal law and rules. The bill would require the Exchange to undertake outreach, marketing, and other efforts to ensure enrollment, which would begin on October 1, 2027.

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

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

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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/5/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was INACTIVE FILE on 8/30/2024)
Location: 8/31/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Dead	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was HEALTH on 6/14/2023)
Location: 8/31/2024-S. DEAD

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

AB 551 **(Bennett D) Public Utilities Commission.**
Current Text: Chaptered: 9/20/2024 html pdf
Status: 9/20/2024-Chaptered by Secretary of State - Chapter 299, Statutes of 2024
Location: 9/20/2024-A. CHAPTERED

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
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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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/5/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/14/2023)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/14/2023)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: Vetoed: 9/29/2024 html pdf
Status: 9/29/2024-Vetoed by Governor.
Location: 9/29/2024-A. VETOED

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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/14/2023)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 807, Statutes of 2024.
Location: 9/28/2024-A. CHAPTERED

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

Summary: The Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission, and authorizes the commission to take specified actions, including advising the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness. Current law authorizes the State Department of Public Health to, among other things, enforce its regulations and protect and preserve the public health. This bill would require the department, in consultation with the commission, to report to specified policy committees of the Legislature, on or before December 31, 2026, 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 the mental health of children and youth is positively, negatively, or neutrally impacted by use of social media and (2) recommendations to strengthen children and youth resiliency strategies and California's use of mental health services related to social media use.

AB 1313 **(Ortega D) Older individuals: case management services.**
Current Text: Amended: 4/27/2023 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 7/3/2023)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 632, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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. 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 assessment, evaluation, and crisis intervention, or placement for evaluation and treatment, under prescribed circumstances. The bill would make conforming and clarifying changes to provisions requiring facilities to provide that treatment.

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: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 678, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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

Summary: The California Environmental Quality Act (CEQA requires a lead agency to prepare a mitigated negative declaration for a project that may have a significant effect on the environment if revisions in the project would avoid or mitigate that effect and there is no substantial evidence that the project, as revised, would have a significant effect on the environment. 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 CEQA, as specified. specified, and authorizes the division to delegate its lead agency responsibility for geothermal exploratory projects to a county that has adopted a geothermal element for its general plan. Current law requires the delegation to provide that the county complete its lead agency responsibility within 135 days of the receipt of the application for the project. This bill would delete the requirement of the delegation to provide that the county complete its lead agency responsibility within 135 days. The bill would specify, upon the request of an applicant of a geothermal exploratory project, that the county in which the project is located is to assume the responsibilities of a lead agency regardless of whether the county has adopted a geothermal element for its general plan. The bill would require the applicant to make the request to the county and the division. If a county assumes lead agency responsibility for a geothermal exploratory project, the bill would require the county and the division to confer regarding necessary information that should be included in the environmental review for the project to facilitate the division's exercise of its authority as a responsible agency.

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
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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: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 633, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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 require a group or individual health care service plan or health insurer offering an outpatient prescription drug benefit to provide coverage without prior authorization, step therapy, or utilization review for at least one medication approved by the United States Food and Drug Administration in each of 4 designated categories, including medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist. 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: Vetoed: 9/29/2024 html pdf
Status: 9/29/2024-Vetoed by Governor.
Location: 9/29/2024-A. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: 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 report 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 the State Department of Health Care Services and the State Department of Public Health. 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 plans to close its perinatal unit, the bill would require the hospital to provide public notice of the proposed 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. The bill would require the public to be permitted to comment on the closure for 60 days after the notice is given, and would require one noticed public hearing be conducted by the hospital. The bill would also require the hospital to accept written public comment. By creating a new crime, this bill would impose a state-mandated local program.

AB 1926 **(Connolly D) Health care coverage: regional enteritis.**
Current Text: Amended: 3/19/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 6/24/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 6/17/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 6/24/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: Vetoed: 9/25/2024 html pdf
Status: 9/25/2024-Vetoed by the Governor
Location: 9/25/2024-A. VETOED

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 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.

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

Current Text: Vetoed: 9/22/2024 html pdf
Status: 9/22/2024-Vetoed by the Governor
Location: 9/22/2024-A. VETOED

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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 6/24/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 818, Statutes of 2024.
Location: 9/28/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 822, Statutes of 2024.
Location: 9/28/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law sets forth specified coverage requirements for health care service plan contracts and health insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services. This bill would require a 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
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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: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 634, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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

Summary: 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: Chaptered: 9/29/2024 html pdf
Status: 9/29/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 950, Statutes of 2024.
Location: 9/29/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law generally regulates contractual provisions between health care service plans and health insurers and their contracting health care providers. This bill would require a contract between a health care service plan or health insurer and a health care provider issued, amended, or renewed on or after January 1, 2025, to authorize a provider to separately bill for devices, implants, or professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a 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: Chaptered: 9/29/2024 html pdf
Status: 9/29/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 951, Statutes of 2024.
Location: 9/29/2024-A. CHAPTERED

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

Summary: Current law requires an adult patient receiving primary care services in certain health care settings to be offered a screening test for hepatitis B and hepatitis C, as specified. This bill would require 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 tuberculosis screening, if tuberculosis 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 follow-up health care or refer the patient to a health care provider who can provide follow-up

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.

AB 2169 **(Bauer-Kahan D) Prescription drug coverage: dose adjustments.**
Current Text: Amended: 3/21/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/5/2024)
Location: 8/15/2024-S. DEAD

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

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

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

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

AB 2198 **(Flora R) Health information.**
Current Text: Chaptered: 9/22/2024 html pdf
Status: 9/22/2024-Chaptered by Secretary of State - Chapter 386, Statutes of 2024
Location: 9/22/2024-A. CHAPTERED

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires health care service plans and health insurers, commencing January 1, 2024, to establish and maintain specified application programming interfaces (API), including patient access API, for the benefit of enrollees, insureds, and contracted providers. Current law authorizes the departments to require health care service plans or health insurers, as applicable, to establish and maintain provider access API and prior authorization support API if and when final federal rules are published. This bill would instead require the departments, commencing January 1, 2027, or when final federal rules are implemented, whichever occurs later, to require health care service plans and health insurers to establish and maintain patient access API, provider access API, payer-to-payer API, and prior authorization API. The bill, until January 1, 2027, would authorize the departments to issue guidance relating to these provisions not subject to the Administrative Procedure Act, as specified. Because a violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.

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: Vetoed: 9/27/2024 html pdf
Status: 9/27/2024-Vetoed by Governor.
Location: 9/27/2024-A. VETOED

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

placed 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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/5/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: Vetoed: 9/22/2024 html pdf
Status: 9/22/2024-Vetoed by Governor.
Location: 9/22/2024-A. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require a health care service plan contract or health insurance policy issued, amended, 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 standardized codes when documenting patient responses to questions asked in these screenings and would require providers to use existing tools or protocols to conduct the 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. 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 2258 **(Zbur D) Health care coverage: cost sharing.**
Current Text: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 708, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: Vetoed: 9/22/2024 html pdf
Status: 9/22/2024-Vetoed by Governor.
Location: 9/22/2024-A. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: Chaptered: 9/26/2024 html pdf
Status: 9/26/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 621, Statutes of 2024.
Location: 9/26/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law makes legislative findings relating to implicit bias and racial disparities in maternal mortality rates. Current law requires a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an evidence-based implicit bias program, as specified, for

all health care providers involved in perinatal care of patients within those facilities. Current law requires the health care provider to complete initial basic training through the program and a refresher course every 2 years thereafter, or on a more frequent basis if deemed necessary by the facility. 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 State Department of Public Health 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. The bill would require specified facilities to, by February 1 of each year, commencing in 2026, provide the Attorney General with proof of compliance with these provisions, as specified. The bill would authorize the Attorney General to pursue civil penalties for violations of these provisions, as specified. The bill would require that Attorney General be awarded all attorney's fees and costs in any civil action in which a court imposes any of those civil penalties. The bill would authorize the Attorney General to post on its internet website a list of facilities that did not timely submit proof of compliance or were assessed penalties under these provisions, as specified. The bill would authorize the Attorney General to post any other compliance data they deem necessary and would authorize the Attorney General to biennially publish a report outlining compliance data related to these provisions.

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

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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: Vetoed: 9/22/2024 html pdf
Status: 9/20/2024-Vetoed by Governor.
Location: 9/20/2024-A. VETOED

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: Chaptered: 9/25/2024 html pdf
Status: 9/25/2024-Chaptered by Secretary of State - Chapter 564, Statutes of 2024
Location: 9/25/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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 medically necessary health care services, through fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under 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 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: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 637, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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. Existing law requires chemical dependency recovery services to comply with specified regulatory requirements for basic services, and optional services if the facility is approved by the department to provide them. Current law only authorizes the colocation of chemical dependency recovery services as a distinct part with other services or distinct parts of its parent hospital, as specified. Current law requires a separately licensed chemical dependency recovery hospital that is not a distinct part of a general acute care hospital to have agreements with one or more general acute care hospitals to provide specified additional services. This bill would expand the definition of "chemical dependency recovery services" to include medications for addiction treatment and medically supervised voluntary inpatient detoxification but would specify that it does not include certain treatment of severe, potentially life threatening, intoxication and withdrawal syndromes. 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 as a supplemental service 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: Vetoed: 9/27/2024 html pdf
Status: 9/27/2024-Vetoed by Governor.
Location: 9/27/2024-A. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
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Summary: Would establish diapers as a covered Medi-Cal benefit for a child greater than 3 years of age who has been diagnosed with a condition, as specified, that contributes to incontinence, and for an individual under 21 years of age if necessary to correct or ameliorate a condition pursuant to certain federal standards. The bill would limit the provided diapers to an appropriate supply based on the diagnosed condition and the age of the Medi-Cal beneficiary. The bill would require the department to seek any necessary federal approvals to implement these provisions. The bill would condition implementation of these provisions on receipt of any necessary federal approvals, the availability of federal financial participation, and an appropriation by the Legislature.

AB 2449 **(Ta R) Health care coverage: qualified autism service providers.**
Current Text: Amended: 6/3/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 6/17/2024)
Location: 8/15/2024-S. DEAD

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

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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: Vetoed: 9/28/2024 html pdf
Status: 9/28/2024-Vetoed by Governor.
Location: 9/28/2024-A. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law sets forth specified coverage requirements for health care service plan contracts and health insurance policies. This bill would require a health care service plan contract or health insurance policy, except as specified, 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: Chaptered: 8/26/2024 html pdf
Status: 8/26/2024-Chaptered by Secretary of State - Chapter 200, Statutes of 2024
Location: 8/26/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would require a health care service plan, 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.

AB 2630 **(Bonta D) Pupil health: oral health assessment.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 838, Statutes of 2024.
Location: 9/28/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Existing law requires a pupil, while enrolled in kindergarten in a public school, or while enrolled in first grade in a public school if the pupil was not previously enrolled in kindergarten in a public school, to present proof of having received an oral health assessment by a licensed dentist, or other licensed or registered dental health professional

operating within the professional's scope of practice, that was performed no earlier than 12 months before the date of the initial enrollment of the pupil, as provided. This bill would define "kindergarten" for these purposes as including both transitional kindergarten and kindergarten and would require the above-described proof only once during a 2-year kindergarten program. To the extent the bill would impose additional duties on public schools, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

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

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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 2685 **(Ortega D) Older individuals: case management services.**
Current Text: Amended: 4/8/2024 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

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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, 2031, and subject to an appropriation, require the department to establish a case management services demonstration project in up to 4 counties located in varying regions of the state, based on a process of selection by the department and voluntary participation by the selected counties. Under the bill, the purpose of the project 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.

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

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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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 6/24/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 638, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would add to that list of practitioners a licensed professional clinical counselor. This bill contains other related provisions and other existing laws.

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
1st House				2nd House							

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

AB 2753 **(Ortega D) Rehabilitative and habilitative services: durable medical equipment and services.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 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: Chaptered: 9/29/2024 html pdf
Status: 9/29/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 971, Statutes of 2024.
Location: 9/29/2024-A. CHAPTERED

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. 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: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was INACTIVE FILE on 8/28/2024)
Location: 8/31/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Dead	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 systems.**
Current Text: Amended: 8/28/2024 html pdf
Status: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was INACTIVE FILE on 8/31/2024)
Location: 8/31/2024-S. DEAD

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

Summary: The Unruh Civil Rights Act provides that all persons within the jurisdiction of this state are free and equal and, regardless of their sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, or immigration status, are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever. The California Fair Employment and Housing Act establishes the Civil Rights Department within the Business, Consumer Services, and Housing Agency and requires the department to, among other things, bring civil actions to enforce the act. This bill would, among other things, require, as prescribed, a deployer, as defined, and a developer of an automated decision system, as defined, to perform an impact assessment on any automated decision system before the system is first deployed and annually thereafter that includes, among other things, a statement of the purpose of the automated decision system and its intended benefits, uses, and deployment contexts. The bill would require a deployer or a developer to provide any impact assessment that it performed to the Civil Rights Department and would exempt an impact assessment provided to the department from the California Public Records Act, as prescribed. This bill would require a deployer to, prior to an automated decision system making a consequential decision, as defined, or being a substantial factor, as defined, in making a consequential decision, notify any natural person that is subject to the consequential decision that an automated decision system is being used and to provide that person with specified information. The bill would require a deployer that has deployed an automated decision system to make, or be a substantial factor in making, a consequential decision concerning a natural person, to provide to the natural person, among other things, an opportunity to correct any incorrect personal data.

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: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 848, Statutes of 2024.
Location: 9/28/2024-A. CHAPTERED

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

Summary: Would require a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence to generate written or verbal patient communications 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: Chaptered: 9/29/2024 html pdf
Status: 9/29/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 975, Statutes of 2024.
Location: 9/29/2024-A. CHAPTERED

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

Summary: 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. The bill would exempt from licensing requirements a hospital storing or distributing human milk obtained from a licensed tissue bank. The bill would require hospitals that collect, process, store, or distribute human milk in any other circumstance to obtain a tissue bank license. To the extent that the bill would expand the class of hospitals subject to tissue bank licensing requirements, thereby expanding a crime, the bill would impose a state-mandated local program.

AB 3129 **(Wood D) Health care system consolidation.**
Current Text: Vetoed: 9/28/2024 html pdf
Status: 9/28/2024-Vetoed by Governor.
Location: 9/28/2024-A. VETOED

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 that directly or indirectly control, are controlled by, are under common control of, or are otherwise 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: enrollees with other health care coverage.**
Current Text: Vetoed: 9/22/2024 html pdf
Status: 9/20/2024-Vetoed by Governor.
Location: 9/20/2024-A. VETOED

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

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

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: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 760, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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.

AB 3245 **(Patterson, Joe R) Coverage for colorectal cancer screening.**
Current Text: Vetoed: 9/29/2024 html pdf
Status: 9/29/2024-Vetoed by Governor.
Location: 9/29/2024-A. VETOED

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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/5/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 763, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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, including a Medi-Cal managed care plan, or health insurer to reimburse a complete claim or a portion thereof within 30 calendar days after receipt of the claim, or, if a claim or portion thereof does not meet the criteria for a complete claim or portion thereof, to notify the claimant as soon as practicable, but no later than 30 calendar days that the claim or portion thereof is contested or denied. The bill would authorize the departments to issue guidance and 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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/16/2023)
Location: 8/15/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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 101 **(Skinner D) Budget Act of 2023.**
Current Text: Chaptered: 6/27/2023 html pdf
Status: 6/27/2023-Approved by the Governor. Chaptered by Secretary of State. Chapter 12, Statutes of 2023.
Location: 6/27/2023-S. CHAPTERED

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

Summary: This bill would make appropriations for the support of state government for the 2023–24 fiscal year. This bill contains other related provisions.

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

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

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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/23/2023)
Location: 8/15/2024-A. DEAD

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

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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/16/2023)
Location: 8/15/2024-A. DEAD

1st House				2nd House				Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 7/2/2024)
Location: 8/15/2024-A. DEAD

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

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: Vetoed: 9/29/2024 html pdf

Status: 9/29/2024-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Location: 9/29/2024-S. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
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Summary: Would require the Secretary of State and the Department of Motor Vehicles 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 license 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. The bill would permit the Secretary of State, upon a determination that sufficient technology infrastructure exists, to promulgate regulations concerning the establishment of a list of individuals who are eligible to be preapproved for voter registration, as specified.

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

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

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: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was APPR. SUSPENSE FILE on 8/23/2023)
Location: 8/31/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	Floor	Conf.	Enrolled	Vetoed	Chaptered
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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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on

8/7/2024)
Location: 8/15/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was DESK on 5/13/2024)
Location: 8/31/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Dead	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: 8/22/2024 html pdf
Status: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was HEALTH on 8/22/2024)
Location: 8/31/2024-A. DEAD

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based

on medical necessity. Current law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Current law requires the criteria or guidelines used to determine whether or not to authorize, modify, or deny health care services to be developed with involvement from actively practicing health care providers. This bill would require the Department of Managed Health Care and the Department of Insurance, by July 1, 2025, to issue instructions to health care service plans and health insurers to report specified information relating to prior authorization, as defined, including designated health care services (services), items, and supplies subject to prior authorization and the percentage rate at which health care service plans, health insurers, or their delegated entities, approve or modify those services, items, and supplies. The bill would require health care service plans and health insurers to report that information to the relevant department by December 31, 2025, or as otherwise specified. The bill would require the relevant department to evaluate the reports received from the health care service plans and health insurers, and identify the services, items, and supplies most frequently approved by the plans or insurers or their delegated entities, as specified. The bill would require each department, after evaluating the reports received from health care service plans and health insurers, to identify, and by December 31, 2026, to publish a list of, the most frequently approved or modified services, items, and supplies, based on a prescribed threshold percentage rate.

SB 537 **(Becker D) City or County of Los Angeles: memorial to forcibly deported Mexican Americans and Mexican immigrants.**

Current Text: Chaptered: 9/28/2024 html pdf

Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 859, Statutes of 2024.

Location: 9/28/2024-S. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law provides for various memorials and monuments on the grounds of the State Capitol. Current law requires the Department of General Services to maintain state buildings and grounds. Existing 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 the City or County of Los Angeles. This bill would authorize a nonprofit organization representing Mexican Americans or Mexican immigrants to enter into negotiations 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 memorial to be located at an appropriate public place in the City or County of Los Angeles. The bill would require the nonprofit organization to enter into negotiations with the Department of General Services and the state agency with jurisdiction over the state property where the memorial is proposed, where applicable, if the nonprofit organization proposes to locate the memorial on state property.

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

Current Text: Chaptered: 9/29/2024 html pdf

Status: 9/29/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 983, Statutes of 2024.

Location: 9/29/2024-S. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: Chaptered: 9/29/2024 html pdf
Status: 9/29/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 930, Statutes of 2024.
Location: 9/29/2024-S. CHAPTERED

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

Summary: Current law imposes various requirements and restrictions on health care service plans and disability insurers, including, among other things, a requirement that every group health care service plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1, 1990, offer coverage for the treatment of infertility, except in vitro fertilization. This bill would require large and small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after July 1, 2025, 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 819 **(Eggman D) Medi-Cal: certification.**
Current Text: Chaptered: 9/22/2024 html pdf
Status: 9/22/2024-Chaptered by Secretary of State - Chapter 448, Statutes of 2024
Location: 9/22/2024-S. CHAPTERED

1st House				2nd House				Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires the State Department of Public Health to license and regulate clinics. Current law exempts from those licensing provisions certain clinics that are directly conducted, maintained, or operated by federal, state, or local governmental entities, as specified. Current law also exempts from those licensing provisions a clinic that is operated by a primary care community or free clinic, that is operated on separate premises from the licensed clinic, and that is only open for limited services of no more than 40 hours per week. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law sets forth various procedures, including the submission of an application package, for providers to enroll in the Medi-Cal program. Under current law, an applicant or provider that is a government-run license-exempt clinic as described above is required to comply with those Medi-Cal enrollment procedures. Under current law, an applicant or provider that is operated on separate premises and is license exempt, including an intermittent site or mobile health care unit that is operated by a licensed primary care clinic that provides all staffing, protocols, equipment, supplies, and billing services, is not required to enroll in the Medi-Cal program as a separate provider or comply with the above-described enrollment procedures, if the licensed primary care clinic has notified the department of its separate locations, premises, intermittent sites, or mobile health care units. This bill would additionally exempt from the Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by the above-described government-run license-exempt clinic if that clinic has notified the department of its separate locations, premises, sites, or units.

SB 966 **(Wiener D) Pharmacy benefits.**
Current Text: Vetoed: 9/28/2024 html pdf
Status: 9/28/2024-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Location: 9/28/2024-S. VETOED

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

Summary: The Knox-Keene Act requires a pharmacy benefit manager under contract with a health care service plan to, among other things, register with the Department of Managed Health Care. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would additionally require a pharmacy benefit manager, as defined, 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.

SB 980 **(Wahab D) The Smile Act.**
Current Text: Amended: 6/10/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/7/2024)
Location: 8/15/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/7/2024)
Location: 8/15/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was APPR. SUSPENSE FILE on 4/15/2024)
Location: 8/31/2024-S. DEAD

Desk	Policy	Dead	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 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) Childcare: alternative payment programs.**
Current Text: Chaptered: 9/30/2024 html pdf
Status: 9/30/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 1016, Statutes of 2024.
Location: 9/30/2024-S. CHAPTERED

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

Summary: Current federal law establishes the Child Care and Development Fund authorized under the Child Care and Development Block Grant Act of 2014 and administered by states to provide assistance to low-income families who need childcare due to specified reasons. Current federal law requires a portion of those funds to be used to disseminate information on existing resources for developmental screenings and descriptions of how a family may utilize those resources to obtain developmental screenings. Current law authorizes, upon departmental approval, the use of appropriated funds for alternative payment programs to allow for maximum parental choice. Current law authorizes the reimbursement to those programs for the cost of child care paid to child care providers and the administrative and support services costs of the alternative program. This bill would state that the costs allowable for administration shall include, but not be limited to, costs associated with disseminating the above-described information.

SB 1120 **(Becker D) Health care coverage: utilization review.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 879, Statutes of 2024.
Location: 9/28/2024-S. CHAPTERED

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

Summary: Would require a health care service plan or disability insurer, including a specialized health care service plan or specialized health insurer, that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, or that contracts with or otherwise works through an entity that

uses that type of tool, to ensure compliance with specified requirements, including that the artificial intelligence, algorithm, or other software tool bases its determination on specified information and is fairly and equitably applied, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

SB 1131 **(Gonzalez D) Medi-Cal providers: family planning.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 880, Statutes of 2024.
Location: 9/28/2024-S. CHAPTERED

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 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, but no more than 10, service addresses under one 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 every other month.

SB 1180 **(Ashby D) Health care coverage: emergency medical services.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 884, Statutes of 2024.
Location: 9/28/2024-S. CHAPTERED

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: Vetoed: 9/27/2024 html pdf
Status: 9/27/2024-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Location: 9/27/2024-S. VETOED

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, commencing no later than July 1, 2026, an individual is eligible to receive treatment services if the individual has a family income at or below 250% of the federal poverty level as determined by the provider performing the screening and diagnosis.

SB 1220 **(Limón D) Public benefits contracts: phone operator jobs.**
Current Text: Vetoed: 9/23/2024 html pdf
Status: 9/22/2024-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Location: 9/22/2024-S. VETOED

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

Summary: Current law prohibits, with specified exceptions, a state agency authorized to enter into contracts relating to public benefit programs from contracting for services provided by a call center that directly serves applicants for, recipients of, or enrollees in, those public benefit programs with a contractor or subcontractor unless that contractor or subcontractor certifies in its bid for the contract that the contract, and any subcontract performed under that contract, will be performed solely with workers employed in California. Current law provides an exception for contracts between a state agency and a health care service plan or a specialized health care service plan regulated by the Department of Managed Health Care and for contracts between a state agency and a disability insurer or specialized health insurer regulated by the Department of Insurance. Current law also authorizes the state to terminate a contract relating to services provided by a call center if the contractor or subcontractor performs services with workers not employed in California. This bill would, until July 1, 2030, instead require any state agency authorized to provide or enter into contracts relating to public benefit programs, or any local government agency authorized to provide or enter into contracts relating to public benefit programs funded by state funds, as specified, to provide services through, or contract for services provided by, a call center that directly serves callers with services performed solely with and by workers employed in California. The bill would also prohibit a state agency or specified local agency from using, or contracting with a call center that uses, artificial intelligence (AI) or automated decision systems (ADS) that would eliminate or automate core job functions of a worker, as specified. The bill would require an agency that utilizes AI or ADS that impact core job functions of workers to notify the workers, their collective bargaining representatives, and the public within a specified timeframe about prescribed information, including a general description of the AI or ADS system. The bill would require a contractor to certify in its bid that any services provided by the contractor, or its subcontractors, are to be performed with and by workers employed in California. The bill would also extend these contracting requirements to local government agencies.

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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/7/2024)
Location: 8/15/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was INACTIVE FILE on 8/28/2024)
Location: 8/31/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Dead	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 perinatal services.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 894, Statutes of 2024.
Location: 9/28/2024-S. CHAPTERED

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 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 unit or a perinatal unit from 90 days to 120 days. By changing the definition of a crime, this bill would impose a state-mandated local program. The bill would require the health facility to provide public notice of the proposed elimination of the supplemental service of either inpatient psychiatric unit or perinatal unit, as specified. The bill would require the health facility to conduct at least one noticed public hearing within 60 days of providing public notice of the proposed elimination of the inpatient psychiatric unit or perinatal unit and would require the health facility to accept public comment. The bill would require the health facility to post the public hearing notice and the agenda along with the public notice.

SB 1308 **(Gonzalez D) Ozone: indoor air cleaning devices.**
Current Text: Amended: 6/11/2024 html pdf
Status: 7/2/2024-Failed Deadline pursuant to Rule 61(b)(13). (Last location was NAT. RES. on 5/28/2024)
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 Air Resources Board to develop and adopt regulations, consistent with federal law, to protect the public health from ozone emitted by indoor air cleaning devices, including medical and nonmedical devices used in occupied spaces. Current law requires those regulations to include, among other things, an emission concentration standard for ozone emissions that is equivalent to the federal ozone emissions limit for air cleaning

devices. Current law generally sets forth crimes and penalties for violations of air pollution laws and any rule, regulation, permit, or order of the state board. This bill would instead require the state board, by July 1, 2026, or as soon as feasible, as provided, to include in these regulations an emission concentration standard for ozone emissions not greater than 0.005 parts per million, to the extent consistent with federal law, thereby imposing a more protective standard. The bill would require the regulations to include a ban on the sale or the offering for sale of devices that exceed that emissions limit, even if previously certified, after a date determined by the state board, unless the state board determines an exemption applies.

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

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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: Chaptered: 9/21/2024 html pdf
Status: 9/21/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 339, Statutes of 2024.
Location: 9/21/2024-S. CHAPTERED

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

Summary: Current law provides for the licensing and regulation of long-term health care facilities, including, among others, skilled nursing facilities and intermediate care facilities, by the State Department of Public Health. A violation of those provisions is generally a crime. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would require the facility to provide aid, care, service, and 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. The bill would find and declare that this requirement is declaratory of existing law and thus not reimbursable under Medi-Cal Long-Term Care Reimbursement Act or any other Medi-Cal ratesetting provisions, as specified. The bill would specify that if reimbursement is found to be required by state or federal law or regulation, as specified, the above requirement shall only become operative upon appropriation by the Legislature. The bill would also provide that this requirement and the above-described prohibition against discrimination on the basis of payment source be implemented only to the extent that these provisions do not conflict with federal law, that any necessary federal approvals are obtained, and that federal financial participation for the Medi-Cal program is available and is not otherwise jeopardized.

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: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/7/2024)
Location: 8/15/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	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: Vetoed: 9/23/2024 html pdf
Status: 9/22/2024-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Location: 9/22/2024-S. VETOED

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, each hospital designated by the State Department of Health Care Services as a critical access hospital, and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, Rural Hospital Flexibility Program, is eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons. Current law sets forth various other provisions regarding Medi-Cal reimbursement in consideration of small and rural hospitals. This bill would require the department 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.

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.

Total Measures: 131

Total Tracking Forms: 131

ALAMEDA Alliance FOR HEALTH

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

Board Business

RESOLUTION APPOINTING REBECCA GEBHART TO THE FINANCE COMMITTEE

RESOLUTION NO. 2024-

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH APPOINTING MS. REBECCA GEBHART TO THE FINANCE COMMITTEE

WHEREAS, pursuant to Section 7.A.1. of the Alameda Alliance for Health ("Alliance") *Bylaws*, the frequency, composition, number, terms, and nominations of members of standing committees shall be as set forth by resolution; and

WHEREAS, Resolution 94-04 established the Finance Committee as a standing committee of the Board; and

WHEREAS, appointments to the Finance Committee shall be for two (2) year terms, and members may be reappointed to additional terms by Board approval; and

WHEREAS, the Finance Committee shall have in its membership no less than three (3) and no more than five (5) Board members; and

WHEREAS, the Finance Committee currently has space for additions to the membership; and

WHEREAS, Board Chair Rebecca Gebhart would like to serve on the Finance Committee

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

SECTION 1. That the Alliance Board appoints Rebecca Gebhart to serve as a member of the Finance Committee for a two-year term.

PASSED AND ADOPTED by the Board at a meeting held on the 11th day of October 2024.

_____
VICE CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

ALAMEDA Alliance FOR HEALTH

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BEHAVIORAL HEALTH UPDATE

Behavioral Health Insourcing Report

ALAMEDA Alliance FOR HEALTH

Agenda

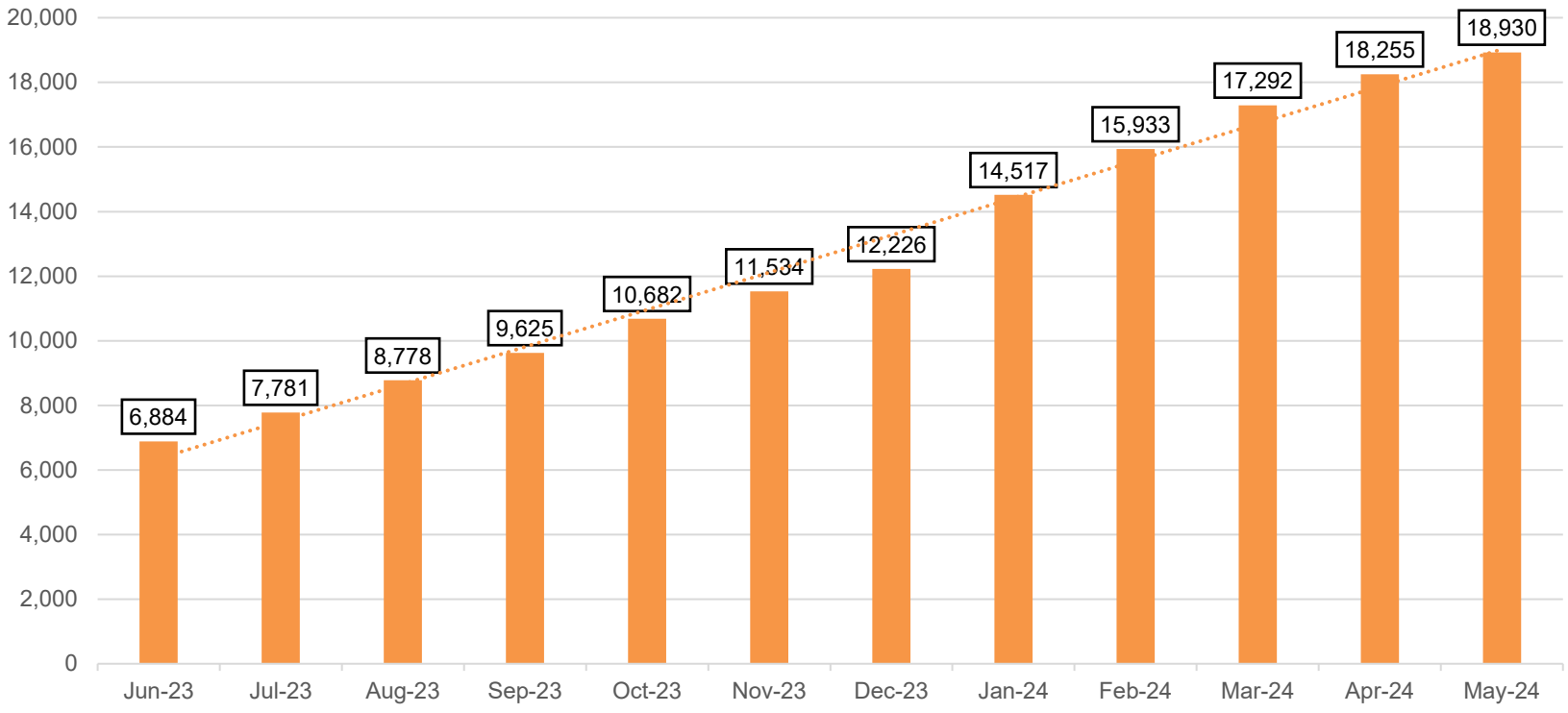
- Lessons Learned
- AAH vs Beacon Health Options Utilization
  - Mental Health
  - Behavioral Health Treatment
- Successes / Challenges
- Looking Forward

Lessons Learned

- On 4/1/23 Alameda Alliance (AAH) insourced Behavioral Health services
- Pent up demand (Mental Health / Behavioral Health Treatment)
- Significant Care Coordination Needs
- Specialized Staff
- Introduced Regulatory requirements at the same time as insourcing
- Coordination of Care with Primary Care and Co-Treating Providers under development
- Strong relationship with ACBH is critical

Unique Utilizers / Month

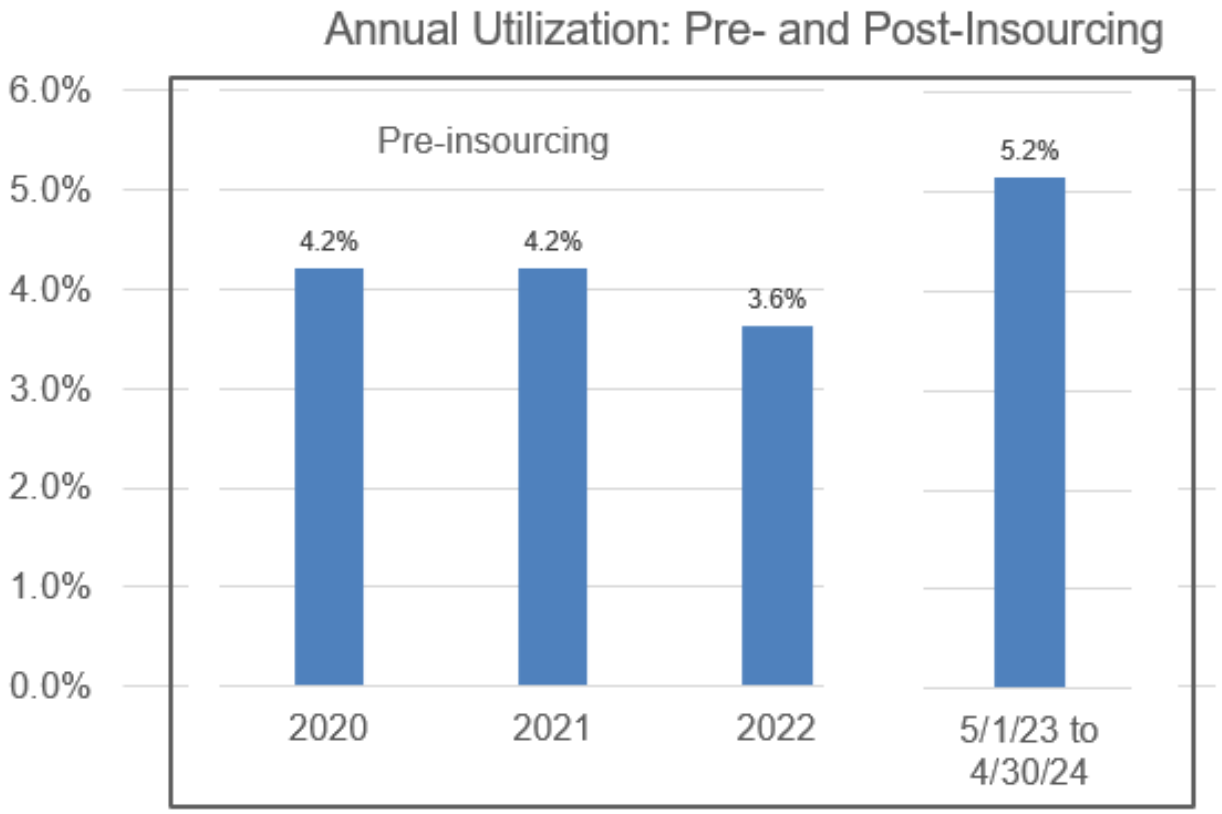
Mental Health



From June 2023 to May 2024, we have seen a 175% increase in unique utilizers

Source: PBI 14637 BH12M Report

Penetration Rate



Post insourcing, we have seen an increase in penetration rate from 3.6% to 5.5%

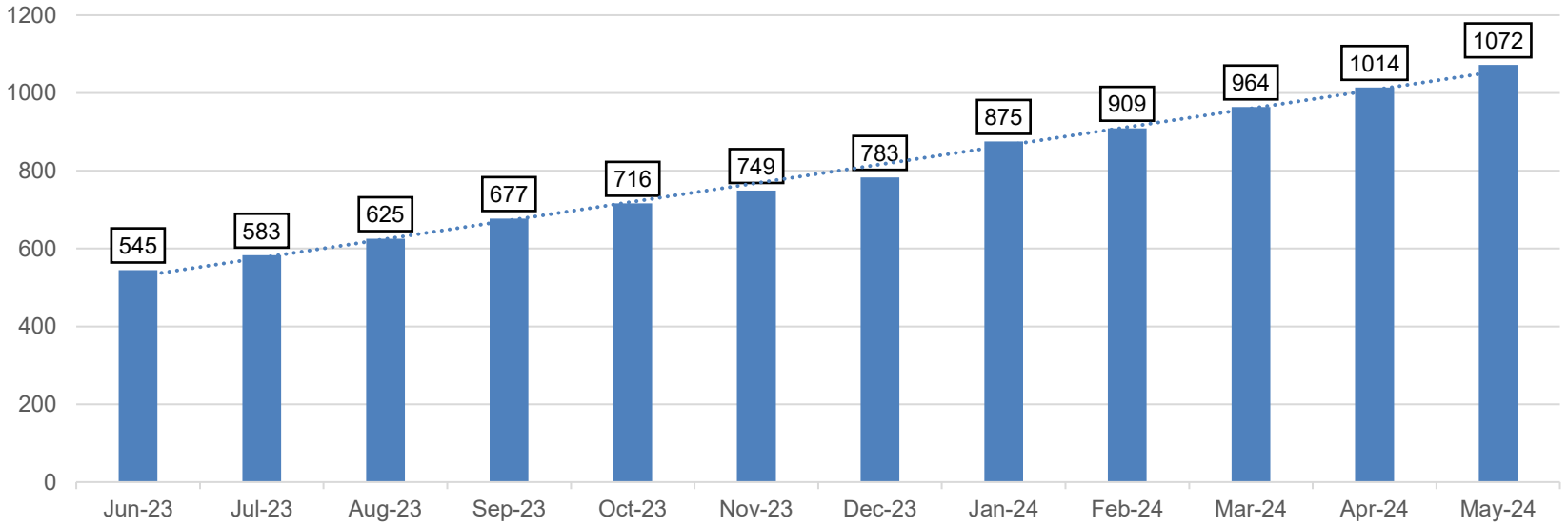
Source: PBI 14637 BH12M Report

Behavioral Health Therapy (BHT)

- BHT is an evidence-based therapy used to assist members with autism and developmental disorders
- Members requiring BHT services have higher touch needs
  - The Alliance assigns a specific care manager that follows up with parents and caregivers to provide care coordination and personalize a member's care

Unique Utilizers / Month

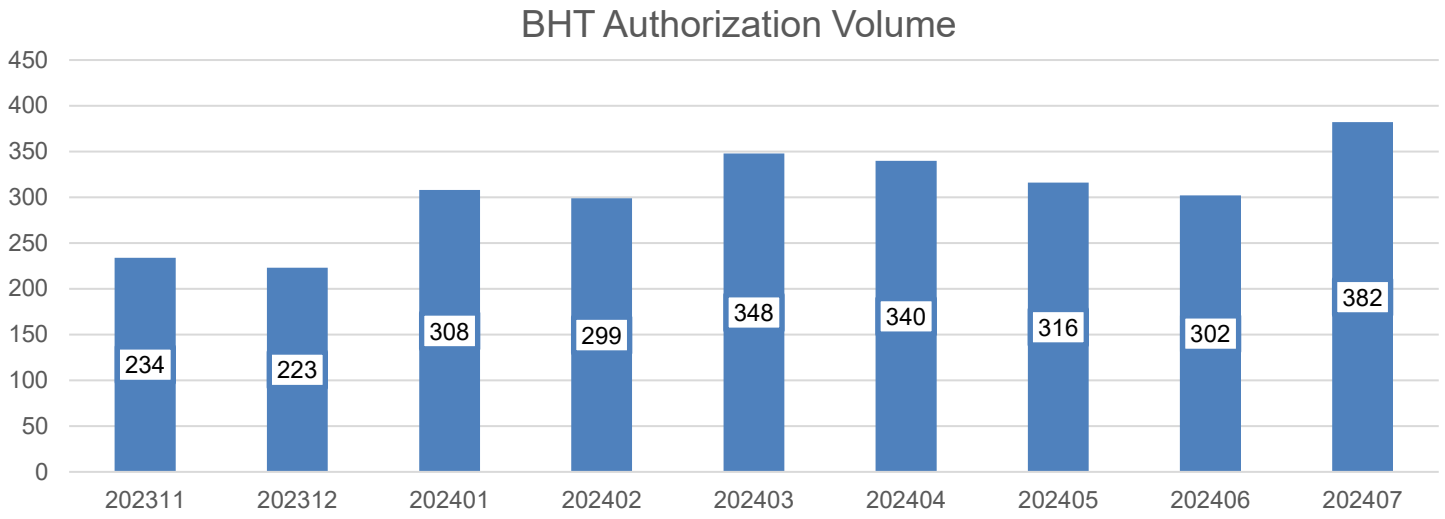
Behavioral Health Therapy



We have seen a 97% increase in unique utilizers from June 2023 to May 2024

Source: PBI 14621 BHT Utilization Report

BHT Authorization

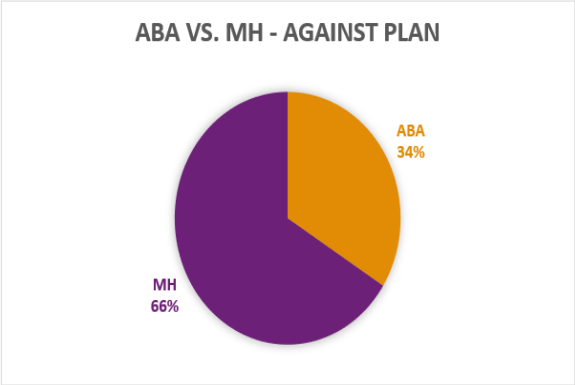


- As shown under BHT Utilization, demand increased by 38% from December 2023 to January 2024 with the Anthem transition. We averaged 328 prior authorization requests per month in 2024.
- Notably, there was a spike in authorizations from June 2024 through July 2024, which is attributed to authorizations expiring every six months requiring updated BHT treatment plans be reviewed for reauthorization.

Successes

- Member Utilization has doubled from pre-launch utilization
- Regulatory Compliance with recent DHCS Audit Success
- Addressing Grievances
- Behavioral Health Team meeting service line requirements
- Strong Community Relationships
  - Special Needs Committee, ACBH, High Volume Providers, Comprehensive Diagnostic Evaluation (CDE) Providers
- Expanded Network Since Insourcing
  - 53% overall increase in Mental Health Network
    - → Language Specific Increase 29% (Spanish), 72% (Chinese), 43% (Arabic)
  - 56% overall increase in Behavioral Health Treatment Network
    - → Language Specific Increase 4% (Spanish), 17% (Chinese), 25% (Arabic)

Downtrending Grievances



Challenges

- Understanding member needs
  - ~35% of authorized ABA services are provided
- Understanding what specific services a provider can provide
- Expanding the BHT Network to meet member needs
  - Encouraging & incentivizing providers to see members between 3P-7P
  - Expanding Network to meet Linguistic and Cultural Member Needs
  - High Turn Over of the ABA paraprofessional providers who provide direct services
- Building out workflow for members flowing from member services to behavioral health team
  - Getting members to the right services at the right time

Network Expansion

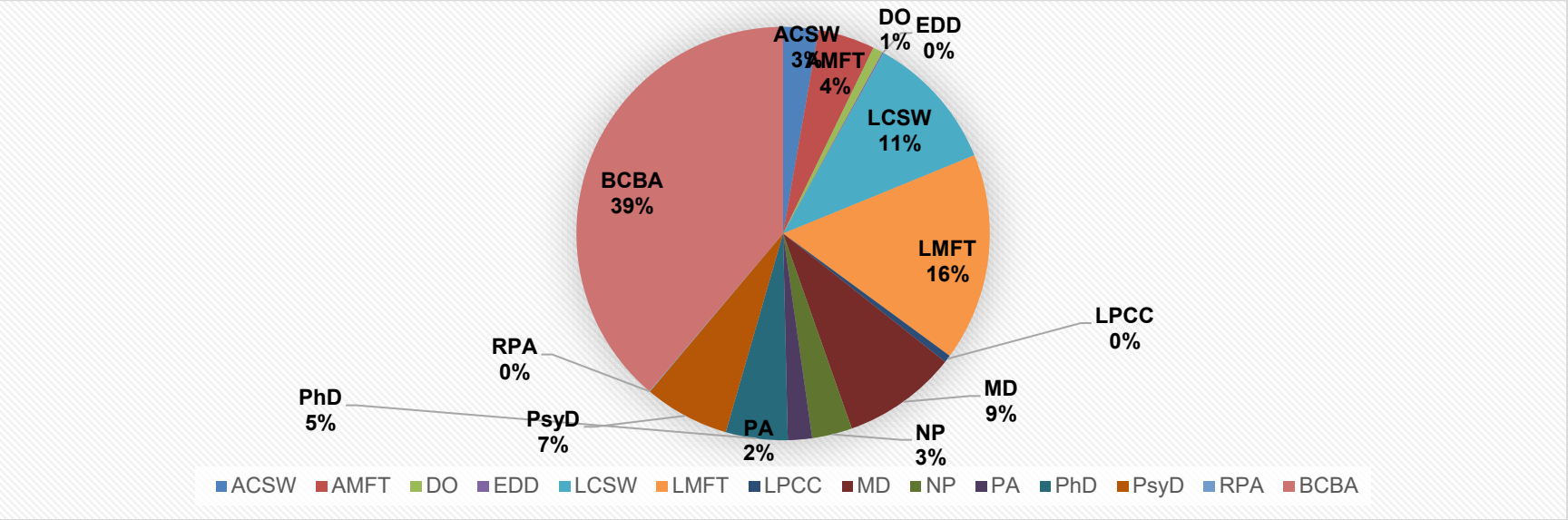
MH Network Type	MH Network - 4/1/23	MH Network 9/5/24	Percent Increase from April 1, 2023
Mental Health	458	1266	76.4%
ABA (BCBA)	260	802	108.4%
Total	718	2068	88%

MH Network Type	Groups as of 4/1/23	Groups as of 9/5/2024	Percent Increase from April 1, 2023
Mental Health	144	221	53.4%
ABA (BCBA)	30	47	57%
Total	174	268	54%

*** Numbers above represent individual providers in solo and group practices**

**** CDE Providers under Blanket LOA: 4 Groups with 10 Individual Providers**

Network Makeup As of 9/5/24



By Specialty Type- Individuals	As of 04/1/2023	As of 9/4/2024	Percent Increase from April 1, 2023
ACSW	19	57	33%
AMFT	33	92	36%
DO	3	16	19%
EDD	1	2	50%
LCSW	110	222	50%
LMFT	123	336	37%
LPCC	2	12	17%
MD	56	185	30%
NP	15	65	23%
PA	18	39	46%
PhD	41	100	41%
PsyD	37	138	27%
RPA	0	1	0%
BCBA	260	802	32%

Looking Forward

- Provider Directory
  - Detailed Survey of Mental Health Providers to Improve Provider Directory and improve matching members with providers
- Care Coordination
  - Implement Sending the Mental Health Treatment Reports to PCPs for Coordination of Care (connecting mental health providers with PCPs)
  - Developing BHT/ABA Treatment Report Web Forms for improved Treatment Review and to send updated ABA Treatment Plans to referring PCPs, Psychologists and Pediatricians
  - Complete Data Exchange with ACBH for Closed Loop Referrals & Coordination of Care
  - Incentivize Mental Health Providers to submit coordination of care Treatment Reports and Transition of Care Forms (referrals to ACBH)

Looking Forward

- Network Development
  - Incentivize availability of BHT/ABA services for High-Demand times (2pm to 7pm)
  - Increase number of Providers who perform a Comprehensive Diagnostic Evaluation (CDE)
- Member Experience
  - Help members better understand how to access Mental Health / BHT benefits

Questions?

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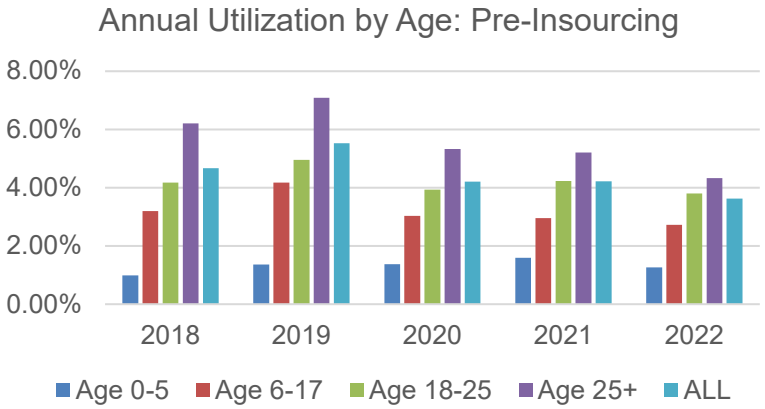
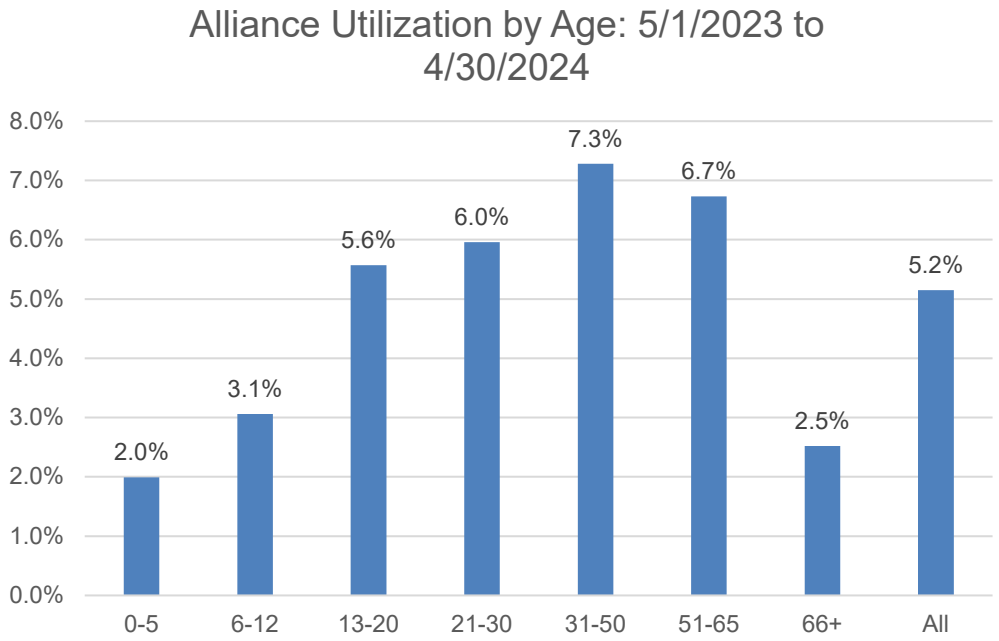
Additional Slides

ALAMEDA Alliance FOR HEALTH

MH Utilization

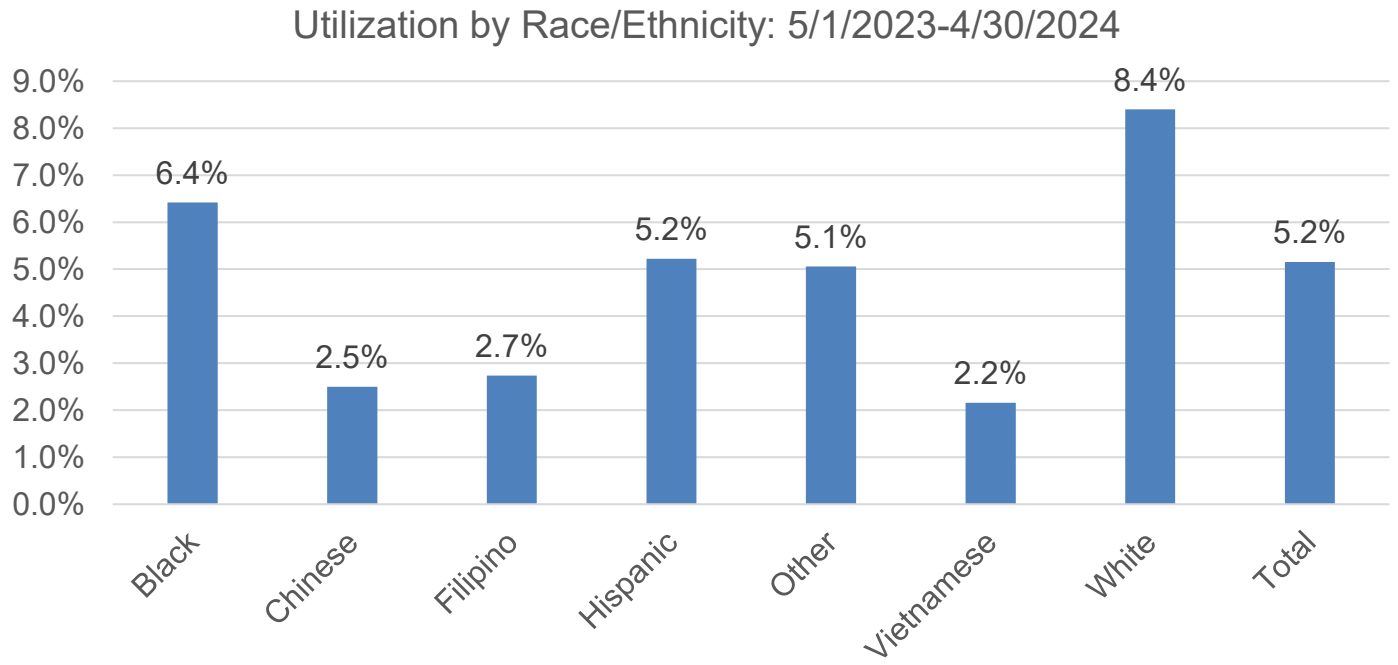
Utilization by Age





- The age categories we are reporting on are not directly comparable to those used by Beacon. However, across the board there has been an increase in utilization across every age group.
- The strongest utilization of the NSMH benefit is generally seen in the 18+ age category. Historically, the County Specialty Mental Health Plan has had more tools to serve children and youth, especially those 0-5. This is starting to change as the NSMH benefit has expanded to allow for family therapy and dyadic care.

Utilization by Race/Ethnicity: Post-Insourcing

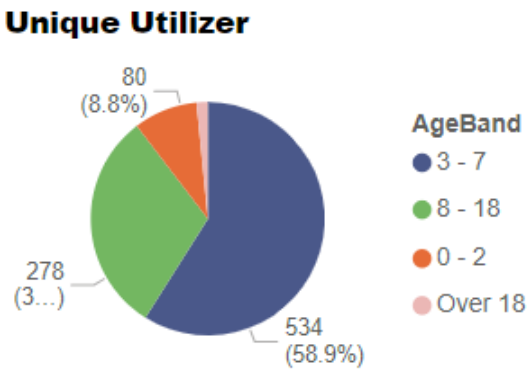


- While those who identify as White still have the greatest utilization of the NSMH benefit, we are seeing stronger utilization by other races/ethnicities than reported under Beacon management.
- For example, those who identify as Black had a 4% utilization rate in 2022 compared to 6.4% since in-sourcing. It is hard to know if this is due entirely to an increase under Alliance management, or if there was claims data Beacon was missing and/or issues in the data in the 834 sent to Beacon.
- While some races/ethnicities are showing improved utilization since in-sourcing the benefit, there is still significant work to do to explore any disparities in utilization and improve access for some populations, such as Chinese, Filipino and Vietnamese.

BHT Utilization

BHT Member Demographics

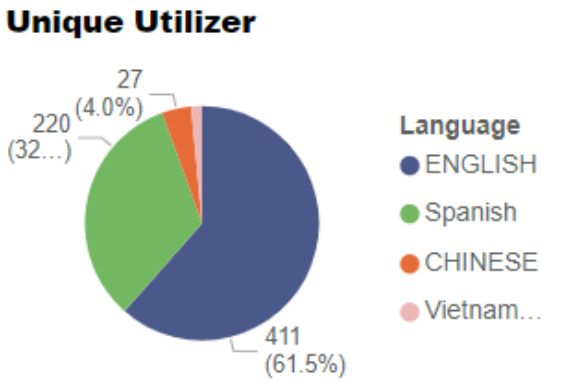
January 2024 through May 2024

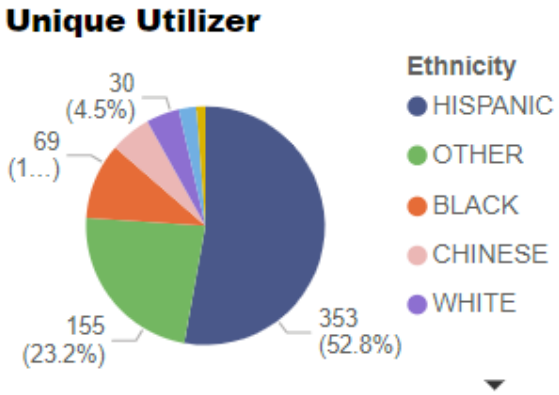


- The age group of 3-7 years old represents the highest number of individuals receiving services.
- Currently, there are 703 males and 203 females undergoing treatment.

BHT Member Demographics

January 2024 and May 2024





- We discovered that some providers were hesitant to accept members who do not speak the same language. This reluctance stems from the challenges associated with conducting comprehensive evaluations and developing effective treatment plans for these members when the provider does not speak the same language as the member's family.
- The Behavioral Health Department is supporting our providers by utilizing AAH interpreter services, Cyracom for telephonic interpretation services, and Hanna for in-person appointments. This approach aims to ensure that our members receive the essential communication support throughout their evaluations and treatments.

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CYBER SECURITY UPDATE

CYBER SECURITY OPERATIONS

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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Goals

- ✓ Protect the confidentiality of all the Alliance information, data, and assets.
- ✓ Preserve the integrity of data.
- ✓ Promote the access and availability of information and data for authorized use ONLY.
- ✓ Proactive risk identification and mitigation.
- ✓ IT Infrastructure Recovery and Restoration.

Security Strategies

- ✓ Enhance the security team and stay proactive against threats with innovative solutions.
- ✓ End to end security monitoring and vulnerability assessment.
- ✓ Enterprise IT security risk management and governance.
- ✓ Improved situational awareness and increased cybersecurity posture.
- ✓ Collaborate with key partners to promote resilience and reduce the incidence and severity of cyber security breaches.
- ✓ Security command center to support incident response management.
- ✓ IT Security audits and remediation.

Accomplishments

- ✓ Enterprise IT hardware and Software Asset Management
- ✓ Enterprise Immutable Cloud Storage
- ✓ Disaster Recovery Procedure for Tier 1 & 2 Systems and Processes.
- ✓ Business Continuity Plan (80% Complete. Remaining targeted to complete before end of Dec 2024).
- ✓ Real time End to end penetration test
- ✓ Total 41 vulnerability patches/upgrades to Alliance IT Ecosystems.
- ✓ Renewed Cybersecurity insurance coverage.
- ✓ Continued to support state of the art in resilient networked systems.
- ✓ Intune remote management capabilities for workstations and mobile devices (In roll-out phase).
- ✓ Security Link Gateway for external entities

Inflight Initiatives

- ➢ IT Security Program 2024.
- ➢ End to end real-time cyber security dashboard.
- ➢ Automate vulnerability management system using Nessus.
- ➢ Annual Enterprise Security Risk Assessment and Remediation Effort.
- ➢ Artificial Intelligence Assessment

Healthcare Incidents in US

Hospital & Healthcare Cyberattacks In 2024

- ✓ 280 Cyber attacks (reported).
- ✓ The records of ~ 700 million individuals have been stolen or compromised.
- ✓ ~ 7.3 billion financial losses.

Top 5 major reason for these cyber attacksare:

a) Lack of awareness and training.

b) People, Process and Technology vulnerabilities.

c) Weaker password and no Multi Factor Authentication.

d) Insufficient Encryption.

e) Poor Firewall and End Point management.

Security Training and Awareness

- ✓ Cyber Security and Phishing training mandate since May 2021.
- ✓ All AAH employees, contractors, and temporary staff must complete the training when they are hired.
- ✓ Mandatory Security training consist of 5 exercises and videos, and these training will be revised each year. The FY2025 training are:

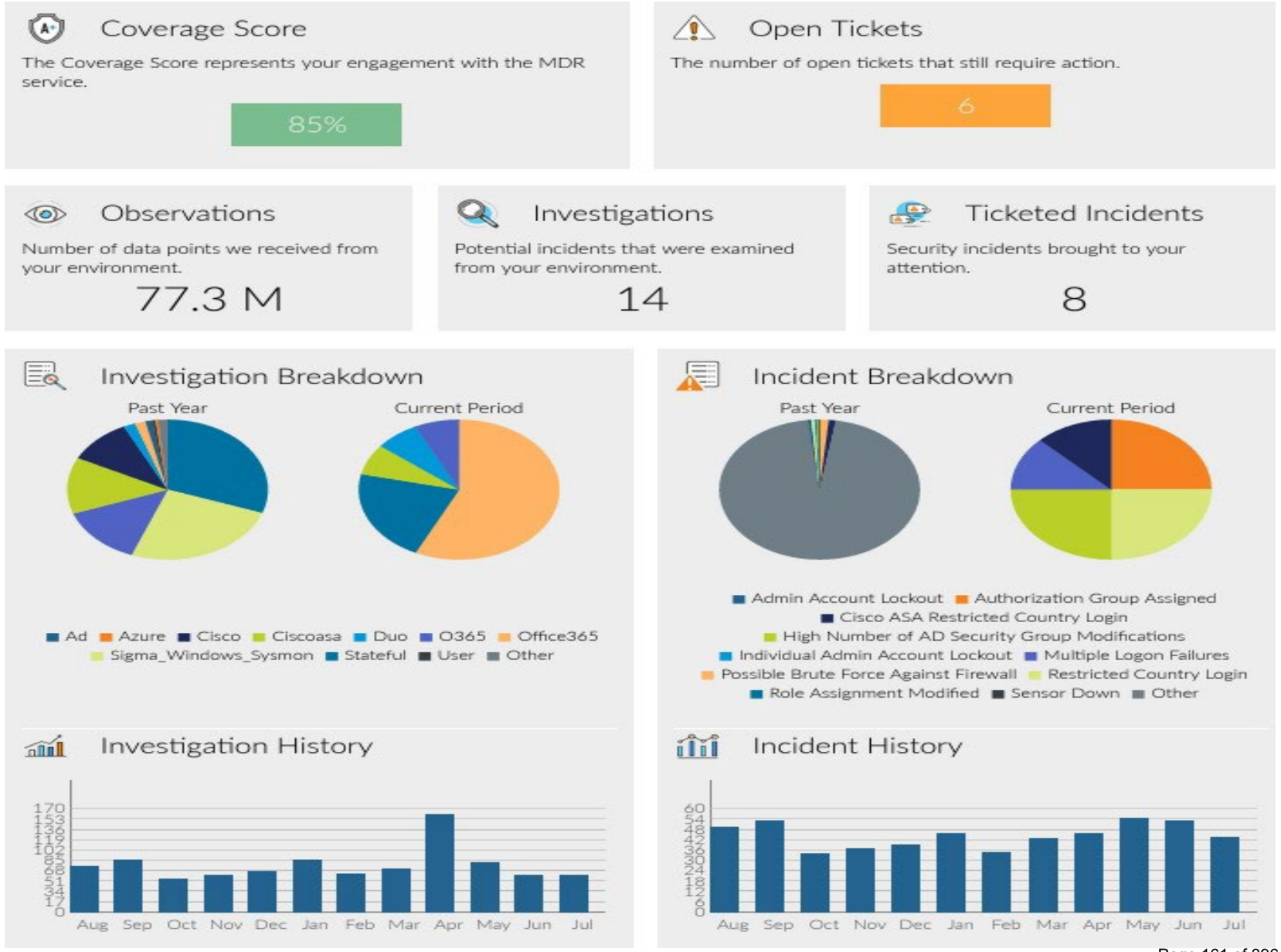
    1. Risks of Connecting to Public Wi-Fi
    2. Smishing and Vishing Attacks
    3. Email and Phone-based Cyber-Attacks
    4. Risks of Scanning Unknown QR Codes
    5. Phishing Fundamentals

24/7 Monitoring Report

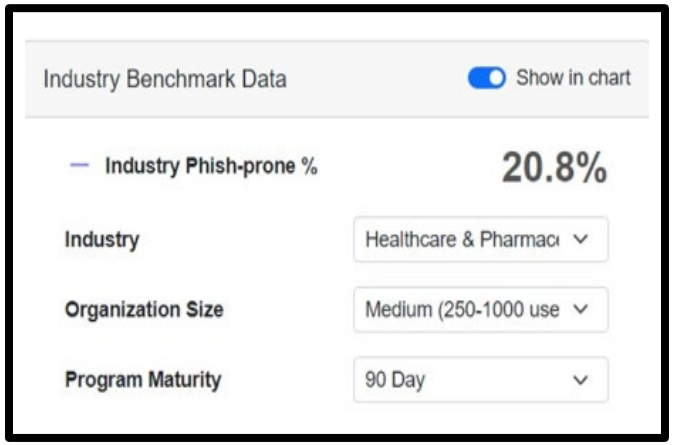
•Arctic Wolf Monthly Security Incident Reporting

•An effective security monitoring program will collect and analyze endpoint telemetry, network and security event logs “Observations”, filter the observations to identify potentially malicious events “Investigations”, and request human interventions that will be actioned by Arctic Wolf and/or AAH “Ticketed Incidents”.

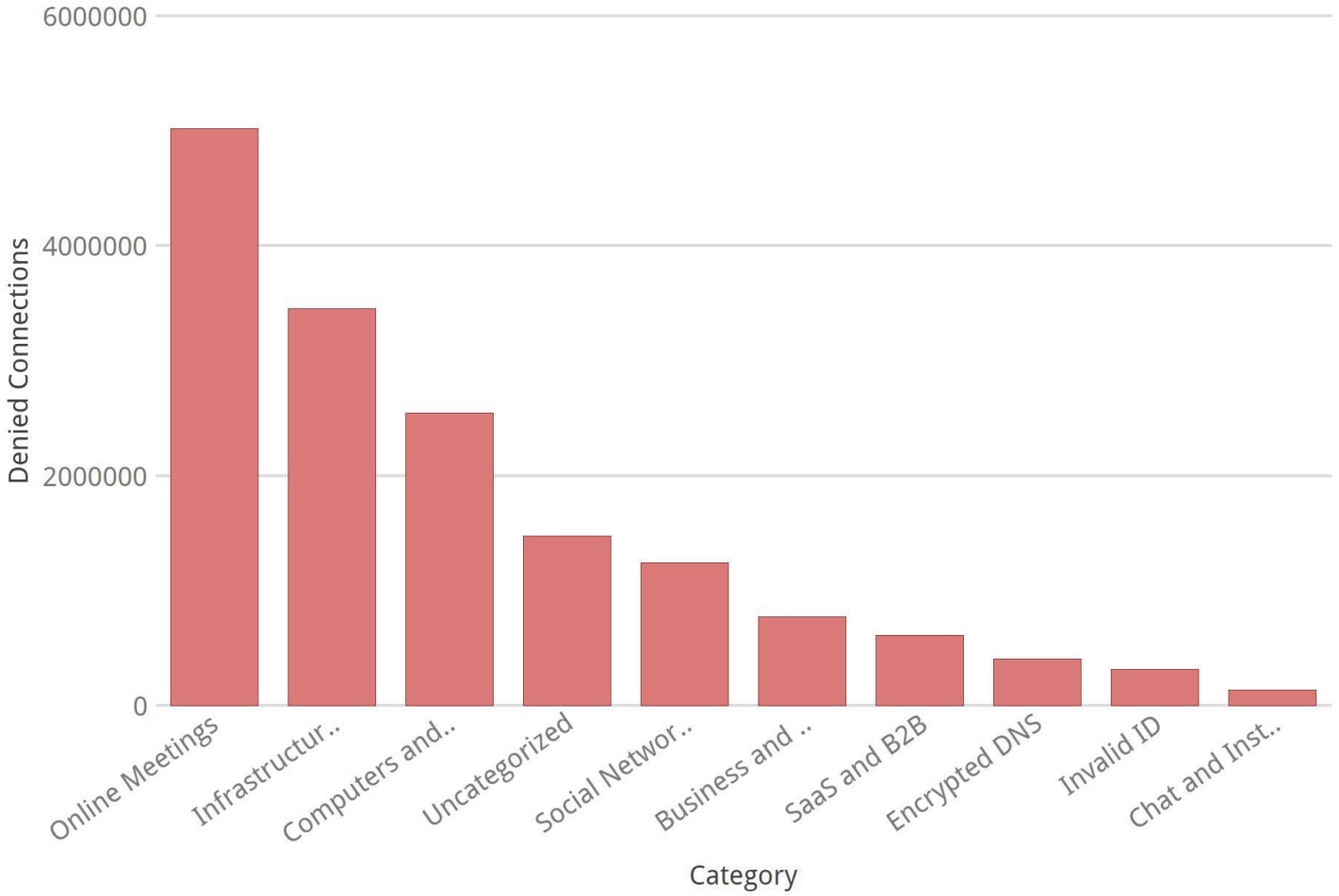
•Access the Arctic Wolf Platform: Arctic Wolf



End User Training Effectiveness



AAH Network Intrusion Detection



Category	Denied Connections
Online Meetings	5,018,050
Infrastructure and Content Delivery Networks	3,452,353
Computers and Internet	2,542,695
Uncategorized	1,476,618
Social Networking	1,242,560
Business and Industry	772,634
SaaS and B2B	610,580
Encrypted DNS	408,474
Invalid ID	314,835
Chat and Instant Messaging	138,051

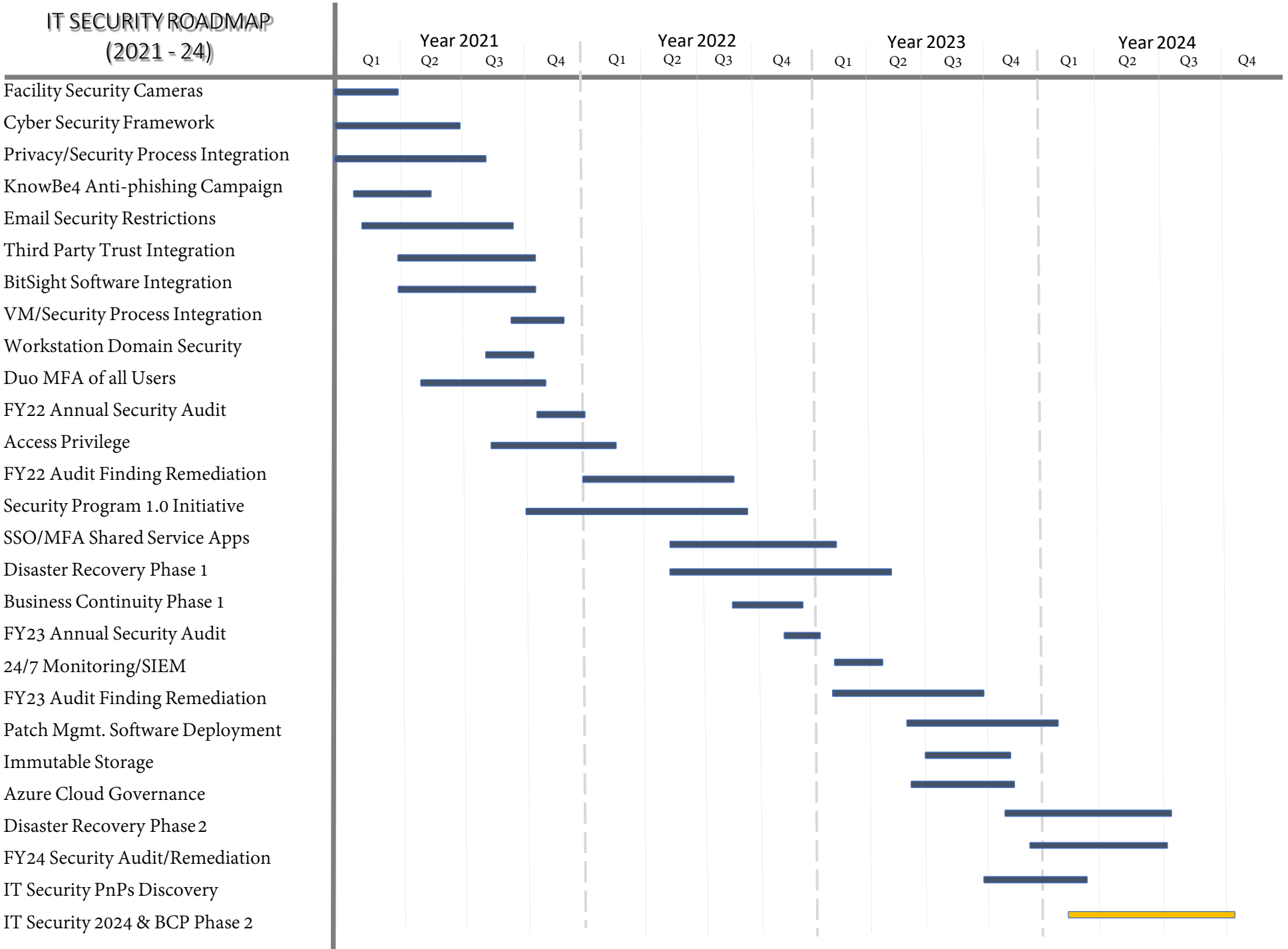
Note: Last 6 months Network Intrusion Detection.

Toolsets and Processes Aligned with Security Framework

Identify	Protect	Detect	Response	Recover
Asset Management	Identity Management	Anomalies and Events	Incident Response	Recovery Planning
Ticket System	Secure End Point	Secure End Point	Secure End Point	Secure End Point
Mobile Device Mgt.	Advanced Firewall	Advanced Firewall	Advanced Firewall	Advanced Firewall
Infrastructure Device Mgt.	Virtual Private Network	Virtual Private Network	Incident Response Plan	Secondary Data Center
Single Sign On	Active Directory	Mobile Device Mgt.	Network Performance	Disaster Recovery Runbook
Advance Patch Management	Vendor Access Mgt.	Network Performance	Mobile Device Mgt.	Cyber Insurance
Risk Management	Mobile Device Mgt.	Email and Web Security	Business Continuity Plan	Business Contiunity Plan
Annual Risk Assessment	Single Sign On	Mobile Iron	Incident Command Center	Recovery
Knowbe4	Multi-Factor Authentication	Securelink	24/7 Monitoring	VEEAM backup
Vendor Access Mgt.	Anti-Spam/Malware	BitSight	Disaster Recovery (DR)	Zerto
Vulnerability scanning	24/7 Monitoring	Detection	Impact Analysis	VM Ware
24/7 Monitoring	Awareness & Training	Vulnerability scanner	24/7 Monitoring	Pure Storage
Vendor Risk Management	Knowbe4	Advance Patch Management	Track-IT	Immutable Storage
CobbleStone (Contracts)	BitSight/BlackKite	Track-IT	Share 911	Mobile Device Mgt.
BitSight/ BlackKite/ Certa	CISA.gov	24/7 Monitoring	Zerto	SolarWinds
Security Risk Assessment and SOC	Quest Notifications	Knowbe4	O365 Email Exchange	Commvault
Third Party Trust	Data Security	Advanced Firewall	Knowbe4	O365 Email Exchange
Policies & Standards	Bit Locker	Anti-Spam	Hotline	Hotline
HIPAA Based Policies	Advance Patch Management	Anti-Malware	Email and Web Security	Commvault
Compliance 360	Data De-identification	Vulnerability Mgt Program	Vendor Management	Forensic Report
Awareness & Training	Physical Security		Privacy and Compliance	Awareness & Training
	Cameras			
	Key cards			
	Data Center Access			

Note: The security tool names are not disclosed in the above table due to security and confidentiality reasons.

IT SECURITY ROADMAP (2021 - 24)



Alliance Cyber Security Score

Alameda Alliance for Health

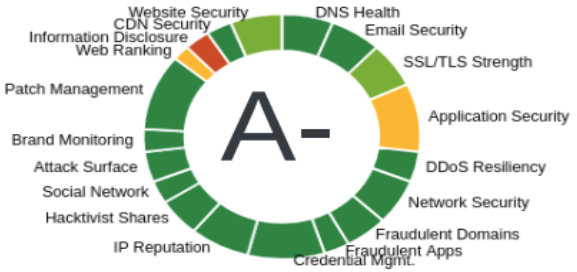
Other Services (except Public Administration) (NAICS: 81)

KEV

Data Breach Index (DBI): 0

Ransomware Susceptibility Index (RSI): 0.208

Cyber Rating



Technical Report

Calculated using MITRE

Probable Financial Impact Rating

RISK (Annualized)	
Aggregate Exposure	$335.2K
Data Breach	$217.1K
Ransomware	$108.7K
Business Interruption	$9.4K

FAIR Model

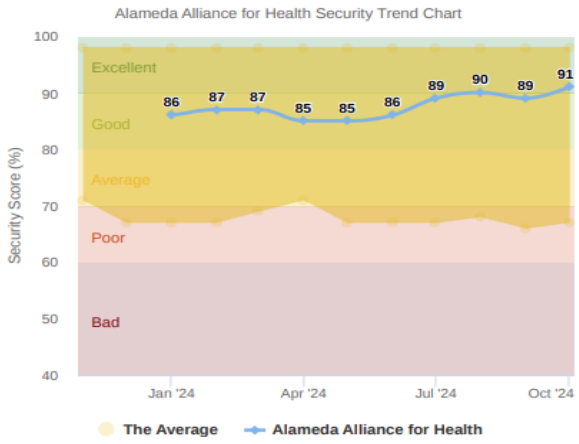
Using the FAIR model

Compliance Rating

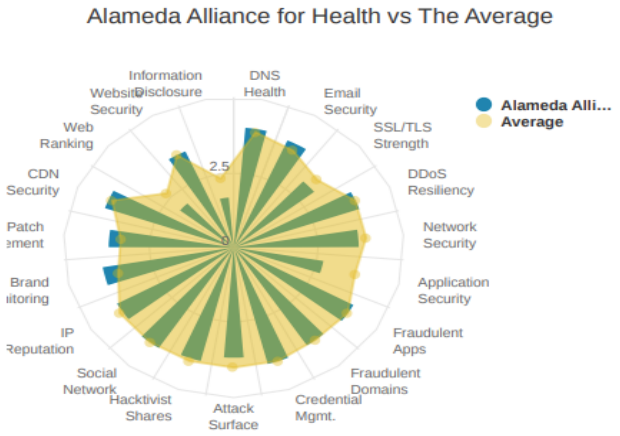
Compliance Report

Multiple Standards and Frameworks

Alameda Alliance for Health vs. Industry Average



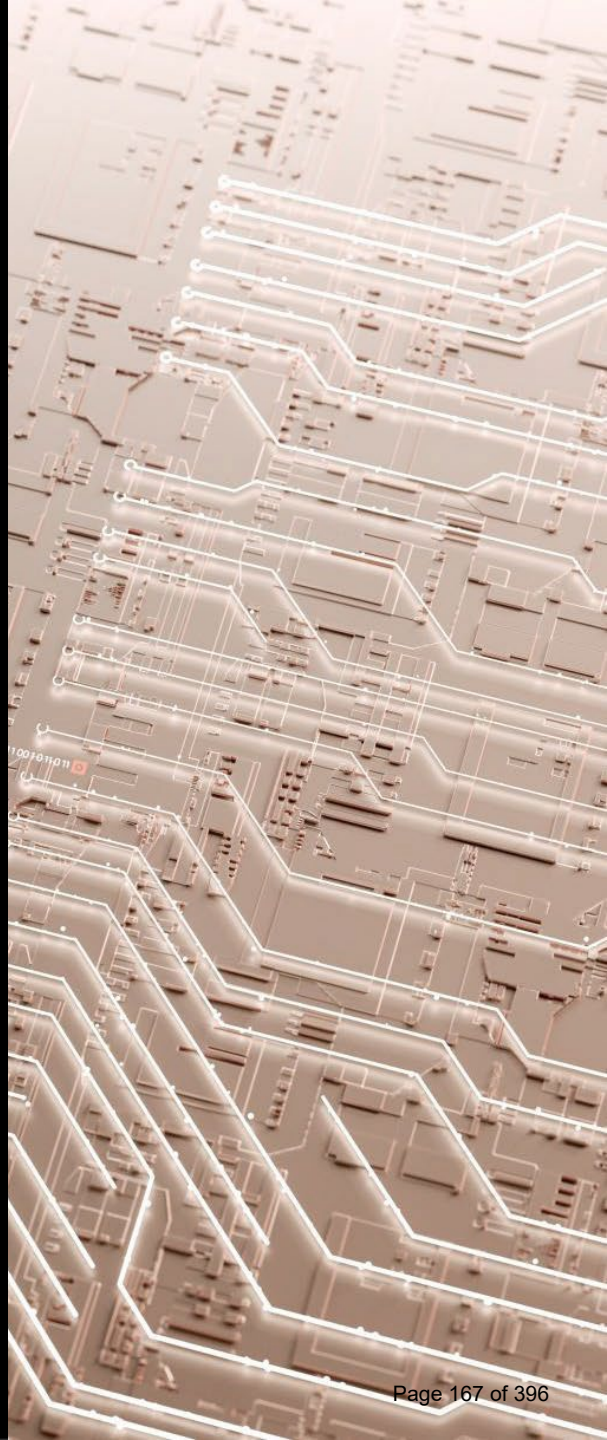
Category Comparison



Vulnerability Heat Map

Distribution	Critical	High	Medium	Low
Failed	0	10	15	56
Warning	0	0	7	128
Passed	36	122	334	342

QUESTIONS



BEHAVIORAL HEALTH COMPARISON AUDIT REPORT

Alameda Alliance for Health – Behavioral Health Comparison Audit [BHCA]: Preliminary Audit Report

Presented By: Richard Golfin III

October 2024

ALAMEDA Alliance FOR HEALTH

Background

- The Behavioral Health Comparison Audit (BHCA) compares the Alliance Behavioral Health Clinical Operations to the DMHC settlement agreement with Kaiser (Settlement Agreement).
- The goal of the audit is to:
  - Identify potential areas for improvement;
  - Mitigate risk, and;
  - Reduce audit findings from the State.
- The BHCA provides an opportunity for the Alliance to evaluate its behavioral health services through the same lens as the DMHC.
  - The review is valuable as it evaluates the Alliance BH insourcing beginning April 1, 2023.

Background

- DMHC Settlement Agreement
  - Was entered into on October 11, 2023.
  - Is a $200 million enforcement action.
    - → $50 million administrative penalty.
    - → $150 million investment commitment to expand and improve behavioral health services.
  - Outlines Kaiser's violations which includes, but is not limited to:
    - → Inadequate oversight,
    - → Inability to provide appointments within timely access standards,
    - → Failure to make proper out-of-network referrals, and
    - → Inadequate handling of member grievances.

Methodology

- The Alliance Internal Audit Department developed 66 Review Criteria based the DMHC Settlement Agreement
- BHCA Details & Procedure:
  - The BHCA excludes criteria for Behavioral Health Treatment and Kaiser delegation.
  - Reviewed current policies, procedures, workflows, and other relevant documentation to evaluate the Alliance.
  - Analyzed data for Q4 2023 (October 1, 2023, through December 31, 2023).
  - Conducted in-depth meetings with subject matter experts (from April 23, 2024, through August 20, 2024).

Preliminary: Summary

- 16 Review Criteria: Preliminary findings and/or observations have been identified.
- 45 Review Criteria: The Alliance is fully compliant.
- 5 Review Criteria: Not applicable because the Alliance does not delegate behavioral health services.

Preliminary: Strengths

- The Alliance demonstrates moderate compliance in comparison to the Settlement Agreement. The Alliance's strengths include:
  - Mental health parity
  - Clinical decision-making and documentation.
  - Regular discussion of behavioral health grievances and network challenges including developing strategies and improvement activities to address these issues.
  - Access to behavioral health appointments are not restricted through prior authorization (for Medi-Cal) or visit limits.
  - Facilitating out-of-network referrals when in-network services are unavailable.

Summary of Preliminary Findings

- The Behavioral Health Department did not pass an audit of Notice of Action letters denying authorizations in Q4 2023.
- The Grievance & Appeals Department did not pass an audit of its grievance resolution letters in Q4 2023.
- The Plan did not follow-up on Missed or Canceled Appointments per the contract. Plan follow-up is only applicable to Primary Care Physicians. The DHCS contract requires this for all Network Provider types.
  - DHCS Contract Exhibit A, Attachment III, Section 5.2.5 (A)(2)(c)

Summary of Preliminary Observations

- Access & Availability reviews medical records, but it does not document its review unless a corrective action is issued against a provider.
- Grievance & Appeals' operational processes do not provide documented steps to ensure members are informed about alternative ways to access immediate services.
- Behavioral Health implemented a form to aid in care coordination and monitoring, but there are no policies or desktop procedures for the form.
  - Also, there is no incentive for providers to submit the form.
- Behavioral health provider expertise was collected in an effort to maximize utilization of the Alliance's existing network, but the information has not been maintained or incorporated into the Provider Repository.
- Processes to address timely access grievances and provider compliance with timely access standards take longer than timely access standards.

Next Steps

- Revise audit findings, observations, and report.
- Meet with audited departments to review final draft of audit findings, observations, and report.
- Issue final audit findings, observations, and report including any necessary corrective action plans.
- Present findings to the Board of Governors.

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Finance

Gil Riojas

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

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

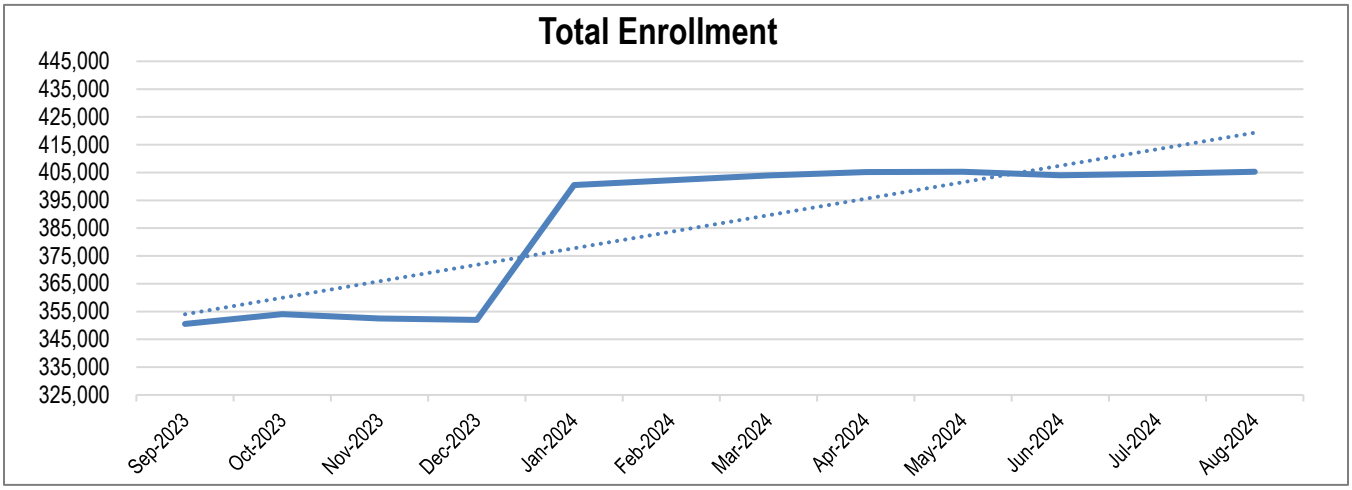
Date: **October 11th, 2024**

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

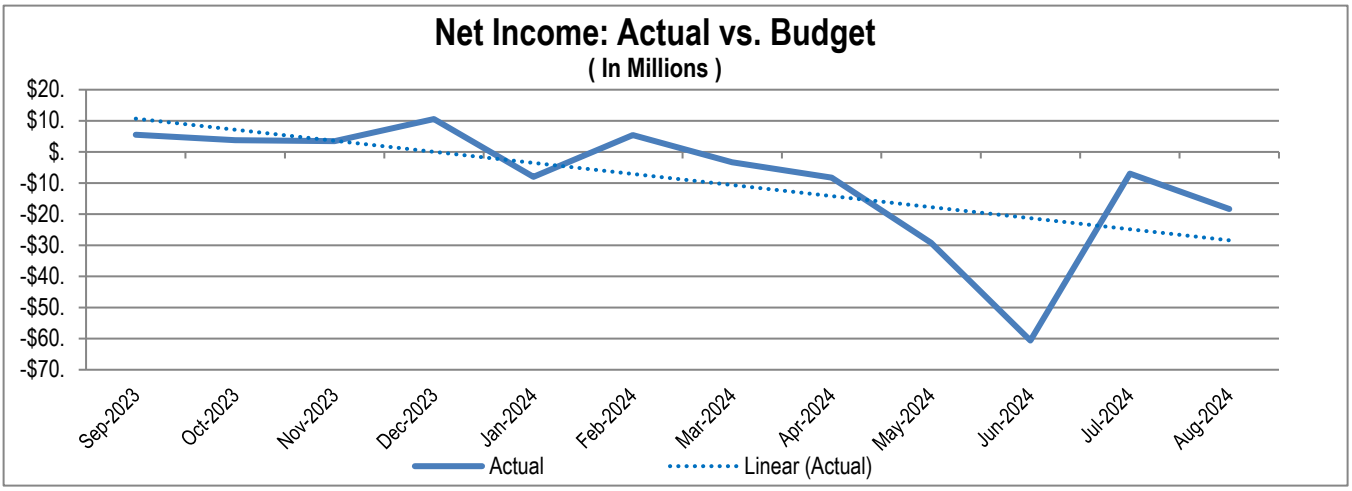
Executive Summary

For the second month of the new fiscal year, the Alliance continued to see slight increases in enrollment, reaching 405,267 members. A Net Loss of $18.4 million was reported, and the Plan's Medical Expenses represented 106.8% of revenue. Alliance reserves decreased to 322% of required but continue to remain above minimum requirements.

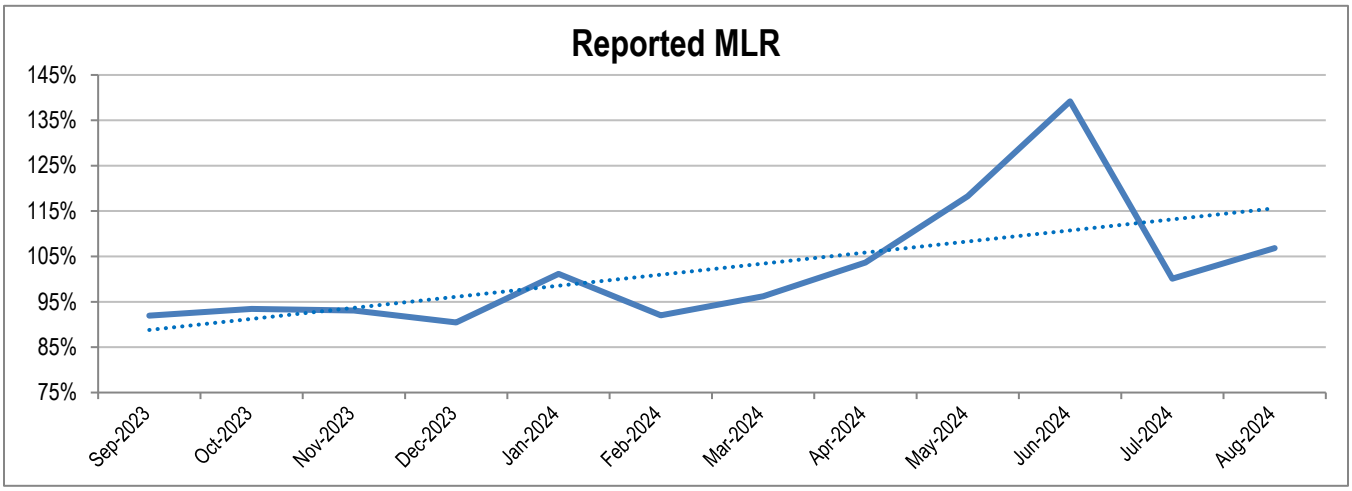
Enrollment – In August, Enrollment increased by 759 members.



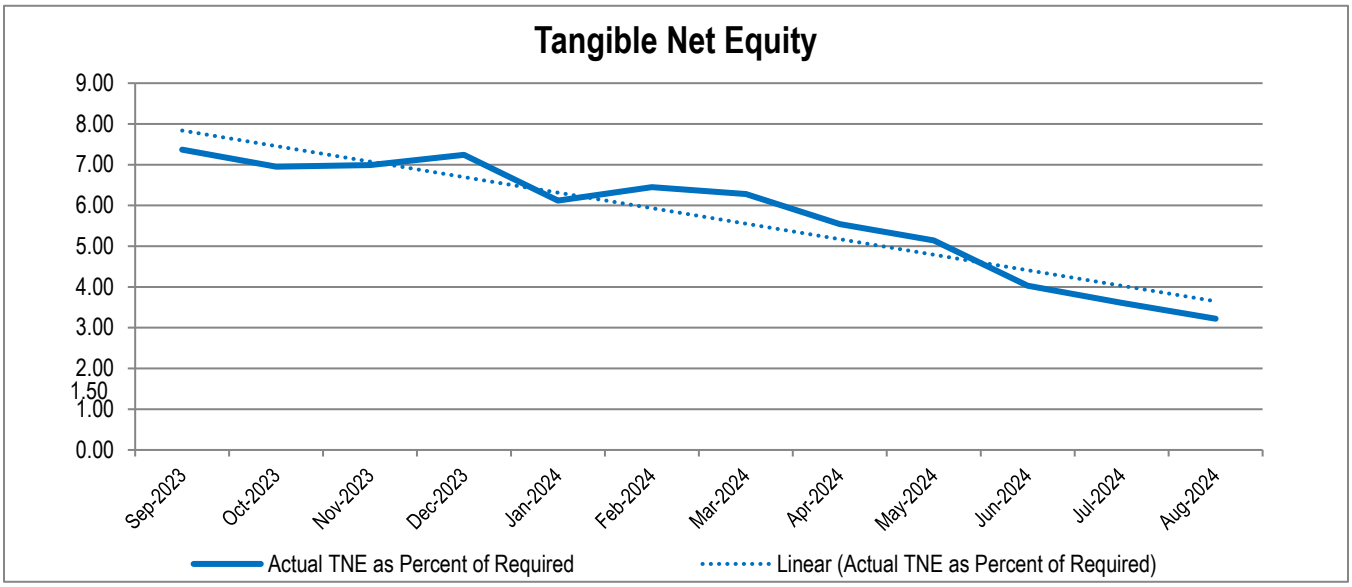
Net Income – For the month ended August 31st, 2024, actual Net Loss was $18.4 million vs. budgeted Net Loss of $2.7 million. For the fiscal YTD, actual Net Loss was $25.3 million vs. budgeted Net Loss of $5.2 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $175.8 million vs. budgeted Revenue of $166.1 million.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 106.8% for the month, and 103.6% for fiscal YTD. The major variances include unfavorable Inpatient/SNF, Emergency Expense, and Long-Term Care expenses.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $71.5M in reserves, we reported $230M. Our overall TNE remains above DMHC requirements at 322%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, we reported returns of $7.2M, in the investment portfolio.

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

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

Date: **October 11th, 2024**

Subject: **Finance Report – August 2024**

Executive Summary

- For the month ended August 31st, 2024, the Alliance had enrollment of 405,267 members, a Net Loss of $18.4 million and 322% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$222,835	$434,087
Medical Expense	187,856	352,367
Admin. Expense	9,489	20,310
MCO Tax Expense	47,015	93,941
Other Inc. / (Exp.)	3,171	7,187
Net Income	**($18,355)**	**($25,344)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	($17,799)	($24,861)
Group Care	(401)	(216)
Medicare	(155)	(268)
	($18,355)	**($25,344)**

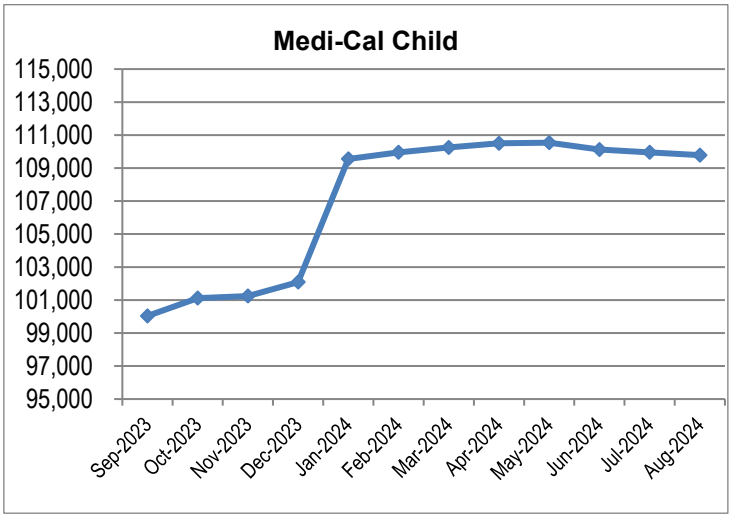
Enrollment

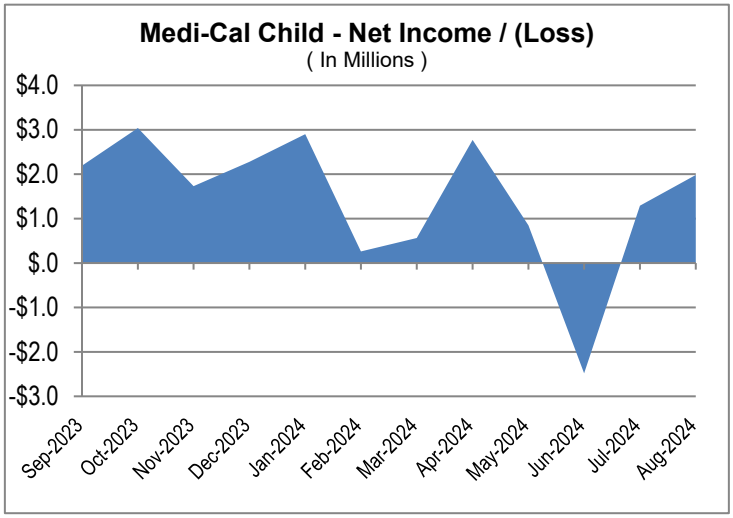
- Total enrollment increased by 759 members since July 2024.
- Total enrollment increased by 1,277 members since June 2024.

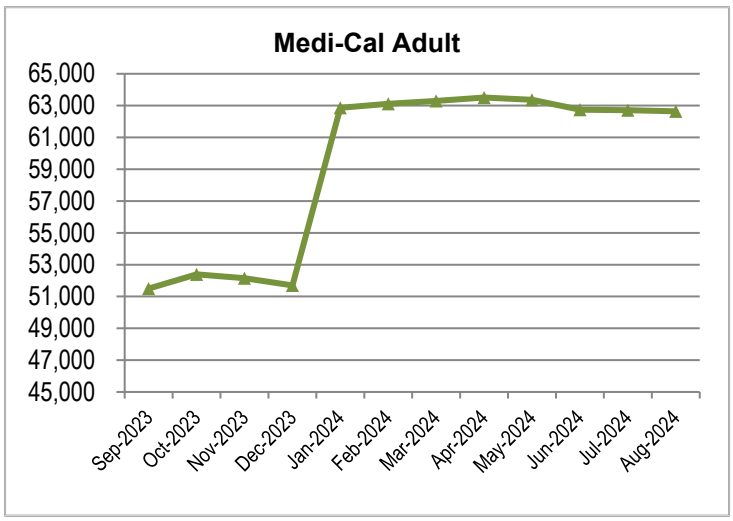
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

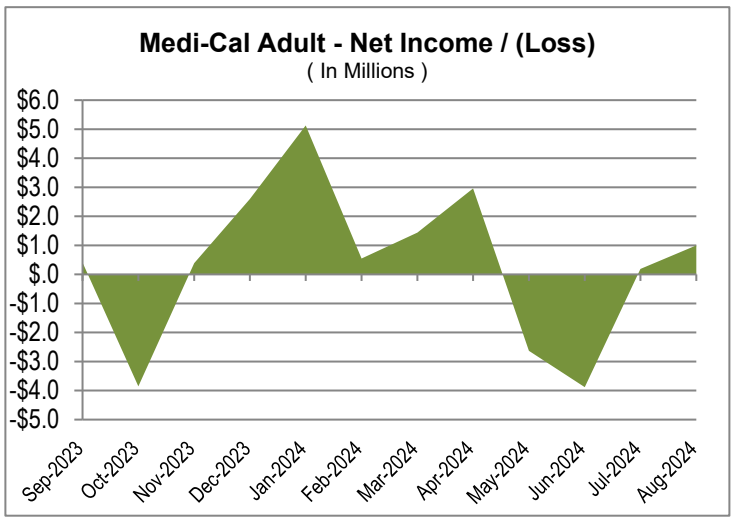
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
62,641	63,635	(994)	-1.6%	Adult	125,349	127,206	(1,857)	-1.5%
109,784	110,944	(1,160)	-1.0%	Child	219,735	221,667	(1,932)	-0.9%
35,177	34,848	329	0.9%	SPD	70,195	69,696	499	0.7%
40,024	39,791	233	0.6%	Duals	79,916	79,582	334	0.4%
150,482	149,466	1,016	0.7%	ACA OE	300,283	298,783	1,500	0.5%
226	224	2	0.9%	LTC	448	448	0	0.0%
1,247	1,285	(38)	-3.0%	LTC Duals	2,488	2,570	(82)	-3.2%
399,581	**400,193**	**(612)**	**-0.2%**	**Medi-Cal Total**	**798,414**	**799,952**	**(1,538)**	**-0.2%**
5,686	5,643	43	0.8%	Group Care	11,361	11,286	75	0.7%
405,267	**405,836**	**(569)**	**-0.1%**	**Total**	**809,775**	**811,238**	**(1,463)**	**-0.2%**

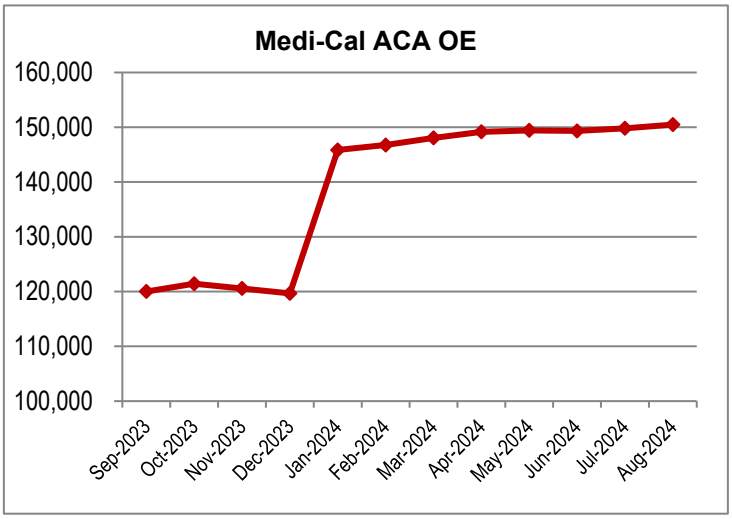
Enrollment and Profitability by Program and Category of Aid

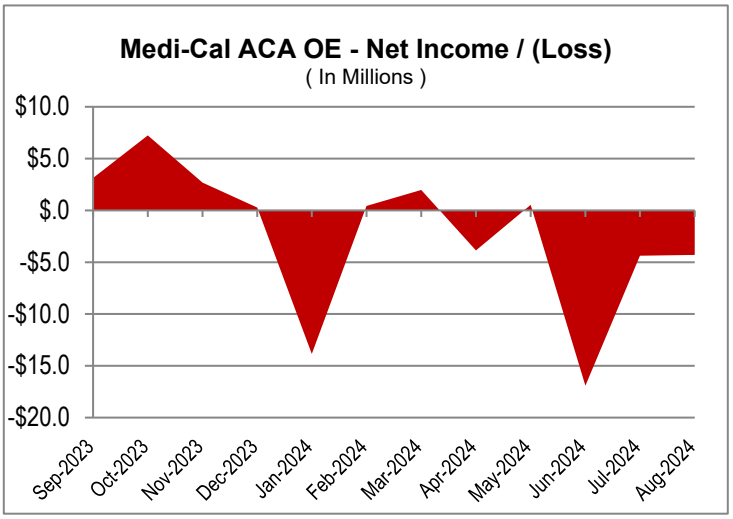




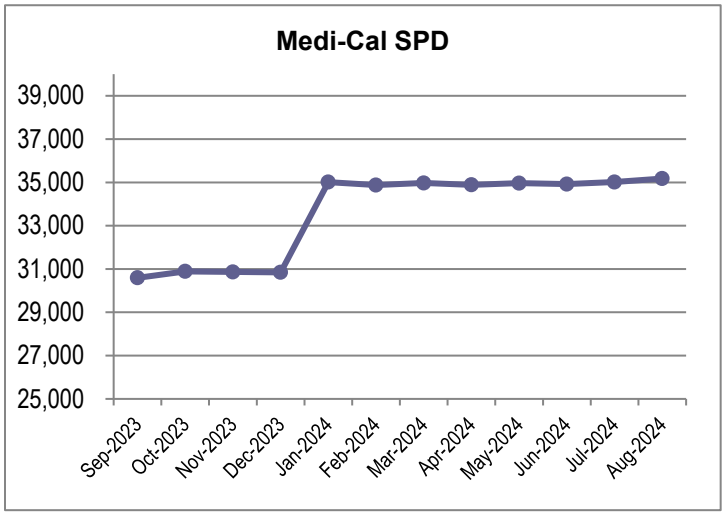


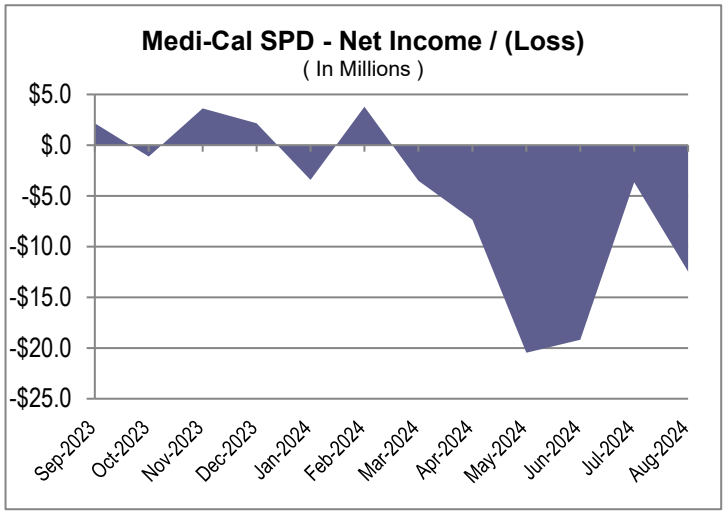


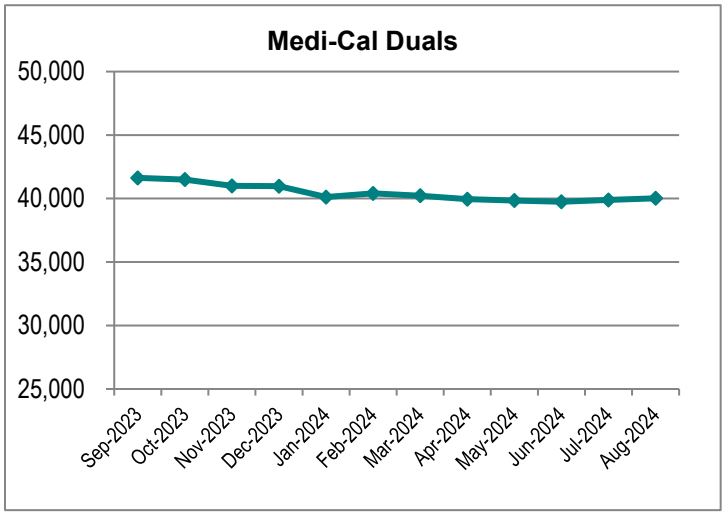


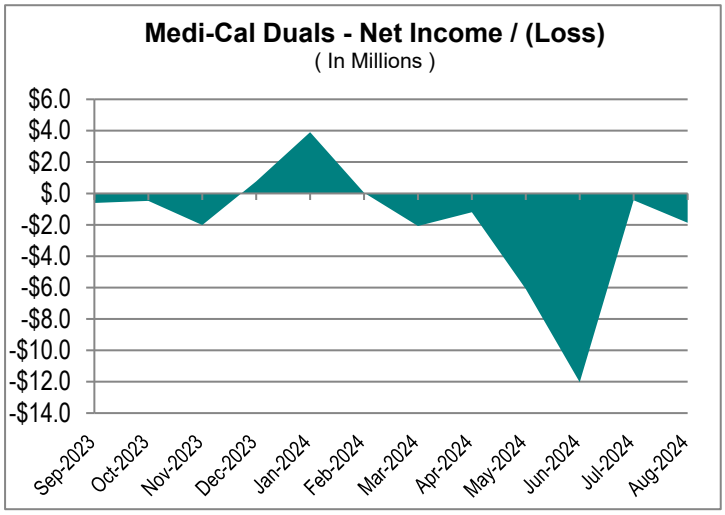


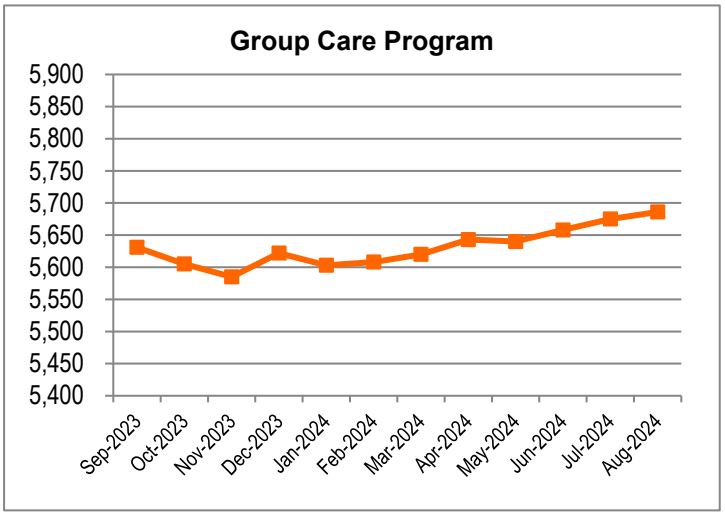
Enrollment and Profitability by Program and Category of Aid

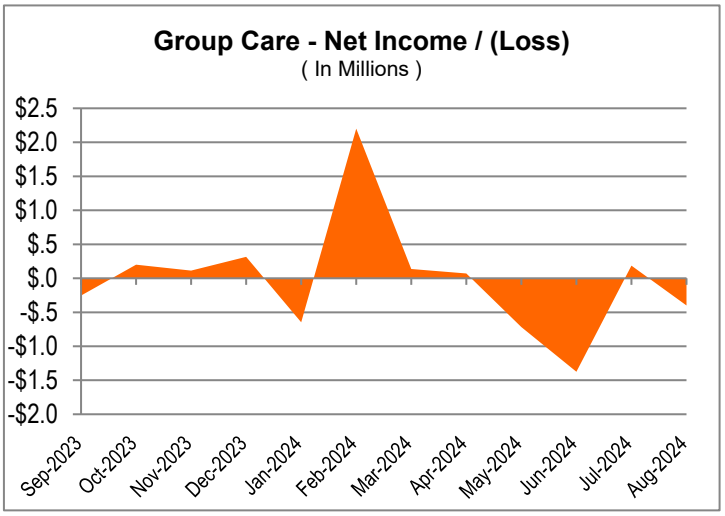




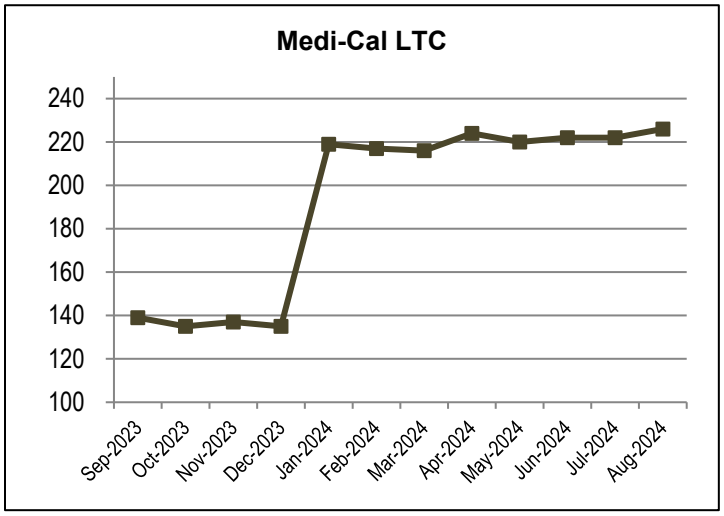


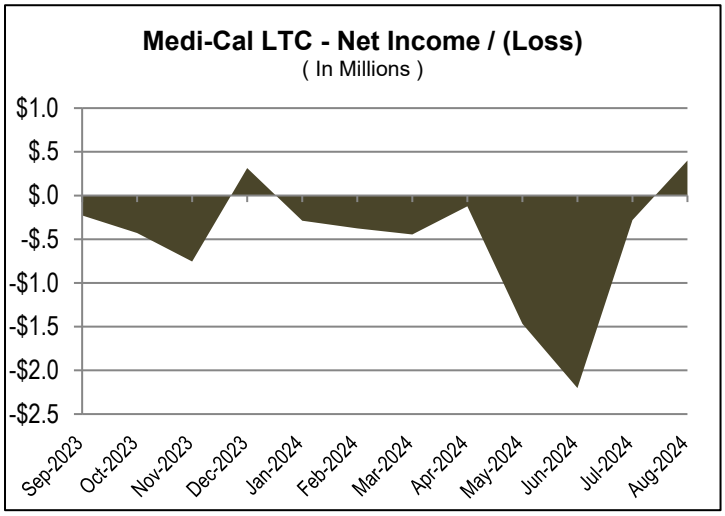


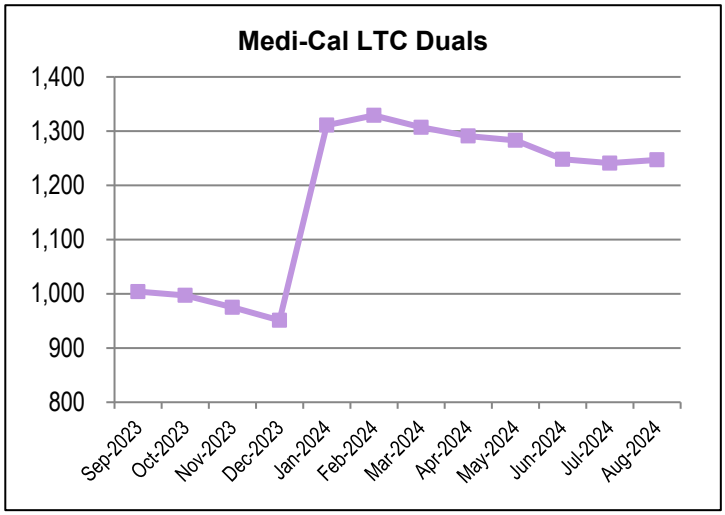


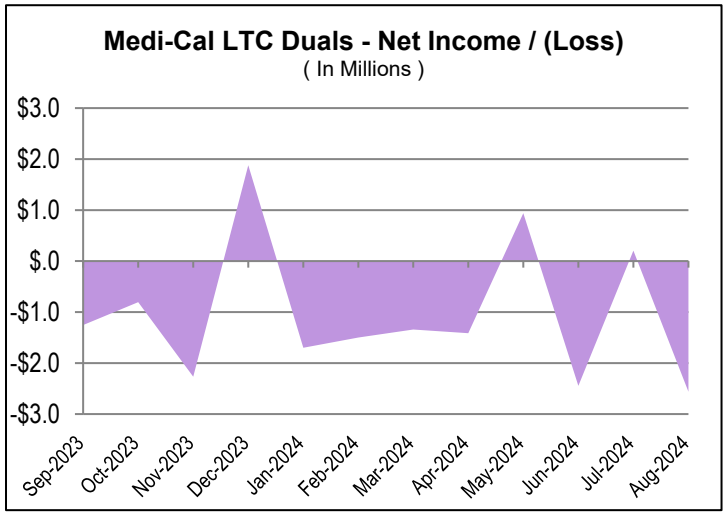


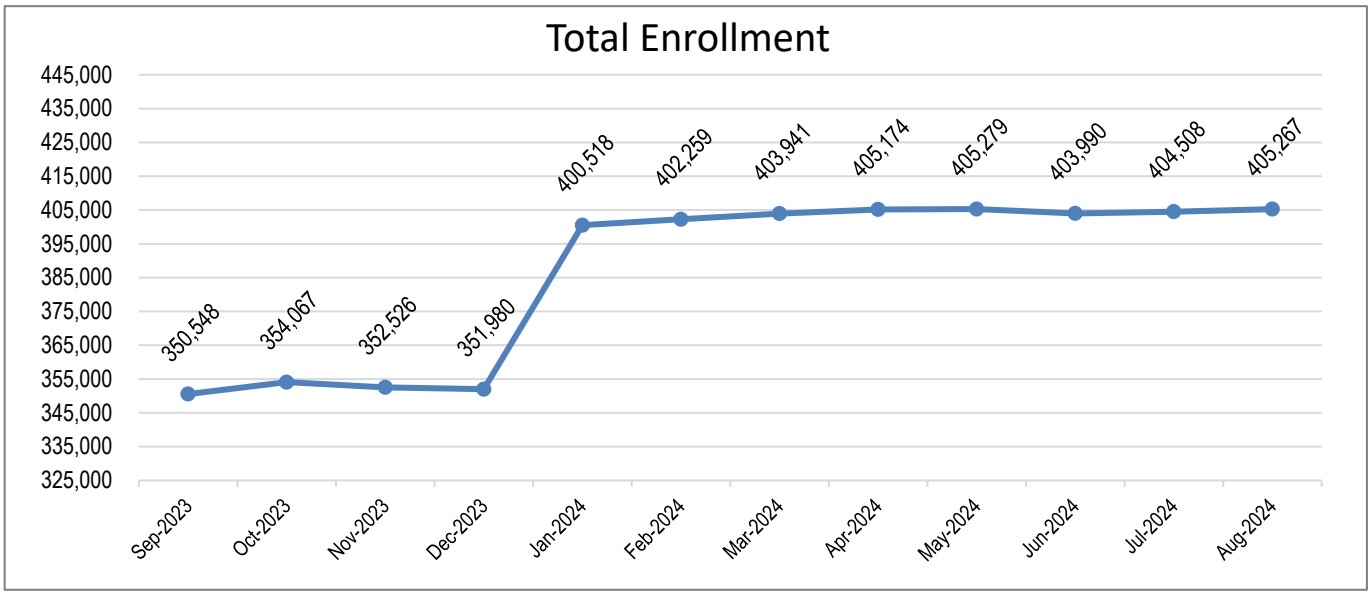
Enrollment and Profitability by Program and Category of Aid

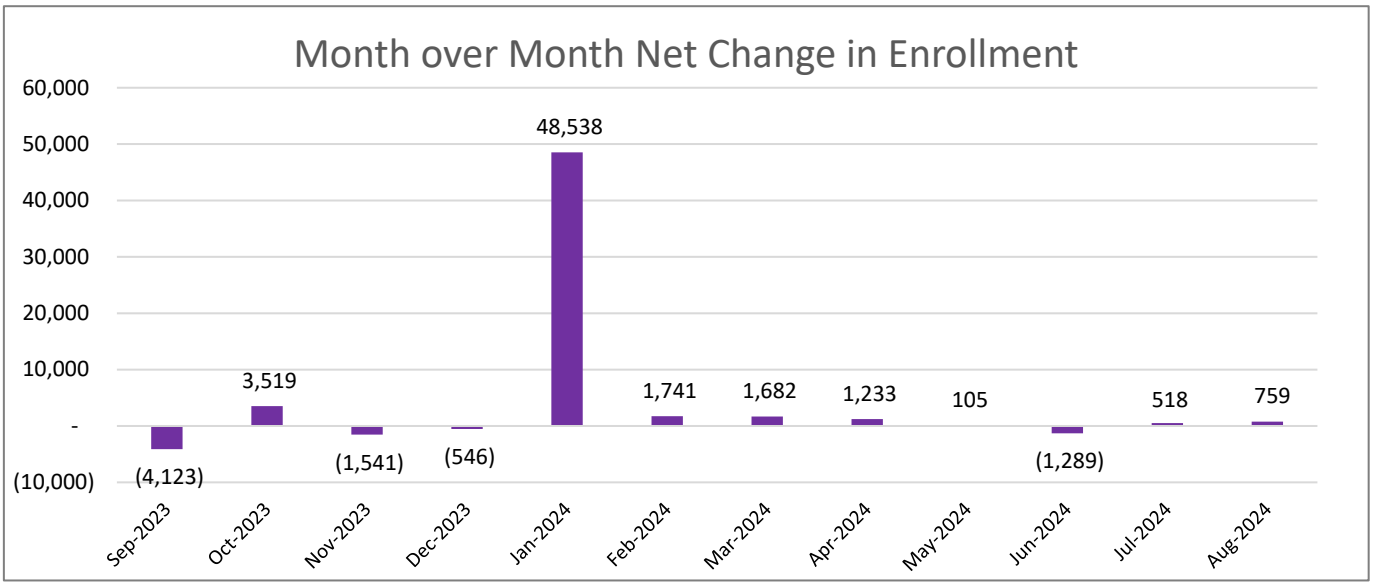








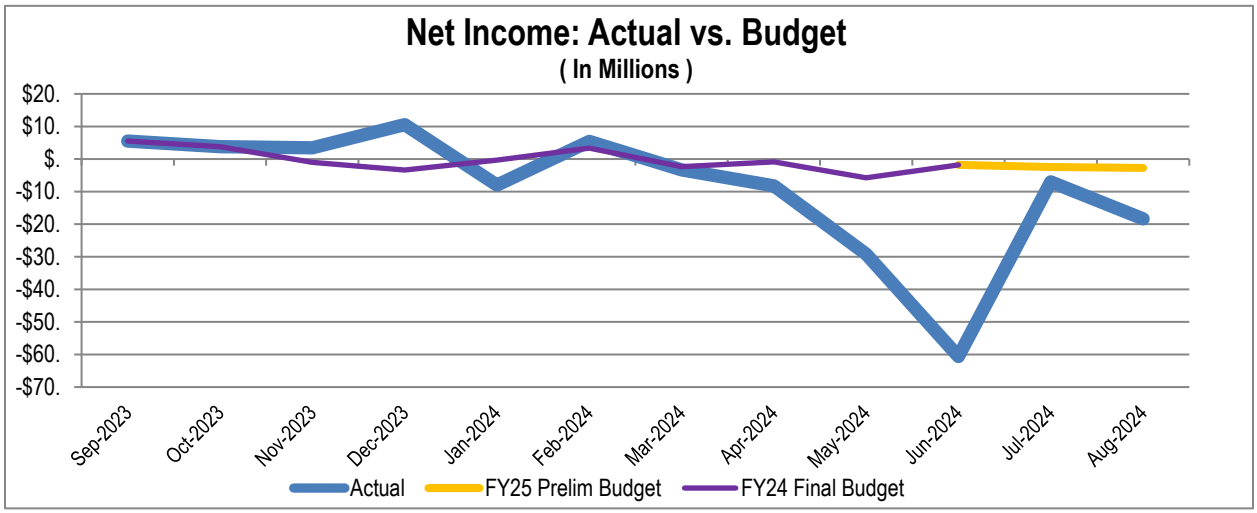




- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and ended May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the Alliance.
- In January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

Net Income

- For the month ended August 31st, 2024:
  - Actual Net Loss $18.4 million.
  - Budgeted Net Loss $2.7 million.
- For the fiscal YTD ended August 31st, 2024:
  - Actual Net Loss $25.3 million.
  - Budgeted Net Loss $5.2 million.

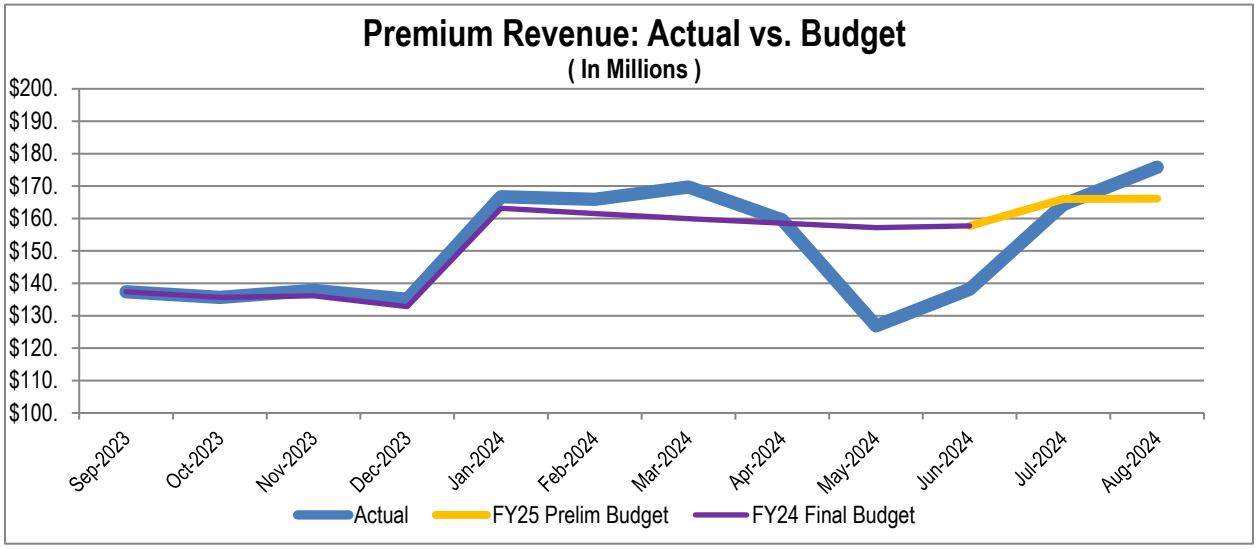


- The unfavorable variance of $15.6 million in the current month is primarily due to:
  - Unfavorable $25.3 million higher than anticipated Medical Expense.
  - Unfavorable $728,000 higher than anticipated Administrative Expense.
  - Partially offset by favorable $9.6 million Premium Revenue.

Premium Revenue

- For the month ended August 31st, 2024:
  - Actual Revenue: $175.8 million.
  - Budgeted Revenue: $166.1 million.

- For the fiscal YTD ended August 31st, 2024:
  - Actual Revenue: $340.1 million
  - Budgeted Revenue: $332.1 million.



- For the month ended August 31st, 2024, the favorable Premium Revenue variance of $9.7 million is primarily due to the following:
  - Favorable $12.3 million CY2024 Rate Acuity Reserve adjustment.
  - Unfavorable $4.3 million CY2022 ECM Risk Corridor adjustment.

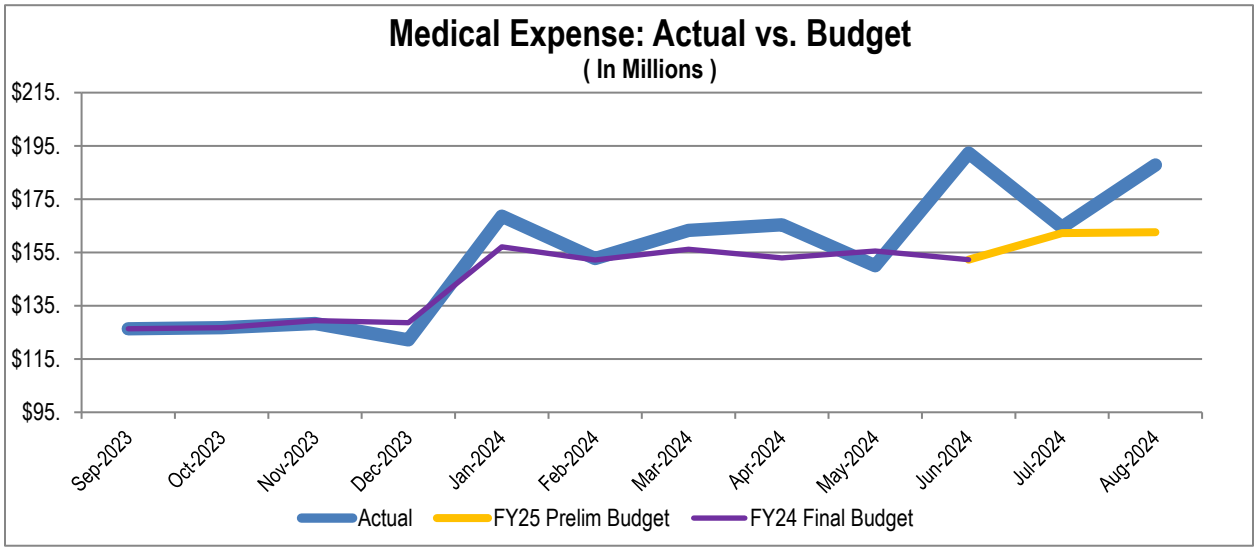
Medical Expense

- For the month ended August 31st, 2024:
  - Actual Medical Expense: $187.9 million.
  - Budgeted Medical Expense: $162.6 million.
- For the fiscal YTD ended August 31st, 2024:
  - Actual Medical Expense: $352.4 million.
  - Budgeted Medical Expense: $324.8 million.

- 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 August, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $13.7 million. Year to date, the estimate for prior years increased by $12.1 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	$39,115,271	$0	$39,115,271	$39,629,633	$514,361	1.3%
Primary Care FFS	$12,104,203	$82,458	$12,186,661	$12,245,773	$141,571	1.2%
Specialty Care FFS	$15,355,861	$896,963	$16,252,824	$16,040,943	$685,081	4.3%
Outpatient FFS	$24,026,299	$453,073	$24,479,372	$22,937,226	($1,089,074)	-4.7%
Ancillary FFS	$30,203,975	$1,571,317	$31,775,292	$33,867,274	$3,663,300	10.8%
Pharmacy FFS	$26,232,356	$730,955	$26,963,311	$24,237,649	($1,994,708)	-8.2%
ER Services FFS	$21,982,966	$710,221	$22,693,187	$17,498,754	($4,484,212)	-25.6%
Inpatient Hospital & SNF FFS	$100,485,873	$5,779,587	$106,265,460	$91,156,751	($9,329,122)	-10.2%
Long Term Care FFS	$63,427,969	$1,891,702	$65,319,670	$58,388,252	($5,039,717)	-8.6%
Other Benefits & Services	$7,098,549	$0	$7,098,549	$8,059,548	$961,000	11.9%
Net Reinsurance	$217,271	$0	$217,271	$771,247	$553,976	71.8%
Provider Incentive	$0	$0	$0	$0	$0	-
	$340,250,593	**$12,116,277**	**$352,366,870**	**$324,833,050**	**($15,417,543)**	**-4.7%**

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	$48.30	$0.00	$48.30	$48.85	$0.55	1.1%
Primary Care FFS	$14.95	$0.10	$15.05	$15.10	$0.15	1.0%
Specialty Care FFS	$18.96	$1.11	$20.07	$19.77	$0.81	4.1%
Outpatient FFS	$29.67	$0.56	$30.23	$28.27	($1.40)	-4.9%
Ancillary FFS	$37.30	$1.94	$39.24	$41.75	$4.45	10.7%
Pharmacy FFS	$32.39	$0.90	$33.30	$29.88	($2.52)	-8.4%
ER Services FFS	$27.15	$0.88	$28.02	$21.57	($5.58)	-25.9%
Inpatient Hospital & SNF FFS	$124.09	$7.14	$131.23	$112.37	($11.72)	-10.4%
Long Term Care FFS	$78.33	$2.34	$80.66	$71.97	($6.35)	-8.8%
Other Benefits & Services	$8.77	$0.00	$8.77	$9.93	$1.17	11.8%
Net Reinsurance	$0.27	$0.00	$0.27	$0.95	$0.68	71.8%
Provider Incentive	$0.00	$0.00	$0.00	$0.00	$0.00	-
	$420.18	**$14.96**	**$435.14**	**$400.42**	**($19.76)**	**-4.9%**

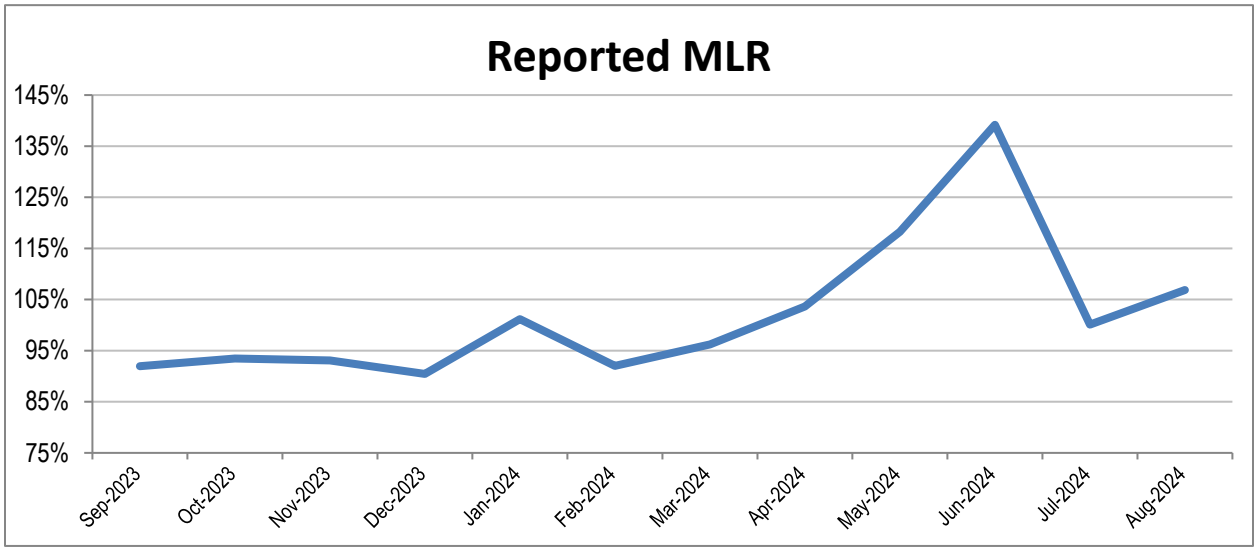
- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $15.4 million unfavorable to budget. On a PMPM basis, medical expense is 4.9% unfavorable to budget. For per-member-per-month expense:
    - Capitated Expense is slightly under budget, largely driven by favorable PCP Capitation FQHC expense, partially offset by unfavorable PCP

Capitation expense due to inception of Provider Targeted Rate Increases (TRI).

- Primary Care Expense is under budget driven by the low utilization in the ACA OE aid category of aid.
- Specialty Care Expense is below budget, driven mostly by less than expected ACA OE utilization in the Adult and Duals COAs.
- Outpatient Expense is over budget mostly due to higher dialysis utilization in the SPD category of aid.
- Ancillary Expense is under budget mostly due to lower than expected utilization in the SPD and ACA OE categories of aid.
- Pharmacy Expense is under budget due to low Non-PBM expense driven by lower utilization in the ACA OE, Adult and Duals COAs.
- Emergency Room Expense is over budget driven by high utilization and unit cost in the SPD and ACA OE COAs.
- Inpatient Expense is over budget driven by higher utilization and unit cost due to increased catastrophic case and contract change expense in the ACA OE, SPD and Adult COAs.
- Long Term Care Expense is over budget due to high utilization in the SPD, ACA OE and Duals COAs.
- Other Benefits & Services is under budget, due to the elimination of grant 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 106.8% for the month and 103.6% for the fiscal year-to-date.



Administrative Expense

- For the month ended August 31st, 2024:
  - Actual Administrative Expense: $9.5 million.
  - Budgeted Administrative Expense: $8.8 million.

- For the fiscal YTD ended August 31st, 2024:
  - Actual Administrative Expense: $20.3 million.
  - Budgeted Administrative Expense: $17.5 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 %**
$5,540,322	$5,635,365	$95,042	1.7%	Employee Expense	$10,900,824	$11,136,942	$236,118	2.1%
74,206	74,512	306	0.4%	Medical Benefits Admin Expense	149,040	148,968	(73)	0.0%
2,097,888	1,587,150	(510,738)	-32.2%	Purchased & Professional Services	5,004,602	3,136,930	(1,867,672)	-59.5%
1,776,852	1,463,954	(312,898)	-21.4%	Other Admin Expense	4,255,713	3,052,393	(1,203,320)	-39.4%
$9,489,268	$8,760,980	($728,288)	-8.3%	Total Administrative Expense	$20,310,180	$17,475,233	($2,834,946)	-16.2%

The year-to-date variances include:

- Unfavorable in Purchased & Professional Services, primarily for the timing for Consulting Services, Other Purchased Services: Legal Fees, HMS Recovery Fees, and Software Expense.
- Unfavorable in Licenses, Insurance & Fees - for IT-related Licenses and Subscriptions as well as increases in Bank Fees and the timing of Insurance Premiums (early payments for the remainder of CY24).
- Unfavorable Printing/Postage/Promotion and Supplies & Other Expenses.
- Favorable Employee and Temporary Services and delayed training, travel, and other employee-related expenses.
- Favorable Building Occupancy costs.

The Administrative Loss Ratio (ALR) is 5.4% of net revenue for the month and 6.0% of net revenue year-to-date. Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $301,000.

Other Income / (Expense)

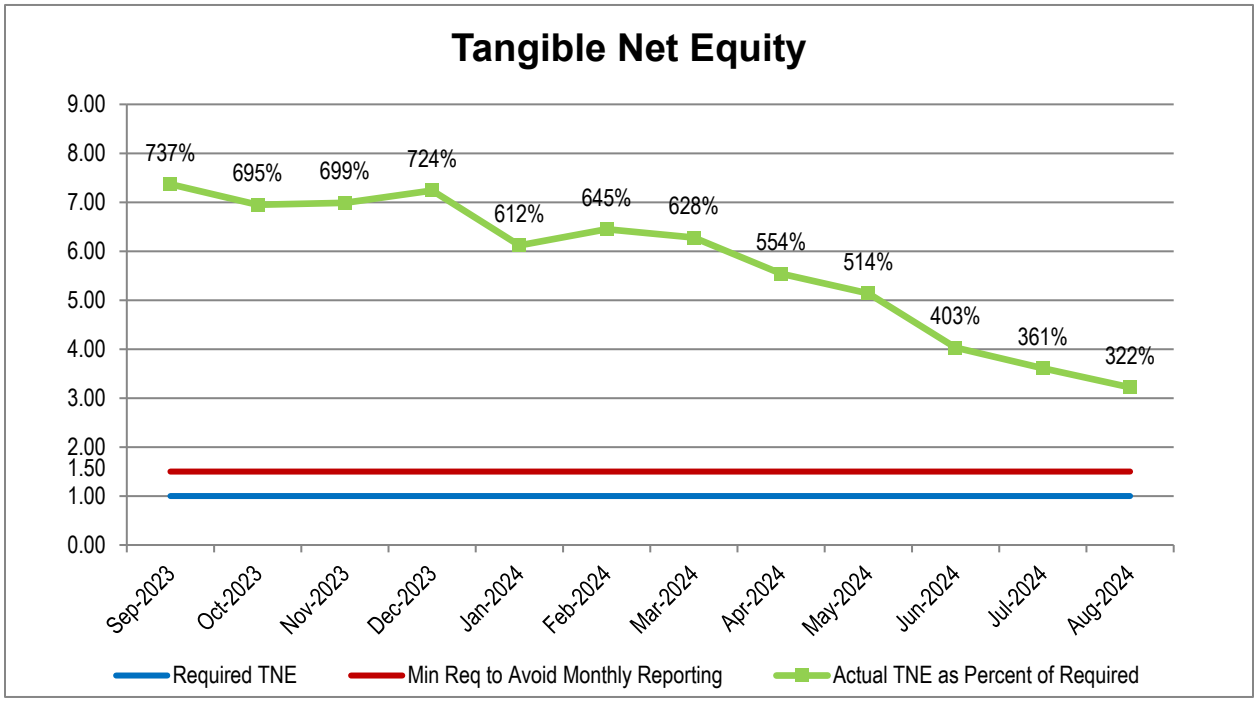
Other Income & Expense is comprised of investment income and claims interest. Fiscal year-to-date net investments show a gain of $7.2 million.

Managed Care Organization (MCO) Provider Tax

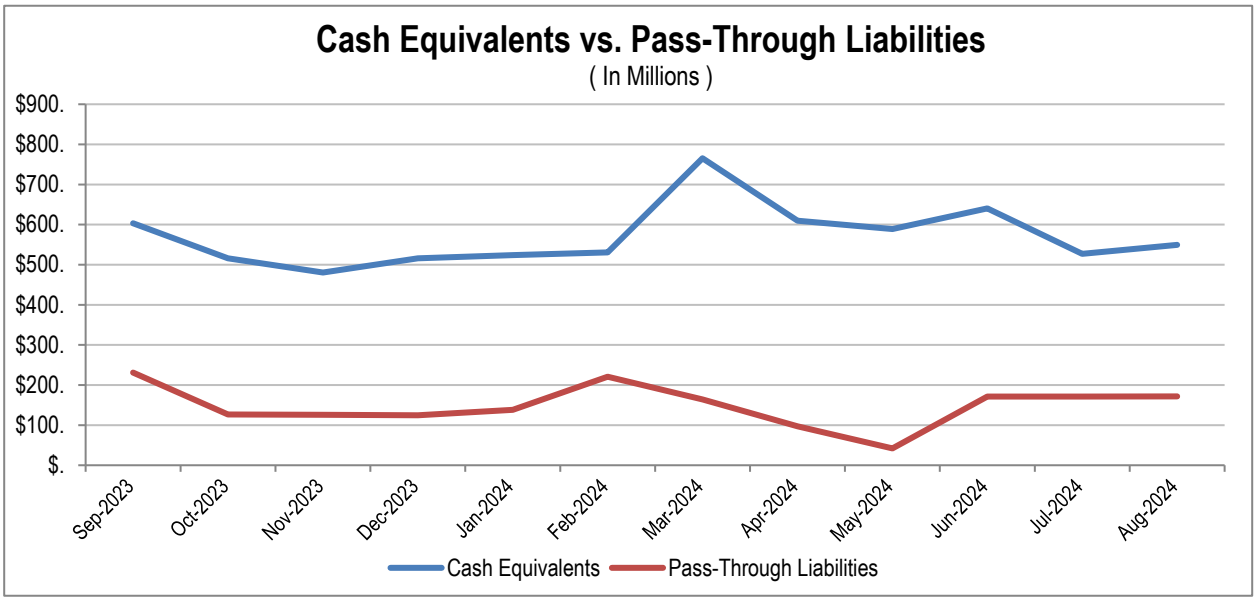
- Revenue:
  - For the month ended August 31st, 2024:
    - Actual: $47.0 million.
    - Budgeted: $47.1 million.
  - For the fiscal YTD ended August 31st, 2024:
    - Actual: $93.9 million.
    - Budgeted: $94.1 million.
- Expense:
  - For the month ended August 31st, 2024:
    - Actual: $47.0 million.
    - Budgeted: $47.1 million.
  - For the fiscal YTD ended August 31st, 2024:
    - Actual: $93.9 million.
    - Budgeted: $94.1 million.

Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
  - Required TNE $71.5 million
  - Actual TNE $230.0 million
  - Excess TNE $158.5 million
  - TNE % of Required TNE 322%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $549.4 million
    - Pass-Through Liabilities $171.6 million
    - Uncommitted Cash $377.8 million
    - Working Capital $158.5 million
    - Current Ratio 1.20 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $530,000.
- Annual capital budget: $1.7 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 AUGUST 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
399,581	400,193	(612)	(0.2%)	1. Medi-Cal	798,414	799,952	(1,538)	(0.2%)
5,686	5,643	43	0.8%	2. GroupCare	11,361	11,286	75	0.7%
405,267	**405,836**	**(569)**	**(0.1%)**	**3. TOTAL MEMBER MONTHS**	**809,775**	**811,238**	**(1,463)**	**(0.2%)**
				REVENUE				
$175,820,071	$166,125,508	$9,694,563	5.8%	4. Premium Revenue	$340,145,411	$332,142,543	$8,002,869	2.4%
$47,014,700	$47,086,708	($72,008)	(0.2%)	5. MCO Tax Revenue AB119	$93,941,391	$94,122,352	($180,961)	(0.2%)
$222,834,771	**$213,212,216**	**$9,622,555**	**4.5%**	**6. TOTAL REVENUE**	**$434,086,802**	**$426,264,895**	**$7,821,908**	**1.8%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$19,570,204	$19,825,562	$255,358	1.3%	7. Capitated Medical Expense	$39,115,271	$39,629,633	$514,361	1.3%
				Fee for Service Medical Expenses				
$55,954,592	$45,626,974	($10,327,618)	(22.6%)	8. Inpatient Hospital Expense	$106,265,460	$91,156,751	($15,108,710)	(16.6%)
$6,316,838	$6,128,608	($188,230)	(3.1%)	9. Primary Care Physician Expense	$12,186,661	$12,245,773	$59,113	0.5%
$9,390,288	$8,028,205	($1,362,083)	(17.0%)	10. Specialty Care Physician Expense	$16,252,824	$16,040,943	($211,882)	(1.3%)
$15,762,436	$16,968,713	$1,206,277	7.1%	11. Ancillary Medical Expense	$31,775,292	$33,867,274	$2,091,982	6.2%
$12,865,495	$11,480,119	($1,385,375)	(12.1%)	12. Outpatient Medical Expense	$24,479,372	$22,937,226	($1,542,147)	(6.7%)
$12,637,357	$8,760,762	($3,876,595)	(44.2%)	13. Emergency Expense	$22,693,187	$17,498,754	($5,194,434)	(29.7%)
$15,162,186	$12,130,054	($3,032,132)	(25.0%)	14. Pharmacy Expense	$26,963,311	$24,237,649	($2,725,662)	(11.2%)
$36,208,879	$29,221,691	($6,987,188)	(23.9%)	15. Long Term Care Expense	$65,319,670	$58,388,252	($6,931,418)	(11.9%)
$164,298,071	$138,345,127	($25,952,944)	(18.8%)	16. Total Fee for Service Expense	$305,935,779	$276,372,621	($29,563,157)	(10.7%)
$4,118,770	$4,037,808	($80,963)	(2.0%)	17. Other Benefits & Services	$7,098,549	$8,059,549	$961,000	11.9%
($130,830)	$385,746	$516,576	133.9%	18. Reinsurance Expense	$217,271	$771,247	$553,976	71.8%
$187,856,215	**$162,594,243**	**($25,261,972)**	**(15.5%)**	**20. TOTAL MEDICAL EXPENSES**	**$352,366,870**	**$324,833,050**	**($27,533,820)**	**(8.5%)**
$34,978,556	**$50,617,973**	**($15,639,418)**	**(30.9%)**	**21. GROSS MARGIN**	**$81,719,932**	**$101,431,845**	**($19,711,913)**	**(19.4%)**
				ADMINISTRATIVE EXPENSES				
$5,540,322	$5,635,365	$95,042	1.7%	22. Personnel Expense	$10,900,824	$11,136,943	$236,119	2.1%
$74,206	$74,512	$306	0.4%	23. Benefits Administration Expense	$149,040	$148,968	($73)	(0.0%)
$2,097,888	$1,587,150	($510,738)	(32.2%)	24. Purchased & Professional Services	$5,004,602	$3,136,930	($1,867,672)	(59.5%)
$1,776,852	$1,463,954	($312,898)	(21.4%)	25. Other Administrative Expense	$4,255,713	$3,052,394	($1,203,319)	(39.4%)
$9,489,268	**$8,760,981**	**($728,287)**	**(8.3%)**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$20,310,180**	**$17,475,235**	**($2,834,945)**	**(16.2%)**
$47,014,700	**$47,086,708**	**$72,008**	**0.2%**	**27. MCO TAX EXPENSES**	**$93,941,391**	**$94,122,352**	**$180,961**	**0.2%**
($21,525,413)	**($5,229,716)**	**($16,295,696)**	**(311.6%)**	**28. NET OPERATING INCOME / (LOSS)**	**($32,531,638)**	**($10,165,742)**	**($22,365,896)**	**(220.0%)**
				OTHER INCOME / EXPENSES				
$3,170,533	**$2,500,000**	**$670,533**	**26.8%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$7,187,456**	**$5,000,000**	**$2,187,456**	**43.7%**
($18,354,879)	**($2,729,716)**	**($15,625,163)**	**(572.4%)**	**30. NET SURPLUS (DEFICIT)**	**($25,344,182)**	**($5,165,742)**	**($20,178,440)**	**(390.6%)**
106.8%	97.9%	-8.9%	-9.1%	31. Medical Loss Ratio	103.6%	97.8%	-5.8%	-5.9%
5.4%	5.3%	-0.1%	-1.9%	32. Administrative Expense Ratio	6.0%	5.3%	-0.7%	-13.2%
-8.2%	-1.3%	-6.9%	-530.8%	33. Net Surplus (Deficit) Ratio	-5.8%	-1.2%	-4.6%	-383.3%

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

	8/31/2024	7/31/2024	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$41,187,550	$37,980,549	$3,207,001	8.44%
CNB Short-Term Investment	508,214,755	489,208,284	19,006,470	3.89%
Interest Receivable	4,360,743	3,513,364	847,378	24.12%
Premium Receivables	373,395,728	369,071,090	4,324,638	1.17%
Reinsurance Recovery Receivable	5,820,012	5,682,832	137,181	2.41%
Other Receivables	4,489,020	4,427,954	61,066	1.38%
Prepaid Expenses	256,172	276,300	(20,128)	-7.28%
TOTAL CURRENT ASSETS	**937,723,979**	**910,160,373**	**27,563,606**	**3.03%**
OTHER ASSETS				
CNB Long-Term Investment	56,176,155	53,139,571	3,036,584	5.71%
CalPERS Net Pension Asset	(6,144,132)	(6,144,132)	0	0.00%
Deferred Outflow	14,319,532	14,319,532	0	0.00%
Restricted Asset-Bank Note	350,000	350,000	0	0.00%
GASB 87-Lease Assets (Net)	675,096	741,010	(65,913)	-8.90%
GASB 96-SBITA Assets (Net)	3,980,524	4,208,657	(228,133)	-5.42%
TOTAL OTHER ASSETS	**69,357,175**	**66,614,637**	**2,742,538**	**4.12%**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.00%
Furniture And Equipment	13,071,003	12,806,493	264,510	2.07%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	38,640,099	38,375,589	264,510	0.69%
Less: Accumulated Depreciation	(32,777,000)	(32,713,219)	(63,782)	0.19%
PROPERTY AND EQUIPMENT (NET)	**5,863,098**	**5,662,370**	**200,728**	**3.54%**
TOTAL ASSETS	**1,012,944,252**	**982,437,380**	**30,506,872**	**3.11%**
CURRENT LIABILITIES				
Trade Accounts Payable	5,953,575	4,829,296	1,124,279	23.28%
Incurred But Not Reported Claims	307,356,497	269,287,348	38,069,149	14.14%
Other Medical Liabilities	153,929,749	190,632,082	(36,702,333)	-19.25%
Pass-Through Liabilities	171,565,662	171,378,121	187,541	0.11%
MCO Tax Liabilities	128,255,973	81,241,273	47,014,700	57.87%
GASB 87 and 96 ST Liabilities	3,768,460	4,236,152	(467,692)	-11.04%
Payroll Liabilities	8,365,561	8,726,180	(360,619)	-4.13%
TOTAL CURRENT LIABILITIES	**779,195,478**	**730,330,452**	**48,865,026**	**6.69%**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	390,283	393,558	(3,275)	-0.83%
Deferred Inflow	3,327,530	3,327,530	0	0.00%
TOTAL LONG TERM LIABILITIES	**3,717,813**	**3,721,088**	**(3,275)**	**-0.09%**
TOTAL LIABILITIES	**782,913,291**	**734,051,540**	**48,861,751**	**6.66%**
NET WORTH				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	254,534,911	254,534,911	0	0.00%
Year-To-Date Net Surplus (Deficit)	(25,344,182)	(6,989,303)	(18,354,879)	262.61%
TOTAL NET WORTH	**230,030,961**	**248,385,841**	**(18,354,879)**	**-7.39%**
TOTAL LIABILITIES AND NET WORTH	**1,012,944,252**	**982,437,381**	**30,506,872**	**3.11%**
Cash Equivalents	549,402,305	527,188,834	22,213,471	4.21%
Pass-Through	171,565,662	171,378,121	187,541	0.11%
Uncommitted Cash	377,836,642	355,810,713	22,025,930	6.19%
Working Capital	158,528,501	179,829,921	(21,301,420)	-11.85%
Current Ratio	120.3%	124.6%	-4.3%	-3.5%

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,108,536	$8,799,259	$16,529,189	$6,211,794
GroupCare Receivable	(7,912)	(557,084)	(557,084)	(3,094,253)
Total	3,100,624	8,242,175	15,972,105	3,117,541
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	219,726,236	678,220,289	1,467,647,997	427,875,009
Premium Receivable	(4,316,726)	(210,503,669)	30,894,351	(3,357,954)
Total	215,409,510	467,716,620	1,498,542,348	424,517,055
Investment & Other Income Cash Flows				
Other Revenues	393,146	1,028,266	1,506,259	1,257,194
Interest Income	2,788,646	9,305,386	17,050,121	5,953,107
Interest Receivable	(847,378)	(2,833,869)	(1,789,597)	(2,444,680)
Total	2,334,414	7,499,783	16,766,783	4,765,621
Medical & Hospital Cash Flows				
Total Medical Expenses	(187,856,218)	(544,684,153)	(1,023,385,662)	(352,366,875)
Other Health Care Receivables	(189,348)	292,076	(3,473,984)	658,830
Capitation Payable	-	-	-	-
IBNP Payable	38,069,149	61,669,003	93,140,347	11,052,238
Other Medical Payable	(36,514,792)	145,767,247	5,662,775	(13,025,537)
Risk Share Payable	-	-	-	-
New Health Program Payable	-	-	-	-
Total	(186,491,209)	(336,955,827)	(928,056,524)	(353,681,344)
Administrative Cash Flows				
Total Administrative Expenses	(9,500,526)	(29,931,286)	(59,039,189)	(20,333,020)
Prepaid Expenses	20,129	688,397	2,234,596	(17,555)
Other Receivables	(8,899)	(71,599)	(16,750)	26,680
CalPERS Pension	-	637,208	637,208	-
Trade Accounts Payable	1,124,279	(838,795)	322,647	(536,721)
Payroll Liabilities	(360,619)	(1,501,386)	(1,479,429)	266,336
GASB Assets and Liabilities	(176,921)	184,945	536,630	4,608
Depreciation Expense	63,782	164,875	(187,648)	114,328
Total	(8,838,775)	(30,667,641)	(56,991,935)	(20,475,344)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(47,014,700)	(208,695,971)	(547,003,762)	(93,941,391)
MCO Tax Liabilities	47,014,700	83,213,722	73,313,377	(31,527,541)
Total	0	(125,482,249)	(473,690,385)	(125,468,932)
Net Cash Flows from Operating Activities	**25,514,564**	**(9,647,139)**	**72,542,392**	**(67,225,403)**

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(3,036,583)	(29,427,488)	(53,849,115)	(23,183,907)
Total	(3,036,583)	(29,427,488)	(53,849,115)	(23,183,907)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	(264,510)	(528,457)	215,752	(529,610)
Purchases of Property and Equipment	(264,510)	(528,457)	215,752	(529,610)
Net Cash Flows from Investing Activities	**(3,301,093)**	**(29,955,945)**	**(53,633,363)**	**(23,713,517)**
Net Change in Cash	**22,213,471**	**(39,603,084)**	**18,909,029**	**(90,938,920)**
Rounding	-	-	-	(1.00)
Cash @ Beginning of Period	527,188,833	589,005,388	530,493,275	640,341,225
Cash @ End of Period	**$549,402,304**	**$549,402,304**	**$549,402,304**	**$549,402,304**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($18,354,880)	($85,958,211)	($126,695,047)	($25,344,182)
Add back: Depreciation & Amortization	63,782	164,875	(187,648)	114,328
Receivables				
Premiums Receivable	(4,316,726)	(210,503,669)	30,894,351	(3,357,954)
Interest Receivable	(847,378)	(2,833,869)	(1,789,597)	(2,444,680)
Other Health Care Receivables	(189,348)	292,076	(3,473,984)	658,830
Other Receivables	(8,899)	(71,599)	(16,750)	26,680
GroupCare Receivable	(7,912)	(557,084)	(557,084)	(3,094,253)
Total	(5,370,263)	(213,674,145)	25,056,936	(8,211,377)
Prepaid Expenses	20,129	688,397	2,234,596	(17,555)
Trade Payables	1,124,279	(838,795)	322,647	(536,721)
Claims Payable and Shared Risk Pool				
IBNP Payable	38,069,149	61,669,003	93,140,347	11,052,238
Capitation Payable & Other Medical Payable	(36,514,792)	145,767,247	5,662,775	(13,025,537)
Risk Share Payable	-	-	0	0
Claims Payable				
Total	1,554,357	207,436,250	98,803,122	(1,973,299)
Other Liabilities				
CalPERS Pension	-	637,208.00	637,208.00	-
Payroll Liabilities	(360,619)	(1,501,385)	(1,479,429)	266,336
GASB Assets and Liabilities	(176,921)	184,945	536,630	4,608
New Health Program	-	-	-	-
MCO Tax Liabilities	47,014,700	83,213,722	73,313,377	(31,527,541)
Total	46,477,160	82,534,490	73,007,786	(31,256,597)
Rounding	-	-	-	-
Cash Flows from Operating Activities	**25,514,564**	**(9,647,139)**	**72,542,392**	**(67,225,403)**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$215,409,510	$467,716,620	$1,498,542,348	$424,517,055
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	3,100,624	8,242,175	15,972,105	3,117,541
Other Income	393,146	1,028,266	1,506,259	1,257,194
Interest Income	1,941,268	6,471,517	15,260,524	3,508,427
Less Cash Paid				
Medical Expenses	(186,491,209)	(336,955,827)	(928,056,524)	(353,681,344)
Vendor & Employee Expenses	(8,838,775)	(30,667,641)	(56,991,935)	(20,475,344)
MCO Tax Expense AB119	0	(125,482,249)	(473,690,385)	(125,468,932)
Net Cash Flows from Operating Activities	**25,514,564**	**(9,647,139)**	**72,542,392**	**(67,225,403)**
Cash Flows from Investing Activities:				
Long Term Investments	(3,036,583)	(29,427,488)	(53,849,115)	(23,183,907)
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	(264,510)	(528,457)	215,752	(529,610)
Net Cash Flows from Investing Activities	**(3,301,093)**	**(29,955,945)**	**(53,633,363)**	**(23,713,517)**
Net Change in Cash	**22,213,471**	**(39,603,084)**	**18,909,029**	**(90,938,920)**
Rounding	-	-	-	(1.00)
Cash @ Beginning of Period	527,188,833	589,005,388	530,493,275	640,341,225
Cash @ End of Period	**$549,402,304**	**$549,402,304**	**$549,402,304**	**$549,402,304**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($18,354,880)	($85,958,210)	($126,695,048)	($25,344,182)
Add Back: Depreciation	63,782	164,875	(187,648)	114,328
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(5,370,263)	(213,674,145)	25,056,936	(8,211,377)
Prepaid Expenses	20,129	688,396	2,234,597	(17,555)
Trade Payables	1,124,279	(838,795)	322,647	(536,721)
Claims Payable, IBNP and Risk Sharing	1,554,357	207,436,250	98,803,122	(1,973,299)
Deferred Revenue	0	0	0	0
Other Liabilities	46,477,160	82,534,490	73,007,786	(31,256,597)
Total	25,514,564	(9,647,139)	72,542,392	(67,225,403)
Rounding	-	-	-	-
Cash Flows from Operating Activities	**$25,514,564**	**($9,647,139)**	**$72,542,392**	**($67,225,403)**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF AUGUST 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	109,784	62,641	35,177	150,482	40,024	226	1,247	399,581	5,686	-	405,267
Revenue	$30,250,954	$31,685,934	$45,210,862	$81,031,946	$17,878,019	$2,454,685	$11,213,835	$219,726,235	$3,108,536	$0	$222,834,771
Medical Expense	15,031,802	22,556,301	51,878,209	65,525,723	14,468,576	1,912,219	13,089,569	184,462,401	3,393,814	-	$187,856,215
Gross Margin	$15,219,152	$9,129,633	($6,667,347)	$15,506,223	$3,409,443	$542,466	($1,875,734)	$35,263,834	($285,278)	$0	$34,978,556
Administrative Expense	$478,462	$1,159,470	$2,506,633	$3,174,811	$858,523	$176,789	$821,588	$9,176,275	$158,205	$154,788	$9,489,268
MCO Tax Expense	$12,917,185	$7,370,340	$4,138,926	$17,705,712	$4,709,224	$26,591	$146,722	$47,014,700	$0	$0	$47,014,700
Operating Income / (Expense)	$1,823,504	$599,823	($13,312,906)	($5,374,301)	($2,158,304)	$339,086	($2,844,044)	($20,927,141)	($443,483)	($154,788)	($21,525,413)
Other Income / (Expense)	$160,329	$397,188	$852,215	$1,084,006	$291,300	$61,316	$281,821	$3,128,176	$42,357	$0	$3,170,533
Net Income / (Loss)	$1,983,834	$997,011	($12,460,691)	($4,290,294)	($1,867,004)	$400,403	($2,562,223)	($17,798,965)	($401,126)	($154,788)	($18,354,879)
PMPM Metrics:											
Revenue PMPM	$275.55	$505.83	$1,285.24	$538.48	$446.68	$10,861.44	$8,992.65	$549.89	$546.70	$0.00	$549.85
Medical Expense PMPM	$136.92	$360.09	$1,474.78	$435.44	$361.50	$8,461.15	$10,496.85	$461.64	$596.87	$0.00	$463.54
Gross Margin PMPM	$138.63	$145.75	($189.54)	$103.04	$85.18	$2,400.29	($1,504.20)	$88.25	($50.17)	$0.00	$86.31
Administrative Expense PMPM	$4.36	$18.51	$71.26	$21.10	$21.45	$782.25	$658.85	$22.96	$27.82	$0.00	$23.41
MCO Tax Expense PMPM	$117.66	$117.66	$117.66	$117.66	$117.66	$117.66	$117.66	$117.66	$0.00	$0.00	$116.01
Operating Income / (Expense) PMPM	$16.61	$9.58	($378.45)	($35.71)	($53.93)	$1,500.38	($2,280.71)	($52.37)	($78.00)	$0.00	($53.11)
Other Income / (Expense) PMPM	$1.46	$6.34	$24.23	$7.20	$7.28	$271.31	$226.00	$7.83	$7.45	$0.00	$7.82
Net Income / (Loss) PMPM	$18.07	$15.92	($354.23)	($28.51)	($46.65)	$1,771.69	($2,054.71)	($44.54)	($70.55)	$0.00	($45.29)
Ratio:											
Medical Loss Ratio	86.7%	92.8%	126.3%	103.5%	109.9%	78.8%	118.3%	106.8%	109.2%	0.0%	106.8%
Administrative Expense Ratio	2.8%	4.8%	6.1%	5.0%	6.5%	7.3%	7.4%	5.3%	5.1%	0.0%	5.4%
Net Income Ratio	6.6%	3.1%	-27.6%	-5.3%	-10.4%	16.3%	-22.8%	-8.1%	-12.9%	0.0%	-8.2%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE AUGUST 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	219,735	125,349	70,195	300,283	79,916	448	2,488	798,414	11,361	-	809,775
Revenue	$57,939,247	$61,068,292	$91,460,972	$154,274,894	$35,856,713	$5,083,423	$22,191,468	$427,875,008	$6,211,794	$0	$434,086,802
Medical Expense	28,146,142	43,544,792	95,914,022	123,264,331	27,525,794	4,666,302	23,096,772	346,158,155	6,210,715	(2,000)	$352,366,870
Gross Margin	$29,793,106	$17,523,500	($4,453,050)	$31,010,563	$8,330,919	$417,121	($905,304)	$81,716,853	$1,080	$2,000	$81,719,932
Administrative Expense	$1,028,442	$2,487,897	$5,351,213	$6,793,885	$1,884,356	$383,104	$1,798,733	$19,727,630	$313,025	$269,525	$20,310,180
MCO Tax Expense	$25,854,020	$14,748,563	$8,259,144	$35,331,298	$9,402,917	$52,712	$292,738	$93,941,391	$0	$0	$93,941,391
Operating Income / (Expense)	$2,910,644	$287,039	($18,063,407)	($11,114,620)	($2,956,354)	($18,695)	($2,996,776)	($31,952,168)	($311,945)	($267,525)	($32,531,638)
Other Income / (Expense)	$363,465	$900,308	$1,931,964	$2,457,432	$660,375	$139,004	$638,885	$7,091,433	$96,023	$0	$7,187,456
Net Income / (Loss)	$3,274,109	$1,187,347	($16,131,443)	($8,657,188)	($2,295,979)	$120,309	($2,357,891)	($24,860,735)	($215,922)	($267,525)	($25,344,182)
PMPM Metrics:											
Revenue PMPM	$263.68	$487.19	$1,302.96	$513.76	$448.68	$11,346.93	$8,919.40	$535.91	$546.76	$0.00	$536.06
Medical Expense PMPM	$128.09	$347.39	$1,366.39	$410.49	$344.43	$10,415.85	$9,283.27	$433.56	$546.67	$0.00	$435.14
Gross Margin PMPM	$135.59	$139.80	($63.44)	$103.27	$104.25	$931.07	($363.87)	$102.35	$0.10	$0.00	$100.92
Administrative Expense PMPM	$4.68	$19.85	$76.23	$22.62	$23.58	$855.14	$722.96	$24.71	$27.55	$0.00	$25.08
MCO Tax Expense PMPM	$117.66	$117.66	$117.66	$117.66	$117.66	$117.66	$117.66	$117.66	$0.00	$0.00	$116.01
Operating Income / (Expense) PMPM	$13.25	$2.29	($257.33)	($37.01)	($36.99)	($41.73)	($1,204.49)	($40.02)	($27.46)	$0.00	($40.17)
Other Income / (Expense) PMPM	$1.65	$7.18	$27.52	$8.18	$8.26	$310.28	$256.79	$8.88	$8.45	$0.00	$8.88
Net Income / (Loss) PMPM	$14.90	$9.47	($229.81)	($28.83)	($28.73)	$268.55	($947.71)	($31.14)	($19.01)	$0.00	($31.30)
Ratio:											
Medical Loss Ratio	87.7%	94.0%	115.3%	103.6%	104.1%	92.8%	105.5%	103.7%	100.0%	0.0%	103.6%
Administrative Expense Ratio	3.2%	5.4%	6.4%	5.7%	7.1%	7.6%	8.2%	5.9%	5.0%	0.0%	6.0%
Net Income Ratio	5.7%	1.9%	-17.6%	-5.6%	-6.4%	2.4%	-10.6%	-5.8%	-3.5%	0.0%	-5.8%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSES SUMMARY (ADMIN. DEPT. ONLY)				
$5,540,322	$5,635,365	$95,042	1.7%	Personnel Expenses	$10,900,824	$11,136,943	$236,119	2.1%
$74,206	$74,512	$306	0.4%	Benefits Administration Expense	$149,040	$148,968	($73)	0.0%
$2,097,888	$1,587,150	($510,738)	(32.2%)	Purchased & Professional Services	$5,004,602	$3,136,930	($1,867,672)	(59.5%)
$496,202	$575,918	$79,716	13.8%	Occupancy	$979,971	$1,136,291	$156,321	13.8%
$709,914	$323,842	($386,071)	(119.2%)	Printing Postage & Promotion	$757,813	$658,204	($99,609)	(15.1%)
$365,893	$417,180	$51,287	12.3%	Licenses Insurance & Fees	$2,087,947	$989,845	($1,098,102)	(110.9%)
$204,843	$147,014	($57,829)	(39.3%)	Other Administrative Expense	$429,983	$268,053	($161,930)	(60.4%)
$3,948,946	$3,125,616	($823,329)	(26.3%)	Total Other Administrative Expenses (excludes Personnel Expenses)	$9,409,356	$6,338,292	($3,071,064)	(48.5%)
$9,489,268	$8,760,981	($728,287)	(8.3%)	Total Administrative Expenses	$20,310,180	$17,475,235	($2,834,945)	(16.2%)

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,584,046	3,889,181	305,135	7.8%	Salaries & Wages	7,259,718	7,736,092	476,374	6.2%
356,018	347,523	(8,495)	(2.4%)	Paid Time Off	548,660	670,184	121,524	18.1%
1,026	3,600	2,574	71.5%	Compensated Incentives	2,531	7,200	4,669	64.8%
59,037	59,467	430	0.7%	Payroll Taxes	120,069	116,297	(3,772)	(3.2%)
90,761	24,960	(65,801)	(263.6%)	Overtime	158,880	49,920	(108,960)	(218.3%)
315,703	278,789	(36,914)	(13.2%)	CalPERS ER Match	637,129	545,140	(91,989)	(16.9%)
935,995	634,804	(301,191)	(47.4%)	Employee Benefits	1,822,259	1,233,445	(588,814)	(47.7%)
297	0	(297)	0.0%	Personal Floating Holiday	1,756	0	(1,756)	0.0%
20,168	28,000	7,832	28.0%	Language Pay	42,606	51,500	8,894	17.3%
4,040	0	(4,040)	0.0%	Med Ins Opted Out Stipend	7,550	0	(7,550)	0.0%
72,297	0	(72,297)	0.0%	Sick Leave	129,152	0	(129,152)	0.0%
950	17,292	16,342	94.5%	Compensated Employee Relations	25	34,058	34,033	99.9%
19,580	23,650	4,070	17.2%	Work from Home Stipend	38,910	46,250	7,340	15.9%
981	6,109	5,127	83.9%	Mileage, Parking & LocalTravel	2,678	11,792	9,115	77.3%
1,337	34,832	33,495	96.2%	Travel & Lodging	7,827	64,588	56,761	87.9%
20,600	218,730	198,130	90.6%	Temporary Help Services	43,423	439,139	395,716	90.1%
18,871	46,209	27,338	59.2%	Staff Development/Training	30,084	88,667	58,583	66.1%
38,615	22,219	(16,396)	(73.8%)	Staff Recruitment/Advertisement	47,568	42,670	(4,898)	(11.5%)
5,540,322	**5,635,365**	**95,042**	**1.7%**	**Personnel Expense**	**10,900,824**	**11,136,943**	**236,119**	**2.1%**
21,741	21,753	12	0.1%	Pharmacy Administrative Fees	44,286	43,507	(779)	(1.8%)
52,464	52,759	294	0.6%	Telemedicine Admin. Fees	104,754	105,461	707	0.7%
74,206	**74,512**	**306**	**0.4%**	**Benefits Administration Expense**	**149,040**	**148,968**	**(73)**	**0.0%**
482,460	208,795	(273,664)	(131.1%)	Consultant Fees - Non Medical	1,395,555	430,466	(965,089)	(224.2%)
353,209	414,203	60,994	14.7%	Computer Support Services	836,442	884,389	47,947	5.4%
16,535	15,000	(1,535)	(10.2%)	Audit Fees	29,035	30,000	965	3.2%
(26,800)	8	26,808	321,828.7%	Consultant Fees - Medical	(15,355)	17	15,372	92,266.9%
213,742	160,651	(53,091)	(33.0%)	Other Purchased Services	549,735	311,491	(238,244)	(76.5%)
0	2,454	2,454	100.0%	Maint.&Repair-Office Equipment	0	4,908	4,908	100.0%
97,272	45,067	(52,205)	(115.8%)	Legal Fees	152,710	90,133	(62,577)	(69.4%)
0	0	0	0.0%	Member Health Education	328	0	(328)	0.0%
22,089	28,133	6,045	21.5%	Translation Services	44,318	56,267	11,949	21.2%
262,115	161,698	(100,417)	(62.1%)	Medical Refund Recovery Fees	812,681	323,396	(489,285)	(151.3%)
586,832	457,256	(129,576)	(28.3%)	Software - IT Licenses & Subsc	1,088,811	812,096	(276,715)	(34.1%)
85,088	43,584	(41,504)	(95.2%)	Hardware (Non-Capital)	55,761	93,168	37,407	40.2%
5,346	50,300	44,954	89.4%	Provider Credentialing	54,581	100,600	46,019	45.7%
2,097,888	**1,587,150**	**(510,738)**	**(32.2%)**	**Purchased & Professional Services**	**5,004,602**	**3,136,930**	**(1,867,672)**	**(59.5%)**
63,782	104,582	40,800	39.0%	Depreciation	114,328	194,142	79,814	41.1%
62,638	76,371	13,733	18.0%	Lease Building	124,124	152,742	28,618	18.7%
4,464	5,960	1,496	25.1%	Lease Rented Office Equipment	8,929	11,920	2,991	25.1%
25,914	17,343	(8,571)	(49.4%)	Utilities	32,377	34,686	2,309	6.7%
79,368	91,065	11,697	12.8%	Telephone	168,817	182,130	13,313	7.3%
31,902	31,462	(440)	(1.4%)	Building Maintenance	71,459	62,400	(9,059)	(14.5%)
228,133	249,136	21,002	8.4%	GASB96 SBITA Amort. Expense	459,936	498,271	38,335	7.7%
496,202	**575,918**	**79,716**	**13.8%**	**Occupancy**	**979,971**	**1,136,291**	**156,321**	**13.8%**
172,630	34,808	(137,822)	(395.9%)	Postage	144,762	80,048	(64,715)	(80.8%)

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
4,769	5,300	532	10.0%	Design & Layout	10,285	10,600	315	3.0%
329,268	44,527	(284,741)	(639.5%)	Printing Services	229,268	89,054	(140,214)	(157.4%)
9,030	6,910	(2,120)	(30.7%)	Mailing Services	9,030	13,820	4,790	34.7%
6,896	11,480	4,583	39.9%	Courier/Delivery Service	12,134	23,029	10,894	47.3%
0	0	0	0.0%	Pre-Printed Materials & Public	0	20	20	100.0%
0	0	0	0.0%	Promotional Products	36,545	0	(36,545)	0.0%
0	150	150	100.0%	Promotional Services	0	300	300	100.0%
187,321	220,667	33,346	15.1%	Community Relations	315,789	441,334	125,545	28.4%
709,914	**323,842**	**(386,071)**	**(119.2%)**	**Printing Postage & Promotion**	**757,813**	**658,204**	**(99,609)**	**(15.1%)**
0	100,000	100,000	100.0%	Regulatory Penalties	0	100,000	100,000	100.0%
41,696	36,000	(5,696)	(15.8%)	Bank Fees	111,601	72,000	(39,601)	(55.0%)
299,371	95,133	(204,238)	(214.7%)	Insurance Premium	976,663	195,504	(781,159)	(399.6%)
10,035	140,456	130,421	92.9%	License,Permits, & Fee - NonIT	930,518	524,951	(405,567)	(77.3%)
14,791	45,591	30,800	67.6%	Subscriptions and Dues - NonIT	69,164	97,390	28,226	29.0%
365,893	**417,180**	**51,287**	**12.3%**	**License Insurance & Fees**	**2,087,947**	**989,845**	**(1,098,102)**	**(110.9%)**
7,139	16,938	9,799	57.9%	Office and Other Supplies	21,304	27,626	6,322	22.9%
0	1,050	1,050	100.0%	Furniture & Equipment	0	2,100	2,100	100.0%
66,780	26,483	(40,296)	(152.2%)	Ergonomic Supplies	84,517	52,967	(31,551)	(59.6%)
13,656	32,543	18,887	58.0%	Meals and Entertainment	23,210	45,361	22,150	48.8%
117,269	70,000	(47,269)	(67.5%)	Provider Interest (All Depts)	300,951	140,000	(160,951)	(115.0%)
204,843	**147,014**	**(57,829)**	**(39.3%)**	**Other Administrative Expense**	**429,983**	**268,053**	**(161,930)**	**(60.4%)**
3,948,946	**3,125,616**	**(823,329)**	**(26.3%)**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**9,409,356**	**6,338,292**	**(3,071,064)**	**(48.5%)**
9,489,268	**8,760,981**	**(728,287)**	**(8.3%)**	**TOTAL ADMINISTRATIVE EXPENSES**	**20,310,180**	**17,475,235**	**(2,834,945)**	**(16.2%)**

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

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 265,100	$ -	**$ 265,100**	$ -	$ (265,100)
	Cisco Routers	IT-FY25-01	$ -	$ -	**$ -**	$ 120,000	$ 120,000
	Cisco UCS Blades	IT-FY25-04	$ -	$ 264,510	**$ 264,510**	$ 873,000	$ 608,490
	PURE Storage	IT-FY25-06	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Exagrid Immutable Storage	IT-FY25-07	$ -	$ -	**$ -**	$ 500,000	$ 500,000
	Network Cabling	IT-FY25-09	$ -	$ -	**$ -**	$ 40,000	$ 40,000
Hardware Subtotal			**$ 265,100**	**$ 264,510**	**$ 529,610**	**$ 1,683,000**	**$ 1,418,490**
2. Software:							
	Zerto renewal and Tier 2 add		$ -	$ -	**$ -**	$ -	$ -
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
3. Building Improvement:							
	1240 Exterior lighting update	FA-FY25-03	**$ -**	$ -	**$ -**	$ 30,000	$ 30,000
Building Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ 30,000**	**$ 30,000**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)		$ -	$ -	**$ -**	$ -	$ -
	Replace, reconfigure, re-design workstations		$ -	$ -	**$ -**	$ -	$ -
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
5. Leasehold Improvement:							
	ExacqVision NVR Upgrade, Cameras/Video System upgrade		$ -		**$ -**	$ -	$ -
Leasehold Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
6. Contingency:							
			$ -		**$ -**	$ -	$ -
Contingency Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
GRAND TOTAL			**$ 265,100**	**$ 264,510**	**$ 529,610**	**$ 1,713,000**	**$ 1,448,490**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 8/31/24	**$ 38,640,099**
Fixed Assets @ Cost - 6/30/24	**$ 38,110,489**
Fixed Assets Acquired YTD	**$ 529,610**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2025

TANGIBLE NET EQUITY (TNE)	QTR. END Jun-24	Jul-24	Aug-23
Current Month Net Income / (Loss)	($60,614,028)	($6,989,303)	($18,354,879)
YTD Net Income / (Loss)	($68,581,898)	($6,989,303)	($25,344,182)
Actual TNE			
Net Assets	$255,375,144	$248,385,841	$230,030,961
Subordinated Debt & Interest	$0	$0	$0
Total Actual TNE	**$255,375,144**	**$248,385,841**	**$230,030,961**
Increase/(Decrease) in Actual TNE	($60,614,028)	($6,989,303)	($18,354,879)
Required TNE[(1)]	**$63,353,150**	**$68,775,910**	**$71,495,154**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$95,029,725	$103,163,865	$107,242,731
TNE Excess / (Deficiency)	$192,021,994	$179,609,931	$158,535,807
Actual TNE as a Multiple of Required	**4.03**	**3.61**	**3.22**

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

LIQUID TANGIBLE NET EQUITY			
Net Assets	$255,375,144	$248,385,841	$230,030,961
Fixed Assets at Net Book Value	(5,447,816)	(5,662,370)	(5,863,098)
Net Lease Assets/Liabilities/Interest	(501,485)	(319,957)	(496,877)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$249,577,328**	**$242,373,471**	**$223,817,863**
Liquid TNE as Multiple of Required	**3.94**	**3.52**	**3.13**

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,951	109,784											219,735
Adult	62,708	62,641											125,349
SPD	35,018	35,177											70,195
ACA OE	149,801	150,482											300,283
Duals	39,892	40,024											79,916
MCAL LTC	222	226											448
MCAL LTC Duals	1,241	1,247											2,488
Medi-Cal Program	398,833	399,581											798,414
Group Care Program	5,675	5,686											11,361
Total	**404,508**	**405,267**											**809,775**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(173)	(167)											(340)
Adult	(38)	(67)											(105)
SPD	98	159											257
ACA OE	477	681											1,158
Duals	144	132											276
MCAL LTC	0	4											4
MCAL LTC Duals	(7)	6											(1)
Medi-Cal Program	501	748											1,249
Group Care Program	17	11											28
Total	**518**	**759**											**1,277**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%											27.5%
Adult % of Medi-Cal	15.7%	15.7%											15.7%
SPD % of Medi-Cal	8.8%	8.8%											8.8%
ACA OE % of Medi-Cal	37.6%	37.7%											37.6%
Duals % of Medi-Cal	10.0%	10.0%											10.0%
Medi-Cal Program % of Total	98.6%	98.6%											98.6%
Group Care Program % of Total	1.4%	1.4%											1.4%
Total	**100.0%**	**100.0%**											**100.0%**

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

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	87,980	88,518											176,498
Alameda Health System	91,091	91,170											182,261
	179,071	179,688											358,759
Delegated:													
CFMG	44,087	43,956											88,043
CHCN	181,350	181,623											362,973
Kaiser	0	0											0
Delegated Subtotal	225,437	225,579											451,016
Total	**404,508**	**405,267**											**809,775**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617											784
Delegated:													
CFMG	96	(131)											(35)
CHCN	255	273											528
Kaiser	0	0											0
Delegated Subtotal	351	142											493
Total	**518**	**759**											**1,277**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%											44.3%
Delegated:													
CFMG	10.9%	10.8%											10.9%
CHCN	44.8%	44.8%											44.8%
Kaiser	0.0%	0.0%											0.0%
Delegated Subtotal	55.7%	55.7%											55.7%
Total	**100.0%**	**100.0%**											**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2025	PRELIMINARY BUDGET												
	Budget Jul-24	Budget Aug-24	Budget Sep-24	Budget Oct-24	Budget Nov-24	Budget Dec-24	Budget Jan-25	Budget Feb-25	Budget Mar-25	Budget Apr-25	Budget May-25	Budget Jun-25	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program by Category of Aid:													
Child	110,723	110,944	111,166	111,388	111,611	111,834	112,058	112,282	112,507	112,732	112,957	113,183	1,343,385
Adult	63,571	63,635	63,699	63,763	63,827	63,891	63,955	64,019	64,083	64,147	64,211	64,275	767,076
SPD	34,848	34,848	34,848	34,848	34,848	34,848	34,848	34,848	34,848	34,848	34,848	34,848	418,176
ACA OE	149,317	149,466	149,615	149,765	149,915	150,065	150,215	150,365	150,515	150,666	150,817	150,968	1,801,689
Duals	39,791	39,791	39,791	39,791	39,791	39,791	39,791	39,791	39,791	39,791	39,791	39,791	477,492
MCAL LTC	224	224	224	224	224	224	224	224	224	224	224	224	2,688
MCAL LTC Duals	1,285	1,285	1,285	1,285	1,285	1,285	1,285	1,285	1,285	1,285	1,285	1,285	15,420
Medi-Cal Program	399,759	400,193	400,628	401,064	401,501	401,938	402,376	402,814	403,253	403,693	404,133	404,574	4,825,926
Group Care Program	5,643	5,643	5,643	5,643	5,643	5,643	5,643	5,643	5,643	5,643	5,643	5,643	67,716
Total	**405,402**	**405,836**	**406,271**	**406,707**	**407,144**	**407,581**	**408,019**	**408,457**	**408,896**	**409,336**	**409,776**	**410,217**	**4,893,642**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	221	222	222	223	223	224	224	225	225	225	226	1,253
Adult	(624)	64	64	64	64	64	64	64	64	64	64	64	80
SPD	(225)	0	0	0	0	0	0	0	0	0	0	0	(225)
ACA OE	(1,260)	149	149	150	150	150	150	150	150	151	151	151	391
Duals	(43)	0	0	0	0	0	0	0	0	0	0	0	(43)
MCAL LTC	(9)	0	0	0	0	0	0	0	0	0	0	0	(9)
MCAL LTC Duals	4	0	0	0	0	0	0	0	0	0	0	0	4
Medi-Cal Program	(3,364)	434	435	436	437	437	438	438	439	440	440	441	1,451
Group Care Program	(15)	0	0	0	0	0	0	0	0	0	0	0	(15)
Total	**(3,379)**	**434**	**435**	**436**	**437**	**437**	**438**	**438**	**439**	**440**	**440**	**441**	**1,436**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	27.7%	27.7%	27.7%	27.8%	27.8%	27.8%	27.8%	27.9%	27.9%	27.9%	28.0%	28.0%	27.8%
Adult % (Medi-Cal)	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%
SPD % (Medi-Cal)	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.6%	8.6%	8.6%	8.6%	8.7%
ACA OE % (Medi-Cal)	37.4%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%
Duals % (Medi-Cal)	10.0%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%	9.8%	9.8%	9.9%
MCAL LTC % (Medi-Cal)	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
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	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%
Group Care Program % of Total	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2025	PRELIMINARY BUDGET												
	Budget Jul-24	Budget Aug-24	Budget Sep-24	Budget Oct-24	Budget Nov-24	Budget Dec-24	Budget Jan-25	Budget Feb-25	Budget Mar-25	Budget Apr-25	Budget May-25	Budget Jun-25	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	89,482	89,539	89,596	89,654	89,712	89,770	89,828	89,886	89,944	90,002	90,060	90,119	1,077,592
Alameda Health System	90,708	90,803	90,898	90,994	91,090	91,186	91,282	91,378	91,475	91,572	91,669	91,766	1,094,821
	180,190	180,342	180,494	180,648	180,802	180,956	181,110	181,264	181,419	181,574	181,729	181,885	2,172,413
Delegated:													
CFMG	43,781	43,864	43,948	44,032	44,116	44,200	44,284	44,368	44,453	44,538	44,623	44,708	530,915
CHCN	181,431	181,630	181,829	182,027	182,226	182,425	182,625	182,825	183,024	183,224	183,424	183,624	2,190,314
Kaiser	0	0	0	0	0	0	0	0	0	0	0	0	0
Delegated Subtotal	225,212	225,494	225,777	226,059	226,342	226,625	226,909	227,193	227,477	227,762	228,047	228,332	2,721,229
Total	**405,402**	**405,836**	**406,271**	**406,707**	**407,144**	**407,581**	**408,019**	**408,457**	**408,896**	**409,336**	**409,776**	**410,217**	**4,893,642**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	305	57	57	58	58	58	58	58	58	58	58	59	942
Alameda Health System	(1,244)	95	95	96	96	96	96	96	97	97	97	97	(186)
	(939)	152	152	154	154	154	154	154	155	155	155	156	756
Delegated:													
CFMG	(441)	83	84	84	84	84	84	84	85	85	85	85	486
CHCN	(1,721)	199	199	198	199	199	200	200	199	200	200	200	472
Kaiser	(278)	0	0	0	0	0	0	0	0	0	0	0	(278)
Delegated Subtotal	(2,440)	282	283	282	283	283	284	284	284	285	285	285	680
Total	**(3,379)**	**434**	**435**	**436**	**437**	**437**	**438**	**438**	**439**	**440**	**440**	**441**	**1,436**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	22.1%	22.1%	22.1%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%
Alameda Health System	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%
	44.4%	44.4%	44.4%	44.4%	44.4%	44.4%	44.4%	44.4%	44.4%	44.4%	44.3%	44.3%	44.4%
Delegated:													
CFMG	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.9%	10.9%	10.9%	10.9%	10.9%	10.9%	10.8%
CHCN	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%
Kaiser	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%
Delegated Subtotal	55.6%	55.6%	55.6%	55.6%	55.6%	55.6%	55.6%	55.6%	55.6%	55.6%	55.7%	55.7%	55.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

	Variance Jul-24	Variance Aug-24	Variance Sep-24	Variance Oct-24	Variance Nov-24	Variance Dec-24	Variance Jan-25	Variance Feb-25	Variance Mar-25	Variance Apr-25	Variance May-25	Variance Jun-25	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	(772)	(1,160)											(1,932)
Adult	(863)	(994)											(1,857)
SPD	170	329											499
ACA OE	484	1,016											1,500
Duals	101	233											334
MCAL LTC	(2)	2											0
MCAL LTC Duals	(44)	(38)											(82)
Medi-Cal Program	(926)	(612)											(1,538)
Group Care Program	32	43											75
Total	**(894)**	**(569)**											**(1,463)**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	(1,502)	(1,021)											(2,523)
Alameda Health System	383	367											750
	(1,119)	(654)											(1,773)
Delegated:													
CFMG	306	92											398
CHCN	(81)	(7)											(88)
Kaiser	0	0											0
Delegated Subtotal	225	85											310
Total	**(894)**	**(569)**											**(1,463)**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED AUGUST 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				
$5,154,851	$1,978,863	($3,175,988)	(160.5%)	PCP Capitation	$10,298,933	$3,954,068	($6,344,865)	(160.5%)
6,164,365	9,515,022	3,350,658	35.2%	PCP Capitation FQHC	12,307,920	19,019,744	6,711,825	35.3%
373,884	380,277	6,393	1.7%	Specialty Capitation	748,084	759,833	11,750	1.5%
5,399,851	5,569,963	170,112	3.1%	Specialty Capitation FQHC	10,787,418	11,135,069	347,651	3.1%
749,282	708,257	(41,025)	(5.8%)	Laboratory Capitation	1,496,448	1,415,752	(80,697)	(5.7%)
339,507	341,188	1,680	0.5%	Vision Capitation	678,049	681,961	3,912	0.6%
108,819	110,558	1,739	1.6%	CFMG Capitation	217,694	220,907	3,213	1.5%
266,419	275,853	9,434	3.4%	ANC IPA Admin Capitation FQHC	532,411	551,437	19,025	3.5%
0	0	0	0.0%	Maternity Supplemental Expense	27,953	0	(27,953)	0.0%
1,013,226	945,581	(67,646)	(7.2%)	DME Capitation	2,020,362	1,890,862	(129,501)	(6.8%)
19,570,204	**19,825,562**	**255,358**	**1.3%**	**7. TOTAL CAPITATED EXPENSES**	**39,115,271**	**39,629,633**	**514,361**	**1.3%**
				FEE FOR SERVICE MEDICAL EXPENSES				
2,381,387	0	(2,381,387)	0.0%	IBNR Inpatient Services	(2,430,759)	0	2,430,759	0.0%
71,443	0	(71,443)	0.0%	IBNR Settlement (IP)	(72,922)	0	72,922	0.0%
190,510	0	(190,510)	0.0%	IBNR Claims Fluctuation (IP)	(194,461)	0	194,461	0.0%
48,928,677	45,626,974	(3,301,704)	(7.2%)	Inpatient Hospitalization FFS	99,176,269	91,156,751	(8,019,518)	(8.8%)
2,847,296	0	(2,847,296)	0.0%	IP OB - Mom & NB	6,484,385	0	(6,484,385)	0.0%
259,933	0	(259,933)	0.0%	IP Behavioral Health	643,645	0	(643,645)	0.0%
1,275,345	0	(1,275,345)	0.0%	Inpatient Facility Rehab FFS	2,659,304	0	(2,659,304)	0.0%
55,954,592	**45,626,974**	**(10,327,618)**	**(22.6%)**	**8. Inpatient Hospital Expense**	**106,265,460**	**91,156,751**	**(15,108,710)**	**(16.6%)**
593,850	0	(593,850)	0.0%	IBNR PCP	352,862	0	(352,862)	0.0%
17,816	0	(17,816)	0.0%	IBNR Settlement (PCP)	10,586	0	(10,586)	0.0%
47,507	0	(47,507)	0.0%	IBNR Claims Fluctuation (PCP)	96,497	0	(96,497)	0.0%
4,386,202	3,736,266	(649,937)	(17.4%)	PCP FFS	9,009,812	7,464,555	(1,545,258)	(20.7%)
334,625	1,438,719	1,104,094	76.7%	PCP FQHC FFS	833,720	2,875,099	2,041,379	71.0%
0	0	0	0.0%	Physician Extended Hrs. Incent	12,000	0	(12,000)	0.0%
679	953,623	952,944	99.9%	Prop 56 Physician Pmt	679	1,906,120	1,905,441	100.0%
16,225	0	(16,225)	0.0%	Prop 56 Hyde	32,349	0	(32,349)	0.0%
74,380	0	(74,380)	0.0%	Prop 56 Trauma Screening	148,676	0	(148,676)	0.0%
79,479	0	(79,479)	0.0%	Prop 56 Developmentl Screening	158,569	0	(158,569)	0.0%
766,075	0	(766,075)	0.0%	Prop 56 Family Planning	1,530,911	0	(1,530,911)	0.0%
6,316,838	**6,128,608**	**(188,230)**	**(3.1%)**	**9. Primary Care Physician Expense**	**12,186,661**	**12,245,773**	**59,113**	**0.5%**
1,593,902	0	(1,593,902)	0.0%	IBNR Specialist	(432,784)	0	432,784	0.0%
47,818	0	(47,818)	0.0%	IBNR Settlement (SCP)	(12,983)	0	12,983	0.0%
127,511	0	(127,511)	0.0%	IBNR Claims Fluctuation (SCP)	(34,624)	0	34,624	0.0%
314,309	0	(314,309)	0.0%	Psychiatrist FFS	642,695	0	(642,695)	0.0%
3,796,765	7,926,597	4,129,832	52.1%	Specialty Care FFS	7,646,817	15,837,944	8,191,126	51.7%
243,820	0	(243,820)	0.0%	Specialty Anesthesiology	486,996	0	(486,996)	0.0%
1,357,006	0	(1,357,006)	0.0%	Specialty Imaging FFS	3,491,682	0	(3,491,682)	0.0%
25,803	0	(25,803)	0.0%	Obstetrics FFS	63,059	0	(63,059)	0.0%
401,576	0	(401,576)	0.0%	Specialty IP Surgery FFS	983,789	0	(983,789)	0.0%
801,423	0	(801,423)	0.0%	Specialty OP Surgery FFS	1,962,124	0	(1,962,124)	0.0%
559,797	0	(559,797)	0.0%	Speciality IP Physician	1,193,888	0	(1,193,888)	0.0%
120,558	101,608	(18,950)	(18.7%)	Specialist FQHC FFS	262,166	202,999	(59,167)	(29.1%)
9,390,288	**8,028,205**	**(1,362,083)**	**(17.0%)**	**10. Specialty Care Physician Expense**	**16,252,824**	**16,040,943**	**(211,882)**	**(1.3%)**
2,537,873	0	(2,537,873)	0.0%	IBNR Ancillary (ANC)	(637,736)	0	637,736	0.0%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
76,134	0	(76,134)	0.0%	IBNR Settlement (ANC)	67,933	0	(67,933)	0.0%
203,028	0	(203,028)	0.0%	IBNR Claims Fluctuation (ANC)	112,892	0	(112,892)	0.0%
66,184	0	(66,184)	0.0%	IBNR Transportation FFS	104,923	0	(104,923)	0.0%
1,674,756	0	(1,674,756)	0.0%	Behavioral Health Therapy FFS	3,957,576	0	(3,957,576)	0.0%
1,519,115	0	(1,519,115)	0.0%	Psychologist & Other MH Prof	3,364,832	0	(3,364,832)	0.0%
386,345	0	(386,345)	0.0%	Other Medical Professional	887,977	0	(887,977)	0.0%
153,285	0	(153,285)	0.0%	Hearing Devices	339,676	0	(339,676)	0.0%
80,984	0	(80,984)	0.0%	ANC Imaging	178,347	0	(178,347)	0.0%
65,354	0	(65,354)	0.0%	Vision FFS	141,453	0	(141,453)	0.0%
1,326,482	0	(1,326,482)	0.0%	Laboratory FFS	2,735,378	0	(2,735,378)	0.0%
138,119	0	(138,119)	0.0%	ANC Therapist	277,965	0	(277,965)	0.0%
1,122,608	0	(1,122,608)	0.0%	Transp/Ambulance FFS	3,159,771	0	(3,159,771)	0.0%
3,125,500	0	(3,125,500)	0.0%	Non-ER Transportation FFS	4,538,710	0	(4,538,710)	0.0%
2,333,584	0	(2,333,584)	0.0%	Hospice FFS	4,775,168	0	(4,775,168)	0.0%
1,658,471	0	(1,658,471)	0.0%	Home Health Services	3,290,199	0	(3,290,199)	0.0%
128	12,482,098	12,481,970	100.0%	Other Medical FFS	128	24,927,218	24,927,090	100.0%
275	0	(275)	0.0%	Medical Refunds through HMS	306	0	(306)	0.0%
35,869	0	(35,869)	0.0%	DME & Medical Supplies FFS	110,013	0	(110,013)	0.0%
(2,553,848)	1,779,713	4,333,561	243.5%	ECM Base/Outreach FFS ANC	(802,221)	3,558,190	4,360,412	122.5%
196,498	45,034	(151,464)	(336.3%)	CS Housing Deposits FFS ANC	264,133	89,622	(174,511)	(194.7%)
543	633,373	632,831	99.9%	CS Housing Tenancy FFS ANC	808,261	1,259,157	450,895	35.8%
1,146	468,284	467,138	99.8%	CS Housing Navi Servic FFS ANC	482,279	933,950	451,670	48.4%
681,386	550,061	(131,325)	(23.9%)	CS Medical Respite FFS ANC	1,180,844	1,100,121	(80,723)	(7.3%)
119,373	206,852	87,479	42.3%	CS Med. Tailored Meals FFS ANC	147,804	410,103	262,299	64.0%
7,608	38,076	30,468	80.0%	CS Asthma Remediation FFS ANC	10,009	63,216	53,207	84.2%
0	10,000	10,000	100.0%	MOT Wrap Around (Non Med MOT)	0	20,000	20,000	100.0%
6,579	15,000	8,421	56.1%	CS Home Modifications FFS ANC	20,244	30,000	9,756	32.5%
330,303	491,426	161,124	32.8%	CS P.Care & Hmker Svcs FFS ANC	916,728	979,205	62,477	6.4%
5,995	76,608	70,614	92.2%	CS Cgiver Respite Svcs FFS ANC	26,686	153,216	126,531	82.6%
0	137,176	137,176	100.0%	CS Sobering Center FFS ANC	0	274,352	274,352	100.0%
460,965	0	(460,965)	0.0%	CommunityBased Adult Svc(CBAS)	1,297,620	0	(1,297,620)	0.0%
1,797	21,888	20,091	91.8%	CS LTC Diversion FFS ANC	17,394	43,300	25,906	59.8%
0	13,125	13,125	100.0%	CS LTC Transition FFS ANC	0	25,625	25,625	100.0%
15,762,436	**16,968,713**	**1,206,277**	**7.1%**	**11. Ancillary Medical Expense**	**31,775,292**	**33,867,274**	**2,091,982**	**6.2%**
900,446	0	(900,446)	0.0%	IBNR Outpatient	1,216,122	0	(1,216,122)	0.0%
27,013	0	(27,013)	0.0%	IBNR Settlement (OP)	36,483	0	(36,483)	0.0%
72,036	0	(72,036)	0.0%	IBNR Claims Fluctuation (OP)	97,289	0	(97,289)	0.0%
2,702,449	11,480,119	8,777,671	76.5%	Outpatient FFS	4,947,012	22,937,226	17,990,214	78.4%
2,836,277	0	(2,836,277)	0.0%	OP Ambul Surgery FFS	5,469,360	0	(5,469,360)	0.0%
2,308,727	0	(2,308,727)	0.0%	Imaging Services FFS	4,885,913	0	(4,885,913)	0.0%
19,108	0	(19,108)	0.0%	Behavioral Health FFS	54,062	0	(54,062)	0.0%
658,087	0	(658,087)	0.0%	Outpatient Facility Lab FFS	1,367,868	0	(1,367,868)	0.0%
196,374	0	(196,374)	0.0%	Outpatient Facility Cardio FFS	402,248	0	(402,248)	0.0%
94,461	0	(94,461)	0.0%	OP Facility PT/OT/ST FFS	188,087	0	(188,087)	0.0%
3,050,518	0	(3,050,518)	0.0%	OP Facility Dialysis Ctr FFS	5,814,929	0	(5,814,929)	0.0%
12,865,495	**11,480,119**	**(1,385,375)**	**(12.1%)**	**12. Outpatient Medical Expense**	**24,479,372**	**22,937,226**	**(1,542,147)**	**(6.7%)**
2,950,917	0	(2,950,917)	0.0%	IBNR Emergency	1,984,243	0	(1,984,243)	0.0%
88,527	0	(88,527)	0.0%	IBNR Settlement (ER)	59,527	0	(59,527)	0.0%
236,073	0	(236,073)	0.0%	IBNR Claims Fluctuation (ER)	158,739	0	(158,739)	0.0%
8,278,244	8,760,762	482,518	5.5%	ER Facility	18,029,176	17,498,754	(530,422)	(3.0%)
1,083,596	0	(1,083,596)	0.0%	Specialty ER Physician FFS	2,461,503	0	(2,461,503)	0.0%
12,637,357	**8,760,762**	**(3,876,595)**	**(44.2%)**	**13. Emergency Expense**	**22,693,187**	**17,498,754**	**(5,194,434)**	**(29.7%)**

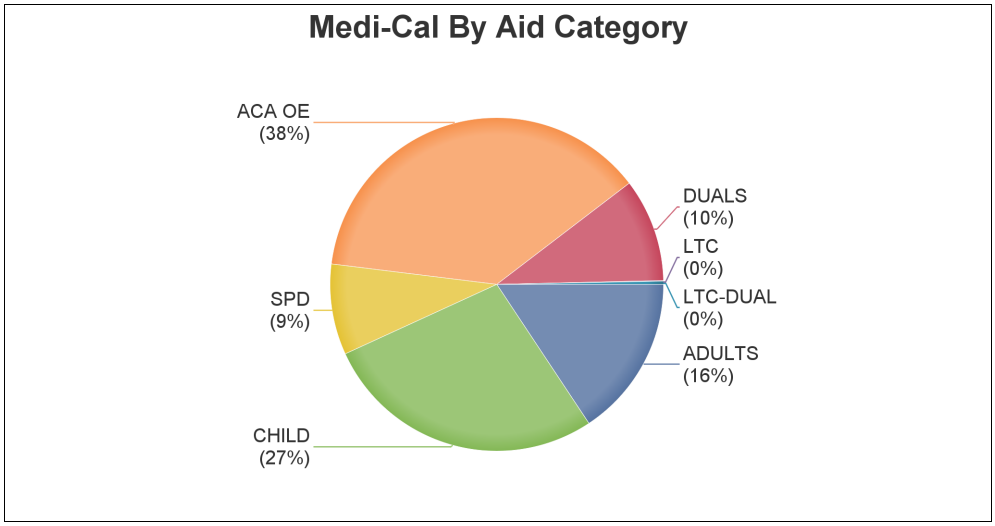
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED AUGUST 31, 2024

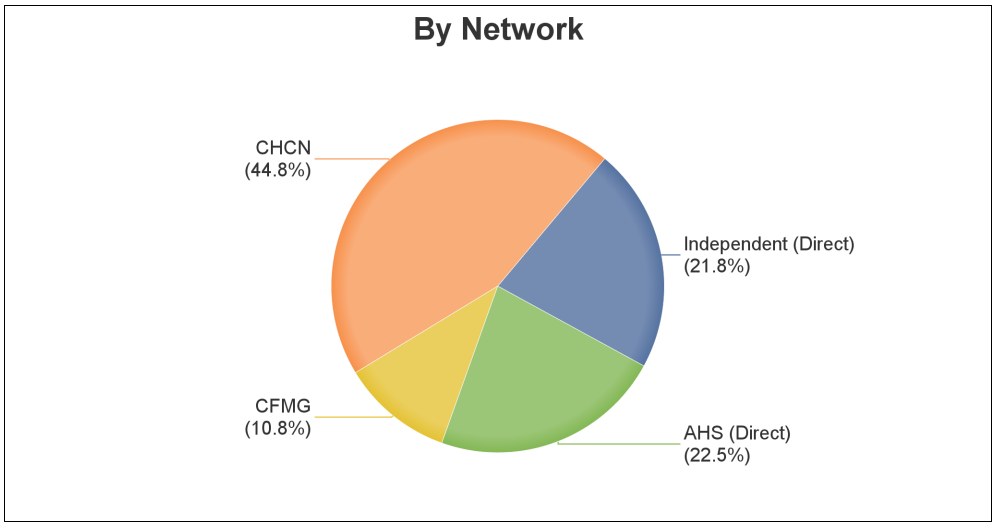
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,143,245	0	(3,143,245)	0.0%	IBNR Pharmacy (OP)	406,051	0	(406,051)	0.0%
94,297	0	(94,297)	0.0%	IBNR Settlement Rx (OP)	12,183	0	(12,183)	0.0%
251,460	0	(251,460)	0.0%	IBNR Claims Fluctuation Rx(OP)	32,484	0	(32,484)	0.0%
689,411	391,068	(298,342)	(76.3%)	Pharmacy FFS (OP)	1,504,419	781,945	(722,474)	(92.4%)
126,140	11,689,244	11,563,104	98.9%	Pharmacy Non PBM FFS Other-ANC	304,414	23,356,258	23,051,844	98.7%
8,390,686	0	(8,390,686)	0.0%	Pharmacy Non PBM FFS OP-FAC	18,588,749	0	(18,588,749)	0.0%
200,646	0	(200,646)	0.0%	Pharmacy Non PBM FFS PCP	499,986	0	(499,986)	0.0%
2,278,097	0	(2,278,097)	0.0%	Pharmacy Non PBM FFS SCP	5,625,022	0	(5,625,022)	0.0%
18,699	0	(18,699)	0.0%	Pharmacy Non PBM FFS FQHC	34,293	0	(34,293)	0.0%
23,780	0	(23,780)	0.0%	Pharmacy Non PBM FFS HH	64,018	0	(64,018)	0.0%
(275)	0	275	0.0%	RX Refunds HMS	(306)	0	306	0.0%
(54,000)	49,742	103,742	208.6%	Medical Expenses Pharm Rebate	(108,000)	99,446	207,446	208.6%
15,162,186	**12,130,054**	**(3,032,132)**	**(25.0%)**	**14. Pharmacy Expense**	**26,963,311**	**24,237,649**	**(2,725,662)**	**(11.2%)**
15,726,117	0	(15,726,117)	0.0%	IBNR LTC	(1,214,100)	0	1,214,100	0.0%
471,783	0	(471,783)	0.0%	IBNR Settlement (LTC)	(36,423)	0	36,423	0.0%
1,258,089	0	(1,258,089)	0.0%	IBNR Claims Fluctuation (LTC)	(97,128)	0	97,128	0.0%
1,109,168	0	(1,109,168)	0.0%	LTC - ICF/DD	3,678,231	0	(3,678,231)	0.0%
10,747,578	0	(10,747,578)	0.0%	LTC Custodial Care	48,542,112	0	(48,542,112)	0.0%
6,896,144	29,221,691	22,325,547	76.4%	LTC SNF	14,446,978	58,388,252	43,941,274	75.3%
36,208,879	**29,221,691**	**(6,987,188)**	**(23.9%)**	**15. Long Term Care Expense**	**65,319,670**	**58,388,252**	**(6,931,418)**	**(11.9%)**
164,298,071	**138,345,127**	**(25,952,944)**	**(18.8%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**305,935,779**	**276,372,621**	**(29,563,157)**	**(10.7%)**
0	0	0	0.0%	Medical Exp. OthClinicalGrants	(809,521)	0	809,521	0.0%
0	167,450	167,450	100.0%	Clinical Vacancy #102	0	430,095	430,095	100.0%
182,466	127,094	(55,372)	(43.6%)	Quality Analytics #123	281,031	307,579	26,549	8.6%
143,820	324,946	181,126	55.7%	LongTerm Services and Support #139	143,820	637,781	493,961	77.4%
988,597	817,885	(170,711)	(20.9%)	Utilization Management #140	2,142,019	1,653,582	(488,437)	(29.5%)
649,541	545,018	(104,523)	(19.2%)	Case & Disease Management #185	1,363,529	1,088,309	(275,220)	(25.3%)
270,839	505,387	234,548	46.4%	Medical Management #230	759,744	954,745	195,001	20.4%
1,378,534	897,323	(481,211)	(53.6%)	Quality Improvement #235	2,233,377	1,684,925	(548,451)	(32.6%)
300,083	354,330	54,247	15.3%	HCS Behavioral Health #238	622,100	706,719	84,618	12.0%
114,660	239,135	124,474	52.1%	Pharmacy Services #245	217,261	477,328	260,066	54.5%
90,230	59,239	(30,990)	(52.3%)	Regulatory Readiness #268	145,189	118,487	(26,702)	(22.5%)
4,118,770	**4,037,808**	**(80,963)**	**(2.0%)**	**17. Other Benefits & Services**	**7,098,549**	**8,059,549**	**961,000**	**11.9%**
(1,878,497)	(1,157,239)	721,258	(62.3%)	Reinsurance Recoveries	(3,271,497)	(2,313,742)	957,755	(41.4%)
1,747,667	1,542,985	(204,682)	(13.3%)	Reinsurance Premium	3,488,768	3,084,989	(403,779)	(13.1%)
(130,830)	**385,746**	**516,576**	**133.9%**	**18. Reinsurance Expense**	**217,271**	**771,247**	**553,976**	**71.8%**
187,856,215	**162,594,243**	**(25,261,972)**	**(15.5%)**	**20. TOTAL MEDICAL EXPENSES**	**352,366,870**	**324,833,050**	**(27,533,820)**	**(8.5%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

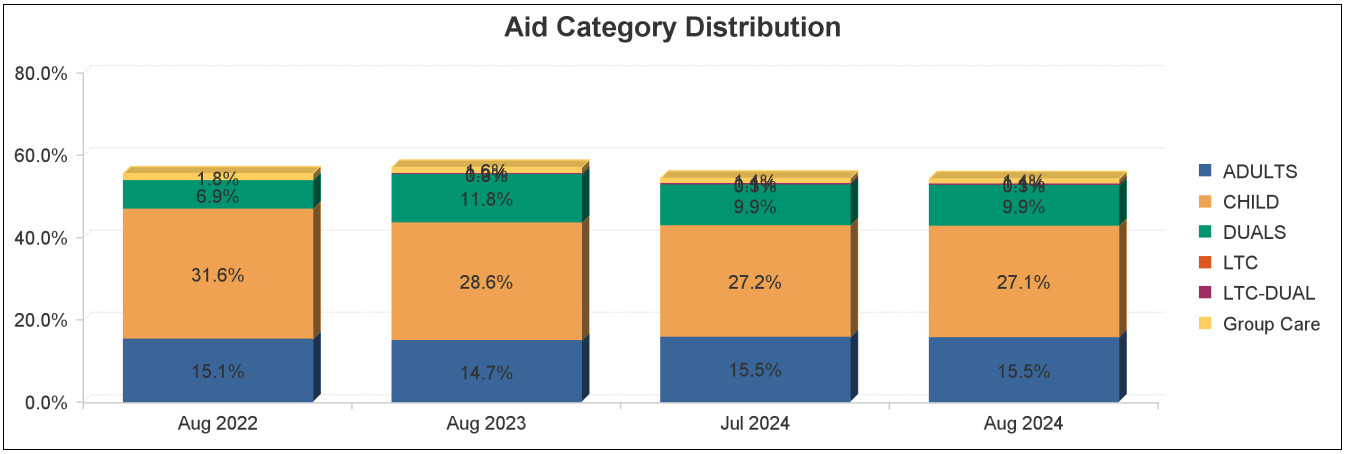
Category of Aid	Aug 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,671	16%	12,681	14,466	5	35,519
CHILD	109,803	27%	8,842	13,705	41,006	46,250
SPD	35,177	9%	11,437	5,581	1,426	16,733
ACA OE	150,482	38%	25,736	53,678	1,516	69,552
DUALS	40,030	10%	26,279	2,841	6	10,904
LTC	226	0%	210	8	0	8
LTC-DUAL	1,247	0%	1,245	0	0	2
Medi-Cal	399,636		86,430	90,279	43,959	178,968
Group Care	5,686		2,120	903	0	2,663
Total	**405,322**	**100%**	**88,550**	**91,182**	**43,959**	**181,631**
Medi-Cal %	98.6%		97.6%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.4%	1.0%	0.0%	1.5%
	Network Distribution		**21.8%**	**22.5%**	**10.8%**	**44.8%**
			% Direct:	**44%**	**% Delegated:**	**56%**





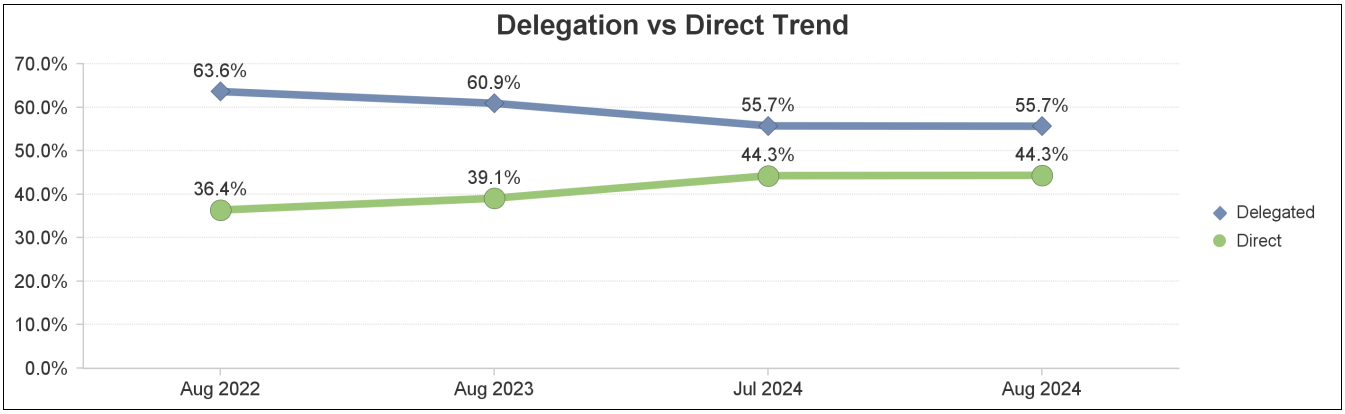
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
ADULTS	48,112	52,176	62,739	**62,671**	15.1%	14.7%	15.5%	15.5%	8.4%	20.1%	-0.1%
CHILD	100,977	101,555	109,962	**109,803**	31.6%	28.6%	27.2%	27.1%	0.6%	8.1%	-0.1%
SPD	28,079	30,864	35,018	**35,177**	8.8%	8.7%	8.7%	8.7%	9.9%	14.0%	0.5%
ACA OE	114,208	121,928	149,801	**150,482**	35.8%	34.3%	37.0%	37.1%	6.8%	23.4%	0.5%
DUALS	22,077	41,722	39,896	**40,030**	6.9%	11.8%	9.9%	9.9%	89.0%	-4.1%	0.3%
LTC	0	138	222	**226**	0.0%	0.0%	0.1%	0.1%	0.0%	63.8%	1.8%
LTC-DUAL	0	1,020	1,241	**1,247**	0.0%	0.3%	0.3%	0.3%	0.0%	22.3%	0.5%
Medi-Cal	313,453	349,403	398,879	**399,636**	98.2%	98.4%	98.6%	98.6%	11.5%	14.4%	0.2%
Group Care	5,803	5,645	5,675	**5,686**	1.8%	1.6%	1.4%	1.4%	-2.7%	0.7%	0.2%
Total	**319,256**	**355,048**	**404,554**	405,322	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.2%**	**14.2%**	**0.2%**



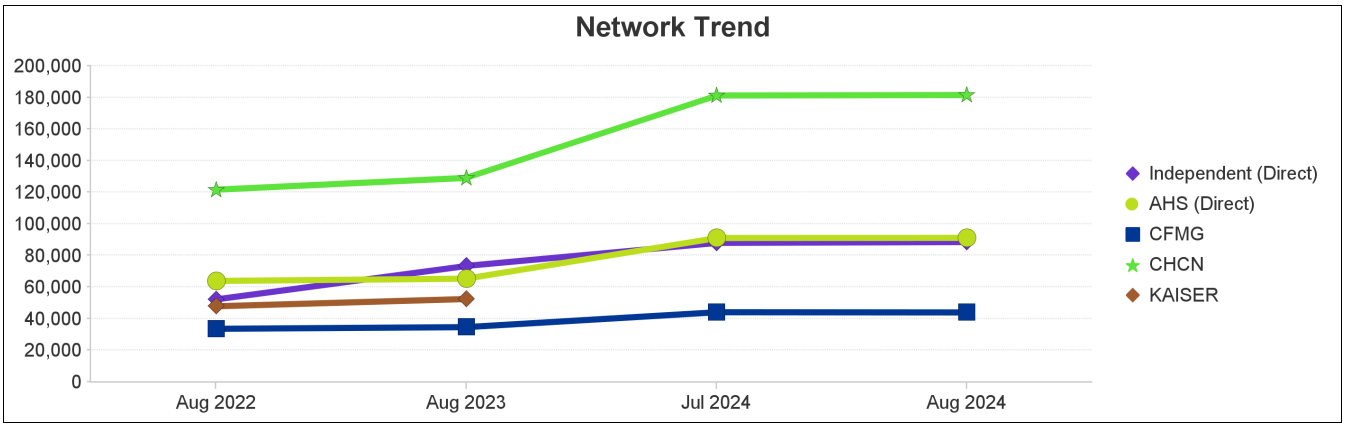
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
Delegated	203,148	216,300	225,445	**225,590**	63.6%	60.9%	55.7%	55.7%	6.5%	4.3%	0.1%
Direct	116,108	138,748	179,109	**179,732**	36.4%	39.1%	44.3%	44.3%	19.5%	29.5%	0.3%
Total	**319,256**	**355,048**	**404,554**	405,322	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.2%**	**14.2%**	**0.2%**



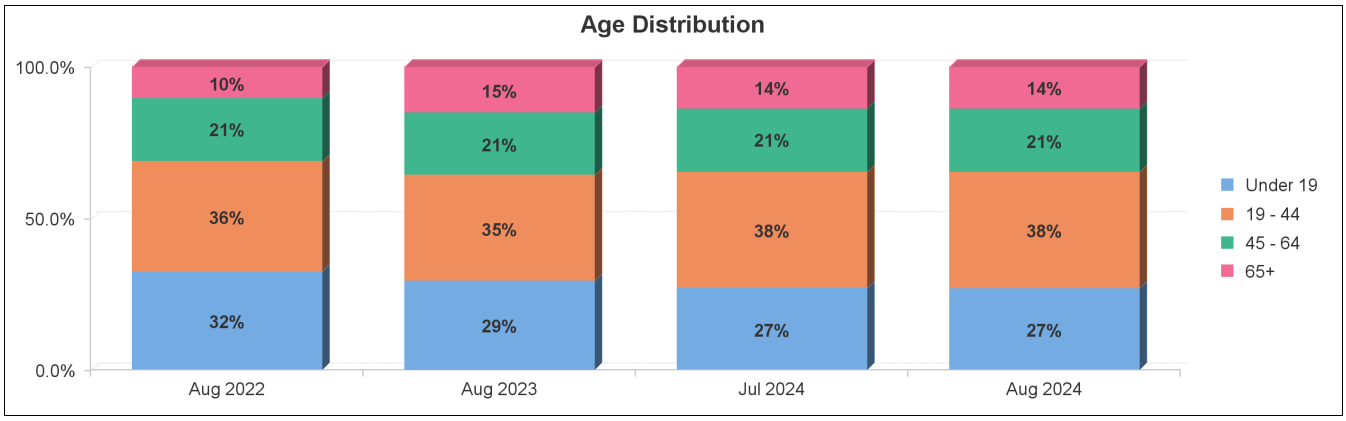
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
Independent (Direct)	52,198	73,404	88,010	**88,550**	16.3%	20.7%	21.8%	21.8%	40.6%	20.6%	0.6%
AHS (Direct)	63,910	65,344	91,099	**91,182**	20.0%	18.4%	22.5%	22.5%	2.2%	39.5%	0.1%
CFMG	33,594	34,649	44,090	**43,959**	10.5%	9.8%	10.9%	10.8%	3.1%	26.9%	-0.3%
CHCN	121,703	129,183	181,355	**181,631**	38.1%	36.4%	44.8%	44.8%	6.1%	40.6%	0.2%
KAISER	47,851	52,468	0	**0**	15.0%	14.8%	0.0%	0.0%	9.6%	-100.0%	0.0%
Total	**319,256**	**355,048**	**404,554**	**405,322**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.2%**	**14.2%**	**0.2%**



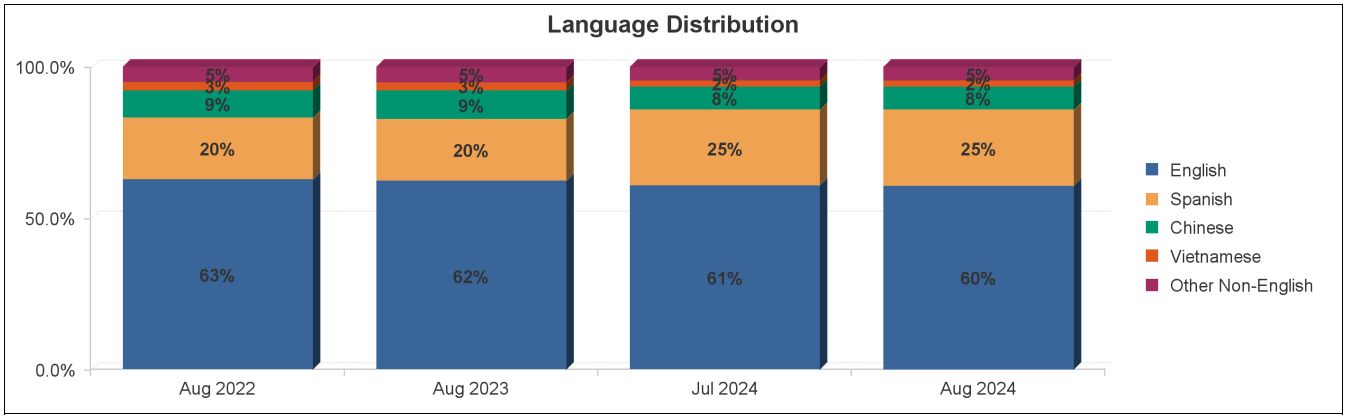
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
Under 19	103,223	103,911	108,451	**108,349**	32%	29%	27%	27%	1%	4%	0%
19 - 44	116,003	123,789	155,339	**155,686**	36%	35%	38%	38%	7%	26%	0%
45 - 64	66,526	73,289	84,037	**84,199**	21%	21%	21%	21%	10%	15%	0%
65+	33,504	54,059	56,727	**57,088**	10%	15%	14%	14%	61%	6%	1%
Total	**319,256**	**355,048**	**404,554**	**405,322**	**100%**	**100%**	**100%**	**100%**	**11%**	**14%**	**0%**



Language Trend

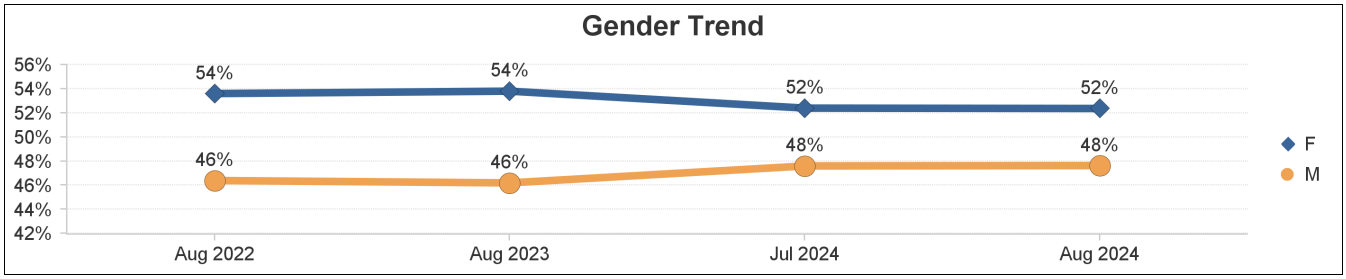
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Aug 2022	Aug 2023	Jul 2024	Aug 2024	ug 2022	ug 2023	Jul 2024	ug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
English	199,798	220,565	245,137	**245,150**	63%	62%	61%	60%	10%	11%	0%
Spanish	64,967	72,596	101,314	**102,034**	20%	20%	25%	25%	12%	41%	1%
Chinese	28,938	33,152	30,651	**30,695**	9%	9%	8%	8%	15%	-7%	0%
Vietnamese	8,869	9,609	8,353	**8,310**	3%	3%	2%	2%	8%	-14%	-1%
Other Non-English	16,684	19,126	19,099	**19,133**	5%	5%	5%	5%	15%	0%	0%
Total	**319,256**	**355,048**	**404,554**	**405,322**	**100%**	**100%**	**100%**	**100%**	**11%**	**14%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

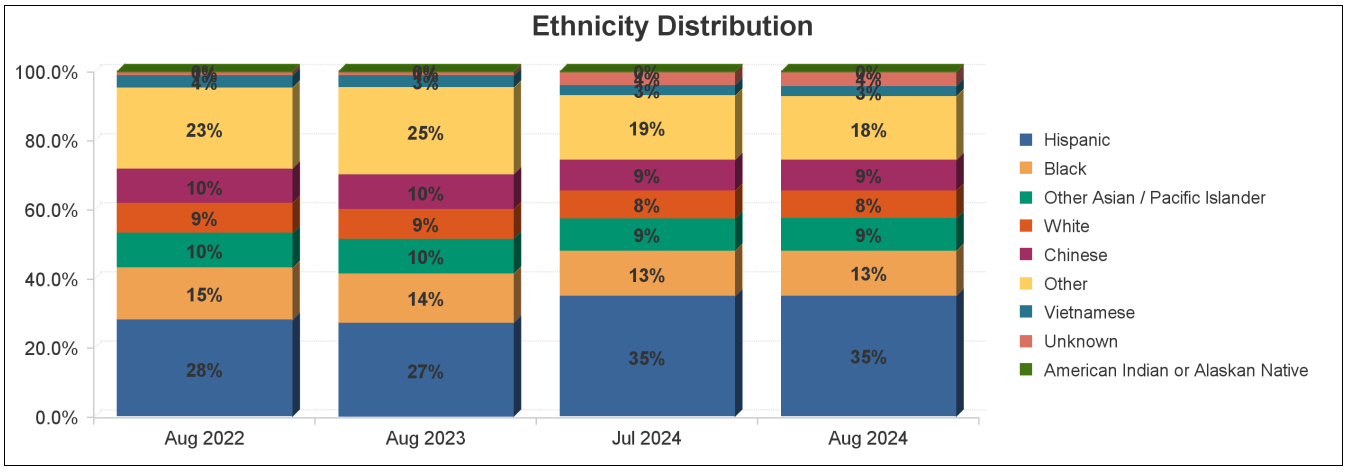
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
F	171,141	191,038	211,979	**212,258**	54%	54%	52%	52%	12%	11%	0%
M	148,115	164,010	192,575	**193,064**	46%	46%	48%	48%	11%	18%	0%
Total	**319,256**	**355,048**	**404,554**	**405,322**	**100%**	**100%**	**100%**	**100%**	**11%**	**14%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
Hispanic	88,998	95,902	140,570	**141,075**	28%	27%	35%	35%	8%	47%	0%
Black	48,133	50,614	53,042	**52,860**	15%	14%	13%	13%	5%	4%	0%
Other Asian / Pacific Islander	32,123	35,566	37,878	**38,062**	10%	10%	9%	9%	11%	7%	0%
White	27,887	30,577	32,713	**32,586**	9%	9%	8%	8%	10%	7%	0%
Chinese	31,586	35,715	35,841	**35,869**	10%	10%	9%	9%	13%	0%	0%
Other	74,839	89,524	75,541	**74,954**	23%	25%	19%	18%	20%	-16%	-1%
Vietnamese	11,428	12,104	11,830	**11,804**	4%	3%	3%	3%	6%	-2%	0%
Unknown	3,579	4,327	16,341	**17,310**	1%	1%	4%	4%	21%	300%	6%
American Indian or Alaskan Native	683	719	798	**802**	0%	0%	0%	0%	5%	12%	1%
Total	**319,256**	**355,048**	**404,554**	**405,322**	**100%**	**100%**	**100%**	**100%**	**11%**	**14%**	**0%**



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

Medi-Cal By City

City	Aug 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	160,557	40%	23,274	42,818	17,444	77,021
HAYWARD	64,039	16%	12,797	17,316	7,482	26,444
FREMONT	37,151	9%	15,368	6,647	2,143	12,993
SAN LEANDRO	33,087	8%	8,103	5,711	4,270	15,003
UNION CITY	14,674	4%	5,513	2,630	873	5,658
ALAMEDA	13,850	3%	3,296	2,496	2,085	5,973
BERKELEY	15,025	4%	4,039	2,314	1,752	6,920
LIVERMORE	12,894	3%	1,825	625	2,231	8,213
NEWARK	9,387	2%	2,744	4,122	525	1,996
CASTRO VALLEY	9,486	2%	2,520	1,639	1,403	3,924
SAN LORENZO	7,320	2%	1,473	1,664	835	3,348
PLEASANTON	7,536	2%	1,751	416	819	4,550
DUBLIN	7,465	2%	1,971	439	882	4,173
EMERYVILLE	2,826	1%	631	623	456	1,116
ALBANY	2,514	1%	654	294	565	1,001
PIEDMONT	470	0%	104	198	51	117
SUNOL	87	0%	27	14	6	40
ANTIOCH	23	0%	2	13	2	6
Other	1,245	0%	338	300	135	472
Total	399,636	100%	**86,430**	**90,279**	**43,959**	**178,968**

Group Care By City

City	Aug 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,792	32%	355	334	0	1,103
HAYWARD	645	11%	300	155	0	190
FREMONT	639	11%	424	71	0	144
SAN LEANDRO	603	11%	235	93	0	275
UNION CITY	295	5%	186	44	0	65
ALAMEDA	295	5%	90	24	0	181
BERKELEY	155	3%	50	11	0	94
LIVERMORE	100	2%	29	4	0	67
NEWARK	133	2%	79	29	0	25
CASTRO VALLEY	191	3%	84	29	0	78
SAN LORENZO	134	2%	40	25	0	69
PLEASANTON	68	1%	21	3	0	44
DUBLIN	120	2%	43	5	0	72
EMERYVILLE	32	1%	11	4	0	17
ALBANY	20	0%	11	2	0	7
PIEDMONT	10	0%	2	1	0	7
SUNOL	2	0%	2	0	0	0
ANTIOCH	26	0%	7	5	0	14
Other	426	7%	151	64	0	211
Total	**5,686**	**100%**	**2,120**	**903**	**0**	**2,663**

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

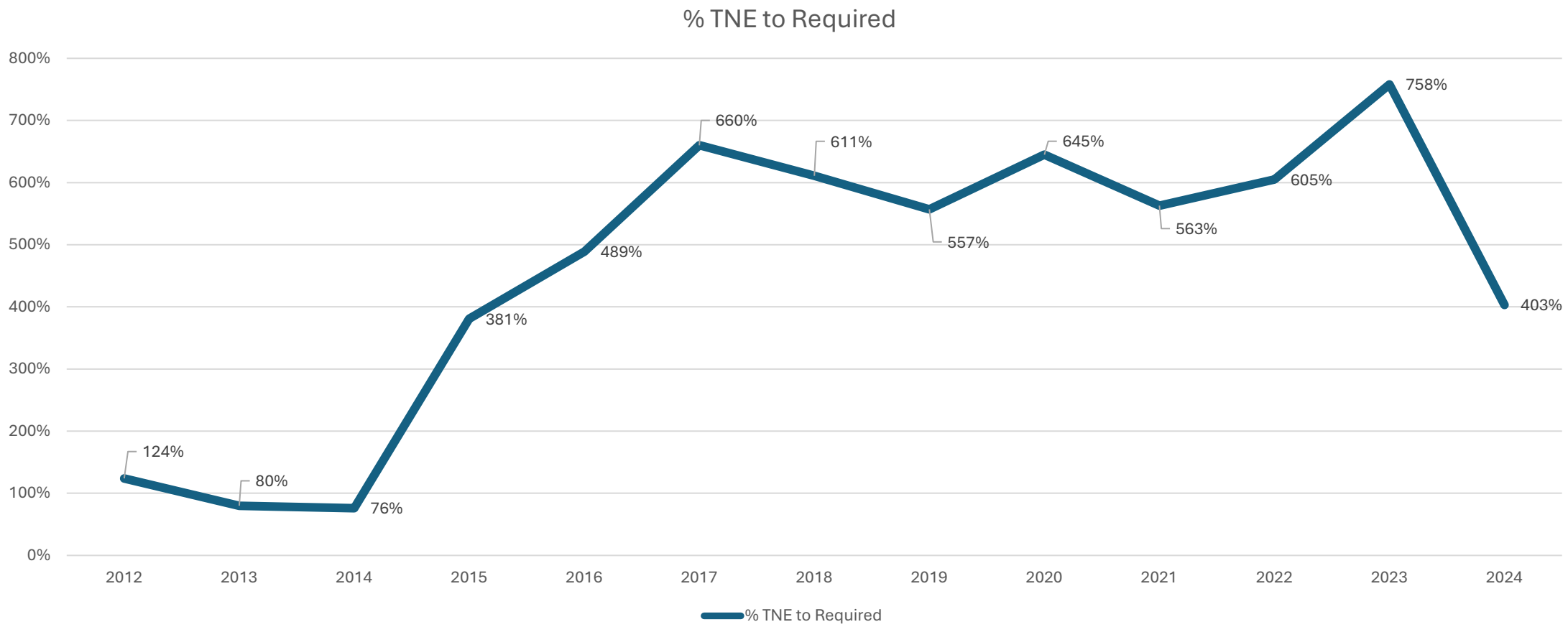
Total By City

City	Aug 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,349	40%	23,629	43,152	17,444	78,124
HAYWARD	64,684	16%	13,097	17,471	7,482	26,634
FREMONT	37,790	9%	15,792	6,718	2,143	13,137
SAN LEANDRO	33,690	8%	8,338	5,804	4,270	15,278
UNION CITY	14,969	4%	5,699	2,674	873	5,723
ALAMEDA	14,145	3%	3,386	2,520	2,085	6,154
BERKELEY	15,180	4%	4,089	2,325	1,752	7,014
LIVERMORE	12,994	3%	1,854	629	2,231	8,280
NEWARK	9,520	2%	2,823	4,151	525	2,021
CASTRO VALLEY	9,677	2%	2,604	1,668	1,403	4,002
SAN LORENZO	7,454	2%	1,513	1,689	835	3,417
PLEASANTON	7,604	2%	1,772	419	819	4,594
DUBLIN	7,585	2%	2,014	444	882	4,245
EMERYVILLE	2,858	1%	642	627	456	1,133
ALBANY	2,534	1%	665	296	565	1,008
PIEDMONT	480	0%	106	199	51	124
SUNOL	89	0%	29	14	6	40
ANTIOCH	49	0%	9	18	2	20
Other	1,671	0%	489	364	135	683
Total	405,322	100%	**88,550**	**91,182**	**43,959**	**181,631**

Alameda Alliance for Health

Tangible Net Equity and Historical Expense Trends

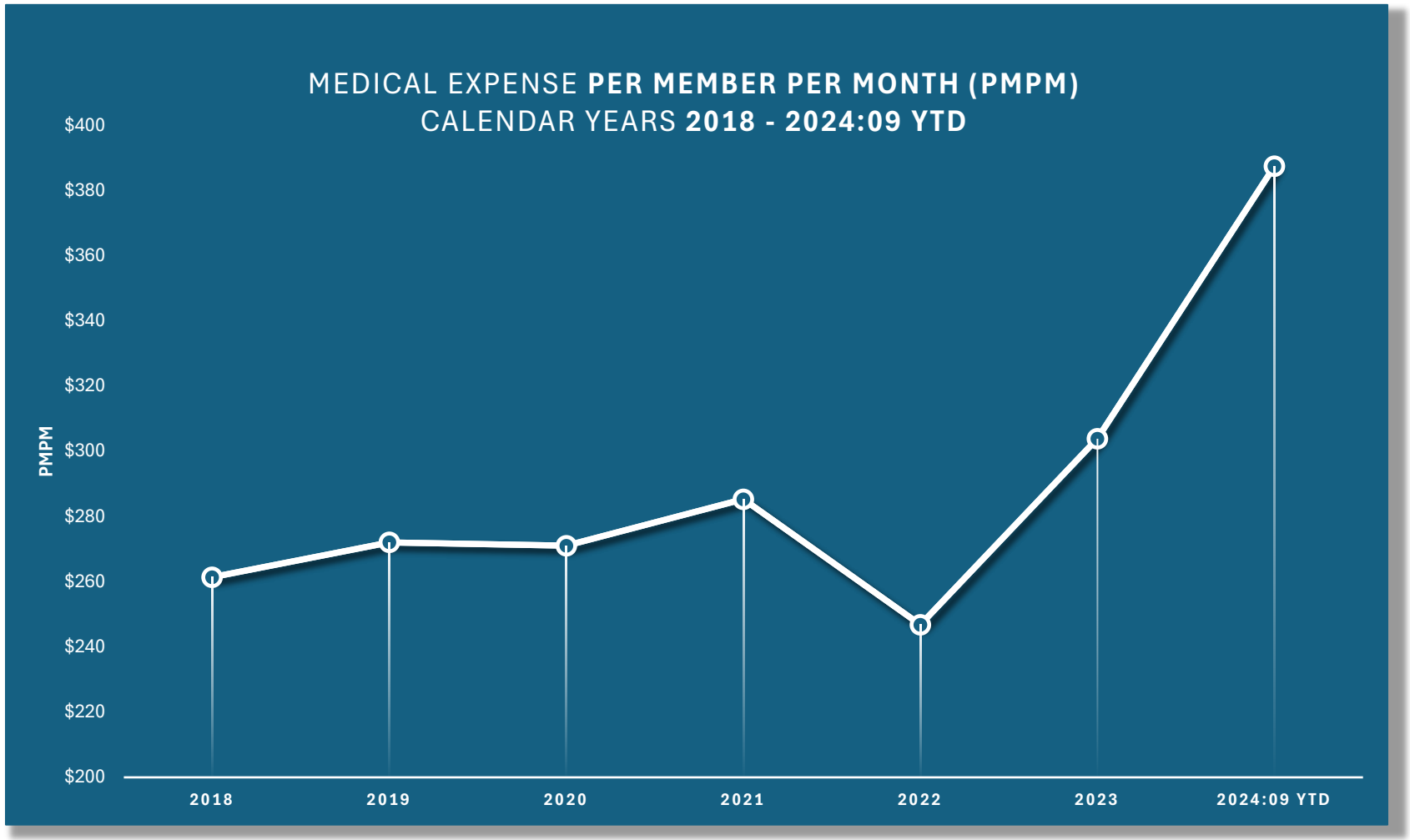
Historical TNE 2012-2024



Tangible Net Equity Trends

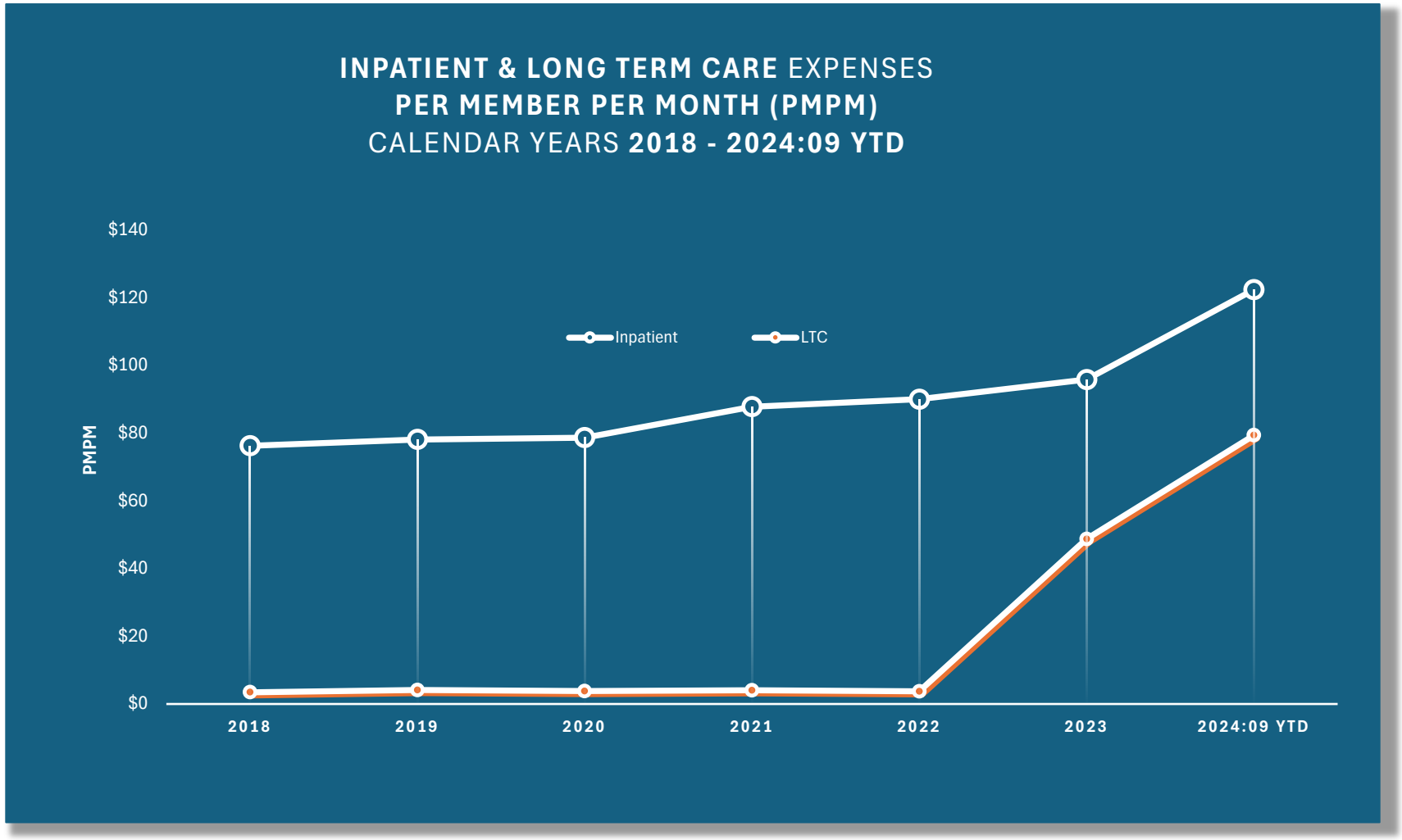
- Tangible Net Equity (TNE) reported below 130% of required in 2012 and below 100% in 2013 and 2014.
- TNE peaked in 2023 at 758% of required.
- Over the past 12 years the TNE requirement has increased by approximately 400%.
- Enrollment has increased by approximately 300%, over 258K members have been added since 2012.
- TNE continues to trend downward in Calendar Year 2024. August TNE was 322%.

Historical Expense Trends



- **Medical expenses stated per member per month**
- **Time horizon includes Covid pandemic as well as pre & post-Covid periods**
- **Medi-Cal Retail Pharmacy expenses carved out as of January 2022 (approx. $36 pmpm)**

Long Term Care and Inpatient Impact



- **Long Term Care added $44 in CY2023 and approx. $75 in 2024 YTD**
- **Inpatient added $5 in CY2023 and approx. $27 in 2024 YTD**

ALAMEDA Alliance FOR HEALTH

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

Operations

Ruth Watson

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

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

Date: **October 11th, 2024**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:

    - The Member Services Department received a 10.5% increase in calls in September 2024, totaling 17,028 compared to 15,405 in September 2023.
    - The abandonment rate for September 2024 was three percent (3%), compared to six percent (6%) in September 2023.
    - The Department's service level was ninety-five percent (95%) in September 2024, compared to eighty-two percent (82%) in September 2023. The average speed to answer (ASA) was fourteen seconds (00:14) compared to thirty-eight seconds (00:38) in September 2023. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
    - The average talk time (ATT) was seven minutes and eleven seconds (07:11) for September 2024 compared to six minutes and thirty-six seconds (06:36) for September 2023.
    - One hundred percent (100%) of calls were answered within 10 minutes for September 2024 and one hundred percent (100%) of calls were answered within 10 minutes for September 2023.
    - Outbound calls totaled seven thousand nine hundred and fifty-five (7,955) in September 2024 compared to seven thousand fifty-eight (7058) in September 2023.
    - The top five call reasons for September 2024 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Benefits, 4). Provider Network, 5). Grievances/Appeals. The top five call reasons for September 2023 were: 1). Change of PCP, 2). Eligibility/Enrollment 3). Benefits, 4). Kaiser, 5). Grievances and Appeals.
    - September utilization for the member automated eligibility IVR system totaled one thousand one hundred ninety-one (1,191) in September 2024 compared to one thousand two hundred sixteen (1,216) in September 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 and fifty-eight (1,158) web-based requests in September 2024 compared to seven hundred seventy-eight (778) in September 2023. The top three web reason requests for September 2024 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information. Sixty-four (64) members were assisted in-person in September

2024 compared to eighteen (18) in 2023.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health Unit received a total of one thousand three hundred forty-six (1,346) calls in September 2024 compared to one thousand one hundred seventy (1,170) in September 2023.
    - The abandonment rate was ten percent (10%) in September 2024 compared to seven percent (7%) in 2023.
    - The service level was seventy-three percent (73%) in September 2024 and eighty-seven percent (87%) in September 2023.
    - The average speed to answer (ASA) was one minute and twenty seconds (01:20) compared to thirty-eight seconds (00:38) in September 2023.
    - Calls answered in 10 minutes were ninety-eight percent (98%) in September 2024 compared to one hundred percent (100%) in September 2023.
    - The Average Talk Time (ATT) was nine minutes and nine seconds (09:09) compared to ten minutes and eleven seconds (10:11) in September 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 and thirty (130) screenings were completed in September 2024 compared to one hundred ninety-nine (199) in September 2023.
    - Thirty-three (33) referrals were made to the County (ACCESS) in September 2024 compared to thirty-eight (38) in September 2023.
    - One thousand one hundred eighty-seven (1,187) outbound calls were completed in September 2024 compared to one thousand six hundred forty-seven (1,647) in September 2023.
    - One hundred and thirty-three (133) outreach campaigns were completed in September 2024, compared to one hundred ninety-six (196) in September 2023.
    - Fourteen (14) members were referred to Center Point for SUD services in September 2024 compared to twenty-five (25) in September 2023.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 322,196 claims in September 2024 compared to 247,423 in September 2023.
    - The Auto Adjudication was 81.3% in September 2024 compared to 80.4% in September 2023.
    - Claims compliance for the 30-day turn-around time was 83.5% in September 2024 compared to 92.0% in September 2023. The 45-day turn-around time was 99.9% in September 2024 compared to 99.9% in September 2023.

- Monthly Analysis:

    - In the month of September, we received a total of 322,196 claims in the HEALTHsuite system. This represents a decrease of 12.50% from August and is higher, by 57,383 claims, than the number of claims received in September 2023.
    - Drivers of the higher volume of received claims includes:
        - The increased membership since January 2024
        - Certain provider types that bill more frequently, e.g., LTC facilities that bill weekly or bi-weekly
        - Providers with dual eligible members who are submitting paper claims even though we receive the same claim in our COBA file
    - We received 90.23% of claims via EDI and 9.77% of claims via paper.
    - During the month of September, 99.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 81.3% for the month of September.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services department's call volume in September 2024 was seven thousand six hundred thirty-four (7,634) calls compared to eight thousand three hundred thirteen (8,313) calls in September 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 three hundred twenty (320) calls/visits during September 2024.
    - The Provider Services department answered six thousand one hundred five (6,105) calls for September 2024 and made eight hundred eighty-nine (889) outbound calls.

Credentialing

- 12-Month Trend Summary:

    - At the Peer Review and Credentialing (PRCC) meeting held on September 17th, 2024, there were three hundred forty-nine (349) initial network providers approved; fourteen (14) primary care providers, thirty-four (34) specialists, ten (10) ancillary providers, twenty-six (26) midlevel providers, and two hundred sixty-five (265) behavioral health providers. Additionally, thirty-three (33) providers were re-credentialed at this meeting; seven (7)

primary care providers, sixteen (16) specialists, two (2) 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 September 2024, the Provider Dispute Resolution (PDR) team received 2,340 PDRs versus 2,219 in September 2023.
  - The PDR team resolved 1,897 cases in September 2024 compared to 1,738 cases in September 2023.
  - In September 2024, the PDR team upheld 68% of cases versus 80% in September 2023.
  - The PDR team resolved 99.6% of cases in September 2024 compared to 97.8% in September 2023; the compliance standard is 95% within 45 working days.

- Monthly Analysis:
  - AAH received 2,340 PDRs in September 2024.
  - In the month of September, 1,897 PDRs were resolved. Out of the 1,897 PDRs, 1,295 were upheld and 602 were overturned.
  - 1,889 out of 1,897 cases were resolved within 45 working days resulting in a 99.6% compliance rate.
  - The average turnaround time for resolving PDRs in September was 40 days.
  - There were 4,159 PDRs pending resolution as of 09/30/2024, with no cases older than 45 working days.
  - The overturn rate for PDRs was 32%, which did not meet our goal of 25% or less.
    - The two primary reasons that caused the Department to miss their goal of 25% or less are:
      - Member OHC corrections – 128 cases that were denied incorrectly.
      - Incorrect LTC/Subacute rate – 86 cases reviewed for updated AB1629 rates.
    - The combined volumes of the two primary reasons for the overturned PDRs this month alone prevented us from achieving the goal of 25% or less.
  - The full breakdown of all 602 overturned PDRs is as follows:

Category	# of Cases	% of Cases	Comments
System Related Issues	**85**	**14%**	
General configuration issues	47	8%	Non-covered code, modifier, etc

Retro eligibility changes	9	1%	Member not eligible at time claim was denied
Claims Editing System (CES)	29	5%	
OHC Issues	**128**	**21%**	OHC Member TPL data, incorrect primary EOB not matching, incorrect manual entry
Authorization Issues	**140**	**23%**	
Processor error	88	15%	Claim denied in error; authorization was on file
System error	2	0%	
UM/retro auth review	50	8%	Auth updated after claim was processed
Additional Documentation	**42**	**7%**	
Duplicate claim	24	4%	Documentation received confirmed claim was not a duplicate
Timely filing	2	0%	Documentation received confirmed claim was submitted on time
Misc documentation	16	3%	
Incorrect Rates	**147**	**25%**	
System	26	4%	Incorrect rates in system
Letter of Agreement (LOA)	2	0%	Underpaid; LOA on file
LTC/Retro Rates	86	15%	Rates updated after claim was paid
COB calculation	28	5%	Incorrectly calculated
Share of Cost (SOC)	5	1%	Underpaid; SOC already met
Processor Errors	**60**	**10%**	
Duplicate claim	20	3%	Claim was a duplicate; processor paid it in error
Incorrect rate	30	5%	Claim manually priced incorrectly
Misc errors	10	2%	
PDR Overturn Totals	**602**	**100%**	

Community Relations and Outreach

- 12-Month Trend Summary:
    - In Q1 2024, the Alliance completed 4,102 member orientation outreach calls and 322 member orientations by phone.
    - The C&O Department reached 3,902 people, 53% identified as Alliance members, compared to 949 individuals who identified as Alliance members in Q1 2023.

- The C&O Department spent a total of $1115.70 in donations, fees, and/or sponsorships, compared to $555 in Q1 2023.
- The C&O Department reached members in 19 cities/unincorporated areas throughout Alameda County, and Bay Area, compared to 15 locations in Q1 2023.

- Quarterly Analysis:

  - In Q1 2024, the C&O Department completed 4,102 member orientation outreach calls, 322 member orientations by phone, 14 community events, and 6 member education events.
  - Among the 3,902 people reached, 53% identified as Alliance members.
  - In Q1 2024, the C&O Department reached members in 19 locations throughout Alameda County and the Bay Area.

- Monthly Analysis:

  - In September 2024, the C&O Department completed 1141 member orientation outreach calls and 98 member orientations by phone, and 44 Alliance website inquiries.
  - Among the 754 people reached, 44% identified as Alliance members.
  - In September 2024, the C&O Department reached members in 16 locations throughout Alameda County and the Bay Area.
  - Please see attached **Addendum A**.

Housing and Community Services Program Report – September Activities

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.

Project Status Updates:

- Housing Team working in partnership with Health Care Services to transition the Housing Community Supports (CS) bundle on 10/1/2024
- Developing curriculum for Housing Learning Symposium
- ROI project for housing-related CS
- Housing Department internal restructuring – in progress
- Finalizing Housing Logic Model
- Revamped Housing Service Plan with Alameda County Health Housing & Homelessness (AC Health H&H) team

Interdepartmental Collaborations:

- Health Equity Department – Housing Logic Model & Health Equity Intersections

Community Networks and Partnership Development:

- 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 Regional Housing Meeting, Homeless Management Information System (HMIS) Committee, and Corporation for Supportive Housing Advisory Council.
    - Racial Equity Committee – developing action plans for the CoC Equity Framework
    - HMIS Committee – working to implement CoC Racial Equity Framework to support Persons with Lived Experience (PWLE) in HMIS evaluation.
    - CoC Notice of Funding – Completed application evaluation with CoC
    - CoC Leadership Board – Integration of REC framework
    - Corporation for Supportive Housing Advisory Council – developing statewide response templates for new Transitional Rent ben.

Staffing:

- Housing and Community Services Housing Program Coordinator (two (2) positions) – offers made; new hires start October 7, 2024

Community Health Worker (CHW) Program—The Community Health Worker (CHW) Benefit 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 and wellness through the deployment of preventative services that create positive outcomes on a member’s social determinants of health.

Staffing:

- CHW Program Manager – second round interviews, in progress

Project Status Updates:

- CHW Logic Model – in development
- CHW Workplan – in development
- CHW Training Cohort Curriculum – curriculum development to establish a community CHW Learning Cohort, designed to engage public health professionals, community-based organizations, hospital partners, and other local health jurisdictions in the CHW work; in progress

Interdepartmental Collaboration:

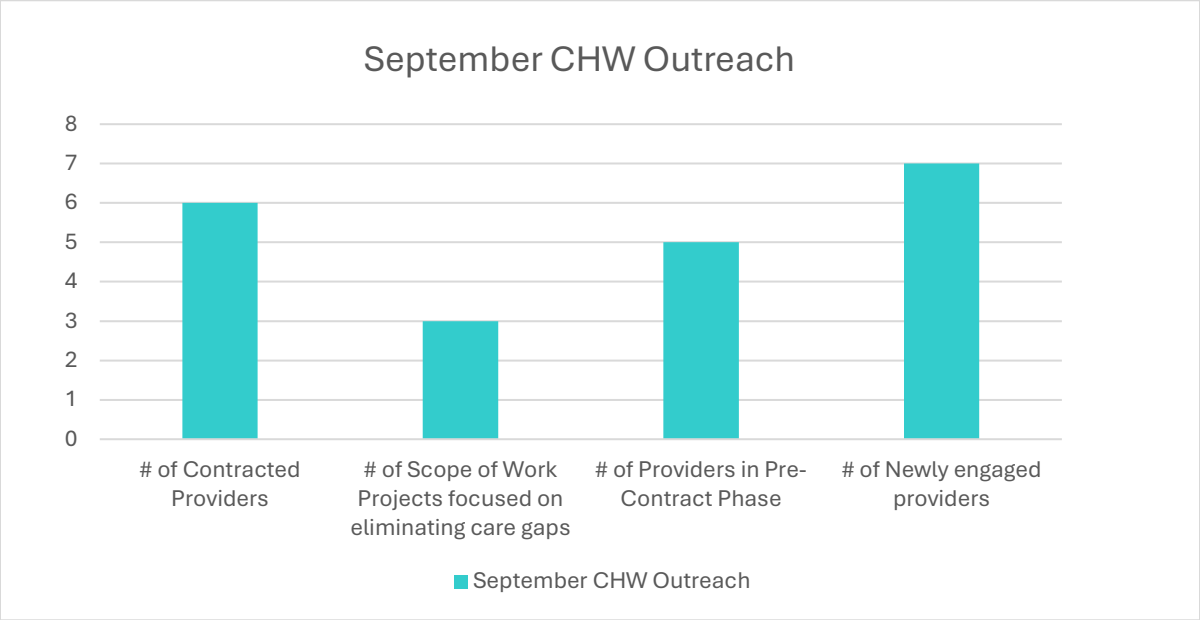
- Health Equity Department – cross-collaboration on the Social Determinants of Health (SDOH) project and CHW Logic Model
- Quality Team – CHW utilization projects

- CHW utilization to support member follow-up for Mental Health (FUM) measures
- CHW integration to improve A1C for Alameda Alliance members

- Population Health management – Integration of CHW within the Population Health Management strategies; completed presentation on 09/24/2024

Community Networks & Partnership Development:

- Six (6) organizations are fully contracted to provide CHW services
- Three (3) active scope of work projects focused on eliminating care gaps
- Five (5) providers remain in the pre-contract phase
- Seven (7) providers newly engaged in September
- CHWs services expanded into Hayward by bringing on Glad Tidings International through Journey Health; Alameda Alliance participated in the grand opening of Glad Tidings Family Complex Wellness Center



Incentives & Reporting Board Report – September 2024 Activities

Current Incentive and Grant Programs

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 ECM and CS programs

- For Program Year 2 (1/1/2023 - 12/31/2023):
    - Alameda Alliance was allocated $15.1M and earned 60% of the allocated funds based on the Submission 3 report which equaled $4.56M; the Plan distributed funding to twelve (12) providers and organizations to support ECM and CS programs
    - The Submission 4 report, reflecting the lookback period of 7/1/2023-12/31/2023, was submitted to DHCS on March 1st, 2024; the Alliance is still awaiting feedback from DHCS
- For Program Year 3 (1/1/2024 - 6/30/2024):
    - The Alliance completed the review of Wave 4 IPP Provider Applications and awarded funding to two (2) entities to support CS programs
    - The Submission 5 report, reflecting the lookback period of 1/1/2024-06/30/2024, was submitted to DHCS on September 9th, 2024; the Alliance is still awaiting feedback from DHCS

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 submitted the Bi-Quarterly Report (BQR) for the reporting period of January – June 2024 on June 27th, 2024; DHCS notified the Alliance on September 18th, 2024, that we had earned 100% of eligible funds tied to the reporting period ($1.1M)
    - The dollars earned are anticipated to be received from DHCS in October 2024
- To date, $7.4M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $6.6M has been 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 eligible dollars available to the Alliance under this program was $44M
- The Alliance earned a total of $38M based on submission of deliverables and achievement of DHCS-defined metrics
    - $18.7M has been awarded to our HHIP partners to date
- A HHIP funding opportunity was released earlier this year to SBHIP LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
    - The Alliance received applications from ten (10) LEAs totaling $1.3M in requests; all submitted applications were approved and work on the funded programs has begun for some LEAs
- Decisions for the HHIP funding opportunity that was released to the community to support HHIP goals of reducing and preventing homelessness utilizing funds earned from the S2 report were announced in September 2024
    - Ten (10) applications were received totaling $19.9M in funding requests related to capacity building, innovation, diversity and health equity, and housing stability

- The Alliance awarded $11.2M in funding to the ten (10) organizations and as a next step, will work with these partners to develop MOUs for the work

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

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

Provider Recruitment Initiative (PRI) – internal Alliance program with funding up to $2M in fiscal year 2024-25.

- Program launched on June 1st, 2024
- Program materials, including provider-facing program overview documents, application materials, evaluation criteria, governance structure, and policy and procedures were finalized and released in June
- Eleven (11) informational sessions were conducted to share program details with interested practices
- The application period closed on September 6th; the Alliance received a total of 15 (fifteen) applications totaling $6M in funding requests
- A multi-disciplinary team started the evaluation of applications; funding decisions are anticipated by the end of October 2024

Recruiting and Staffing

Incentives & Reporting Open position(s):

- The Business Analyst, Incentives & Reporting has been filled with a scheduled start date of October 14th

Incentive and Grant 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

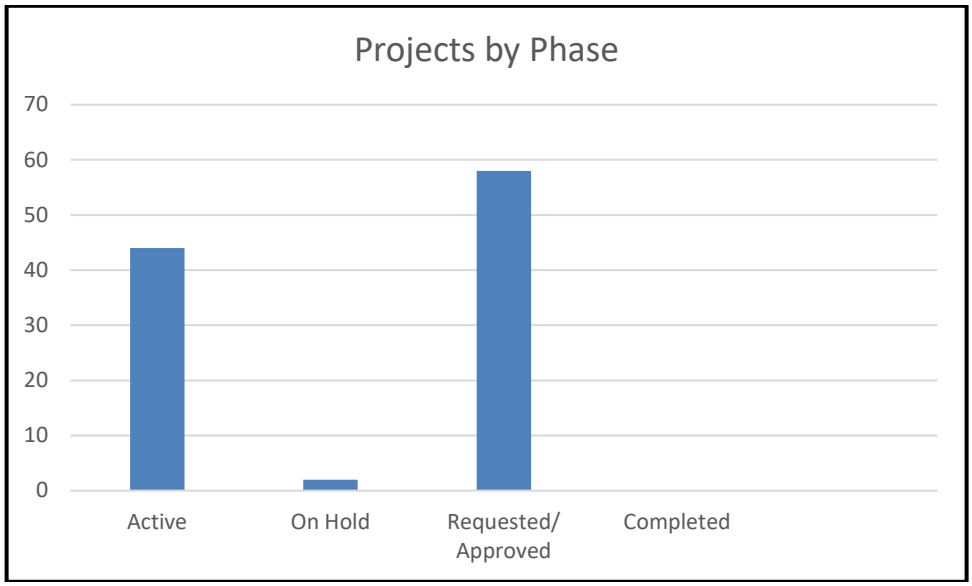
Equity and Practice Transformation (EPT) Payments Program – new program released by DHCS in August 2023 as a one-time primary care provider practice transformation program designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment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

The Provider Recruitment Initiative (PRI) – program launched on June 1st, 2024, and is designed to provide grants to support the Alameda County Safety Net and community-based organizations to hire and retain healthcare professionals who serve the Alameda County Medi-Cal population. The PRI aims to grow the Alliance provider network and support our community partners' ability to supply culturally and linguistically competent care to increase accessibility and to reflect the diversity of Alliance members. Program goals include:

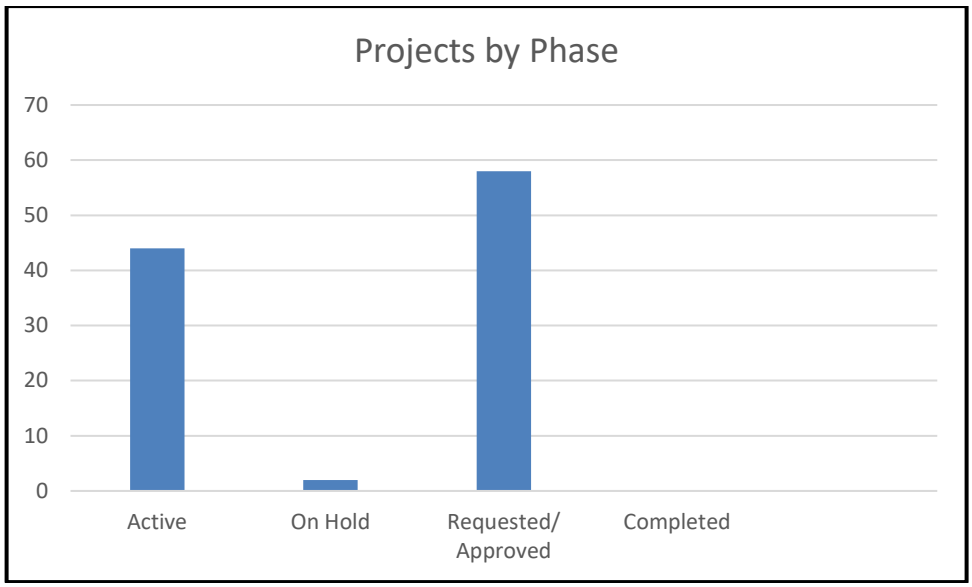
- Expanding the Alameda Alliance Provider network
- Improving member access to Primary Care Providers, Specialists, and Behavioral Health professionals
- Promoting diverse and culturally inclusive care reflective of Alliance members

Integrated Planning Division

- Enterprise Portfolio
    - 75 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
        - 35 Active projects (discovery, initiation, planning, execution, warranty)
        - 7 On Hold projects
        - 33 Requested and Approved Projects
        - 1 Completed Projects



- D-SNP Portfolio
  - 100 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 40 Active projects (discovery, initiation, planning, execution, warranty)
    - 58 Requested and Approved Projects
    - 2 On Hold
      - 1G – Provider Services & Call Center
      - 10F – MTM & BM Delegation Oversite & Monitoring



  - D-SNP Key Initiatives and Dates
    - DMHC Material Modification Submission – MA Service Area Expansion – March 2024
    - DMHC Material Modification Submission – DSNP Product – August 2024
    - CMS Notice of Intent to Apply – November 2024

        - CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025
        - CMS Formulary & Bid Submission (Benefit Determination) – June 2025
        - CMS SMAC Submission – July 7th, 2025
        - Rebate Allocation with CMS and Health Plan – July / August 2025
        - Annual Enrollment Period (AEP) – October thru December 2025
        - IT System Readiness – December 15th, 2025
        - Open Enrollment Period (OEP) Begins – January 1st, 2026
    - D-SNP Activities – August 2024
        - Provider Services & Contracting
            - Provider Contracting started July 22nd, 2024. To date, 129 providers have returned signed contracts for AAH execution.
            - The first Save the Date for the Provider D-SNP Consideration Campaign 2 theme "*Understanding what matters the most. Creating a vision for the future*" were sent September 24th.
            - Business process future state workflows and requirements development continue for the Provider Portal and Provider Repository.
        - Product
            - Development of business requirements for Enrollment, Disenrollment and Eligibility are in process.
            - Engagement with the following vendors to support Supplemental Benefit Offering(s).
                - Dental –selected Liberty Dental
                - Vision – re-released RFP on 8/16 with proposals received by 9/20
                - Hearing – RFP released on 8/8 with proposals due 10/6
                - Flex Card – RFQ went out on 9/16
                - HRA – RFQ went out on 9/27
                - Med Therapeutic Management (MTM) – RFQ released on 9/16 with proposals due 10/8
            - Staffing Update:
                - Director, Stars Strategy & Program Management started September 23rd.
                - Candidate interviews for the Manager, Medicare Marketing, Communications, and Branding position are in process.

- Quality

MOC Element	Total Factors	# Draft Complete	# In Progress	# Not Started
MOC 1	8	6	2	0
MOC 2	32	32	0	0
MOC 3	12	4	7	0
MOC 4	21	9	0	12
Totals	**73**	**51**	**9**	**12**
		70%	**15%**	**16%**

- Health Care Services / Behavioral Health
  - UM – Future State (DSNP) Business Process Documented for Inpatient UM.
  - Future State (DSNP) Inpatient UM Business BRD – Documentation Started.
  - CM – Future State DSNP Global Workflow in draft – Outlining process flows for new DSNP components to include Face-to-Face visit, Palliative Care Program, and Dementia Care Program.
  - BH UM Future State (DSNP) Business Process Documentation in progress – Defining structure and needs as this will be a new process for DSNP.
  - BH CM – Continuing to document program structure and model.
  - Defining specific goals and objectives for QIP and CCIP initial stages.
- Finance
  - Continued review of CMS D-SNP regulations and development of requirements for 5C – Financial Reconciliation and Reporting.
  - Finalized Business Requirements for 5A – Finance Planning & Decisions and 5B – Medicare Finance Program.
- Compliance
  - DMHC Material Modification – MA Service Area Expansion (filing #20241128) received full approval from DMHC on 9/19/24.
  - DMHC Material Modification – D-SNP Product (Filing #20244060) exhibits E-1 Filing Summary and D-2 Coordination with Other Agencies submitted to DMHC on September 9th.
- Pharmacy
  - Pre-delegation audit workstreams in development.
  - Compliance and Pharmacy are in receipt of PBM files for Pre-Delegation audit.
  - MTM RFQ finalized and released.
  - Policy and Procedures reviewed and redlined.
  - Interim Pharmacy Director in place. Start date 9/23/24.

        - Operations (Claims / Member Services / Mailroom / IVR)
            - Planning with Claims, Member Services, Mailroom, and IVR are in process.
        - IT
            - TruCare: Completed Zyter demo sessions supporting the development of requirements supporting D-SNP.
            - HEALTHsuite: Continued RAM discovery sessions. To date, 5 sessions have been completed with 1 session planned.
            - QualitySuite: Requirement development supporting G&A, PDR, PQI & Part D are in process.
        - P&Ps / SOPs / KPIs
            - Completed SOP Oversight and Policy Tech process flow development.
            - Introduced Standard Operating Procedure (SOP) development process at Medicare State of the Union on September 3rd.
            - Completed development of the Key Performance Indicators (KPI) Strategy and initiated development of KPI measures by business area.
    - Program Decisions
        - Delegate Provider Credentialing – UCSF, Physical Therapy PN, Lucille Packard, Teledoc, PerformRx (Pre-Delegation audit not credentialing).
        - Delegate Provider Training to CHCN.
        - Delegate Bid Preparation & Development to Milliman.
        - Extend current Medi-Cal contract for Medicare within DME to CHME, Transportation to ModivCare, Telehealth to Teladoc, NAL to Optum, and CAHPS to Press Ganey.
        - Delegate Health Risk Assessment (HRA) to a vendor.
        - DoFR for CHCN for Capitation.
        - One HMO PBP for 1/1/26.

- **<u>CalAIM Initiatives:</u>**
    - Community Supports (CS):
        - The following CS services are expected to launch by January 2025:
            - Sobering Centers
            - Day Habilitation Programs
            - Short-Term Post-Hospitalization Housing
            - Caregiver Respite (expansion of provider network)
            - Asthma Remediation (expansion of provider network)
        - 9 new providers have been identified for the new/expanded services
            - The healthcare services team is currently providing introductory calls to the identified providers.
            - 7 providers have agreed to move forward with kick-off calls, more are expected to move forward as the introductory meetings complete.
        - The new providers will be meeting with AAH weekly to walk through site certification, contracting, credentialing, billing, and provider training.

    - 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 go-live date is determined based on DHCS readiness assessment and will go-live with pre-release services within a 24 month phase in period (10/1/2024 – 9/30/2026).
    - Santa Rita Jail is targeting to go-live on 7/1/2026 with pre-release services; Juvenile Justice Center's go-live is TBD.
    - Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of October 1st, 2024, even if facilities in their county will go-live at a later date.
    - 3 counties going live with pre-release services on 10/1/24: Yuba, Inyo, and Santa Clara.
    - JI project team is developing a contact list for the counties going live with pre-release to support coordination of referrals for any AAH members being released from these counties.
  - DHCS has indicated they intend to release a revised JI Policy Guide by October 1st, 2024; impacts to project scope and schedule will be assessed once this is released.
  - DHCS JI Learning Collaboratives initiated in August and continues through December. These collaborative sessions include correctional facilities, county behavioral health agencies, probation, managed care plans, and ECM providers.
  - DHCS has announced that MCPs will be notified of individuals who are eligible for pre-release services and therefore eligible for ECM through the daily/monthly 834 file with the JI indicator starting in September 2024.
    - Internal working sessions to document use cases for this JI indicator have been initiated with IT, Analytics, ECM, and other impacted departments.
  - Bi-weekly workgroup meetings with Alameda County Sheriff's Office, Probation, Alameda County Behavioral Health, Social Security Administration, Kaiser Permanente and AAH continue to support collaboration on the strategy for this initiative.
  - ACSO bi-weekly workgroup is transitioning to a quarterly meeting cadence; final bi-weekly call was held on 9/26. First quarterly meeting is set for 11/13. 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.
  - Alameda County Behavioral Health, Wellpath, and Alameda County Sheriff's office are creating a draft care plan for adults at Santa Rita Jail.
    - Collaborative working session with ACBH, Wellpath, and ACSO to review initial draft of the care plan held on 9/23.
    - 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 analysis of the data from July 2023 through June 2024 is complete. On 9/16, the final report was presented to Roots, and they have indicated they have supplemental data they would like us to incorporate in our analysis. Once the additional data is received and incorporated, the final analysis will be presented to AAH Senior Leadership to provide insights on the trends in the key data metrics identified by the project team.
    - Initial data analysis has shown a disparity between the number of males vs. females seeking help upon release (roughly 10% of males vs. near 100% females). Roots is proposing an extension to the pilot period. The proposal from Roots is still under review with senior leadership as of October 1st, 2024.

- Community Health Worker (CHW) Benefit – Medi-Cal benefit effective July 1st, 2022, designed to promote the MCP's contractual obligations to meet DHCS broader Population Health Management standards and as adjunctive services as part of the interventions to positively impact health outcomes.
  - Provider Recruitment – the Alliance is working or meeting with several organizations in order to grow the CHW network.
    - Journey Health – contract fully executed
    - Pair Team – contract fully executed
    - Roots – contract fully executed
    - 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
    - Save DV – pre-contract phase
    - Youth Alive, West Oakland Collaborative, Alta Bates Medical – conducted CHW presentation with these groups
  - CHW Workgroup Activities:
    - Project workgroup is conducting a final audit of previously approved documentation, communications, and workflows to ensure they align with the requirements of APL 24-006.
    - Project closeout will occur in October.

- CYBHI Fee Schedule – Effective January 1st, 2024, the Alliance is partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule.
  - Cohort 1 is intended to be a "learning" cohort.
  - DHCS continues holding a series of meetings with Cohort participants; these include Onboarding Sessions for the LEAs as well as Technical Office Hours each Thursday of the month.
    - The meetings held have been heavily focused on the LEA process.

- The Alliance will utilize Carelon as the Third Party Administrator (TPA).
- The Claims submission date has been extended from April 1st, 2024 to July 1st, 2024.
    - It may not be true that all MCPs or LEAs have systems set up however, LEAs may submit claims for up to 180 days from the date of service.
    - Claims may be submitted retroactively back to July 1st, 2024 as long as it is submitted by end of the year
- MCPs have expressed concern over the initial TPA model and DHCS is considering two options, requesting MCP feedback.
- DHCS has developed a new engagement model for the Health Plan Work Group (HPWG and will meet every week, Fridays between August and September 10-11am.
    - An email will be shared each Monday with recaps and agendas for subsequent meetings
- High Level Timeline provided by Carelon for Claims Processing without solid Go Live Date
    - Interim ASO Model proposed
    - MOU & BAAs between Plans and Carelon not yet finalized, as well as clearinghouses
        - Third MOU draft republished for MCPs to review and provide feedback. Due back to LHPC on 10/7
    - Program Design and Documentation not yet finalized
    - Invoice Template introduced
    - Establish electronic fund transfer with Carelon
    - Testing invoice and claims reconciliation

Recruiting and Staffing

- Integrated Planning Open position(s):
    - Business Process Change Analyst – 1 Position pending
    - Business Analyst – Integrated Planning – Position pending
    - Backfill Business Analyst – Integrated Planning – Position pending

Integrated Planning

Ruth Watson

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 h 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.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	September2024
Incoming Calls (R/V)	17,028
Abandoned Rate (R/V)	3%
Answered Calls (R/V)	16,461
Average Speed to Answer (ASA)	00:14
Calls Answered in 30 Seconds (R/V)	95%
Average Talk Time (ATT)	07:11
Calls Answered in 10 minutes	100%
Outbound Calls	7,955

Top 5 Call Reasons (Medi-Cal and Group Care) September2024
Change of PCP
Eligibility/Enrollment
Benefits
Provider Network Info
Grievances/Appeals

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) September2024
Change PCP
ID Card Requests
Update Contact Info

MSBH	SEPTEMBER2024
Incoming Calls (R/V)	1,346
Abandoned Rate (R/V)	10%
Answered Calls (R/V)	1,215
Average Speed to Answer (ASA)	01:20
Calls Answered in 30 Seconds (R/V)	73%
Average Talk Time (ATT)	09:09
Calls Answered in 10 minutes	98%
Outbound Calls	1,187
Screenings Completed	130
ACBH Referrals	33
SUD referrals to Center Point	14

Claims Department
August 2024 Final and September 2024 Final

METRICS

Claims Compliance	Aug-24	Sep-24
90% of clean claims processed within 30 calendar days	87.1%	83.5%
95% of all claims processed within 45 working days	99.9%	99.9%
Claims Volume (Received)	**Aug-24**	**Sep-24**
Paper claims	33,158	31,470
EDI claims	335,077	290,726
Claim Volume Total	**368,235**	**322,196**
Percentage of Claims Volume by Submission Method	**Aug-24**	**Sep-24**
% Paper	9.00%	9.77%
% EDI	91.00%	90.23%
Claims Processed	**Aug-24**	**Sep-24**
HEALTHsuite Paid (original claims)	229,210	225,229
HEALTHsuite Denied (original claims)	75,094	79,577
HEALTHsuite Original Claims Sub-Total	**304,304**	**304,806**
HEALTHsuite Adjustments	6,383	18,762
HEALTHsuite Total	**310,687**	**323,568**
Claims Expense	**Aug-24**	**Sep-24**
Medical Claims Paid	$127,162,733	$137,769,061
Interest Paid	$117,294	$113,063
Auto Adjudication	**Aug-24**	**Sep-24**
Claims Auto Adjudicated	257,555	247,723
% Auto Adjudicated	84.6%	81.3%
Average Days from Receipt to Payment	**Aug-24**	**Sep-24**
HEALTHsuite	16	16
Pended Claim Age	**Aug-24**	**Sep-24**
0-29 calendar days	43,863	42,285
HEALTHsuite		
30-59 calendar days	19,456	7,187
HEALTHsuite		
Over 60 calendar days	24	4
HEALTHsuite		

Overall Denial Rate	Aug-24	Sep-24
Claims denied in HEALTHsuite	75,094	79,577
% Denied	24.2%	24.6%

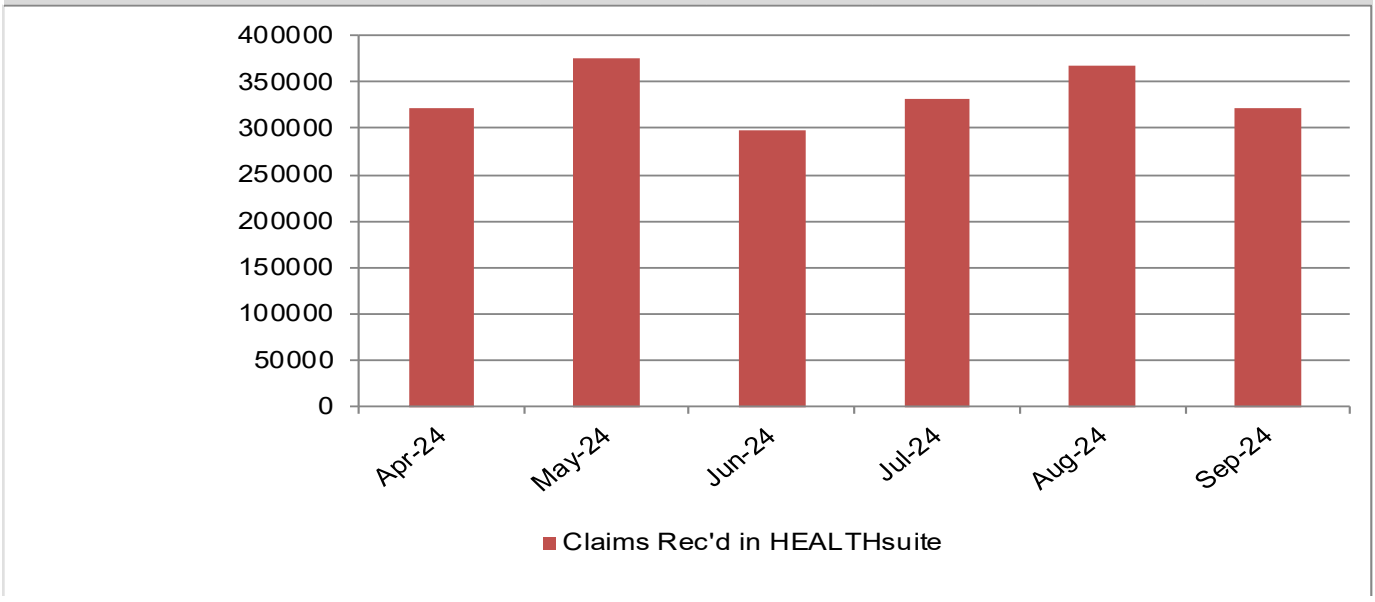
Claims Department
August 2024 Final and September 2024 Final

Sep-24

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	22%
Non-Covered Benefit For This Plan	12%
No Benefits Found For Dates of Service	11%
Duplicate Claim	11%
Must Submit Paper Claim With Copy of Primary Payor EOB	10%
% Total of all denials	**66%**

Claims Received By Month

Run Date	5/1/2024	6/1/2024	7/1/2024	8/1/2024	9/1/2024	10/1/2024
Claims Received Through	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**
Claims Rec'd in HEALTHsuite	322,786	375,454	297,267	332,150	368,235	322,196



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing September 2024 to September 2023 as follows: 30 Days - 83.5% (2024) vs 92.0% (2023) 45 Days - 99.9% (2024) vs 99.9% (2023) 90 Days - 99.9% (2024) vs 99.9% (2023)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 322,196 claims in September 2024 vs 247,423 in September 2023	N/A	N/A
EDI - the volume of EDI submissions was 90.23% which exceeded our normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 304,806 in September 2024 (21 working days) vs 211,487 in September 2023 (21 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in September 2024 was $137,769,061 (4 check runs) vs $82,532,918 in September 2023 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in September 2024 was $113,022.77 vs $36,688 in September 2023	N/A	0.05% - 0.075% of medical expense
Auto Adjudication - the AAH rate in September 2024 was 81.3% vs 80.4% in September 2023	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in September 2024 was 16 days vs 14 days in September 2023	N/A	<= 25 days
Pended Claim Age - comparing September 2024 to September 2023 as follows: 0-29 calendar days - 42,285 (2024) vs 23,915 (2023) 30-59 calendar days - 7,187 (2024) vs 2,251 (2023) Over 60 calendar days - 4 (2024) vs 7 (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 September 2024 to September 2023	N/A	N/A

Provider Relations Dashboard September 2024

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10695	9359	9033	8064	7469	6825	8593	8233	7634			
Abandoned Calls	4806	4325	3272	2275	1519	1207	1787	1663	1529			
Answered Calls (PR)	5889	5034	5761	5789	5950	5618	6806	6570	6105			
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	413	2551	1970	1595	1093	896	1247	1211	985			
Abandoned Calls (R/V)												
Answered Calls (R/V)	413	2551	1970	1595	1093	896	1247	1211	985			
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	1140	1358	1298	831	1018	829	1066	893	889			
N/A												
Outbound Calls	1140	1358	1298	831	1018	829	1066	893	889			
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	11835	13268	12301	10490	9580	8550	10906	10337	9508			
Abandoned Calls	4806	4325	3272	2275	1519	1207	1787	1663	1529			
Total Answered Incoming, R/V, Outbound Calls	7442	8993	9029	8215	8061	7343	9119	8674	7979			

Provider Relations Dashboard September 2024

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.5%	5.6%	5.5%	6.1%	6.4%	6.4%	6.0%	6.0%	6.4%			
Benefits	4.3%	3.6%	2.4%	3.0%	2.5%	2.8%	2.8%	2.9%	2.9%			
Claims Inquiry	38.5%	41.7%	45.4%	40.1%	43.3%	42.1%	43.8%	44.0%	44.9%			
Change of PCP	3.3%	3.9%	2.6%	3.6%	2.6%	2.9%	2.9%	2.9%	2.9%			
Check Tracer	1.1%	1.1%	1.2%	1.0%	1.3%	1.2%	0.9%	0.9%	1.0%			
Complaint/Grievance (includes PDR's)	4.4%	4.3%	6.1%	5.8%	7.9%	7.5%	7.6%	8.0%	7.5%			
Contracts/Credentialing	1.1%	1.0%	1.5%	1.4%	0.7%	0.7%	0.6%	0.9%	1.0%			
Demographic Change	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Eligibility - Call from Provider	23.0%	20.5%	17.5%	20.9%	18.2%	17.7%	17.8%	18.1%	17.8%			
Exempt Grievance/ G&A	0.6%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%			
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Intrepreter Services Request	0.5%	0.6%	0.7%	1.1%	0.6%	0.7%	0.4%	0.4%	0.7%			
Provider Portal Assistance	3.7%	3.8%	3.2%	3.2%	3.6%	3.6%	3.5%	3.2%	2.9%			
Pharmacy	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.2%			
Prop 56	0.2%	0.4%	0.3%	0.3%	0.4%	0.4%	0.2%	0.2%	0.4%			
Provider Network Info	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%			
Transportation Services	0.2%	0.2%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%			
Transferred Call	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%			
All Other Calls	13.4%	13.1%	13.1%	13.1%	12.3%	13.5%	12.9%	12.4%	11.4%			
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	13	56	38	40	28	60	66	65	77			
Contracting/Credentialing	9	21	50	26	19	49	63	99	53			
Drop-ins	27	49	29	30	54	73	77	174	119			
JOM's	3	2	2	2	2	1	2	3	2			
New Provider Orientation	104	103	140	101	113	219	82	125	N/A			
Quarterly Visits	0	0	0	0	82	89	125	94	65			
UM Issues	0	0	0	0	0	1	7	7	4			
Total Field Visits	156	231	259	199	298	492	422	567	320	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS						
Practitioners		BH/ABA 2,293	AHP 569	PCP 378	SPEC 732	PCP/SPEC 13
AAH/AHS/CHCN Breakdown			AAH 2,786	AHS 291	CHCN 555	COMBINATION OF GROUPS 353
Facilities	**429**					

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	220	18	Y	Y	Y
Recred Files in Process	98	29	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**318**				
		*** 25 business days = 35 calendar days**			

September 2024 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	14
SPEC	34
ANCILLARY	10
MIDLEVEL/AHP	26
BH/ABA	265
Sub-total	**349**
Recredentialing	
PCP	7
SPEC	16
ANCILLARY	2
MIDLEVEL/AHP	8
Sub-total	**33**
TOTAL	**382**

September 2024 Facility Approvals	
Initial Credentialing	**5**
Recredentialing	**7**
Sub-total	**12**
Facility Files in Process	**53**

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

LAST NAME	FIRST NAME	CATEGORY	INITIAL RE-CRED	CRED DATE
Aboujaoude	Elias	BH-Telehealth	INITIAL	9/17/2024
Acosta	Chelsea	BH-Telehealth	INITIAL	9/17/2024
Aguayo	Stephanie	ABA-Telehealth	INITIAL	9/17/2024
Ahmad	Eman	Specialist	INITIAL	9/17/2024
Ahmad	Siti	ABA-Telehealth	INITIAL	9/17/2024
Ajayi	Adebolanle	ABA-Telehealth	INITIAL	9/17/2024
Alamo Ramos	Kristy	Specialist	INITIAL	9/17/2024
Ali	Ameka	Doula	INITIAL	9/17/2024
Amerson	Apryl	BH	INITIAL	9/17/2024
Andrews	Elizabeth	Allied Health	INITIAL	9/17/2024
Arandia	Ruel	Allied Health	INITIAL	9/17/2024
Arreola	Francisco	BH-Telehealth	INITIAL	9/17/2024
Ashfaq	Adeel	Specialist	INITIAL	9/17/2024
Atreya	Prerana	ABA	INITIAL	9/17/2024
Babayan	Liana	ABA-Telehealth	INITIAL	9/17/2024
Bains	Yasmin	Primary Care Physician	INITIAL	9/17/2024
Baker	Annissa	BH	INITIAL	9/17/2024
Baker	Christal	ABA-Telehealth	INITIAL	9/17/2024
Barber	Kristin	ABA-Telehealth	INITIAL	9/17/2024
Barroso	Ryan	ABA-Telehealth	INITIAL	9/17/2024
Bavery	Karina	BH-Telehealth	INITIAL	9/17/2024
Beane	Kathryn	Allied Health	INITIAL	9/17/2024
Beer	Adam	BH	INITIAL	9/17/2024
Behrens	Beatriz	BH-Telehealth	INITIAL	9/17/2024
Bell	Stephanie	ABA-Telehealth	INITIAL	9/17/2024
Belle	Valerie	Allied Health	INITIAL	9/17/2024
Benjelloun	Nouhayla	ABA-Telehealth	INITIAL	9/17/2024
Bennett	Tara	BH-Telehealth	INITIAL	9/17/2024
Benvegnu	Neilen	Specialist	INITIAL	9/17/2024
Biragbara	Dumka	BH-Telehealth	INITIAL	9/17/2024
Blaylock	Amber	Ancillary	INITIAL	9/17/2024
Bloomberg	Laura	BH-Telehealth	INITIAL	9/17/2024
Booth	Destine	ABA-Telehealth	INITIAL	9/17/2024
Boykin	Rosalind	BH	INITIAL	9/17/2024
Brown	Bianca	ABA-Telehealth	INITIAL	9/17/2024
Buenafe	Stephanie	ABA-Telehealth	INITIAL	9/17/2024
Bukhari	Syeda	Allied Health	INITIAL	9/17/2024
Burnham	Marisa	ABA	INITIAL	9/17/2024
Call	AnaElia	ABA-Telehealth	INITIAL	9/17/2024
Cambronne	Marie-Addly	BH-Telehealth	INITIAL	9/17/2024
Campbell	Marvilla	BH-Telehealth	INITIAL	9/17/2024
Cantu	Natalie	BH	INITIAL	9/17/2024
Carag	Jamaila	ABA	INITIAL	9/17/2024
Carey-Simms	Katiana	Allied Health	INITIAL	9/17/2024
Carlos	Megan	BH-Telehealth	INITIAL	9/17/2024
Carter	Kesia	BH	INITIAL	9/17/2024
Castellanos	Mariajose	BH	INITIAL	9/17/2024
Castellanos Monroy	Jose	BH	INITIAL	9/17/2024
Ceballos	Sonia	Specialist	INITIAL	9/17/2024
Chagolla	Gabriela	ABA-Telehealth	INITIAL	9/17/2024
Chambers	Cassandra	BH-Telehealth	INITIAL	9/17/2024
Chau	Ngan	ABA-Telehealth	INITIAL	9/17/2024
Chavez	Beatriz	BH	INITIAL	9/17/2024
Cherry	Ashley	BH	INITIAL	9/17/2024
Chew	Mariah	BH-Telehealth	INITIAL	9/17/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL RE-CRED	CRED DATE
Childs	Eka	BH-Telehealth	INITIAL	9/17/2024
Chocha	Puja	ABA	INITIAL	9/17/2024
Clague	Heather	BH	INITIAL	9/17/2024
Clark	Lynsey	BH	INITIAL	9/17/2024
Clarke	James	BH-Telehealth	INITIAL	9/17/2024
Combs	Maya	Allied Health	INITIAL	9/17/2024
Connis	Elizabeth	ABA-Telehealth	INITIAL	9/17/2024
Corona	Mercedes	BH-Telehealth	INITIAL	9/17/2024
Cortez	Colette	ABA	INITIAL	9/17/2024
Crandall	Rebecca	BH-Telehealth	INITIAL	9/17/2024
Crusos	Amanda	BH-Telehealth	INITIAL	9/17/2024
Cummings	Tamalina	BH-Telehealth	INITIAL	9/17/2024
Davani	Sohyila	BH	INITIAL	9/17/2024
DaVault	Heather	BH	INITIAL	9/17/2024
Davis	Arthur	BH	INITIAL	9/17/2024
De La Cruz	Brenda	BH-Telehealth	INITIAL	9/17/2024
De La Cruz	Maria	BH-Telehealth	INITIAL	9/17/2024
De Leon	Megan	ABA	INITIAL	9/17/2024
Deculing	Erol	Allied Health	INITIAL	9/17/2024
Deculing	Joselyn	Allied Health	INITIAL	9/17/2024
Del Pilar	Alberto	Primary Care Physician	INITIAL	9/17/2024
Dennis	Christopher	BH-Telehealth	INITIAL	9/17/2024
Dennis	Shelby	ABA-Telehealth	INITIAL	9/17/2024
Denny	Ariel	ABA-Telehealth	INITIAL	9/17/2024
Deveau	Janelle	ABA-Telehealth	INITIAL	9/17/2024
DeYoung	Alice	Ancillary	INITIAL	9/17/2024
Diaz	Juan	BH	INITIAL	9/17/2024
Dickerson	Michael	BH-Telehealth	INITIAL	9/17/2024
Doeden	Stephanie	ABA-Telehealth	INITIAL	9/17/2024
Dotson	Shawn	ABA-Telehealth	INITIAL	9/17/2024
Duncan	Taylor	ABA-Telehealth	INITIAL	9/17/2024
Ealy	Danita	ABA-Telehealth	INITIAL	9/17/2024
Ebron	Ashley	ABA-Telehealth	INITIAL	9/17/2024
Eddy	Kristen	BH-Telehealth	INITIAL	9/17/2024
Egenias	Aurora	ABA	INITIAL	9/17/2024
Elzarka	Ayya	BH-Telehealth	INITIAL	9/17/2024
Estill	Audrey	ABA-Telehealth	INITIAL	9/17/2024
Evans	John	Specialist	INITIAL	9/17/2024
Ezeigwe	Maureen	BH-Telehealth	INITIAL	9/17/2024
Fagundes	Nicole	BH	INITIAL	9/17/2024
Fain	Kevin	Allied Health	INITIAL	9/17/2024
Farhat	Laura	Allied Health	INITIAL	9/17/2024
Ferguson	A'Kiara	ABA-Telehealth	INITIAL	9/17/2024
Fernandes	Dionisio	Specialist	INITIAL	9/17/2024
Figueroa	Veronica	Ancillary	INITIAL	9/17/2024
Fisher	Molly	BH-Telehealth	INITIAL	9/17/2024
Fleming	Montida	Primary Care Physician	INITIAL	9/17/2024
Foley	Cassidy	ABA-Telehealth	INITIAL	9/17/2024
Foote	Richard	ABA-Telehealth	INITIAL	9/17/2024
Fortier	Tara	ABA-Telehealth	INITIAL	9/17/2024
Francis	Fiona	BH-Telehealth	INITIAL	9/17/2024
Franklin	Rosanna	BH	INITIAL	9/17/2024
Fuentes-Mendoza	Yvette	ABA-Telehealth	INITIAL	9/17/2024
Galindez	Janis Arian	Ancillary	INITIAL	9/17/2024
Gallaher	Allison	Specialist	INITIAL	9/17/2024
Ganguli	Mary	ABA-Telehealth	INITIAL	9/17/2024
Garcia	Nora	Primary Care Physician	INITIAL	9/17/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL RE-CRED	CRED DATE
Geraga	Dianne Lisa	Allied Health	INITIAL	9/17/2024
Giboney	Katelyn	ABA	INITIAL	9/17/2024
Gomez	Jorge	BH-Telehealth	INITIAL	9/17/2024
Gomez	Miguel	BH	INITIAL	9/17/2024
Gomez	Silvia	BH	INITIAL	9/17/2024
Gonzalez	Jamie	BH-Telehealth	INITIAL	9/17/2024
Gordon	Scott	BH-Telehealth	INITIAL	9/17/2024
Graham	Cody	ABA	INITIAL	9/17/2024
Green	Andrea	Primary Care Physician	INITIAL	9/17/2024
Green	David	Specialist	INITIAL	9/17/2024
Guller	Tarannum	Primary Care Physician	INITIAL	9/17/2024
Gustafson	Carissa	BH-Telehealth	INITIAL	9/17/2024
Halemano	Ashley	ABA-Telehealth	INITIAL	9/17/2024
Hansen	Charlene	ABA-Telehealth	INITIAL	9/17/2024
Hardcastle	Lauren	ABA-Telehealth	INITIAL	9/17/2024
Harris	Susan	BH-Telehealth	INITIAL	9/17/2024
Haynes	Ariellah	ABA	INITIAL	9/17/2024
Headley	Mary Patricia	BH-Telehealth	INITIAL	9/17/2024
Hefley	Allison	BH-Telehealth	INITIAL	9/17/2024
Hegr	Aerielle	ABA-Telehealth	INITIAL	9/17/2024
Hendon	Faith	ABA-Telehealth	INITIAL	9/17/2024
Hill	Carlee	BH	INITIAL	9/17/2024
Hinerman	Nathaniel	BH-Telehealth	INITIAL	9/17/2024
Ho	Jennefer	BH-Telehealth	INITIAL	9/17/2024
Hoey	Margaret	ABA-Telehealth	INITIAL	9/17/2024
Holloran	Kathryn	ABA-Telehealth	INITIAL	9/17/2024
Holt	Mallory	ABA	INITIAL	9/17/2024
Hoskinson	Jordan	ABA-Telehealth	INITIAL	9/17/2024
Howard	Alisha	ABA-Telehealth	INITIAL	9/17/2024
Hunnings	Nicole	ABA-Telehealth	INITIAL	9/17/2024
Huynh	Jonathan	Specialist	INITIAL	9/17/2024
Huynh	Lam-Thuy	Ancillary	INITIAL	9/17/2024
Jang	Jung	BH-Telehealth	INITIAL	9/17/2024
Jearls	Emilie	ABA-Telehealth	INITIAL	9/17/2024
Jin	Wenwu	Specialist	INITIAL	9/17/2024
Johl	Jewel	Specialist	INITIAL	9/17/2024
Johnson	Celeste	ABA-Telehealth	INITIAL	9/17/2024
Johnson	Hannah	ABA-Telehealth	INITIAL	9/17/2024
Johnson	Willishia	BH	INITIAL	9/17/2024
Jones	Ingrid	ABA	INITIAL	9/17/2024
Jones	Vontrece	ABA-Telehealth	INITIAL	9/17/2024
Jorgensen	Kaley	ABA-Telehealth	INITIAL	9/17/2024
Kang	Tyler	Specialist	INITIAL	9/17/2024
Kapis	Kelly	BH	INITIAL	9/17/2024
Karmur	Amit	Specialist	INITIAL	9/17/2024
Karunaratne	Mythilla	Allied Health	INITIAL	9/17/2024
Katsarelis	Emmeline	Allied Health	INITIAL	9/17/2024
Kemper	Christina	BH-Telehealth	INITIAL	9/17/2024
Kenan	Joseph	BH-Telehealth	INITIAL	9/17/2024
Khavari	Ali	Specialist	INITIAL	9/17/2024
Kliger	Jared	BH-Telehealth	INITIAL	9/17/2024
Koblenz	Eric	BH	INITIAL	9/17/2024
Krakora	Breanne	ABA-Telehealth	INITIAL	9/17/2024
Krieger	Troy	ABA-Telehealth	INITIAL	9/17/2024
Kuang	Mary Jennalyn	Allied Health	INITIAL	9/17/2024
Kwan	Irene	Allied Health	INITIAL	9/17/2024

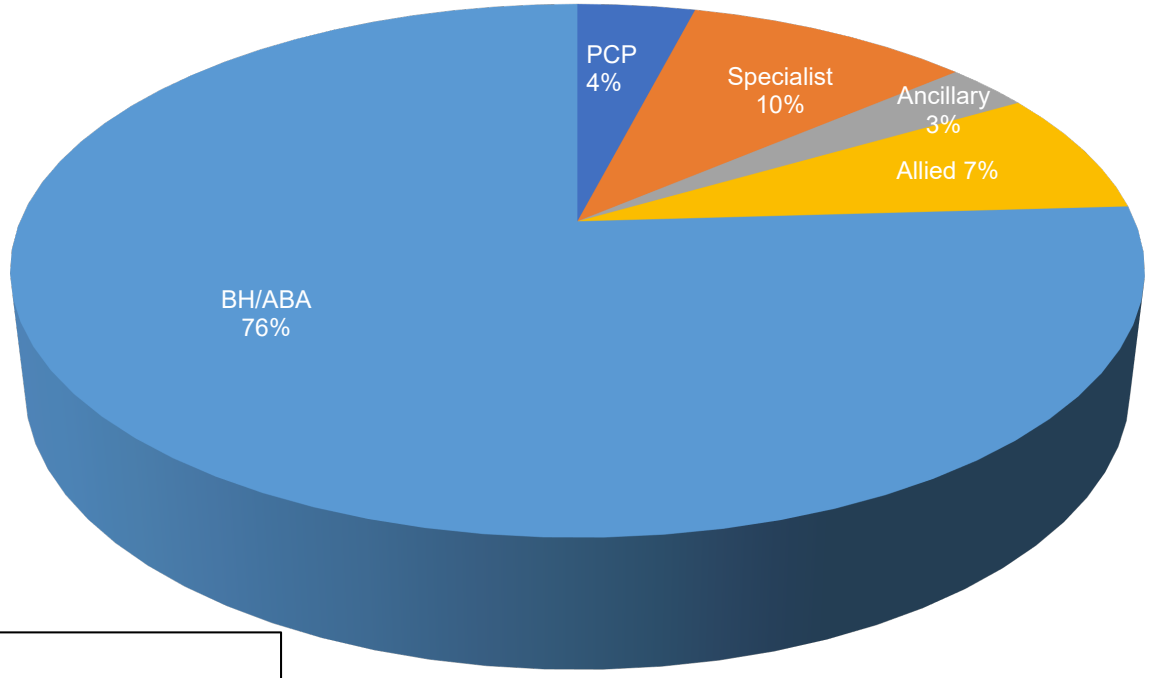
LAST NAME	FIRST NAME	CATEGORY	INITIAL RE-CRED	CRED DATE
LaTour	Jessica	BH-Telehealth	INITIAL	9/17/2024
Lau	Patricia	BH	INITIAL	9/17/2024
Laver	David	Specialist	INITIAL	9/17/2024
Lawver	Timothy	BH	INITIAL	9/17/2024
Le	Trini	BH	INITIAL	9/17/2024
Le	Vincent	Specialist	INITIAL	9/17/2024
Lee	John	BH-Telehealth	INITIAL	9/17/2024
Leon	David	BH-Telehealth	INITIAL	9/17/2024
Lewis	Samantha	BH	INITIAL	9/17/2024
Li	Grace	ABA-Telehealth	INITIAL	9/17/2024
Lim	Stephanie	BH-Telehealth	INITIAL	9/17/2024
Lisenbey	Genevieve	BH-Telehealth	INITIAL	9/17/2024
Lopez	Laura	BH-Telehealth	INITIAL	9/17/2024
Loustaunau	Katherine	Primary Care Physician	INITIAL	9/17/2024
Lowi-Teng	Alexia	BH	INITIAL	9/17/2024
Lu	Po-Haong	BH-Telehealth	INITIAL	9/17/2024
Lucey	Catherine	BH	INITIAL	9/17/2024
Ludwig	Robin	ABA	INITIAL	9/17/2024
Lusson	Robert	BH-Telehealth	INITIAL	9/17/2024
Lutz	Alison	Specialist	INITIAL	9/17/2024
Machtinger	Rachel	BH	INITIAL	9/17/2024
Mangigian	Shannon	BH	INITIAL	9/17/2024
Mason	Aaron	BH-Telehealth	INITIAL	9/17/2024
Mathenia	Mary	ABA-Telehealth	INITIAL	9/17/2024
Matthews	Eliza	ABA-Telehealth	INITIAL	9/17/2024
McCarthy	Samantha	ABA-Telehealth	INITIAL	9/17/2024
McClintock Greenberg	Andrew	Specialist	INITIAL	9/17/2024
McCormick	Jamey	BH	INITIAL	9/17/2024
McKenna	Alexis	BH-Telehealth	INITIAL	9/17/2024
Meiselman	Elizabeth	Allied Health	INITIAL	9/17/2024
Mendoza	Andrea	BH	INITIAL	9/17/2024
Merino	Sandra	BH-Telehealth	INITIAL	9/17/2024
Merritt	Mary Jeanne	ABA	INITIAL	9/17/2024
Moon	Amanda	ABA	INITIAL	9/17/2024
Moore	Angela	ABA-Telehealth	INITIAL	9/17/2024
Moschella	Joann	Primary Care Physician	INITIAL	9/17/2024
Mrazek	Pamela	BH	INITIAL	9/17/2024
Muniz	Oscar	ABA-Telehealth	INITIAL	9/17/2024
Murad	Omar	Specialist	INITIAL	9/17/2024
Murphy	Danielle	BH-Telehealth	INITIAL	9/17/2024
Mutrie	Jimel	ABA-Telehealth	INITIAL	9/17/2024
Navarro	Erika	BH-Telehealth	INITIAL	9/17/2024
Navarro-Gomez	Verenice	BH-Telehealth	INITIAL	9/17/2024
Nelli	Dina	BH-Telehealth	INITIAL	9/17/2024
Newman	Kari	ABA-Telehealth	INITIAL	9/17/2024
Ng	Samuel	Specialist	INITIAL	9/17/2024
Nguyen	Baotran Amanda	BH	INITIAL	9/17/2024
Nobles	AndreAnna	ABA-Telehealth	INITIAL	9/17/2024
Norby	Tyler	ABA-Telehealth	INITIAL	9/17/2024
Nwaneri Nwosu	Tochi	Primary Care Physician	INITIAL	9/17/2024
Nzeogu	Moses	BH	INITIAL	9/17/2024
O'Keefe	Galina	ABA	INITIAL	9/17/2024
Okoye	Uchenna	BH	INITIAL	9/17/2024
O'Malley	Brandon	BH-Telehealth	INITIAL	9/17/2024
Omar	Pushtana	BH	INITIAL	9/17/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL RE-CRED	CRED DATE
Omotoso	Omoniyi	Primary Care Physician	INITIAL	9/17/2024
Ontiveros-Lopez	Daisy	ABA-Telehealth	INITIAL	9/17/2024
Orebiyi	Anuoluwapo	BH	INITIAL	9/17/2024
Palis	Nathalia	BH-Telehealth	INITIAL	9/17/2024
Parker	Joseph	ABA-Telehealth	INITIAL	9/17/2024
Parris	Roberto	BH-Telehealth	INITIAL	9/17/2024
Passoff	Lauren	BH-Telehealth	INITIAL	9/17/2024
Patel	Ekta	Allied Health	INITIAL	9/17/2024
Patel	Kayla	BH	INITIAL	9/17/2024
Patel	Shimaben	ABA-Telehealth	INITIAL	9/17/2024
Penmer	Andrew	ABA-Telehealth	INITIAL	9/17/2024
Phan	Kristine	ABA-Telehealth	INITIAL	9/17/2024
Phung	Jenny	BH	INITIAL	9/17/2024
Pokharel	Anu	Primary Care Physician	INITIAL	9/17/2024
Pretzer	Gina	Ancillary	INITIAL	9/17/2024
Putnam	Claire	Specialist	INITIAL	9/17/2024
Quan	Gary	BH-Telehealth	INITIAL	9/17/2024
Rajan	Nikita	BH	INITIAL	9/17/2024
Rana	Noreen	BH	INITIAL	9/17/2024
Randhawa	Harman	BH	INITIAL	9/17/2024
Randt	Jennifer	BH	INITIAL	9/17/2024
Reyes	Jennifer	ABA-Telehealth	INITIAL	9/17/2024
Richards	Andalin	ABA	INITIAL	9/17/2024
Richmond	Katelynn	ABA-Telehealth	INITIAL	9/17/2024
Rico-Kaainoa	Diann	BH	INITIAL	9/17/2024
Rios	Claritza	Specialist	INITIAL	9/17/2024
Rivas	Vanessa	BH	INITIAL	9/17/2024
Robles	Maribel	BH	INITIAL	9/17/2024
Rodriguez	Danyelle	ABA-Telehealth	INITIAL	9/17/2024
Rodriguez	Maritza	BH-Telehealth	INITIAL	9/17/2024
Rodriguez-Avila	Ilce	Ancillary	INITIAL	9/17/2024
Roessler	Sarah	ABA-Telehealth	INITIAL	9/17/2024
Rosa	Elaine	BH-Telehealth	INITIAL	9/17/2024
Rosas	Erica	ABA	INITIAL	9/17/2024
Rothhammer-Ruiz	Ana	Allied Health	INITIAL	9/17/2024
Ruff	Debra	ABA-Telehealth	INITIAL	9/17/2024
Ruffalo	Monica	ABA-Telehealth	INITIAL	9/17/2024
Sabado	Rosemarie	Allied Health	INITIAL	9/17/2024
Sadovich	Kimberly	ABA-Telehealth	INITIAL	9/17/2024
Salazar	Francisca	BH	INITIAL	9/17/2024
Salgado	Jacqueline	BH-Telehealth	INITIAL	9/17/2024
Schatz	Avery	ABA-Telehealth	INITIAL	9/17/2024
Scherba	Alicia	Allied Health	INITIAL	9/17/2024
Schneider	Kristen	BH-Telehealth	INITIAL	9/17/2024
Sellin	Nicole	BH	INITIAL	9/17/2024
Sencion	Juan	ABA-Telehealth	INITIAL	9/17/2024
Sevilla	Pamela	Primary Care Physician	INITIAL	9/17/2024
Sih	Allison	Specialist	INITIAL	9/17/2024
Simone	Agnes	BH-Telehealth	INITIAL	9/17/2024
Skerbec	Linda	BH	INITIAL	9/17/2024
Sklar	Abraham	Specialist	INITIAL	9/17/2024
So	Jennifer	BH-Telehealth	INITIAL	9/17/2024
Soberanes	Sarah	BH	INITIAL	9/17/2024
Solano	Christina	BH-Telehealth	INITIAL	9/17/2024
Sophie	Ian	BH-Telehealth	INITIAL	9/17/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL RE-CRED	CRED DATE
Sosa	Andrea	ABA	INITIAL	9/17/2024
Sosa	Rebecca	BH-Telehealth	INITIAL	9/17/2024
Sossenheimer	Philip	Specialist	INITIAL	9/17/2024
Steinberg	Desiree	Allied Health	INITIAL	9/17/2024
Steiner	Alexander	BH-Telehealth	INITIAL	9/17/2024
Street	Janella	BH	INITIAL	9/17/2024
Stronach	David	ABA-Telehealth	INITIAL	9/17/2024
Stroud	Ariel	ABA-Telehealth	INITIAL	9/17/2024
Su	Janie	ABA-Telehealth	INITIAL	9/17/2024
Swartz	Barbara	Specialist	INITIAL	9/17/2024
Syed	Omair	Primary Care Physician	INITIAL	9/17/2024
Taiwo	Adefemi	BH-Telehealth	INITIAL	9/17/2024
Tajon	Joan	ABA-Telehealth	INITIAL	9/17/2024
Takado	Rie	BH-Telehealth	INITIAL	9/17/2024
Takher	Ellen	BH-Telehealth	INITIAL	9/17/2024
Tam	Yuen Sin Larissa	BH	INITIAL	9/17/2024
Terry	RocÃ-o	BH-Telehealth	INITIAL	9/17/2024
Tesfai	Adhanet	ABA-Telehealth	INITIAL	9/17/2024
Thai	Daniel	Allied Health	INITIAL	9/17/2024
Theiding	Kara	Allied Health	INITIAL	9/17/2024
Thielen	Scott	BH-Telehealth	INITIAL	9/17/2024
Thind	Jasmine	BH	INITIAL	9/17/2024
Thomas	Arielle	ABA	INITIAL	9/17/2024
Thomas	Kaleb	Specialist	INITIAL	9/17/2024
Thompson	Alexandra	BH-Telehealth	INITIAL	9/17/2024
Thompson	Courtney	ABA-Telehealth	INITIAL	9/17/2024
Thorndyke	Earl	BH-Telehealth	INITIAL	9/17/2024
Thrower	Natasha	BH	INITIAL	9/17/2024
Timmerman	Peter	BH	INITIAL	9/17/2024
Tonkovich	Debbie	BH-Telehealth	INITIAL	9/17/2024
Tovey	Wendi	BH-Telehealth	INITIAL	9/17/2024
Tracy	Michelle	BH-Telehealth	INITIAL	9/17/2024
Trager	Evan	BH	INITIAL	9/17/2024
Trammel	Samantha	ABA-Telehealth	INITIAL	9/17/2024
Tran	Andrew	BH-Telehealth	INITIAL	9/17/2024
Tran	Bao Anh Patrick	Specialist	INITIAL	9/17/2024
Tran	Toai	ABA-Telehealth	INITIAL	9/17/2024
Trinity	Dhalys	ABA	INITIAL	9/17/2024
Tulisso	Alessandro	BH-Telehealth	INITIAL	9/17/2024
Tuman	Christina	BH	INITIAL	9/17/2024
Umana	Walter	ABA-Telehealth	INITIAL	9/17/2024
Underwood	Virginia	BH-Telehealth	INITIAL	9/17/2024
Urzua Rivas	Fabiola	ABA	INITIAL	9/17/2024
Valle	Ronald	BH-Telehealth	INITIAL	9/17/2024
Vaquera	Peggy	BH-Telehealth	INITIAL	9/17/2024
Vashi	Saloni	Ancillary	INITIAL	9/17/2024
Velasquez	Roseanne Jamie	Allied Health	INITIAL	9/17/2024
Vellichor	Marissa	BH-Telehealth	INITIAL	9/17/2024
Veltman	Yevgeniy	Specialist	INITIAL	9/17/2024
Verano	Mae-Richelle	BH	INITIAL	9/17/2024
Vickery	Lucy	ABA-Telehealth	INITIAL	9/17/2024
Vutescu	Emil	Specialist	INITIAL	9/17/2024
Wagner	Janine	BH	INITIAL	9/17/2024
Waldemer-Streyer	Rachel	Specialist	INITIAL	9/17/2024
Wall	Daniel	Specialist	INITIAL	9/17/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL RE-CRED	CRED DATE
Watkins	Lindsay	ABA-Telehealth	INITIAL	9/17/2024
Wilson	Kisha	ABA-Telehealth	INITIAL	9/17/2024
Wolf	Stephanie	ABA	INITIAL	9/17/2024
Wollin	Hez	BH	INITIAL	9/17/2024
Wong	Kendall	BH	INITIAL	9/17/2024
Wong	Matthew	ABA	INITIAL	9/17/2024
Wong	Rita	BH	INITIAL	9/17/2024
Yalom	Anisa	Specialist	INITIAL	9/17/2024
Yang	Helen	Primary Care Physician	INITIAL	9/17/2024
Yapudzhian	Sose	BH-Telehealth	INITIAL	9/17/2024
Young	Taylor	ABA-Telehealth	INITIAL	9/17/2024
Youngsmith	Wendy	BH	INITIAL	9/17/2024
Yu	Zhewen	Allied Health	INITIAL	9/17/2024
Zahur	Sharjina	ABA-Telehealth	INITIAL	9/17/2024
Zavala-Garcia	Sandra	BH	INITIAL	9/17/2024
Zoller	Mackenzie	Ancillary	INITIAL	9/17/2024
Aboelata	Noha	Primary Care Physician	RE-CRED	9/17/2024
Ahn	Jeanie	Specialist	RE-CRED	9/17/2024
Amin	Krina	Primary Care Physician	RE-CRED	9/17/2024
Ashbaugh	Shane	Allied Health	RE-CRED	9/17/2024
Berletti	Monica	Specialist	RE-CRED	9/17/2024
Cardenas	Jonathan	Allied Health	RE-CRED	9/17/2024
Critchlow	Kevin	Primary Care Physician	RE-CRED	9/17/2024
Dang	Phuong	Primary Care Physician	RE-CRED	9/17/2024
Fisher	Emily	Primary Care Physician	RE-CRED	9/17/2024
Gaines	Nathan	Specialist	RE-CRED	9/17/2024
Galvez	Cynthia	Allied Health	RE-CRED	9/17/2024
Goss	Adeline	Specialist	RE-CRED	9/17/2024
Huen	Floyd	Primary Care Physician	RE-CRED	9/17/2024
Ikharo-Okhomina	Afishetu	Allied Health	RE-CRED	9/17/2024
Insogna	Marta	Allied Health	RE-CRED	9/17/2024
Kothari	Nisreen	Specialist	RE-CRED	9/17/2024
Lit	Eugene	Specialist	RE-CRED	9/17/2024
Lynch	Scott	Primary Care Physician	RE-CRED	9/17/2024
Maningding	Ernest	Specialist	RE-CRED	9/17/2024
Miraflor	Emily	Specialist	RE-CRED	9/17/2024
Nassiri	Massoud	Ancillary	RE-CRED	9/17/2024
Niaz	Qaiser	Specialist	RE-CRED	9/17/2024
Patel	Chirag	Specialist	RE-CRED	9/17/2024
Patel	Swati	Specialist	RE-CRED	9/17/2024
Pfeiff	Cynthia	Allied Health	RE-CRED	9/17/2024
Reyzelman	Alexander	Specialist	RE-CRED	9/17/2024
Roe	Bernardita	Allied Health	RE-CRED	9/17/2024
Sachdeva	Gopal	Specialist	RE-CRED	9/17/2024
Sandhu	Sharnjeet	Ancillary	RE-CRED	9/17/2024
Schofield	Jennifer	Allied Health	RE-CRED	9/17/2024
Slabaugh	Peter	Specialist	RE-CRED	9/17/2024
Subramanian	Indhu	Specialist	RE-CRED	9/17/2024
Tuan	Karen	Specialist	RE-CRED	9/17/2024

SEPTEMBER PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	14
SPECIALIST	34
ANCILLARY	10
ALLIED	26
BH/ABA	265
TOTAL	349

Provider Dispute Resolution
August 2024 and September 2024

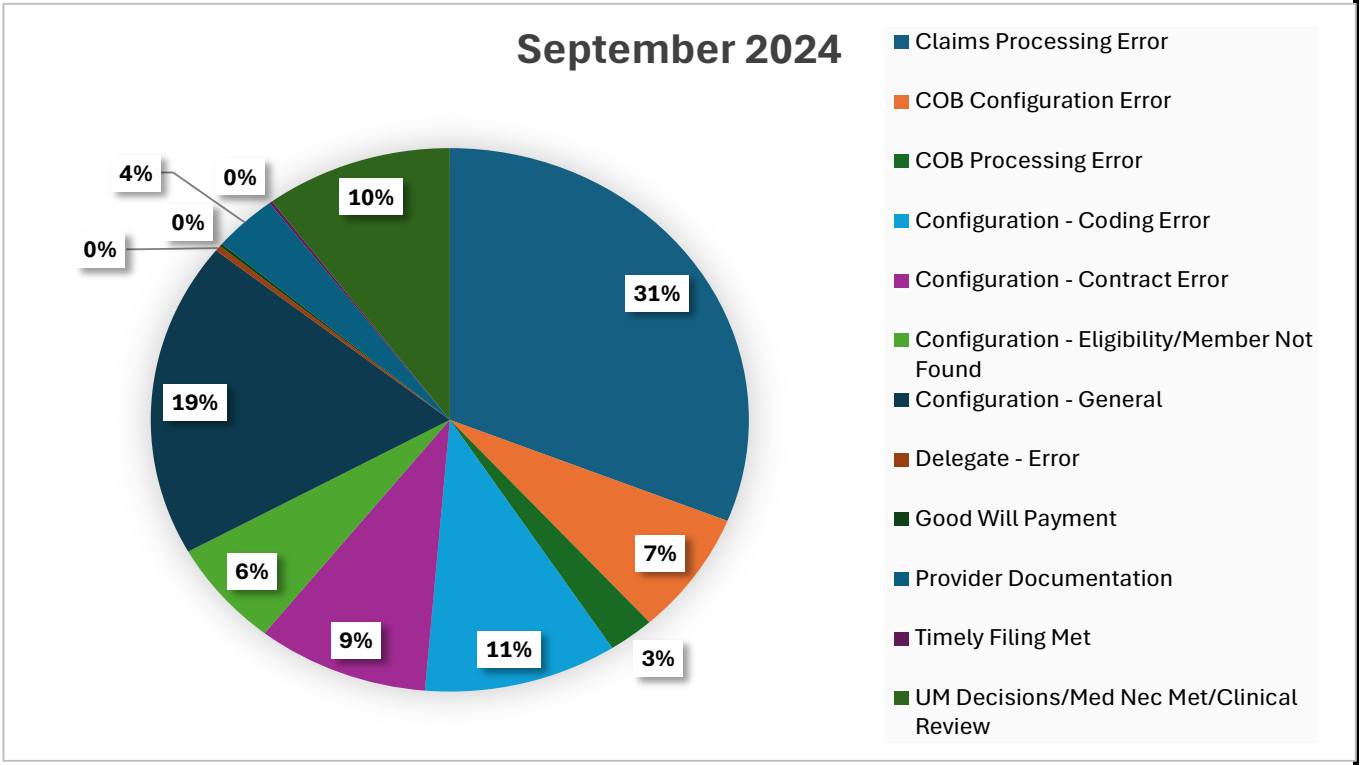
METRICS

PDR Compliance	Aug-24	Sep-24
# of PDRs Resolved	2,602	1,897
# Resolved Within 45 Working Days	2,591	1,889
% of PDRs Resolved Within 45 Working Days	99.5%	99.6%
PDRs Received	**Aug-24**	**Sep-24**
# of PDRs Received	2,193	2,340
PDR Volume Total	**2,193**	**2,340**
PDRs Resolved	**Aug-24**	**Sep-24**
# of PDRs Upheld	1,623	1,295
% of PDRs Upheld	62%	68%
# of PDRs Overturned	979	602
% of PDRs Overturned	38%	32%
Total # of PDRs Resolved	**2,602**	**1,897**
Average Turnaround Time	**Aug-24**	**Sep-24**
Average # of Days to Resolve PDRs	43	40
Oldest Resolved PDR in Days	75	112
Unresolved PDR Age	**Aug-24**	**Sep-24**
0-45 Working Days	4,368	4,159
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**4,368**	**4,159**

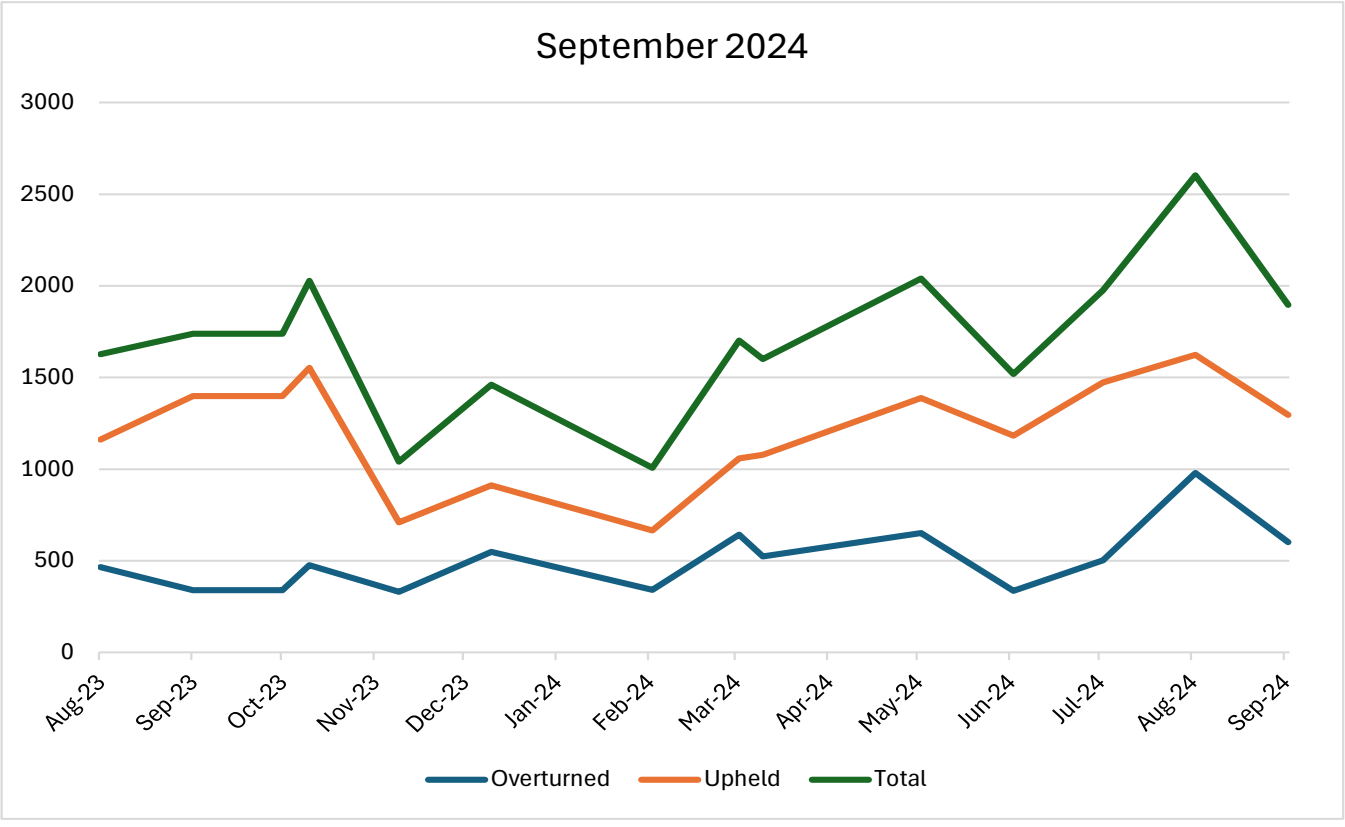
Provider Dispute Resolution
August 2024 and September 2024

Sep-24

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Received - 2,340 in September 2024 vs 2,219 in September 2023	N/A	N/A
# of PDRs Resolved within 45 working days - 1,889 in September 2024 vs 1,699 in September 2023	N/A	N/A
% of PDRs Resolved within 45 working days - 99.6% in September 2024 vs 97.8% in September 2023	95%	95%
Average # of Days to Resolve PDRs - 40 days in September 2024 vs 39 days in September 2023	N/A	30
Oldest Resolved PDR in Days - 112 days in September 2024 vs 50 days September 2023	N/A	N/A
# of PDRs Upheld - 1,295 in September 2024 vs 1,399 in September 2023	N/A	N/A
% of PDRs Upheld - 68% in September 2024 vs 80% in September 2023	N/A	75
# of PDRs Overturned - 602 in September 2024 vs 339 in September 2023	N/A	N/A
% of PDRs Overturned - 32% in September 2024 vs 20% in September 2023	N/A	25
PDR Overturn Reasons: Claims processing errors - 31% (2024) vs 34% (2023) Configuration errors -45% (2024) vs 47% (2023) COB -9% (2024) vs 12% (2023) Clinical Review/UM Decisions/Medical Necessity Met -10% (2024) vs 6% (2023)	N/A	N/A

Between July 2024 and September 2024, the Alliance completed **4,102** member orientation outreach calls among net new members and non-utilizers and conducted **322** member orientations (**7.8%** member participation rate). In addition, the Outreach team completed **154** Alliance website inquiries, **24** service requests, **3** social media inquiries, **14** community events, and **6** member education events in Q1.

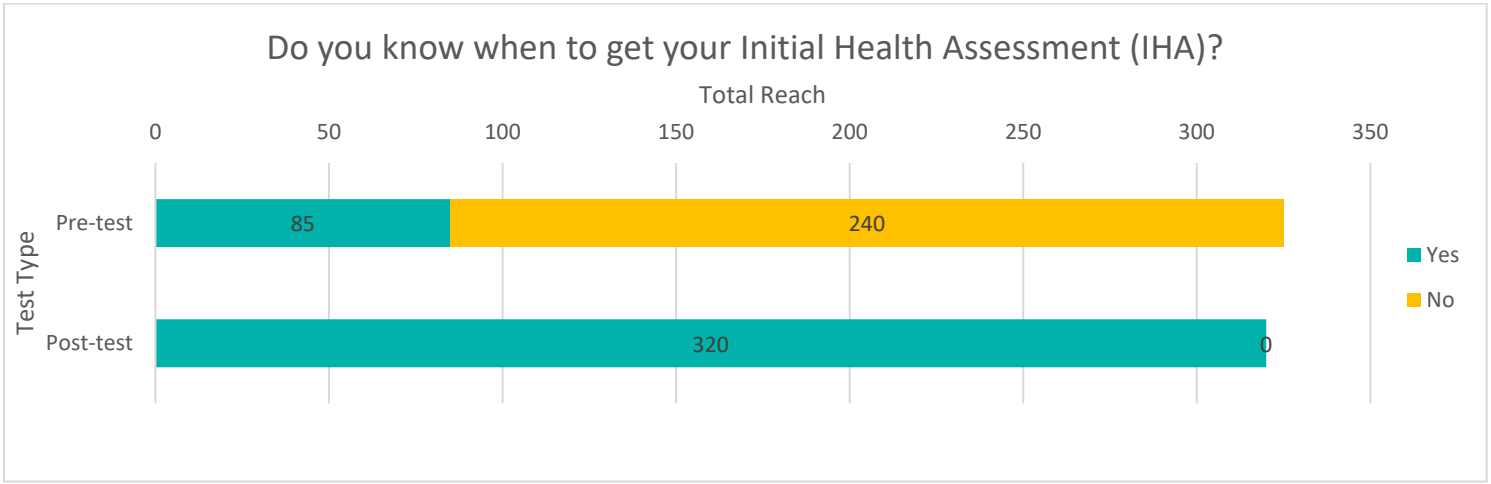
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **35,211** self-identified Alliance members have been reached during outreach activities.

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 **Monday, September 30, 2024**, the Outreach Team completed **41,605** member orientation outreach calls and conducted **8,944** member orientations (22.5%-member participation rate).

The Alliance Member Orientation (MO) program started 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 September 30, 2024) – **8,944** members completed our MO and Non-utilizer program by phone.

After completing a MO **100%** of members who completed the post-test survey in Q1 FY 24-25 reported knowing when to get their IHA, compared to only **26.2%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 24-25\Q1\3. September 2024**

Q1 FY 2024-2025 TOTALS

14 COMMUNITY EVENTS	**2996** TOTAL REACHED AT VIRTUAL COMMUNITY EVENTS
6 MEMBER EDUCATION EVENTS	**584** TOTAL REACHED AT MEMBER EDUCATION EVENTS
322 MEMBER ORIENTATIONS	**322** TOTAL REACHED AT MEMBER ORIENTATIONS
0 MEETINGS/ PRESENTATIONS	**0** TOTAL REACHED AT MEETINGS/PRESENTATIONS
29 TOTAL INITIATED/INVITED EVENTS	**2055** TOTAL MEMBERS REACHED AT EVENTS
342 TOTAL EVENTS	**3902** 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 Q1 2024: Walnut Creek, Richmond, San Jose, San Mateo, and San Ramon. The C&O Department started including these cities in the Q3 FY21 Outreach Report.

$1115.70

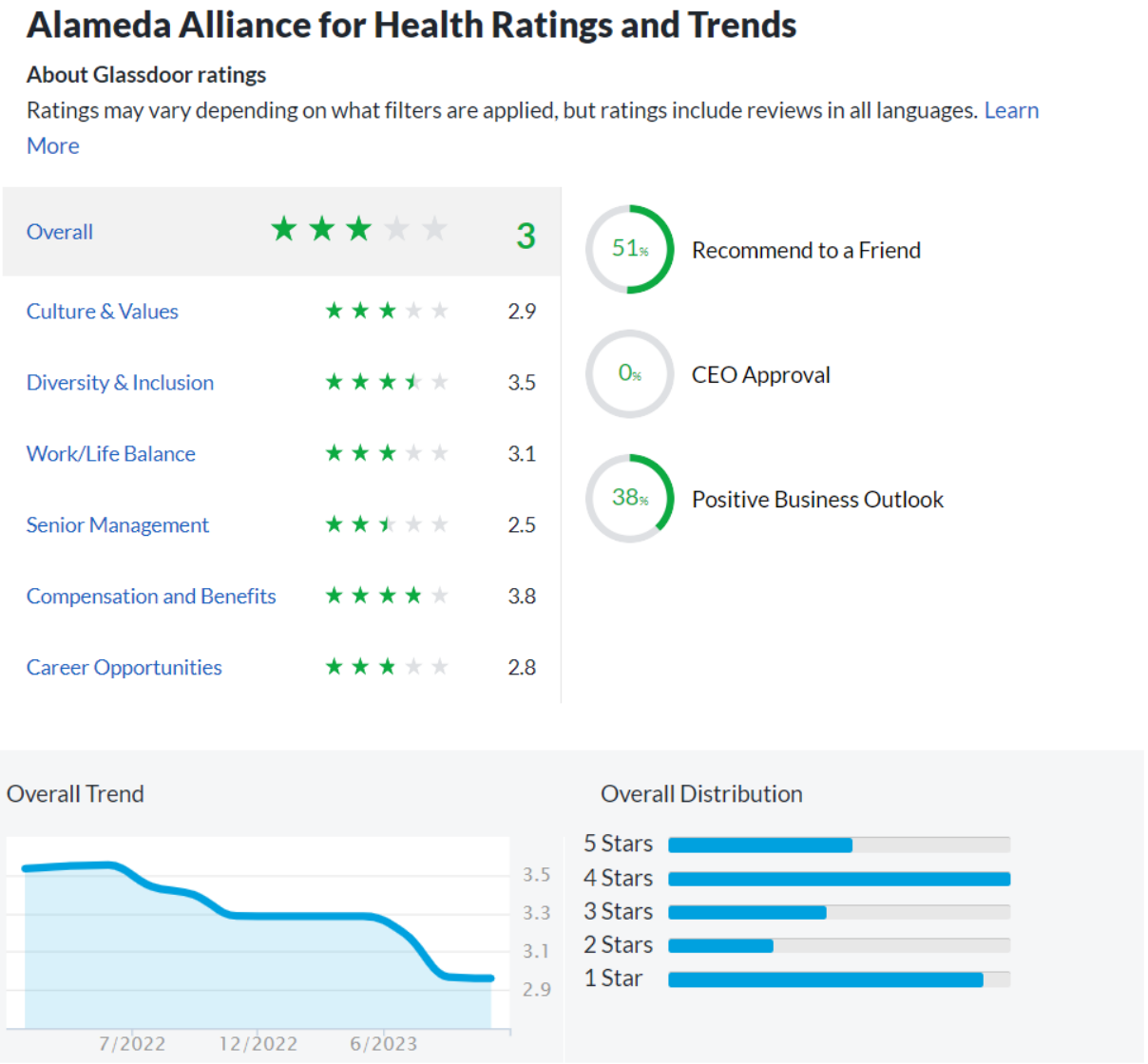
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** 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 **September 1, 2024**, and **September 30, 2024**:

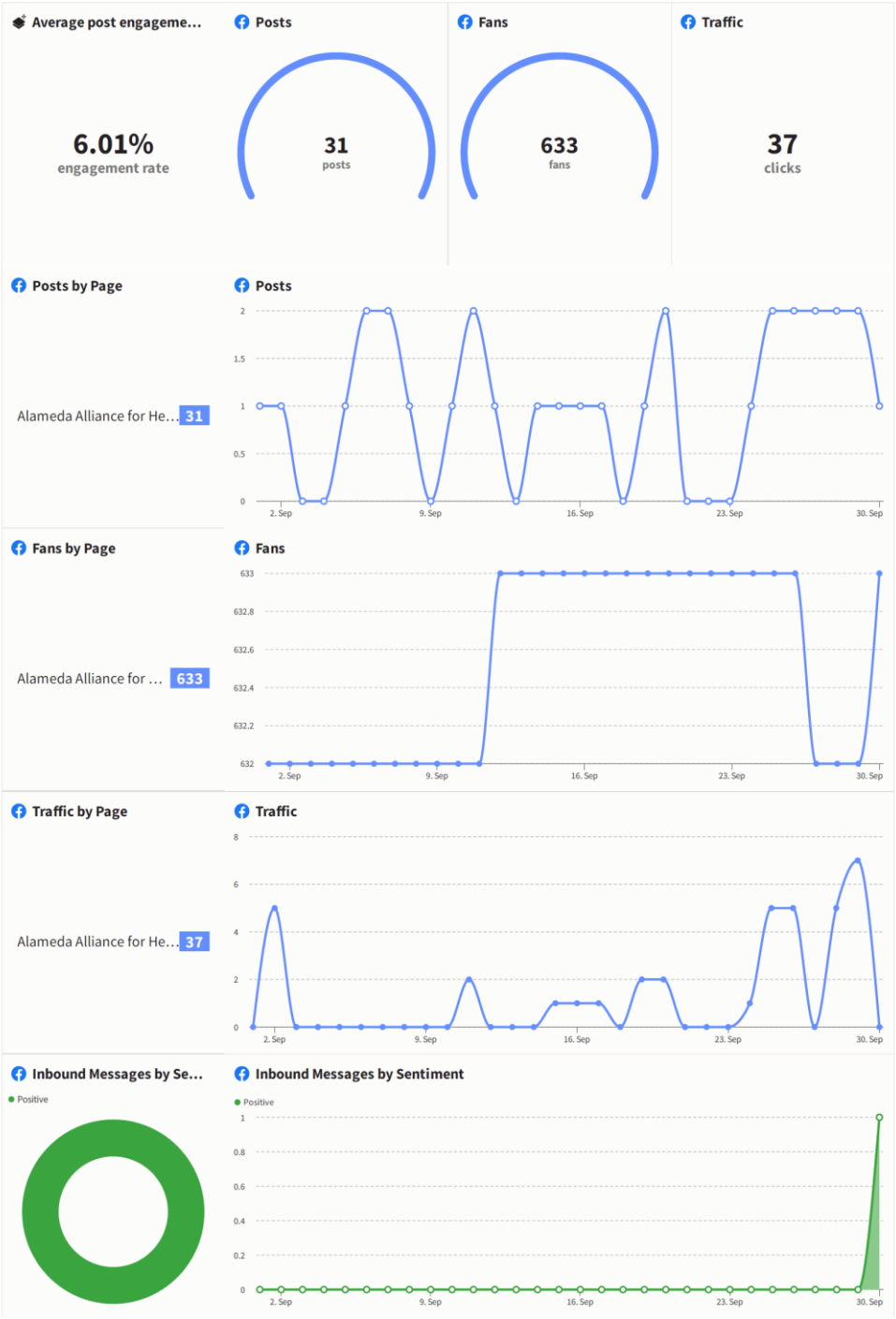
1. Alliance Website:
    - Received **26,000** unique visits
    - Received **23,000** new user visits
    - The top **10** website page visits were:
        i. Homepage
        ii. Provider Page
        iii. Find a Doctor
        iv. Check in for Check-ups
        v. Careers
        vi. Medi-Cal Benefits and Services
        vii. Members Medi-Cal
        viii. Contact Us
        ix. Members
        x. Get a New ID Card
2. Facebook Page:
    - Maintained Fans at **633**
    - Did not receive any reviews in **September 2024**
3. Glassdoor Page:
    - **3** out of a **5-star** overall rating
    - Did not receive any reviews in **September 2024**
4. Instagram Page:
    - Page debuted **June 10, 2021**
    - Increased in followers from **575** to **576**
5. X (previously Twitter) Page:
    - Slight Increase in followers from **362** to **365**
6. LinkedIn Page:
    - Increased followers from **5.8k** to **5.9k**
    - Received **367-**page clicks
7. Yelp Page:
    - Page visits **48**
    - Appeared in Yelp searches **92** times
    - Did not receive any reviews in **September 2024**
8. Google Page:
    - **4,362** website clicks made from the business profile
    - **1,318** calls made from the business profile
    - Received **3** (three) reviews in **September 2024**

GLASSDOOR OVERVIEW



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q1\3. September 2024

FACEBOOK OVERVIEW

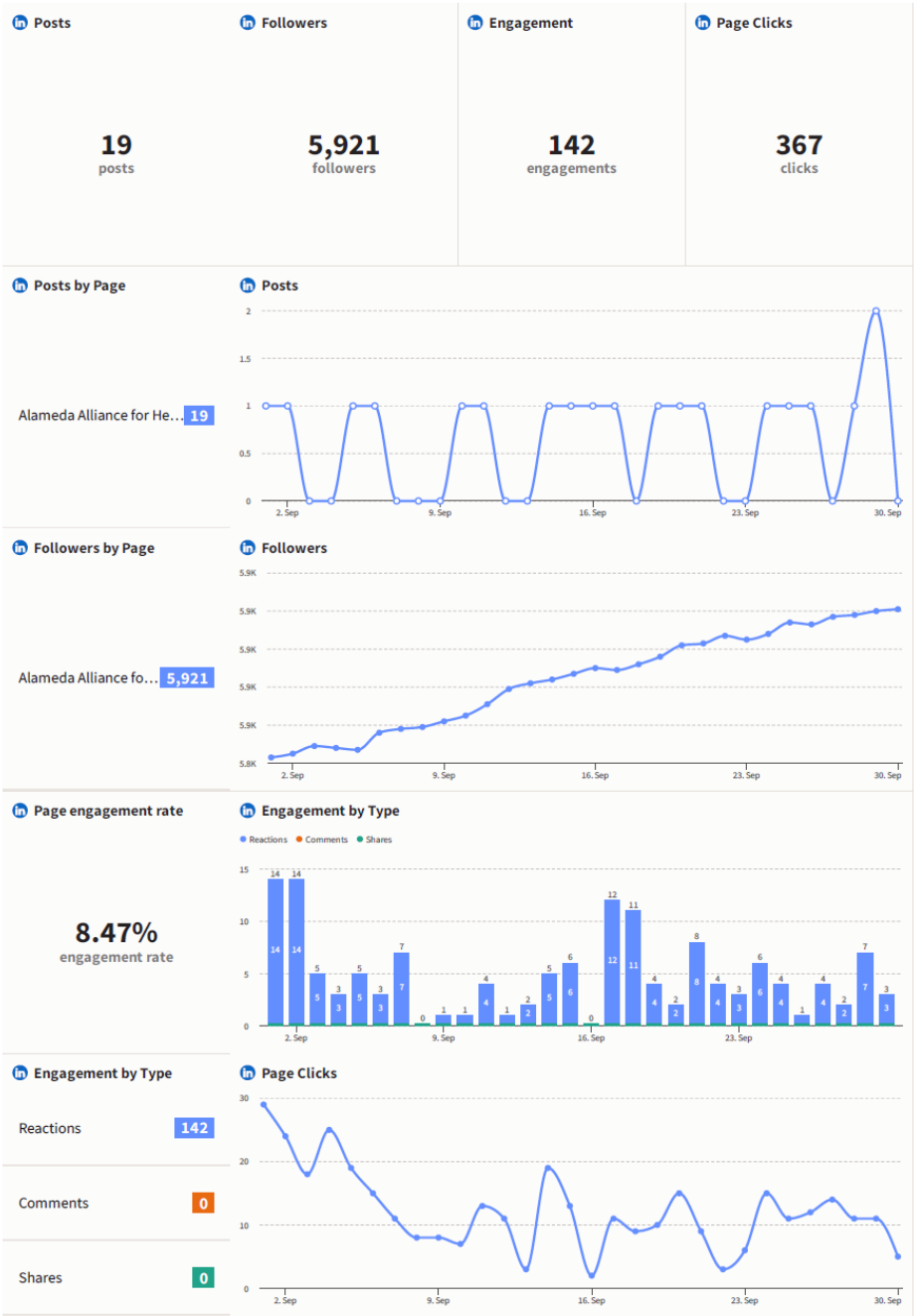


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q1\3. September 2024

X (previously TWITTER) OVERVIEW

All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q1\3. September 2024

LINKEDIN OVERVIEW



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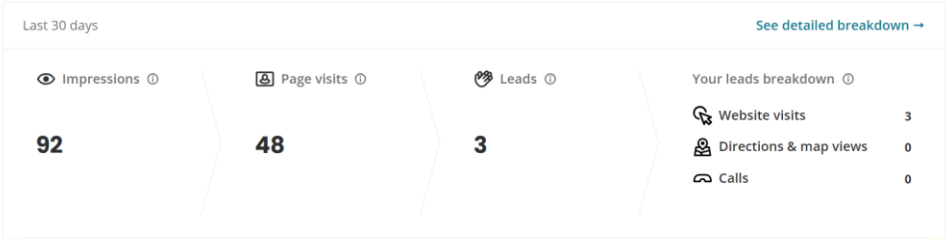
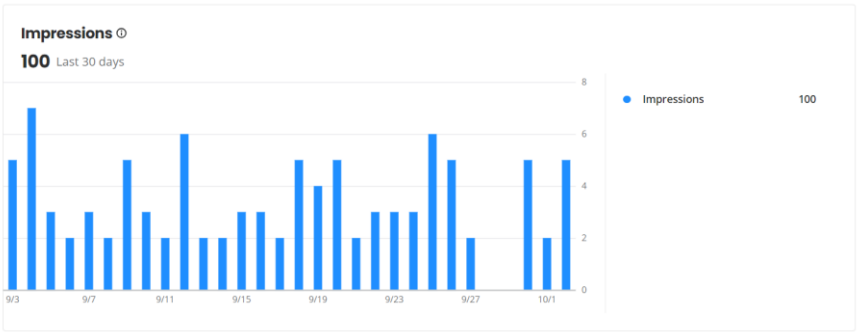
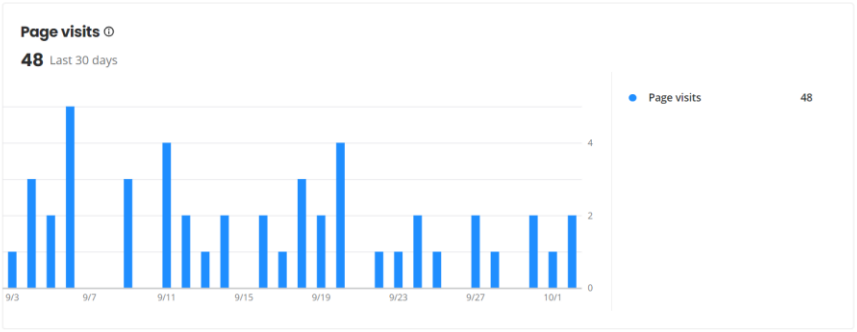
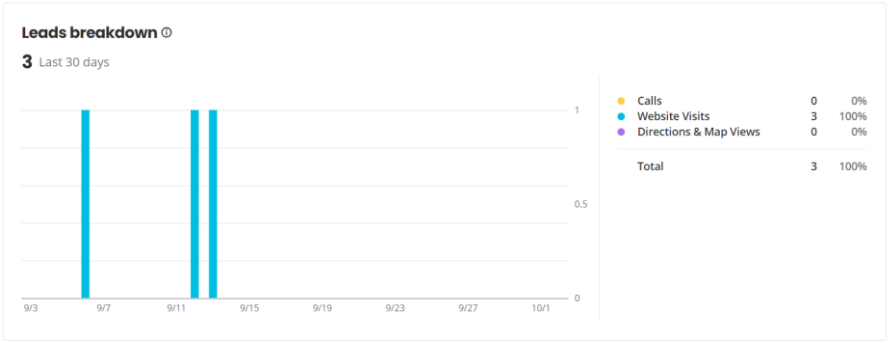
YELP OVERVIEW









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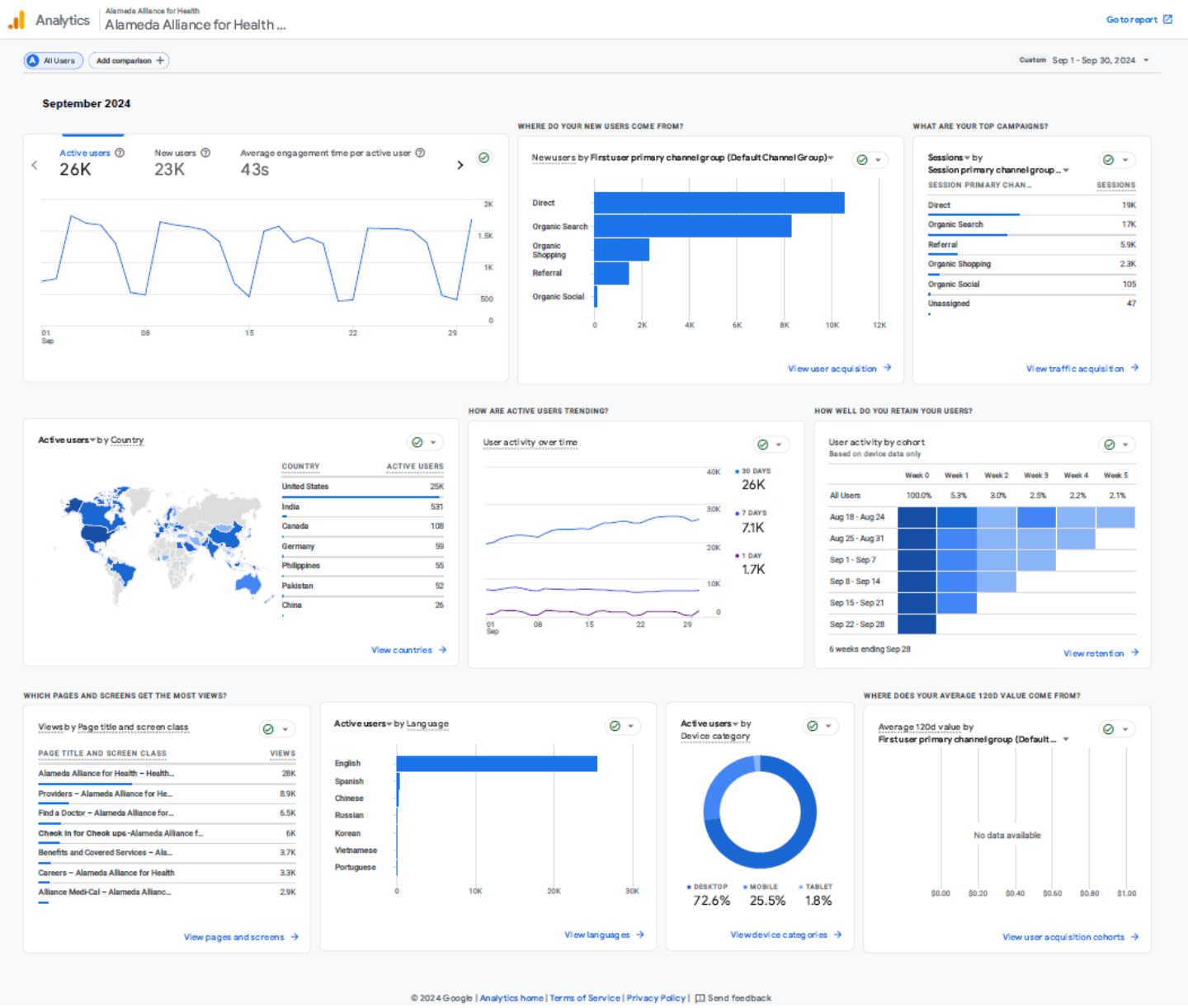
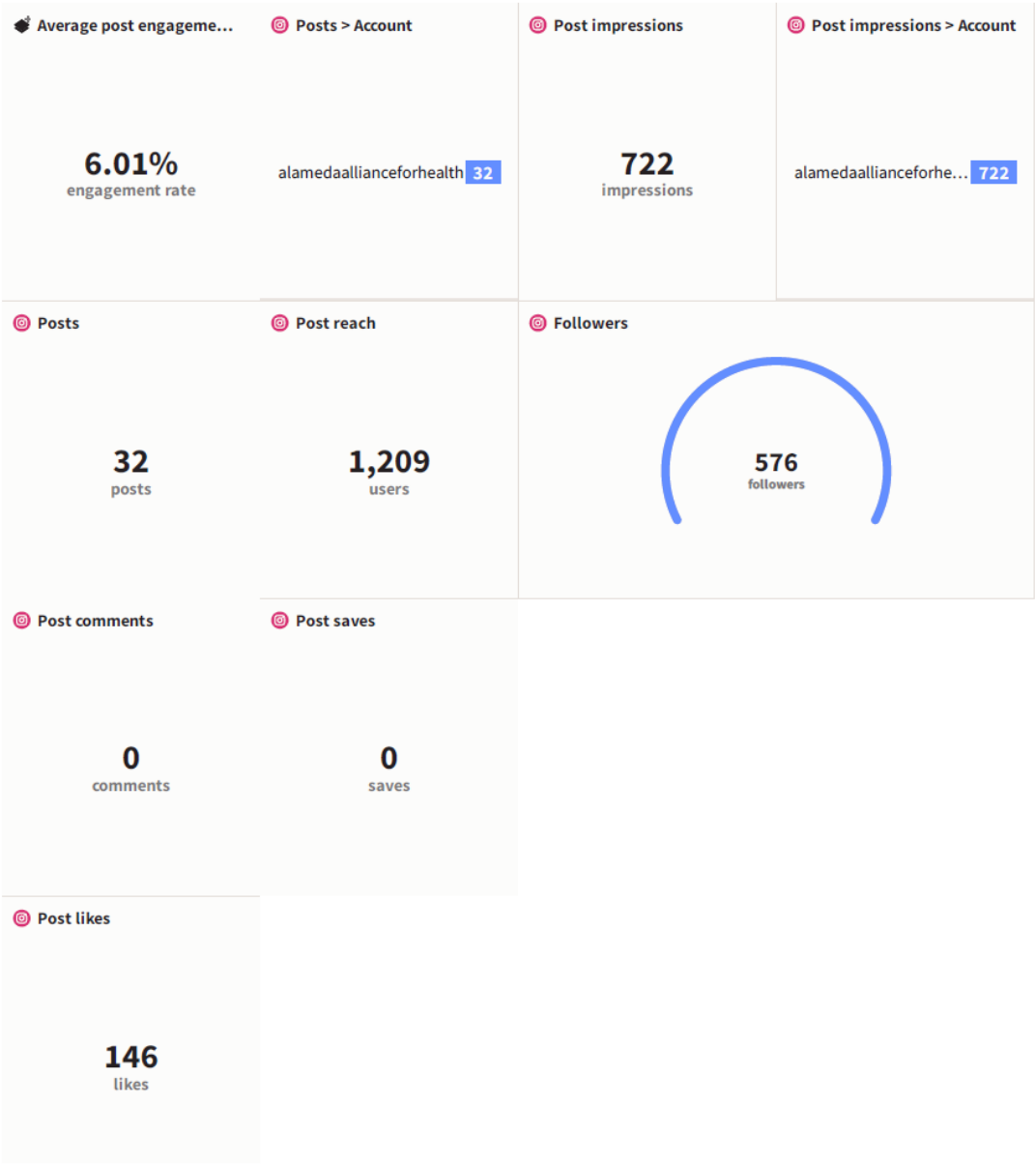
ALLIANCE WEBSITE OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q1\3. September 2024

Instagram OVERVIEW:



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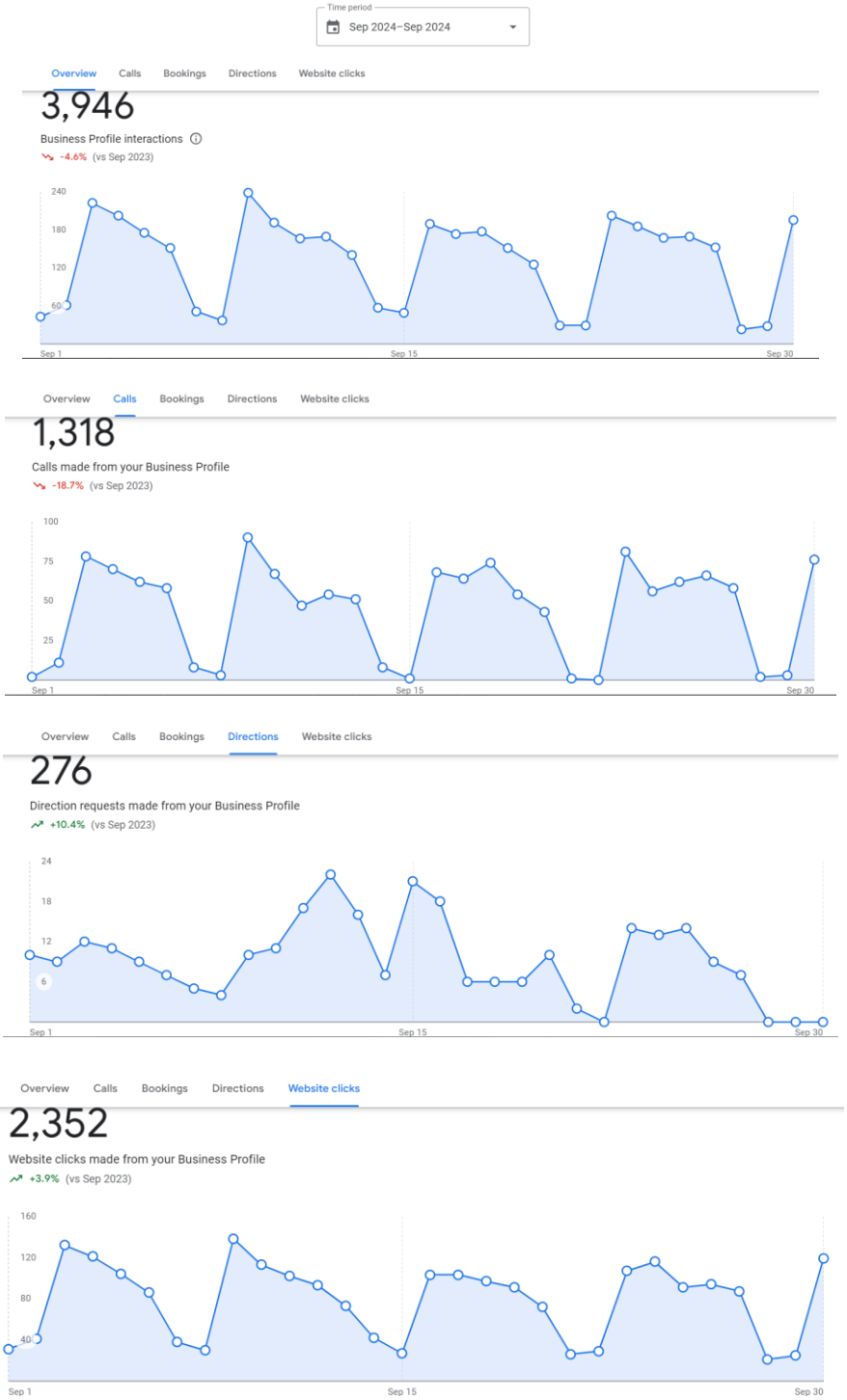
Google OVERVIEW:



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Compliance

Richard Golfin III

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

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

Date: **October 11th, 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 was from June 17th, 2024 - June 28th, 2024. The Plan received notification on September 19th, 2024, stating the exit conference will be held on October 16th, 2024. The Plan expects to receive the preliminary report by October 14th, 2024. The final report is expected by the end of October, and a CAP response will be due thirty (30) days after the DHCS issued CAP request.
- 2023 Department of Health Care Services (DHCS) Focused Medical Survey
    - On September 4th, 2024, the Plan received the Medical Survey Audit Report and CAP Request Letter for the 2023 DHCS Focused Medical Survey. The Plan received findings related to Behavioral Health Services and Transportation Services. Compliance held eight (8) office hour sessions to assist SMEs with questions, clarifications, or concerns that they may have in order to document their CAP responses. The Plan is on track to submit the CAP response to the DHCS on October 4th, 2024.
- 2024 Health Services Advisory Group, Inc. (HSAG) Network Adequacy Validation Audit (NAV)
    - On March 15th, 2024, HSAG informed the Plan of its 2024 NAV Audit. The virtual NAV Audit was held on July 15th, 2024, and July 17th, 2024. The Plan received the formal close out of the NAV audit on September 30th, 2024. All items have been resolved and there were no identified opportunities or recommendations.

- 2024 DHCS Facility Site Review (FSR) and Medical Record Review (MRR)

    - On August 13th, 2024, the DHCS notified the Plan that it will be conducting its required random full-scope FSR and MRR consistent with APL 22-017 from September 17th, 2024, through September 19th, 2024, for Alameda County. Ten (10) PCPs were selected from the Plan by DHCS. The Plan's FSR Team provided guidance to the selected PCPs in preparation for the audit. A nurse reviewer from the Plan was onsite during the reviews which are now completed. On September 24th, 2024, the Plan received the Critical Elements findings report from DHCS. Eight (8) providers were identified as having these findings. The providers are expected to submit a CAP and evidence of corrections to the Plan's FSR Team on October 4th, 2024.

Compliance Activity Updates

- DMHC Medicare Filings – 2026 Medicare Launch
    - 2024 Medicare License Expansion Material Modification Filing (E-Filing *No. 20241128*): On September 19th, 2024, the DMHC issued an Order of Approval for the Plan to expand the existing license to include Medicare-covered services in Alameda County.
    - 2024 D-SNP (Dual-Eligible Special Needs Plan) Material Modification Filing (E-Filing *No. 20244060*): On September 9th, 2024, the Plan submitted a second filing requesting DMHC's approval to add a D-SNP product to the Plan's current offerings. On October 4th, the DMHC issued an Order of Postponement and ten comments to which the Plan must respond by November 3rd, 2024.
- 2024 Corporate Compliance Annual Training:
    - On Monday, September 9th, 2024, the Plan distributed the Annual Corporate Compliance Trainings. The Annual Corporate Training covers the following areas: HIPAA, FWA, and Cultural Sensitivity. Ten percent (10%) of Staff have completed the assigned training, which is due on December 9th, 2024.
- 2024 LTC-ICF/DD Phase I Corrective Action Plan (CAP):
    - As of January 1st, 2024, the Plan is contractually required to cover Long Term Care Intermediate Care Facilities/Intermediate Care Facility for the Developmentally Disabled (LTC-ICF/DD) Services. The Plan must demonstrate it meets this requirement by attempting to contract with all California Department of Public Health (CDPH) licensed and certified LTC-ICF/DDs within California. On July 3rd, 2024, DHCS issued a Corrective Action (CAP) requiring the Plan to submit monthly contracting status reports. The Plan submitted a monthly status report to DHCS on October 1st, 2024. October 3rd, 2024, DHCS sent a letter to the Plan closing this CAP.

- 2022 Behavioral Health Insourcing: Material Modification

Undertaking No. 6		
Undertaking Deliverable	**Progress**	**Next Milestone**
"Submit 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."	The Plan must demonstrate it does not impose financial requirements and/or treatment limitations on mental health/substance use disorder (MH/SUD) benefits are on par with or are no more restrictive than the financial requirements and treatment limitations that it applies to medical/surgical (Med/Surg) benefits in the same classification. The Plan's outside counsel is performing a final review of the prepared responses and updated policies and may need to meet with the Plan's subject matter experts to resolve any follow up questions.	The Plan will be prepared to submit a detailed and responsive filing by October 11th, 2024. The Plan anticipates closing this filing in December 2024.

Compliance

Supporting Documents

COMPLIANCE DASHBOARD SUMMARY											
	Resource	Type								TOTAL	% Completed
			2018	2019	2020	2021	2022	2023	2024		
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	24	TBD	145	
		Total Self-Identified Issues	12	0	0	2	0	2	23	39	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**23**	**184**	
		Total In Progress	0	0	0	0	0	9	23	32	
		Total Completed	50	28	7	35	15	17	0	152	**94%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**23**	**161**	
	DMHC	Total State Audit Findings			5	6	8			19	
		Total Self-Identified Issues			3	0	0			3	
		Total Findings			**8**	**6**	**8**			**22**	
		Total In Progress			0	0	1			1	
		Total Completed			8	6	7			21	**95%**
		Total Findings	**NA**	**NA**	**8**	**6**	**8**	**NA**		**22**	
	DMHC Financial Services	Total State Audit Findings		5			4			9	
		Total Self-Identified Issues		0			0			0	
		Total Findings		**5**			**4**			**9**	
		Total In Progress		0			0			0	
		Total Completed		5			4			9	**100%**
		Total Findings	**NA**	**5**	**NA**	**NA**	**4**	**NA**		**9**	
STATE AUDIT FINDINGS		In Progress	0	0	0	0	1	9	0	10	
		Completed	38	33	12	39	26	15	0	163	**94%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**24**	**0**	**173**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	23	23	
		Completed	12	0	3	2	0	2	0	19	**45%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**23**	**42**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**26**	**23**	**215**	

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

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

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

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

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

	Total Findings	**2**	

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

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

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

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

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

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

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

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

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
R = Repeat Observation
Yellow = Plan Observations

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
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

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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
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
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

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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**
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 provided 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
#	**Category**	**Areas of Opportunity**	**Department Responsible**
1	G & A	The Discrimination Grievance Workflow should be updated to included the timelines and tracking.	Compliance
2	Compliance	Consultants and Independent Contractors not consistently trained, or the trainings are not tracked per policy CMP-026 Compliance Training and Education	Compliance
3	Compliance	Board of Governors does not consistently complete trainings per regulations and contract requirements.	Privacy Office
4	HIPAA	The Privacy Reporting Desktop Procedure should be updated to include the steps regarding educating internal stake holders on timely referrals and correct categorization in HealthSuite.	Privacy Office

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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**
5	HIPAA	Privacy Office should update workflows for timely investigation of referrals sent to the incorrect inbox.	Privacy Office
6	Compliance	Updates should be made to the Compliance Plan on an annual basis. The Code of Conduct should be updated to reflect the new CEO.	Compliance
7	Compliance	Timeliness of reporting of Chief Medical Officer Transition	Compliance
8	Compliance	The Plan should include regulatory language in job descriptions for liaison positions. Changes to liaisons should be communicated to Compliance in a reasonable time with updated lists of liaisons provided to the State regularly.	Compliance
9	Case Management and CoC	There are no separate CCS and EPSDT review during the annual UM delegation audit.	Delegation Oversight
10	Claims	Delegate reimbursement of Prop 56 claims There is no separate review of Prop 56 claims during annual audits.	Claims Delegation Oversight
11	Provider Qualifications	The virtual care provider had 2 involuntary terminations during the audit period. The Plan did not report provider terminations to DHCS.	Credentialing Delegation Oversight Compliance
12	Credentialing	A delegate reported terminations under quality of care in error.	Credentialing Delegation Oversight Compliance
13	UM	Policy UM-063 Gender Affirmation Surgery Services, does not include WPATH 8 Guidelines	UM
14	Transportation	The transportation provider conducts spot checks, the resulting reports are available to the Plan but the Plan has not requested or reviewed them	Vendor Management
15	Transportation	Confirmation of minor consent collected by the transportation provider for transportation of minor members.	Vendor Management

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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**
16	Delegation of Utilization Management	Ownership and Disclosure forms are not collected and reviewed from all subcontractors per contract requirements.	Provider Services Vendor Management

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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	BH	(2.1) Case Management and Care Coordination The Plan did not ensure the provision of coordination of care to deliver mental health care services to its members. Recommendation: Revise and implement policies and procedures to ensure the Plan coordinates care with the MHP.	Behavioral Health UM Provider Services
2	BH	(2.2) Information Exchange with the County Mental Health Plan (MHP) The Plan did not follow the written policies and procedures in its MOU for the timely sharing of medical information with the MHP. Recommendation: Implement policies and procedures to ensure the Plan follows agreed upon written policies and procedures in its MOU for the timely exchange of medical information with the MHP.	Behavioral Health UM Privacy IT
3	BH	(2.3) Confirmation of Referred Treatments for Substance Use Disorder (SUD) The Plan did not make good faith efforts to confirm whether members received referred treatment for SUD and document when and where treatment was received, and any next steps following treatment. Recommendation: Revise and implement policies and procedures to ensure the Plan makes good faith efforts to confirm whether members received referred SUD treatment and document when and where treatment was received, and any next steps following treatment.	Behavioral Health UM Continuity of Care
4	BH	(2.4) Follow Up for Referred Substance Use Disorder Treatments The Plan did not follow up with members who did not receive referred treatments to understand barriers and make subsequent adjustments to referrals. Recommendation: Revise and implement policies and procedures to ensure the Plan awareness of members who did not receive referred SUD treatments, to understand barriers and make subsequent adjustment to referrals, if warranted.	Behavioral Health UM Case Management

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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**
5	NMT & NEMT	(3.1) Door-to-Door Assistance The Plan did not have a process in place to ensure that door-to-door assistance was provided for all members receiving NEMT services. Recommendation: Revise and implement policies and procedures to ensure door-to-door assistance is being provided for all members receiving NEMT services.	Vendor Management
6	NMT & NEMT	(3.2) Monitoring of Door-to-Door Assistance The Plan did not conduct monitoring activities to verify NEMT providers were providing door-to-door assistance for members receiving NEMT services, per APL 22-008 Recommendation: Revise and implement policies and procedures to ensure the Plan conducts monitoring activities, to ensure providers provide door-to-door assistance, for all members receiving NEMT services.	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. Recommendation: Revise and implement policies and procedures to ensure there is a direct line to the transportation liaison and authorizations are processed after business hours.	UM
8	NMT & NEMT	(3.4) **R** Physician Certification Statement Forms The Plan did not ensure that members had the required PCS forms for NEMT services, nor did the Plan ensure that PCS forms contained all required components. Recommendation: Implement policies and procedures to ensure PCS forms are on file for all members receiving NEMT services and that the forms contain all the required components.	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**
9	NMT & NEMT	(3.5) Ambulatory Door-to-Door The Plan did not ensure its delegate, provided the appropriate level of service for members requiring ambulatory door-to-door service. Recommendation: Revise and implement policies and procedures to ensure its delegate provides the appropriate level of service for members requiring ambulatory door-to-door service.	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 member and that outreach was completed to confirm that services approved or had denial modification authorizations were utilized by members. The delegate also developed workflows to detect and mitigate failures. The CAP includes the delegate's implementation of a remediation plan. The remediation plan includes updates in their workflow, training, and an internal monthly audit- with results submitted to The Alliance for review. The Plan reviewed and evaluated the delegate's CAP implementation and progress during the interim and provided guidance. The CAP was approved and closed on 09/25/2023. (Completed) The delegate is expected to continue its internal monthly audit for the NOA letters and fax confirmation. The Plan will continue to monitor the audit results for compliance. Please see document 1.5.1_AAH Response for full details. (On Track) Additionally, the Plan will review the UM delegates' P&P's to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation and these will be evaluated annually at minimum. (On Track) 1a. Monitoring of the delegate's monthly internal audit is ongoing. (On Track) 2. Review the UM delegates' policies and procedures to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation. (On Track) Update 3/8/2024 P&P review complete and P&P deemed adequate. Review of the delegate's P&P regarding NOAs is ongoing and The Alliance will continue to meet with the delegate to have P&P appropriately updated. **Update 4/5/2024** The delegates have submitted all requested policies for review. The policies have been reviewed and the delegates have made all necessary revisions.	**3/31/2024**	Completed	Compliance UM	State	DHCS	2023

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
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

ALAMEDA ALLIANCE FOR HEALTH
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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	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 institutiona 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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#	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 nee to be completed in a timely manner. The Grievance Processing Timeline will be updated to include when a request for translation needs to be sent out and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted on 10/10/2023. (Completed and ongoing)	10/10/2023	Completed	G&A	State	DHCS	2023
11	Member Rights	(4.1.3) R Written Notification of Grievance Resolution Delays The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days and did not resolve grievances by the estimated resolution date in the delay letters.	The Plan's Grievance and Appeals Department will be updating our system, Quality Suite, to better capture data on if and/or when a delay letter is sent out. Once the system is updated, we will be able to create a reporting mechanism in our daily aging reports to monitor for when a case needs a delay letter and if the letter was sent out. The Grievance Processing Timeline will also be updated to include the process for sending out a delay letter and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted. (Completed and Ongoing)	12/1/2023	Completed	G&A	State	DHCS	2023
12	Member Rights	(4.1.4) Grievance Delay Timeframes The Plan inappropriately utilized a 14 calendar day delay timeframe for grievance resolutions.	In review of our current policy and procedures, and workflows; they were in line with the APL requirements. There was miscommunication in the staff training to us 14 calendar days instead of an estimated resolution date in the delay letters. There was a refresher training for the Grievance and Appeals staff held on 4/18/2023, the staff was provided the requirement and were reminded to provide an estimated resolution date in the delay letters if a resolution is not reached within 30 calendar days. (Completed)	4/18/2023	Completed	G&A	State	DHCS	2023
13	Member Rights	(4.1.5) Exempt Grievance Resolution The Plan did not resolve exempt grievances by close of the next business day.	In conjunction with the Grievance Department, the Member Services Grievance Guide was revised on 10/9/2023. (Completed) Training was provided to all Member Services staff on these revisions by 11/1/2023. (Completed)	11/1/2023	Completed	Member Services	State	DHCS	2023
14	Member Rights	(4.1.6) Grievance Identification The Plan did not process and resolve all member expressions of dissatisfaction as grievances.	Member Services has implemented a process to identify expressions of dissatisfaction that were not classified appropriately. (Completed) A Member Services Supervisor works with the agent to ensure the case is classified accurately and resolved in a timely manner. (Completed)	3/15/2023	Completed	Member Services	State	DHCS	2023
15	State Supported Services	(SSS.1) Minimum Proposition 56 Payments The Plan did not distribute minimum payments for a State Supported Services claim as described in APL 1 013.	The claims system configuration team has corrected the fee schedule for the provider and adjusted the impacted claims to pay the correct rate. (Completed)	4/26/2023	Completed	Claims	State	DHCS	2023
16	CM	(2.2) PCP and members are not consistently notified of Case Management case closures	Configuration made in TruCare to ensure consistent notification	4/26/2023	Completed	Case Management	Self	DHCS	2023

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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 whe 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 equit specific to the Plan's enrollee population.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	Quality Assurance Behavioral Health	State	DMHC
3	Enrollee Experience	Enrollees experience difficulties obtaining appointments.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	Quality Assurance Behavioral Health	State	DMHC

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

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

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

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

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
4	QI	(2.1.1) The Plan did not document attempts to contact members and schedule the IHA.	1. The plan will continue to inform members of the IHA through the EOC, welcome letters to all new members, and videos. - In addition, all members are eligible for a new member orientation (including a financial incentive). - Information regarding the IHA will be included in the member newsletter. The Alliance will initiate a new phone campaign where all new members will receive a phone call encouraging the member to receive an IHA. This phone log will be appropriately documented. The Alliance will create a call script for new member phone calls. 2. The plan will create a report to identify new plan membersUpdate 5/12/2023: Fulfillment Report created to track mailing of member Orientation reports that contain reminder to schedule IHA to new members. Member Orientation Service Request tracking report tracks outreach attempts to members to complete new member orientation, which includes communication about scheduling IHAs 3. The plan will create workflows for informing members of the IHAUpdate 5/12/2023: Clinical QI Program Coordinator will review IVR reports to determine all new members have received an outreach call. 4. The plan will update the IHA P&P to reflect the updated workflowsUpdate 3/10/2023: Draft policy QI-124 completed, IVR outreach is pending DHCS approval of script. Upon DHCS approval we will continue to develop the process for IVR outreach and develop desktop procedures. Update 4/15/2023: The updated P&P was approved at Compliance Committee 3/21/2023 5. The plan will create a phone call campaign, create a script, and work with the state for approvalUpdate 3/10/2023: Awaiting DHCS approval of script. Update 6/9/2023: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreach attempts via providers, by reviewing documentation as part of FSRs.	9/8/2023	Completed	QI		State	DHCS	2022
5	CM	**R** (2.5.1) The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.	1. The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with the MHP to review redline changes to the MOU. The MHP is currently under review of the redline changes and will notify the Alliance when they can move forward wit 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 sheetsUpdate 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 CommitteeUpdate 4/15/2023: Reports developed and presented at UM Committee Q4 2022.	4/1/2023	Completed	UM		State	DHCS	2022
9	Member Rights	**R** (4.1.1) The Plan did not send acknowledgement and resolution letters within the required timeframes.	1. The G & A Department Leadership and Quality Assurance Specialist will reference the daily reports to ensure the acknowledgment and resolution letters are sent timely 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement and resolution letters. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/20222	Completed	G&A		State	DHCS	2022

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

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

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

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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
4	UM	(1.5.2) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The delegate did not ensure that requests to see out of network providers were reviewed and decisions were made by a qualified health care professional. It did not include the decision-maker's name in the NOA.	1.The Plan will inform Delegate of DHCS findings about qualified health care professional did not always make decisions to deny or only authorized an amount, duration, or scope that was less than requested, and the lack of name and contact information on the NOA of the decision-maker. 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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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
13	Case Management	(2.2.4) The Plan did not ensure that interdisciplinary team assessments were included in the updating of members' care plans. The Plan did not ensure timely documentation of the interdisciplinary team meeting notes.	1. The Plan created an additional column in the Complex Case Log to monitor timely entry of IDT Round note into system of record. 2. The Plan will develop a workflow for staff to include the IDT note in the updated care plans. 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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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
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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						
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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						
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6	Delegation	The Plan did not ensure the Delegate met standards set forth by the Plan and DHCS. The Delegate did not ensure that concurrent review denials were reviewed and made by a qualified physician. It did not send NOA letters with "Your Rights" information for denial of services that occurred after initial denial. It did not include the decisions maker's name in the initial and only NOA sent to providers.	1. The Plan's revised policy UM-003 Concurrent Review and Discharge Planning Process and the revised process expectations were shared with Delegate on 3/26/2021. 2. The Plan will require the Delegate to do the following: a. Adopt the Plan's policies, to reflect that the concurrent review denials are reviewed and made by a qualified physician, that the clinical case is reviewed using the regulatory requirements on a regular cadence after the initial denial, that NOA letters with "Your Rights" information are sent after every subsequent review, and that the decision-maker's name is on each NOA. Update 6/11/2021 The Alliance's Health Care Services is working with the delegate to update the policies. b. Provide evidence of policy and procedure approval. Update 7/9/2021: Delegate has provided evidence that the revised policy was approved on 6/23/2021 c. Train its staff on the new Concurrent review process. Update 7/9/2021: Delegate states they are developing the training for their staff and are on track to provide the documents to The Alliance. Update 9/10/2021: Staff training completed, training documents provided. d. Provide evidence of the training, including the training materials and the attendance records. Update 9/10/2021: Delegate provided attestations to show training completed 6/23/2021 3. The Plan will audit the Delegate on a quarterly basis to ensure that the process is implemented, starting at the end of Q3 2021, and report the results of the audit at the Plan's UM Committee on a quarterly basis. Update 10/8/2021: Q3 2021 audit completed 9/29/2021, and initial audit results provided to the Delegate; final audit report will be issued to the Delegate by 10/13/2021. Update 11/12/2021: The next quarterly audit is scheduled for 12/17/2021. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022 4. At annual Delegate oversight audits, concurrent reviews and letters will be examined to ensure compliance. Update 11/12/2021: The next annual Delegation Oversight Audit is scheduled for February 2022. Concurrent reviews and letters will be reviewed at that time. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 5/13/2022: The delegate does not have any cases that meet the criteria for audit for Q1 2022. DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 07/08/2022: The Alliance is currently in the process of quarterly delegate audit. Update 09/09/2022: The quarterly delegate audit is in progress and is expected to be completed by October 2022. Update 10/14/2022: The quarterly delegate audit has been completed, there were no findings. This audit will be closed and the findings noted by DHCS will continue to be reviewed during the annual audit.	9/23/2022	Completed	UM		State	DHCS	2020	In Progress

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

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

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

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

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

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#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
10	Prior Authorizations	The Plan did not ensure that all contracting practitioners were aware of the procedures for orthotic items; the Plan provided inaccurate information about authorization requirements for orthotic items	The Alliance's Authorization Grid will be updated to include the accurate information about authorization requirements for orthotics. The updated grid will be uploaded on the website. Update as of 12/5/2019: A meeting will be scheduled the week of 12/9 to discuss changes. Update as of 1/8/2020: Meeting was conducted and PA grid will be updated to reflect corrections. Update as of 2/7/2020. PA grid is being updated for all services requiring PA, so that MDs do not receive repeat communication about changes to the PA grid. Orthotics will be included in the comprehensive update. Update as of 3/5/2020 Prior Auth requirement for Orthotics was added to the PA grid on the Provider Portal	No	3/2/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
11	Appeals	The Plan's appeal notification letters did not comply with contractual regulations. NAR letters were not clear or concise, and contained inaccurate information	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
12	Case Management & Care Coordination - HRAs	The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members. The Plan did not ensure that HRAs were completed within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk, and within 105 calendar days of enrollment for those identified as lower risk.	HRA tracking had been implemented in early 2019, and continues at present. HRAs are sent out within the required timeframes. Robo calls are made to low risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls are made by CM staff on high risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log is kept to ensure that the required timelines are met.	No	9/16/2019	Completed	Case Management		State	DHCS	2019	Completed
13	Case Management & Care Coordination - Initial Health Assessment (IHA)	The Plan did not ensure that all providers documented all required components of an IHA. Preventive services identified as USPSTF "A" and "B" recommended services were not provided, or status of these recommended services was not documented	The QI Department revised its provider medical record request letter to include: all categories that support IHA completion; a hyperlink and/or copy of the SHA/IHEBA form; and sample documentation of a compliant SHA/IHEBA. Providers were re-educated on the SHA/IHEBA requirements.	No	9/30/2019	Completed	Quality		State	DHCS	2019	Completed
14	Complex Case Management (CCM)	2.2.1 The Plan did not implement its monitoring of the CCM program to address member needs. The Plan did not close its CCM cases after 90 days, or present them at Case Rounds as stated in its policy	Existing aging reports are being utilized by the Case Management Department in CCM Rounds to ensure that members' cases are either reviewed and closed, or extended past 90 days.	Yes	10/14/2019	Completed	Case Management	✓	State	DHCS	2019	Completed
15	Access & Availability	3.1.1 The Plan did not maintain an accurate provider directory.	The Plan will continue to verify 10 providers per week and has added the following two processes to continuously maintain an accurate provider directory: 1. Provider Data Comparison to manually review provider data received from our delegates started September 2019 and 2. Provider Data Validation Yearly Project to review directly contracted providers who appear in the Provider Directory. In addition, the Provider Relations Department includes a Provider Demographic form in all provider quarterly packets and work with providers to obtain the completed forms during provider visits.	Yes	11/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
16	Emerg Family Planning Claims/SSS	The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-For-Service rate. The Plan's claim system misclassified non-contracted family services as non-billable. The Plan is required to pay all covered family planning services regardless if these services are contracted with the Plan.	This finding is specific to one provider based on the list of services identified in the contract. No other provider was impacted by this issue. The claims system has been re-configured to reimburse services as follows: * services listed in the provider contract will be reimbursed at the contracted rate * covered Medi-Cal services not listed in the contract will be reimbursed at 100% of the prevailing Medi-Cal rate	No	9/5/2019	Completed	Claims	✓	State	DHCS	2019	Completed
17	Emerge Family Planning Claims	The Plan did not inform members of the correct minor consent provision for family planning services in its Evidence of Coverage (EOC).	The Plan has updated its 2020 EOC to include the appropriate minor consent provisions. The EOC was submitted to DHCS for review and approval on 10/7/2019.	No	10/7/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
18	Access to Pharm Services	The Plan did not monitor the provision of drugs prescribed in emergency situations.	The Pharmacy Department is working with the PBM to create routine monitoring reports of drugs prescribed in emergency situations. Update as of 1/8/20: Internal meeting was conducted to ensure requirements are clear and next steps for updating policy and monitoring reports. Update as of 2/11/2020: Draft P&P and monitoring log have been created and are under review. Update as of 4/10/2020: The P&P and monitoring log were approved at the most recent P&T Committee meeting.	Yes	3/17/2020	Completed	Pharmacy	✓	State	DHCS	2019	Completed
19	Grievances	4.1.1 The Plan did not document review and final resolution of clinical grievances by a qualified health care professional	The G&A workflow for Quality of Care review was updated and implemented on 4/15/2019 to include the CMOs review and final resolution.	Yes	4/15/2019	Completed	G&A	✓	State	DHCS	2019	Completed
20	Grievances	4.1.2 The Plan's grievance system did not capture all complaints and expressions of dissatisfaction reported by members.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training was conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
21	Grievances	The Plan's grievance system did not capture all complaints and expressions of dissatisfaction filed through Plan providers.	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. Clinics will be trained by the delegate to ensure that the Alliance is capturing all complaints. Update as of 1/8/2020: Medical group provided training sign in sheet. The delegate is working on next steps of educating providers. Update as of 2/7/2020: the delegate provided an attestation to complete its provider training by the end of Q1 2020. Update as of 4/10/2020: Meeting medical group week of 4/6 to discuss implementation. Update as of 4/20/2020: Process for forwarding complaints received by medical group has been implemented as of 4/20/2020.	Yes	~~3/31/2020~~ 5/1/2020	Completed	G&A/Provider Services/ Compliance	✓	State	DHCS	2019	Completed
22	Grievances	4.1.4 The Plan sent member resolution letters without completely resolving all complaints.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training was conducted on 11/14/2019.	Yes	11/22/2019	Completed	G&A		State	DHCS	2019	Completed

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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

DASHBOARD KEY

Internal CAP Status Performance Measures	
Indicator	**Criteria**
Green	CAP responses have been completed and fully address the findings

Notes
1) **Potential Self-Identified findings** are developed by the Alliance from regulatory agency feedback or self identification of a deficiency found. They are monitored internally by the Alliance.
2) **State Audit Findings** have been issued by the regulatory agencies in a audit report that requires a corrective action.
3) **Compliance Internal Audit** is conducted as the last step once the item has been fully resolved and all actions have been completed.

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

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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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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

Q1 2024 - PRESENT APL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
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	Me Ca Ma a e Ca e P a 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.

#	Regulatory Agency	APL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
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.
24	DMHC	24-014	7/8/2024	Guidance Regarding Dental Rate Review Reporting Requirements	N/A	Assembly Bill 1048 (Wicks, 2023) added section 1385.14 to the California Health and Safety Code. Section 1385.14 requires health plans offering a specialized health care service plan contract covering dental services to file premium rate information and information regarding the methodology, factors, and assumptions used to determine rates with the Department of Managed Health Care (DMHC) annually and at least 120 days before implementing any change in the methodology, factors, or assumptions that would affect rates. This All Plan Letter (APL) provides guidance on dental rate review filing requirements.
25	DMHC	24-015	7/22/2024	High Deductible Health Plan Products and Coverage of COVID-19 Testing	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-015 which addresses coverage of COVID-19 tests delivered to enrollees in high deductible health plan (HDHP) products.
26	DMHC	24-016	7/25/2024	Request for Health Plan Contact Information	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-016 to request that all health care service plans (health plans) provide the Department with updated health plan contact information.
27	DMHC	24-017	7/31/2024	RY 2025 MY 2024 Provider Appointment Availability Survey NPMH Provider Follow-Up Appointment Rate of Compliance	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues APL 24-017 (OPM) – RY 2025/MY 2024 Provider Appointment Availability Survey NPMH Provider Follow-Up Appointment Rate of Compliance.
28	DMHC	24-018	8/15/2024	Compliance with Senate Bill 923	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues All Plan Letter (APL) 24-018 – Compliance with Senate Bill 923 to provide guidance regarding the implementation of SB 923, including filing and compliance requirements for all full-service and certain specialized health care service plans (plan or plans).
29	DHCS	24-009	9/16/2024	Skilled Nursing Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) on the Skilled Nursing Facility (SNF) Long Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of Medi-Cal members to managed care.

#	Regulatory Agency	APL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
30	DHCS	24-010	9/16/2024	Subacute Care Facilities - Long Term Care Benefit Stnadardization and Transition of Members to Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) on the Subacute Care Facility Long Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of Medi-Cal members to managed care.
31	DHCS	24-011	9/16/2024	Intermediate Care Facilities for Individuals with Developmental Disabilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) for the Long-Term Care (LTC) Intermediate Care Facility/Home for Individuals with Developmental Disabilities services provisions of the California Advancing and Innovating Medi-Cal (CalAIM) benefit standardization initiative. This APL contains requirements related to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes.
32	DHCS	24-012	9/17/2024	Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) regarding requirements for Member outreach, education, and assessing Member experience for Non-Specialty Mental Health Services (NSMHS), as required by Senate Bill (SB) 1019 (Gonzalez, Chapter 879, Statutes of 2022).
33	DHCS	24-013	9/18/2024	Managed Care Plan Child Welfare Liaison	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify the intent and objectives of the Medi-Cal managed care plan (MCP) Child Welfare Liaison, formerly referred to as the Foster Care Liaison, as outlined and required by the 2024 MCP Contract (MCP Contract) with the Department of Health Care Services (DHCS). Additionally, this APL provides guidance regarding the requirements and expectations in relation to the role and responsibilities of the MCP Child Welfare Liaison.
34	DHCS	24-014	9/27/2024	Continuity of Care for Medi-Cal Members who are Foster Youth and Former Foster Youth in Single Plan Counties	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) in Single Plan counties with guidance on enhanced continuity of care protections for Foster Youth and Former Foster Youth Medi-Cal members who live in a Single Plan county and are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) to enroll as Members in Medi-Cal managed care.

ALAMEDA Alliance FOR HEALTH

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

Health Care Services

Donna Carey, MD

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

From: **Dr. Donna Carey, Chief Medical Officer**

Date: **October 11th, 2024**

Subject: **Health Care Services Report**

2023 Trilogy Document Summary

Case Management (CM)

- Types of CM: Enhanced Case Management (ECM), Complex Case Management (CCM), Basic Case Management (BCM), Care Coordination, Transitional Care Services (TCS)

- Trilogy documents also include CM teams of Behavioral Health and Long-term Support Services

- Health Risk Assessment (HRA) & HIF/MET Screener
    - Overall 12% HRA completion rate (2% decrease compared to 2022)
    - Increase in HIF/MET screening return rate in Q4 2023

- Case Volumes (open/active)
    - PH Care Coordination: average 434 cases/month
    - BH Care Coordination: average 147 cases/month
    - Disease Management – Asthma: 128 members served
    - Disease Management – Diabetes: 514 members served
    - Complex Case Management: average 34 cases/month
    - Enhanced Case Management: 972 adults & 369 children/youth served
    - Transitional Care Services: average 253 cases/month

- Opportunities incorporated into 2024 Program/Workplan:
    - Incorporate DHCS PHM Key Performance Indicators to workplan:
        - Increase % members enrolled in CCM & ECM
        - Care manager engagement for high-risk members within 7 days post-discharge
    - Expand ECM network providers (to increase access to ECM services)
    - Expand CS services and network providers (to increase access to and availability of CS services)

Utilization Management (UM)

- Authorization Volumes
    - Significant increase in total auth volume (+99,578 compared to 2022)
        - Membership growth, increased utilization with LTC membership
        - System and reporting configuration updates leading to more accurate data capture

- Denial Rates
    - Overall 2.5% (0.7% decrease from 2022)

- Authorization Turn-Around Times (goal = 95%)
    - Inpatient/outpatient: overall 98%, above goal
    - LTC: overall 68%, below goal
    - BH: overall 82%, below goal

- Pharmacy:
    - Outpatient RX: overall 100%, above goal
    - Physician Administered Medications/Injections: overall 99%, above goal

- Over/Under Utilization Measures
    - ER visits: average 525 visits/K
    - Acute Inpatient Hospitalization Readmission Rate: 20.1%

- Opportunities incorporated into 2024 Program/Workplan:
    - Stabilizing team infrastructure
    - Enhanced coordination across internal departments to support Population Health Management and Quality Improvement activities
    - Increased collaboration with external partners to improve over/under utilization

Quality

- MCAS/HEDIS (3 below minimum performance level MPL)
    - Lead Screening, Follow up after an ED visit for Mental illness, Topical Fluoride

- DHCS QI projects
    - Well Child visits for African American Children
    - Follow up after an emergency visit for substance use or mental illness

- Women's Health
    - Above MPL: Screenings: Breast Cancer, Cervical Cancer, Chlamydia, Prenatal/Postpartum Visits

- Initial Health Appointment rates
    - 70% with all completed elements

- Non-utilizer outreach
    - 50% outreach success

- CAHPS
    - Getting Care Quickly (73%) Child; 72.9% (Adult)
    - Getting Needed Care (79.2%) Child; 75.2% (Adult)

- Clinical Safety
    - 9,077 PQIs closed, no significant clinical trends

- Population Health Management (PHM) Program
    - PHM Strategy
    - Community Health Assessment /Community Health Improvement Project (CHA/CHIP)
    - Key Performance Indicators(KPI) Monitoring

- Health Education Program
    - Diabetes Prevention Program, Maternal Mental Health

- Disease Management
    - Asthma, Diabetes, Depression, Hypertension

- Cultural and Linguistic Services
    - Over 57,000 services provided, in 112 languages by 3 vendors
    - Community Advisory Committee
    - Cultural Sensitivity Training – 100% attendance

- Opportunities incorporated into 2024 Program/Workplan
    - Increase HEDIS Rates MY 2024 to meet/exceed minimum performance level (MPLs)
    - Pay for Performance: webinars and joint meetings with delegates/directs
    - Health Equity Incentive Pilot
    - Non/Under Utilization Outreach
    - Increase Initial Health Appointment rates

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

- There was a month-over-month increase in total authorization volume from August to September 2024.

Total Authorization Volume (Medical Services)			
Authorization Type	**July 2024**	**August 2024**	**September 2024**
Inpatient	2,353	2,159	2,277
Outpatient	4,237	4,565	4,367
Long-Term Care	826	710	882
Total	**7,416**	**7,434**	**7,526**

***Source**: #02569_AuthTAT_Summary*

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

Utilization Management: Outpatient

- Anthem CoC volume has reduced to 5-10% of all incoming authorizations at any given time.

- We have successfully transitioned 90% of Anthem DME under CoC to our in-network provider CHME. Final transition will occur at the end of the year when our specific Anthem CoC DME contracts expire.

- 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.

- OP processed a total of 4,367 authorizations in the month of September.

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

Total Outpatient Authorization Volume			
Authorization Status	**July 2024**	**August 2024**	**September 2024**
Approvals	4,107	4,375	4,201
Partial Approvals	6	14	16
Denials	124	176	150
Total	**4,237**	**4,565**	**4,367**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**July 2024**	**August 2024**	**September 2024**
Overall Denial Rate	**2.5%**	**3.1%**	**2.7%**
Denial Rate Excluding Partial Denials	**2.4%**	**2.9%**	**2.5%**
Partial Denial Rate	**0.1%**	**0.1%**	**0.1%**

***Source**: #03690_Executive_Dashboard*

Outpatient Turn Around Time Compliance			
Line of Business	**July 2024**	**August 2024**	**September 2024**
Overall	**100%**	**99%**	**100%**
Medi-Cal	**100%**	**99%**	**100%**
IHSS	**100%**	**100%**	**100%**
Benchmark	*95%*	*95%*	*95%*

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- Total inpatient auth volume increased from 2159 in August to 2277 authorizations processed in September.

- Inpatient overall average LOS decreased from 5.4 in July to 5.1 in August, that corresponded with a decrease in admits per thousand from 52.6 in July to 48.8 in August and days per thousand, 286.5 in July down to 250.9 in August. The trend is consistent among Child, Adult, ACA and SPD categories.

- IP overall denial rate was 3.7% in August, and 2.2% in September.

- IP Auth TAT compliance continues to surpass benchmark, with overall TAT of 98% in August and September.

- IP UM receives ADT feed for automation of Authorization creation from Alameda Health System's, Alta Bates Summit Medical Center, Eden Hospital, Washington Hospital, and St Rose. Authorizations are tasked to clinical reviewers for concurrent review and care coordination needs for discharge to post acute levels of care.IP UM team has, in working with IT, automated the auth request process for these hospitals. This has reduced the administrative burden on the hospital provider side while facilitating real time communication on member admissions. The team continues to pursue ADT feeds at Stanford and UCSF, and is working with IT to increase SNF ADT feeds.

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

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

Total Inpatient Authorization Volume			
Authorization Status	**July 2024**	**August 2024**	**September 2024**
Approvals	2,302	2,120	2,239
Partial Approvals	0	0	0
Denials	51	39	38
Total	**2,353**	**2,159**	**2,277**

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**June 2024**	**July 2024**	**August 2024***
Authorized LOS	**5.9**	**5.4**	**5.1**
Admits/1,000	**50.5**	**52.6**	**48.8**
Days/1,000	**299.2**	**286.5**	**250.9**

*Source: #01034_AuthUtilizationStatistics – *data only available through August 2024*

Inpatient Authorization Denial Rates			
Denial Rate Type	**July 2024**	**August 2024**	**September 2024**
Full Denials Rate	**0.9%**	**1.2%**	**0.8%**
Partial Denials	**1.2%**	**0.8%**	**1.2%**
All Types of Denials Rate	**2.1%**	**2.0%**	**2.1%**

Source: #01292_AllAuthDenialsRates

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

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

Transition of some of the long-term care staff to the new manager was effective 09/30/24. Health Navigator started on 09/16/24.

- LTC census during September 2024 was 2,500 members. This is a decrease of 3 members from July 2024.

- Month to Month, the admissions, days and readmissions are decreasing. From June to August the admissions decreased by 68.75%, the days decreased by 79.57% and the readmissions also decreased by 76.09%. Some of this could be due to a lag in claims data being available, but we are seeing a decrease, overall.

Totals	June 2024	July 2024	August 2024*
Admissions	160	143	50
Days	1,243	1,030	254
Readmissions	46	47	11

*Source: #14236_LTC_Dashboard - *data only available through August 2024*

- 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

- Established internal Long Term Care rounds to discuss members coming into and leaving a long-term care setting.

- Social Workers continue visiting LTC facilities in person, on monthly and quarterly basis depending on census to assist with discharge planning and access to other resources. The team continues referrals to TCS and other internal/external programs to provide wraparound supports to members preparing to discharge from an LTC custodial facility.

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

- Authorization volume had an increase in September by 24.23%, compared to August 2024.

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

Total LTC Authorization Volume			
Authorization Status	**July 2024**	**August 2024**	**September 2024**
Approvals	778	678	834
Partial Approvals	0	0	0
Denials	48	32	48
Total	**826**	**710**	**882**

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

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

Source: #02569_AuthTAT_Summary

Behavioral Health

- In September, Behavioral Health processed 563 authorizations, 465 Care Coordination referrals, and 201 Medi-Cal Mental Health Screenings and maintained a turnaround time performance level above 95%.

Total BH Authorization Volume			
	24-July	**24-Aug**	**24-Sep**
Approvals	552	576	561
Partial Approval	0	0	0
Denials	1	2	2
Total	551	578	563

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
**Goal ≥95%*	**24-July**	**24-Aug**	**24-Sep**
Determination TAT%	95%	99%	96%
Notification TAT%	98%	97%	98%

Source: 14939_BH_AuthTAT

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
**Goal ≥95%*	**24-July**	**24-Aug**	**24-Sep**
Determination TAT%	99%	99%	99%
Notification TAT%	100%	100%	100%

Source: 14939_BH_AuthTAT

Behavioral Health Denial Rates

**Goal ≤ 5%*	BH Denial Rates	
24-July	**24-Aug**	**24-Sep**
0.01%	0.01%	0.01%

Source: 14939_BH_AuthTAT

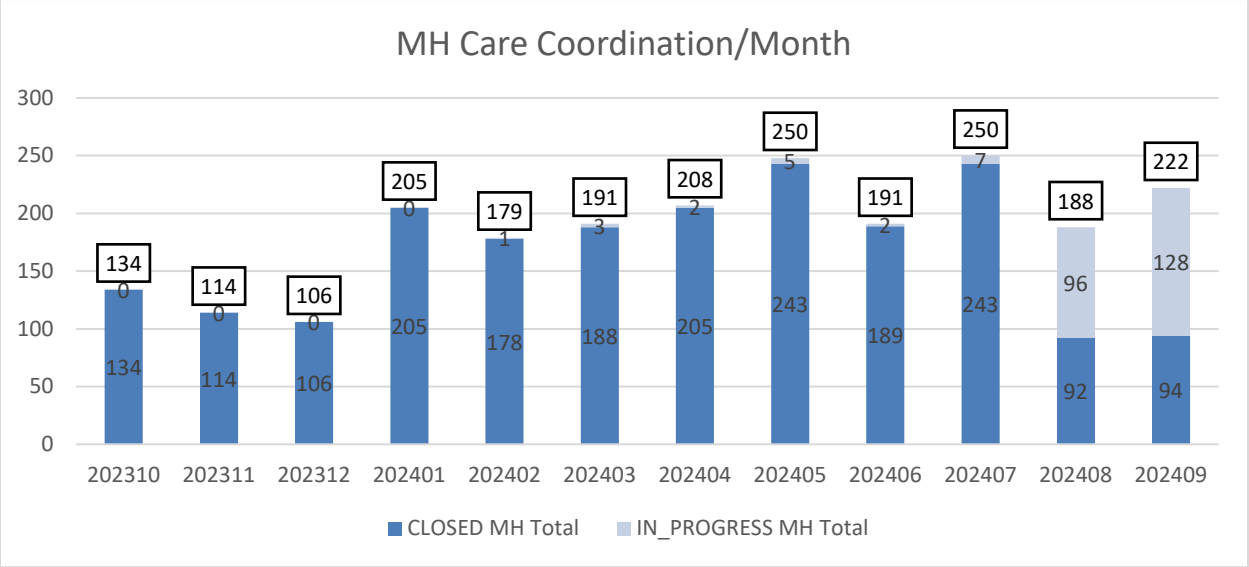
Mental Health Care Coordination

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

Total # Medi-Cal Screening Tools			
	24-July	24-Aug	24-Sep
Youth Screenings	66	59	78
Adults Screenings	160	141	123

Source: PBI_14460 – MLS BH TruCare Assessments

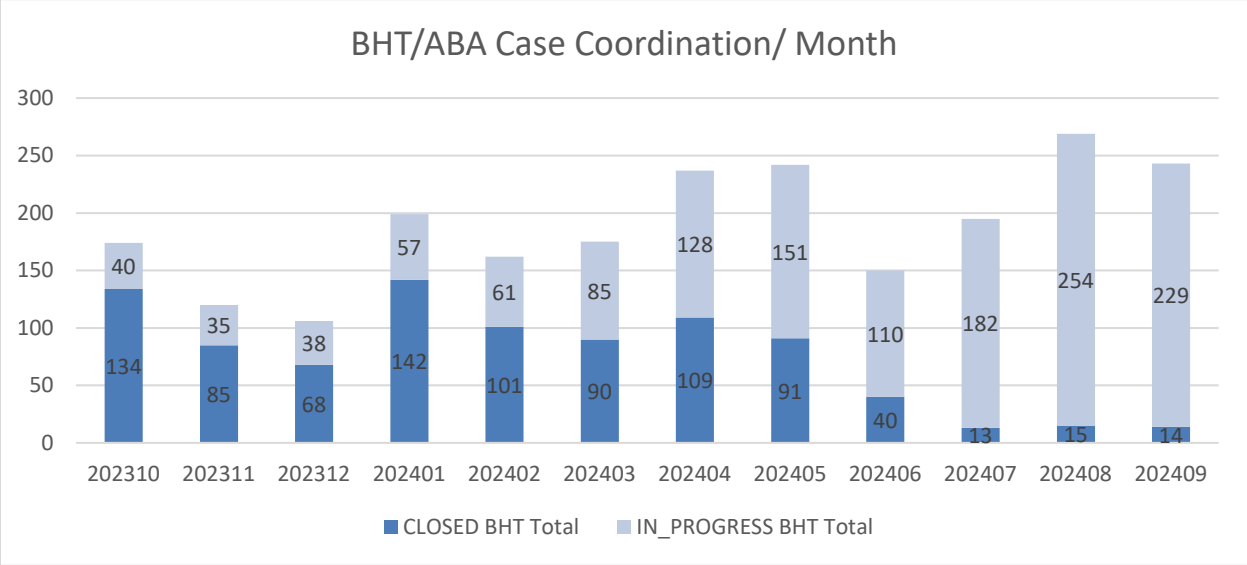
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA)

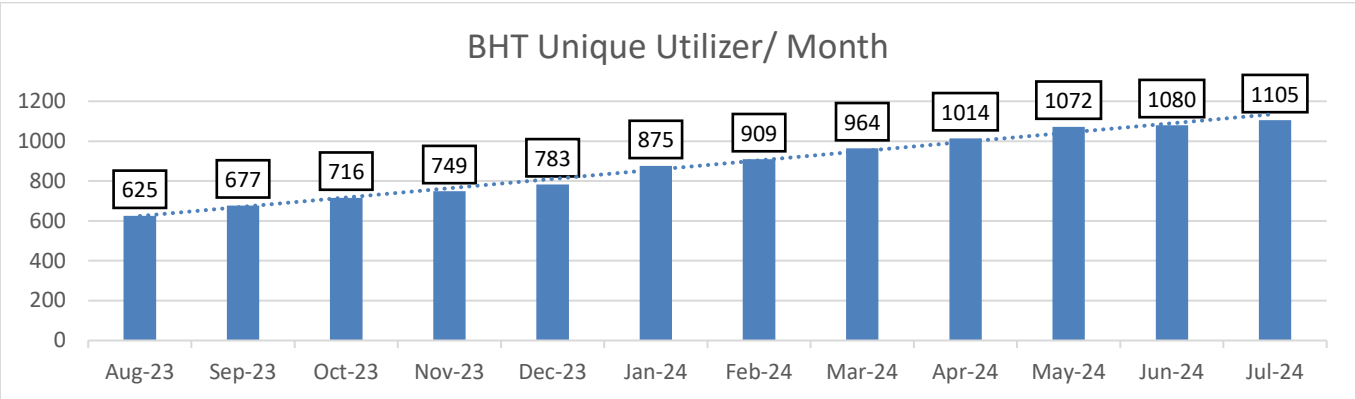
- Children and youth referred for BHT/ABA services including Applied Behavioral Analysis (ABA) and Comprehensive Diagnostic Evaluations (CDE) require Care Coordination to access the services they need. The Alliance manages each child's unique needs and follows up with parents and caregivers to resolve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



Source: 14665_BH_Cases

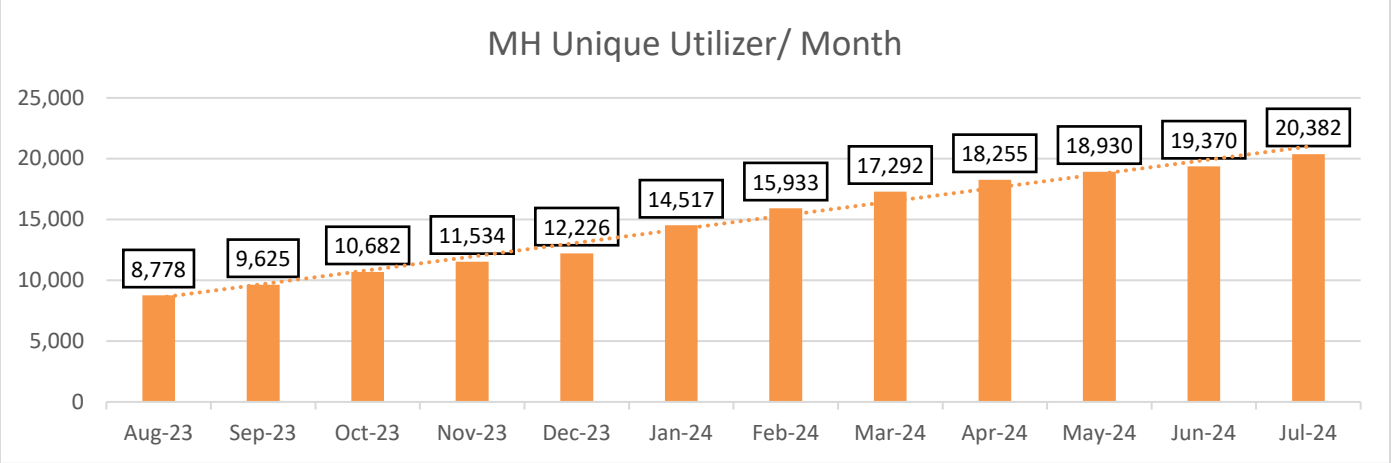
Behavioral Health Therapies (BHT/ABA) Utilization

- Removing barriers to accessing BHT/ABA 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 2% increase from the prior month.



Source: PBI 14621 BHT Utilization Report

- Rise in MH UU, showing a 5% increase from the prior month.



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 Q3, 2024

LOB	Quarterly Number of Outpatient PAs Processed	Quarterly Turn Around Rate Compliance (%)
GroupCare	545	99.82%

Decisions	Number of PAs Processed in September
Approved	39
Denied	57
Closed	74
Total	**170**

- Medications for weight management, nerve pain, eczema, acne, 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	LIDOCAINE EXTERNAL PATCH 5 %	Nerve Pain	Criteria for approval not met
3	ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	Eczema	Criteria for approval not met
4	TRETINOIN EXTERNAL CREAM 0.025 %	Acne	Criteria for approval not met
5	SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG	Diabetes	Criteria for approval not met
6	TRETINOIN EXTERNAL CREAM 0.05 %	Acne	Criteria for approval not met
7	ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 7.5 ML/0.5ML	Weight Management	Criteria for approval not met
8	WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.5ML	Weight Management	Criteria for approval not met
9	TRETINOIN EXTERNAL CREAM 0.1 %	Acne	Criteria for approval not met
10	TACROLIMUS EXTERNAL OINTMENT 0.1 %	Eczema	Criteria for approval not met

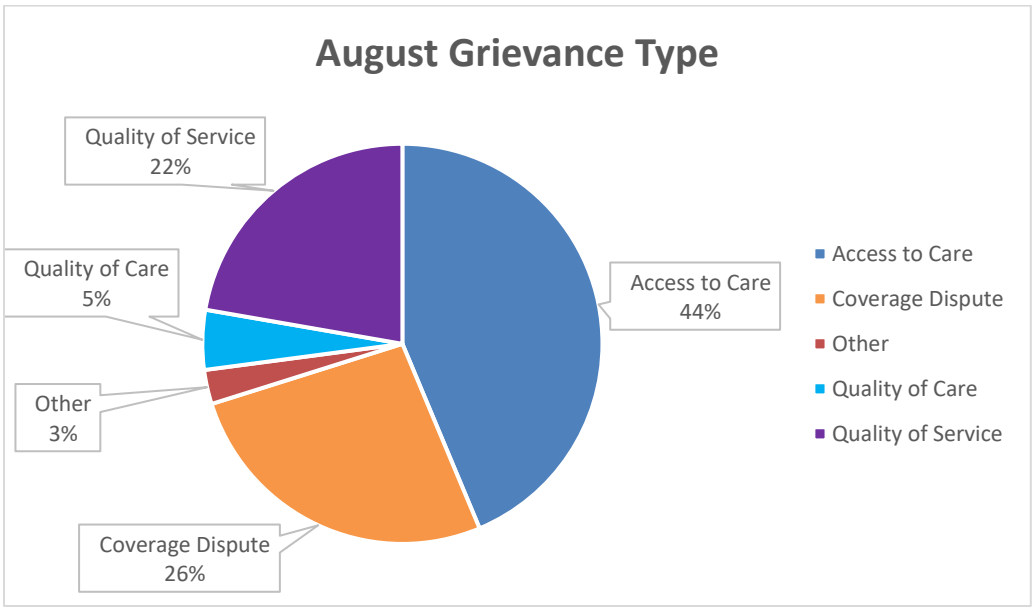
Grievances & Appeals

- All cases were resolved within the goal of 95% of regulatory timeframes.
- Total Unique grievances resolved in September were 7.71 complaints per 1,000 members.

September 2024 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,550	30 Calendar Days	95% compliance within standard	1,548	99.87%	3.31
Expedited Grievance	4	72 Hours	95% compliance within standard	4	100.00%	0.009
Exempt Grievance	1,532	Next Business Day	95% compliance within standard	1,532	100.00%	3.27
Standard Appeal	41	30 Calendar Days	95% compliance within standard	41	100.00%	0.1
Expedited Appeal	3	72 Hours	95% compliance within standard	3	100.00%	0.007
Total Cases:	3,130		95% compliance within standard	3,128	99.93%	6.59

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

Standard Grievances:

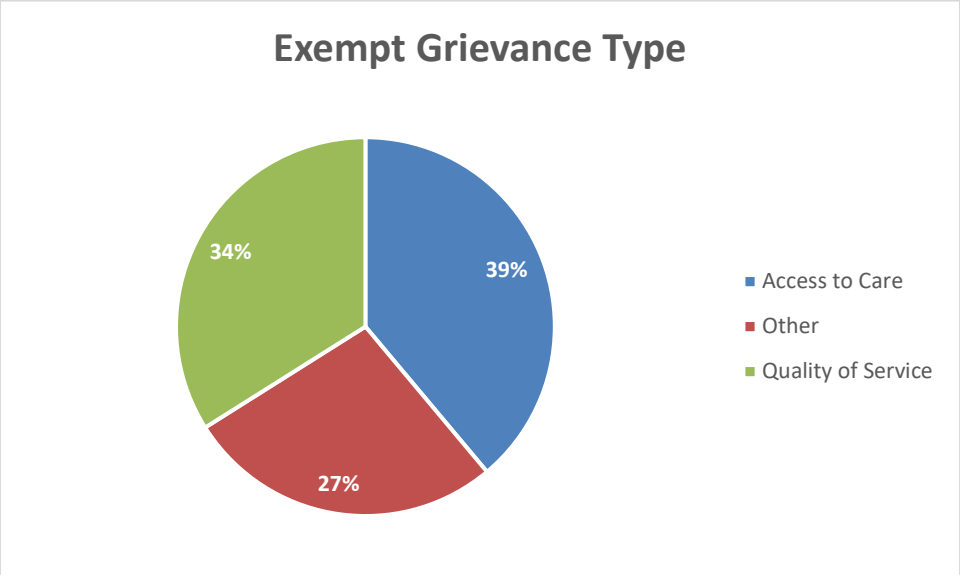


- **679** of 1,554 (44%) cases were related to Access to Care, the top 3 grievance categories are:
  - (251) Timely Access
  - (174) Technology/Telephone
  - (109) Authorization

- **411** of 1,554 (26%) cases were related to Coverage Dispute, the top 2 grievance categories are:
  - (217) Provider Direct Member Billing
  - (124) Provider Balance Billing

- **346** of 1,554 (22%) cases were related to Quality of Service, the top 3 categories are:
  - (93) Plan Customer Service
  - (71) Transportation
  - (52) Provider/Staff Attitude

Exempt Grievances:



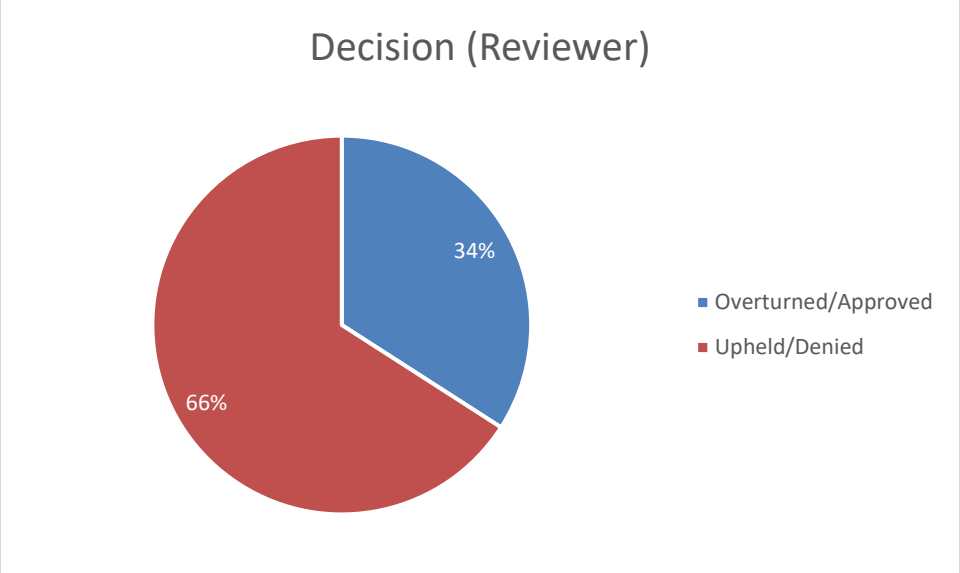
- 596 of 1,532 (39%) cases were related to Access to Care, the top 3 categories were:
  - (453) Telephone/Technology
  - (148) Provider Availability
  - (70) Geographic Access

- 520 of 1,532 (34%) cases were related to Quality of Service, the top 3 categories were:
  - (254) Plan Customer Service
  - (243) Provider/Staff Attitude
  - (14) Transportation

- 416 of 1,532 (27%) cases were related to Other, the top 2 categories were:
  - (393) Enrollment
  - (23) Eligibility

Appeals:

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



- **15** out of 44 (34%) cases were overturned for the month of August 2024:
  - (7) Disputes Involving Medical Necessity
  - (5) Out of Network
  - (3) Coverage Disputes

Quality

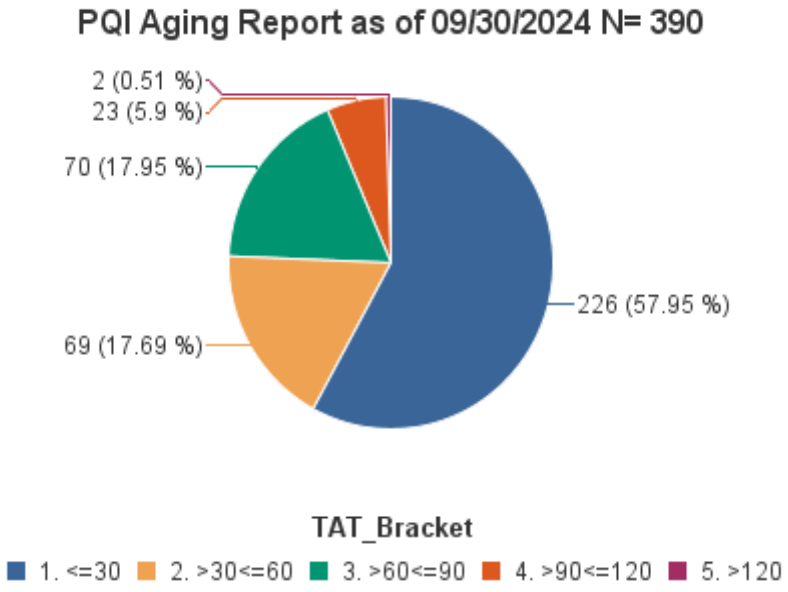
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQI cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

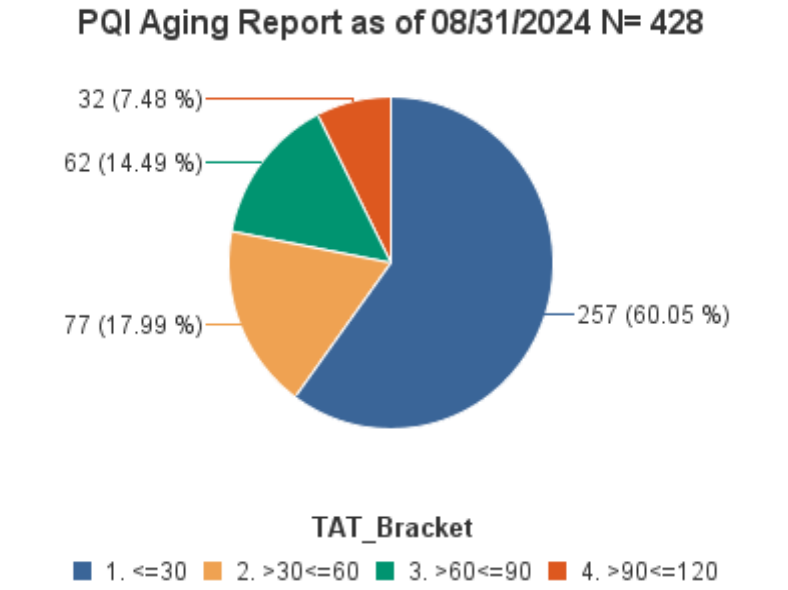
- Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics Services team after they are triaged by the QI Clinical team. Quality of Care and Service issues are reviewed by the QI RN Reviewers. Final leveling for Quality-of-Care cases is determined by the Sr Medical Director of Quality after RN review is completed. Weekly meetings are scheduled for the purpose of Quality-of-Care case review with the Sr Medical Director.

- Zero cases in August and 0.51% cases in September 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.

- The total number of PQIs including all categories decreased by 38 referrals from August to September. TATs are closely monitored on a weekly basis to ensure timely closure of cases within the standard 95%.





- 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.
-
- The Alliance PHM Workgroup meets weekly as a cross-departmental collaborative to develop, implement, and monitor the Alliance PHM Strategy and programs. In the last three months, the PHM Workgroup has:
    - Discussed Community Advisory Committee (CAC) feedback on PHM Strategy goals and use of telehealth.
    - Reported midpoint PHM Strategy progress for goals ending in December.
    - Monitored key performance indicator progress over the first half of 2024.
    - Held a series of meetings to document Alliance perinatal services and identify improvements in care coordination.
    - Discussed Community Health Worker and PHM integration.
    -
- Continued Community Health Assessment and Improvement Plan (CHA/CHIP) collaborations with Local Health Jurisdictions (LHJs) Alameda County Health and City of Berkeley.
    - Completed signed DHCS MCP-LHJ Collaboration Worksheets with both LHJs and Kaiser Permanente on August 1. Worksheet submission was not required.
    - LHJs attended the September 19th CAC meeting and invited CAC member participation in their CHA and/or CHIP processes. Alameda County Public Health Department presented an overview of the CHA/CHIP, and CAC members provided input on CHNA focus group recruitment and the Alameda County CHA/CHIP findings. The City of Berkeley provided instructions on how CAC members could participate in their CHA by completing an online survey.
    - The City of Berkeley revised its shared goal in September. The current goals with the LHJs are:
        - Alameda County
            - **Shared Goal:** Promote access to care and preventative services for pregnant and parenting individuals.
            - **SMART Objective:** Between July 2024 and December 2025, at least 5% of (or approximately 60) Black (African American) Alameda County Medi-Cal members who are identified as pregnant will receive doula services.
        - City of Berkeley
            - **Shared Goal:** Improve access to care for at least one priority population in the City of Berkeley (LGBTQ+, adolescents, older adults, or perinatal residents).
            - **SMART Objective:**
                - By December 2024, Alameda Alliance for Health and Kaiser Permanente will share and analyze data on subpopulations, including racial/ethnic disparities, to inform City of Berkeley’s first formal Community Health Assessment (CHA).

    - By September 2025, City of Berkeley, the Alliance, and Kaiser will identify at least one priority population and measurable opportunities from CHA findings to improve population and client health to be included in the City of Berkeley's Community Health Implementation Plan (CHIP). The Alliance and Kaiser will participate in collaborative and integrated planning with the City of Berkeley for ongoing services to this priority population(s).

- The Alliance will submit a PHM deliverable to DHCS by October 31 reporting on LHJ CHA/CHIP collaborations, other projects related to the Bold Goals, and the NCQA PHM Strategy.

Health Equity

Lao Paul Vang

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

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

Date: **October 11th, 2024**

Subject: **Health Equity Report**

Internal Collaboration –

- **Meetings and check-ins with Division Chiefs Update** –
    - The CHEO meets with the Alliance division chiefs on a 1x1 basis monthly to update on Health Equity (HE) and Diversity, Equity, and Inclusion (DEI) activities.

- **Population Health Management (PHM), Quality Improvement (QI), and Utilization Management (UM) Update** –
    - PHM worked directly with the consultant to ensure the new design of the DEI Training meets APL 23–025.

- **NCQA – Data Collection Meeting**
    - Met to discuss the 2024 Health Equity Standards and Guidelines for Surveys.
    - Discussed collection of data on race/Ethnicity and data on language

- **Strategic Collaboration with Internal Stakeholders to Advance Health Equity**
    - Strategic value-add partnerships, namely PHM, QI, specifically Women's Health, where health disparity was observed among selected ethnic minorities. Specific data analysis has been mapped out for potential collaboration to address targeted health disparity.
    - Exploratory discussions with HCS, specifically LTCS, ECM, and CS teams, to streamline and consolidate resources to promote health equity.
    - Formulate potential collaborations with the Housing and Community Services Program, which has embedded SDOH services.

- **Partnership with HR-DEI and PHM to work with contracted vendor Elevated Diversity**
    - Completed the curriculum development of APL-23-025. DEI-HE Training and DHCS submission due in Dec 2024

Collaboration with Integrated Planning to implement APL-SB923 TGI

- A comprehensive work plan is set in motion with IP team to implement the APLs (DHCS and DHMC) for the Transgender, Gender Diverse or Intersex (TGI) cultural competency program and provider directory in compliance with SB923.

External Collaboration –

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update –**
  - Ongoing discussions regarding health equity related issues and DEI training curriculum.
- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update** –
  - DHCS CHEO and MCPs CHEOs met to collaborate on Health Equity and DEI initiatives.
  - The meeting consisted of DHCS and CHEO Updates and a CAC APL Presentation.
- **Local Initiatives DEI Training Monthly Collaborative Meeting –**
  - The meeting consisted of requesting if there had been any feedback from the DHCS.
  - An update was given on the Health Industry Collaboration Effort (HICE).
- **Debrief pf DHCS–MCP Quality and Health Equity Think Tank (QHETT Meeting)**
  - Quarterly meeting with LHPC Quality Improvement and Health Equity Think Tank to discuss:
    - 1) Community reinvestment policy
    - 2) MCAS sanction policy
    - 3) Auto assignment incentive program
    - 4) Quality withholds incentive program
- **Quarterly Quality Improvement and Health Equity (QIHE) Steering Committee**
  - The CHEO presented an update on Health Equity.
  - Other meeting topics discussed were MCAS Rates for MY23 & 24, 2023 P4P update.
  - The Quality Workgroup gave an update on Chronic Disease

Management.

Advancing Health Equity Initiative (AHEI) –

- **Alliance Strategic Roadmap Update –**
    - Consolidated, verified, and adjusted the report compiled by the Strategic Planning Committee based on prevailing health equity best practices.
    - Currently developing the Alliance Health Equity Roadmap that would include key milestones to address major SDOH faced by our members.
    - Presented the strategic roadmap draft to CHEO for review and consideration.

- **KPI Framework**
    - Began work developing the overarching strategy and approach to crafting metrics and accountability for strategic roadmap recommendations
    - Committee work is slated to begin next month (10/24)

- **DEI Training Curriculum (APL 23–025) Updates –**
    - Delivered the Health Equity staff version course to HR for interim usage
    - Continued work on (3) storyboards as well as began production on the following e-learning modules:
        - Health Equity: Version - staff/vendor
        - Health Equity: Version - provider
        - Cultural Competency: Version - staff/vendor
        - Cultural Competency: Version - provider
        - DEIB: Version - staff/vendor
        - DEIB: Version – provider
    - Incorporated edits requested
    - Developed and presented the APL Audit Tool for client review and consideration

- **Community Engagement –**
    - Establish internal alignment with Communications and Outreach

regarding community events; and identify potential collaboration for future outreach events for 2025.
  - Develop a list of high-value CBOs, including faith-based organizations we could partner with in community outreach events.
  - Plan to visit the Oakland LBGTQ Center in October to further collaborative opportunities that will add value to our members.

- **DEI Training Curriculum Timeline –**

    - October - Final draft,
    - Mid-October - Submission to DHCS for approval.
    - Mid-November - California Cardiovascular Consultants was selected for the provider pilot training process.
    - January 2025 – Launch pilot training process.
    - April – June, completion of pilot training and launch all training to all providers and downstream networks.

- **Communications Update –**

  - Completed a video communication with the CHEO introducing the DEI Training Curriculum.

<u>Diversity, Equity, Inclusion, and Belonging Committee (DEIBC) and Values in Action Committee (VIAC):</u>

- **DEIB Committee Update –**

  - The DEIB Committee met on September 30th, and our special guest was Matt Woodruff.
  - The Committee discussed and asked Matt questions about combining the VIA and DEIB Committees and updating the charter.

- **VIA Committee Update** –

  - The VIA Committee was canceled for September.
  - October 10th is the Fall Fest, and in November, we will report on all the food and fun that took place at the event.

- **LGBTQIA+ Training**

  - The Health Equity Department sponsored two trainings on LGBTQIA+, which received positive feedback.

Information Technology

Sasikumar Karaiyan

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

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

Date: **October 11th, 2024**

Subject: **Information Technology Report**

Call Center System Availability

- In September 2024, AAH phone systems and call center applications maintained 100% availability even as they supported 97% of employees working remotely.

- Call center applications now support English speech to text. Alliance is aiming to extend the system to include Spanish.

Encounter Data

- In the month of September 2024, the Alliance submitted 180 encounter files to the Department of Health Care Services (DHCS) with a total of 393,963 encounters.

Enrollment

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

HealthSuite

- The Alliance received 322,196 claims in the month of September 2024.

- A total of 304,806 claims were finalized during the month out of which 247,723 claims auto adjudicated. This sets the auto-adjudication rate for this period to 81.3%.

- Claims Operational Database (COD) application encountered an outage on September 27th, 2024, which lasted 3 hours. This sets the uptime to 98.21% for the application.

TruCare

- A total of 17,404 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.99%.

IT Security Program

- The IT Security 3.0 initiative ranks among the Alliance's foremost objectives for fiscal year 2025. Our aim is to consistently enhance and advance our security measures, secure our network perimeter against threats and vulnerabilities, and bolster our security policies and procedures.

- To enhance workstation security, Alliance is deploying Microsoft Intune on our workstations and mobile devices. This cloud-based service specializes in mobile device and application management, allowing the Alliance to secure and manage access to corporate data on mobile devices while protecting information. Intune enables device and app management, data protection, and policy compliance.

  The engineering team has finished the core technical setups and is currently concentrating on user testing and documentation. Emails have been dispatched to all staff members, initiating the campaign and rollout plan.

Data Retention Project (Phase 1)

- One of the Alliance major goals for fiscal year 2025 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 scan of the Windows file share (SFTP) is completed with 8.79 million files. Data retention policies are being evaluated. A meeting with stakeholders is planned to review the findings.

- The scan of two domains (Finance and Pharmacy) within data warehouse is in progress. Medical Encounter domain will be initiated early next week. Completion of scanning for all eight domains is estimated to take three weeks.

Information Technology

Supporting Documents

Enrollment

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

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
July	405,914	7,049	7,057	5,711	156	132

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 September 2024

Auto-Assignments	Member Count
Auto-assignments MC	2,068
Auto-assignments Expansion	2,009
Auto-assignments GC	40
PCP Changes (PCP Change Tool) Total	4,117

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of September 2024”.
- There were 17,404 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 September 2024*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,264
Provider Portal Requests (Zipari)	5,360
EDI (CHCN)	5,506
Provider Portal to AAH Online (Long Term Care)	6
ADT	1168
Behavioral Health COC Update - Online	48
Behavioral initial evaluation - Online	48
Manual Entry (all other not automated or faxed vs portal use)	3,004
Total	17404

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 August 2024

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	7,499	5,613	430,253	691
MCAL	116,507	4,012	9,627	1,314
IHSS	3,809	81	224	32
Total	127,815	9,706	440,104	2,037

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

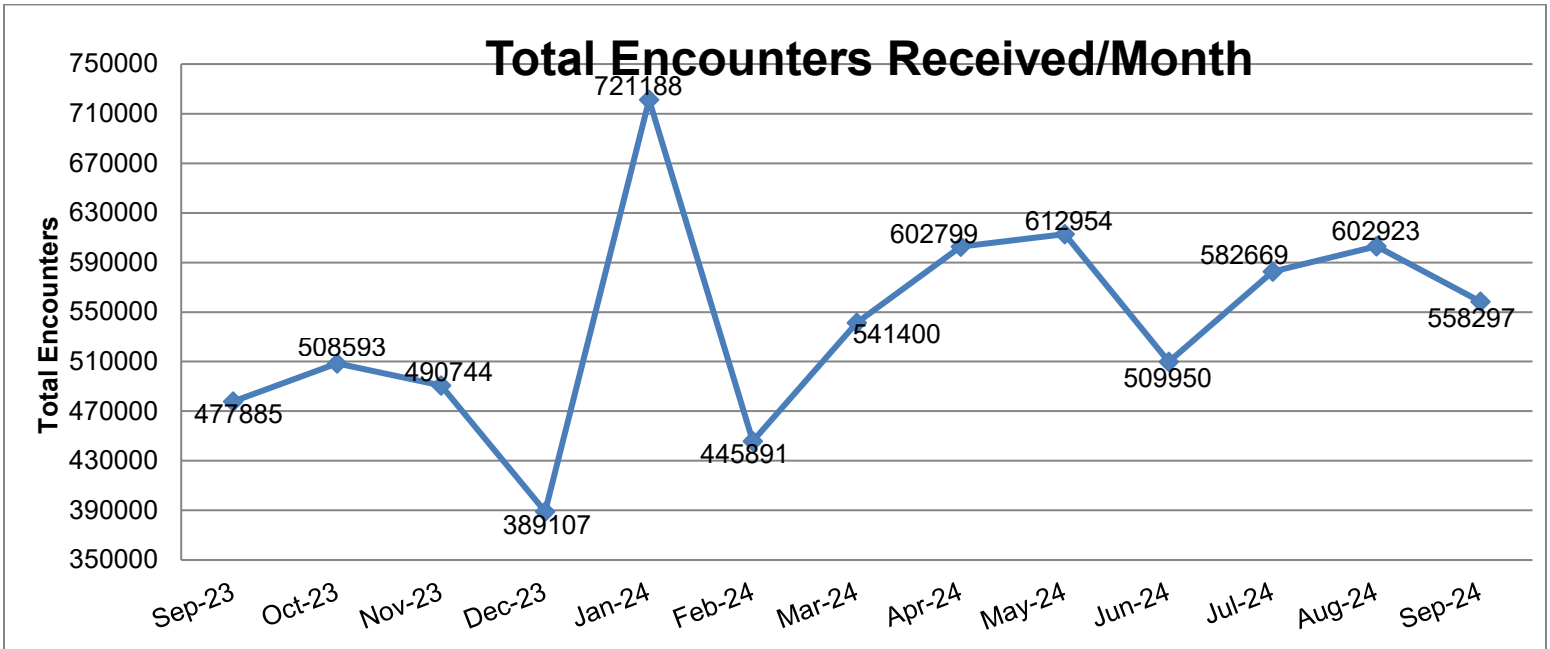
Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1507529
Provider - Claims	Claim Status	250067
Provider - eligibility/claim	Claim Status	28457
Provider - authorizations	Auth Submit	17782
Provider - authorizations	Auth Search	8187
Member My Care	Member Eligibility	5094
Provider - Claims	Submit professional claims	4404
Member Help Resources	Find a Doctor or Hospital	3592
Member Help Resources	ID Card	2969
Member Help Resources	Select or Change Your PCP	2258
Provider - eligibility/claim	Member Roster	1863
Member Home	MC ID Card	1851
Member My Care	My Claims Services	1371
Provider - Provider Directory	Provider Directory 2019	1063
Provider - reports	Reports	897
Member My Care	Authorization	654
Provider - Home	Behavior Health Forms SSO	587
Provider - Home	Forms	518
Member My Care	My Pharmacy Medication Benefits	458
Member Help Resources	FAQs	385
Member My Care	Member Benefits Materials	377
Member Help Resources	Forms Resources	376
Provider - Provider Directory	Manual	306

Encounter Data From Trading Partners 2024

- **AHS**: September weekly files (7,498 records) were received on time.
- **BAC**: September monthly files (85 records) were received on time.
- **CHCN**: September weekly files (135,145 records) were received on time.
- **CHME**: September monthly files (7,680 records) were received on time.
- **CFMG**: September monthly files (16,421 records) were received on time.
- **Docustream**: September monthly files (1,067 records) were received on time.
- **EBI**: September monthly files (3,394 records) were received on time.
- **FULLCIR**: September monthly files (3,809 records) were received on time.
- **HCSA**: September monthly files (3,386 records) were received on time.
- **IOA**: September monthly files (4,227 records) were received on time.
- **Kaiser**: September bi-weekly files (236 records) were received on time.
- **LAFAM**: September monthly files (63 records) were received on time.
- **LIFE**: September monthly files (168 records) were received on time
- **LogistiCare**: September weekly files (16,139 records) were received on time.
- **March Vision**: September monthly files (5,769 records) were received on time.
- **MED**: September monthly files (610 records) were received on time.
- **OMATOCHI**: September monthly files (0 records) were received on time.
- **PAIRTEAM**: September monthly files (9359 records) were received on time.
- **Quest Diagnostics**: September weekly files (18,004 records) were received on time.
- **SENECA**: September monthly files (101 records) were received on time.
- **TITANIUM**: September monthly files (2,815 records) were received on time.
- **TVHC**: September monthly files (125 records) were received on time.
- **Magellan**: September monthly files (407,274 records) were received on time.

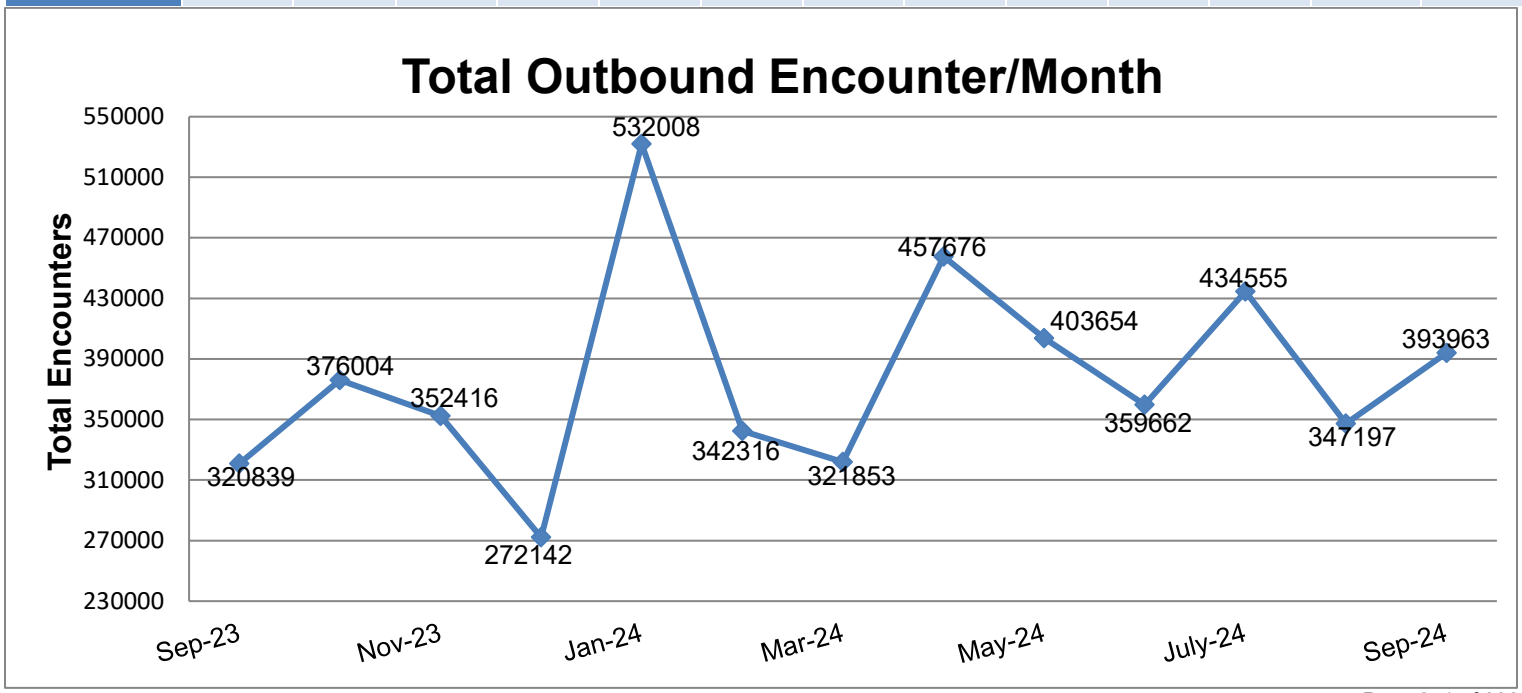
Trading Partner Encounter Inbound Submission History

Trading Partners	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Health Suite	247423	241298	247537	215246	298465	266339	308453	322786	375454	297267	332150	368235	322196
AHS	5479	5371	5243	6284	4570	7736	7005	6573	8412	13316	7296	8859	7498
BAC	38	57	73	55	59	57	55	64	70	77	88	86	85
CHCN	77060	111275	87839	58566	96124	103674	122217	170653	122445	110650	135444	122293	135145
CHME	6212	7609	6445	5694	5843	5560	6022	7969	7107	7449	7242	6902	7680
Claimsnet	12302	12167	11670	18995	12043	10557	12651	16394	15934	21143	10776	22335	16421
Docustream	562	400	705	476	930	814	698	302	1589	749	934	1102	1067
EBI	867	718	823	811	1047	2903	1625	1700	184	2043	1623	1825	3394
FULLCIR		888	598	177	828	1586	213	2261	8478	2842	1362	1798	3809
HCSA	2490	1913	2403	2087	2223	2097	2822	7118	5535	3663	6841	3256	3386
IOA	1086	967	1073	1250	1453	1233	1054	1925	1163	1280	847	752	4227
Kaiser	79751	81985	87005	26208	77407	3725	9966	2286	886	1079	2052	172	236
LAFAM		24				60	39	105	116	86	70	88	63
LIFE										1694		614	168
LogistiCare	22456	25509	20781	32181	182822	20774	35600	32632	27531	16205	43038	29732	16139
March Vision	4933	4427	4428	4562	9693		6183	3633	8546	7092	6404	7719	5769
MED	144	194	523	532	535	742	683	633	722	744	615	608	610
OMATOCHI								29				2	
PAIRTEAM								5344	7582		5763		9359
Quest	17008	13712	13077	15834	27022	17658	22306	18000	18001	22500	18000	22502	18004
SENECA	74	79	56	52	124	222	112	159	113	71	109	129	101
TITANIUM			465	97		154	3696	2233	3086		2015	3914	2815
TVHC													125
Total	477885	508593	490744	389107	721188	445891	541400	602799	612954	509950	582669	602923	558297



Outbound Encounter Submission

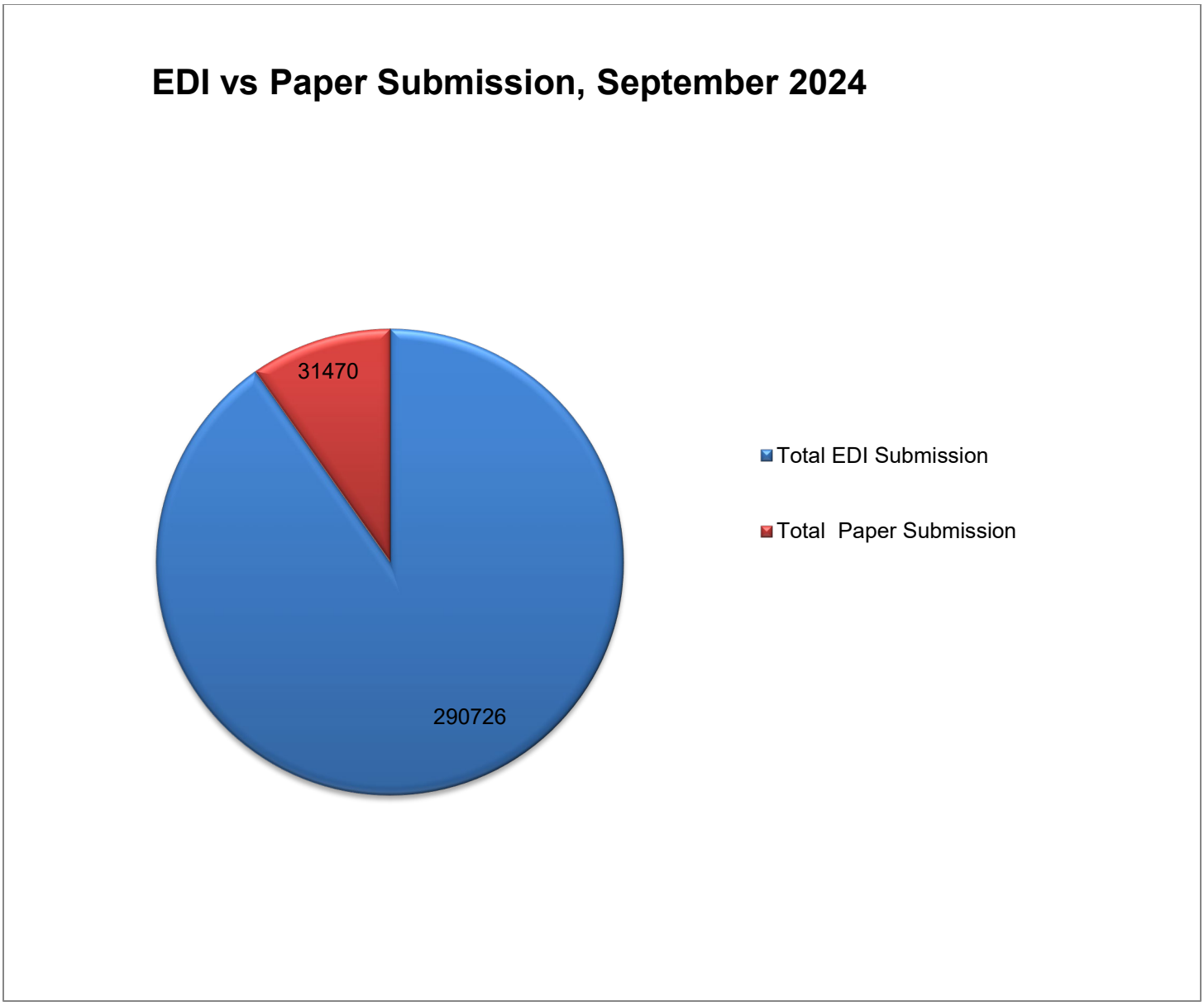
Trading Partners	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Health Suite	127465	163149	134823	136233	172386	177658	147776	250835	198595	204068	230706	183371	210971
AHS	4253	6355	5147	4936	5667	7497	6968	6524	7002	10684	6703	7101	8727
BAC	38	52	67	53	55	55	47	59	66	72	80	80	78
CHCN	55365	62962	73866	39846	67063	74336	80498	104625	107577	77200	94476	87485	87806
CHME	6063	7475	6321	5588	5703	5470	5889	7558	6749	7310	7095	6762	6994
Claimsnet	7075	7452	8031	11581	10145	7730	6757	13467	11561	11506	9994	4	24076
Docustream	441	270	573	404	387	600	377	267	839	570	725	806	715
EBI	855	710	794	802	987	1347	1002	1589	60	1835	1443	1727	3242
FULLCIR		806	516	124	653	540	116	1636	5401	2410	1084	674	1515
HCSA	2349	1876	2342	1991	2142	2013	2769	4710	5363	3493	6757	3171	3310
IOA	984	65	934	1228	1378	1156	1000	1868	1029	1221	749	680	1374
Kaiser	78162	81165	85807	26113	76335	3542	9650	1905	1292	812	1404	113	216
LAFAM		2					16	92	103	58	66	81	58
LIFE										28		598	159
LogistiCare	22142	24497	25951	31546	157548	40529	34931	32247	27487	16221	43019	30006	16046
March Vision	2992	2863	2661	2752	2700	2616	3736	2407	5719	4553	3766	3482	4066
MED	126	145	438	428	446	624	528	518	579	654	552	540	514
OMATOCHI								56					
PAIRTEAM								4279	4422		3246		4617
Quest	12456	16082	3655	8394	28299	16589	16333	20983	16912	16898	20898	16854	16937
SENECA	73	78	52	48	114	14	199	140	109	69	108	127	94
TITANIUM			438	75			3261	1911	2789		1684	3535	2332
TVHC													116
Total	320839	376004	352416	272142	532008	342316	321853	457676	403654	359662	434555	347197	393963



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
24-Sep	290726	31470	322196

Key: EDI – Electronic Data Interchange

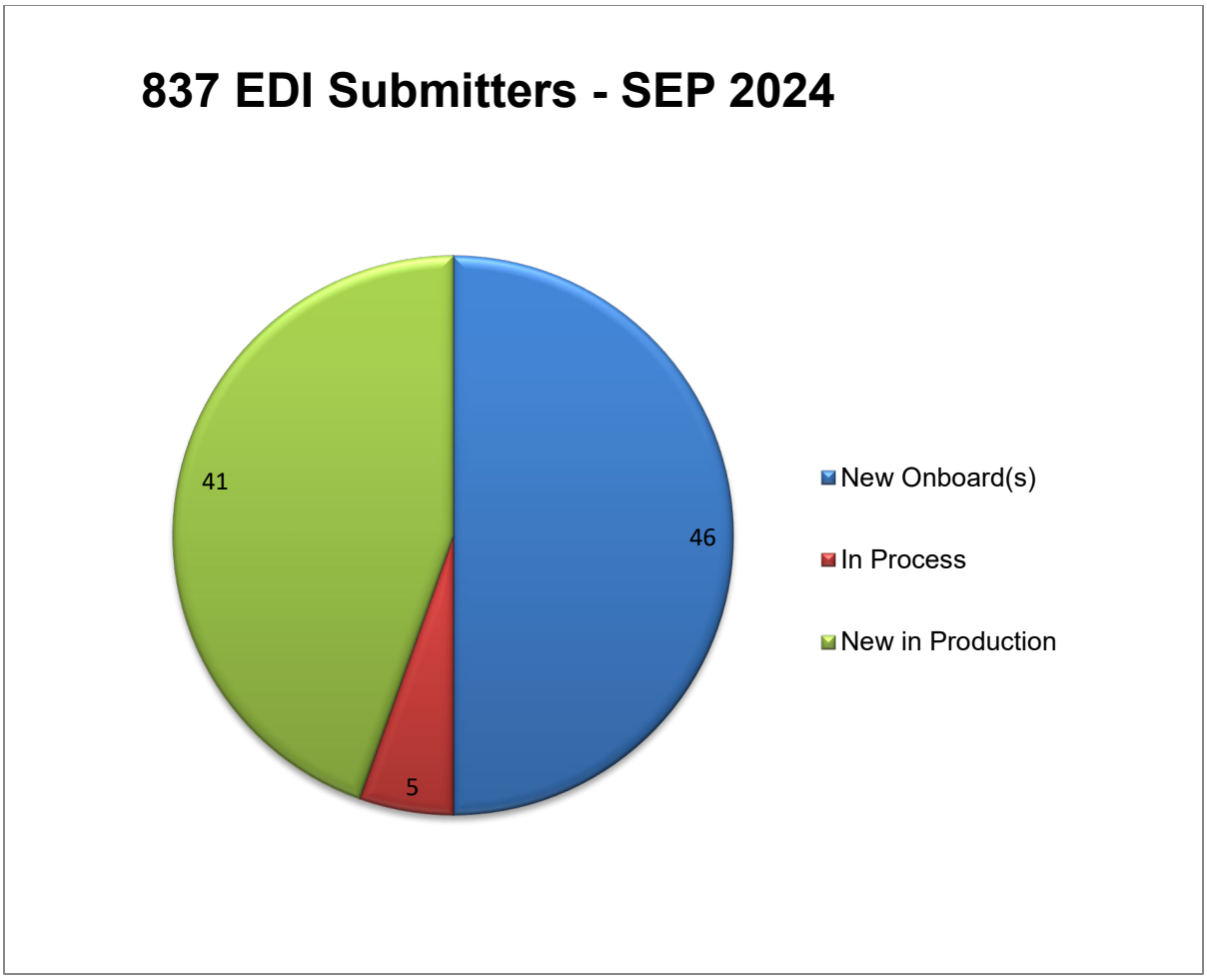


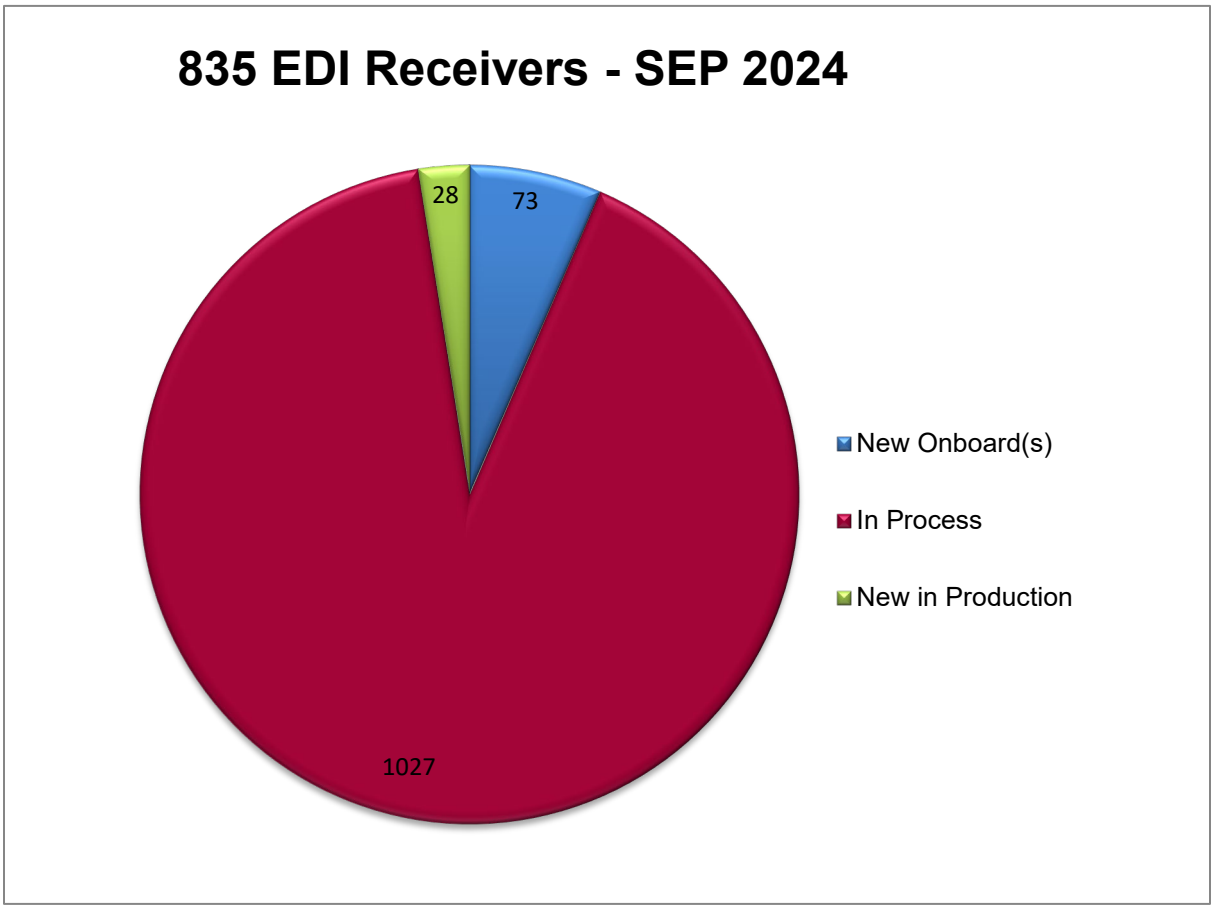
Onboarding EDI Providers – Updates

- SEP 2024 EDI Claims:
  - A total of 2683 new EDI submitters have been added since October 2015, with 41 added in September 2024.
  - The total number of EDI submitters is 3423 providers.

- SEP 2024 EDI Remittances (ERA):
  - A total of 1122 new ERA receivers have been added since October 2015, with 28 added in September 2024.
  - The total number of ERA receivers is 1138 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
Oct-23	36	2	34	2665	21	640	2	837
Nov-23	47	2	45	2710	45	679	6	843
Dec-23	25	2	23	2733	63	716	26	869
Jan-24	63	2	61	2794	76	751	41	910
Feb-24	37	17	20	2814	59	783	27	937
Mar-24	111	25	86	2900	60	822	21	958
Apr-24	120	3	117	3017	83	851	54	1012
May-24	81	13	68	3085	63	874	40	1052
Jun-24	39	4	35	3120	50	908	16	1068
Jul-24	86	3	83	3203	54	937	25	1093
Aug-24	181	2	179	3382	62	982	17	1110
Sep-24	46	5	41	3423	73	1027	28	1138


837 EDI Submitters - SEP 2024
41
46
5
New Onboard(s)
In Process
New in Production


835 EDI Receivers - SEP 2024
28
73
1027
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 **September** 2024.

File Type	Sep-24
837 I Files	37
837 P Files	143
Total Files	180

Lag-time Metrics/Key Performance Indicators (KPI)

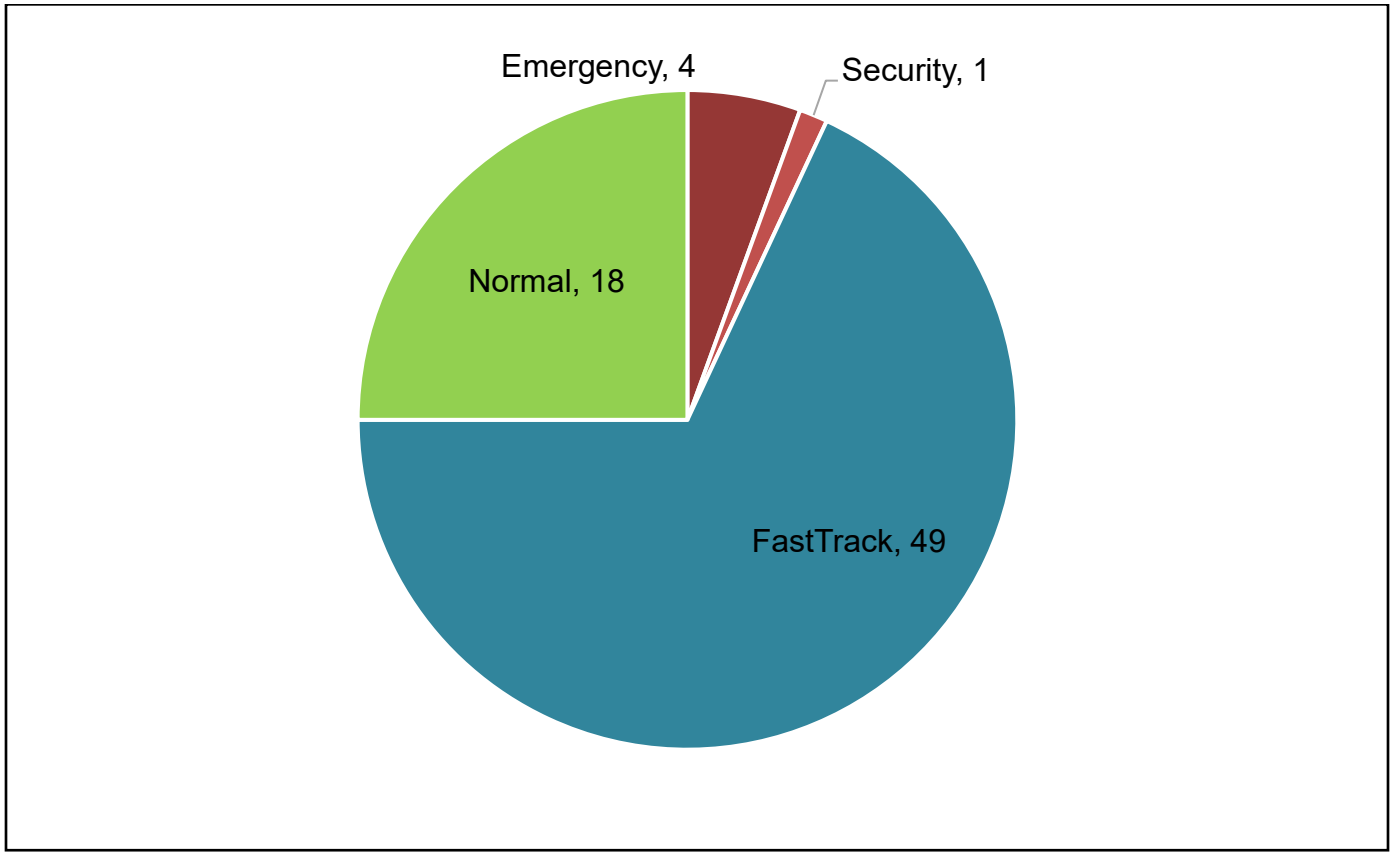
AAH Encounters: Outbound 837	Sep-24	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	92%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	97%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	89%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	97%	80%

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

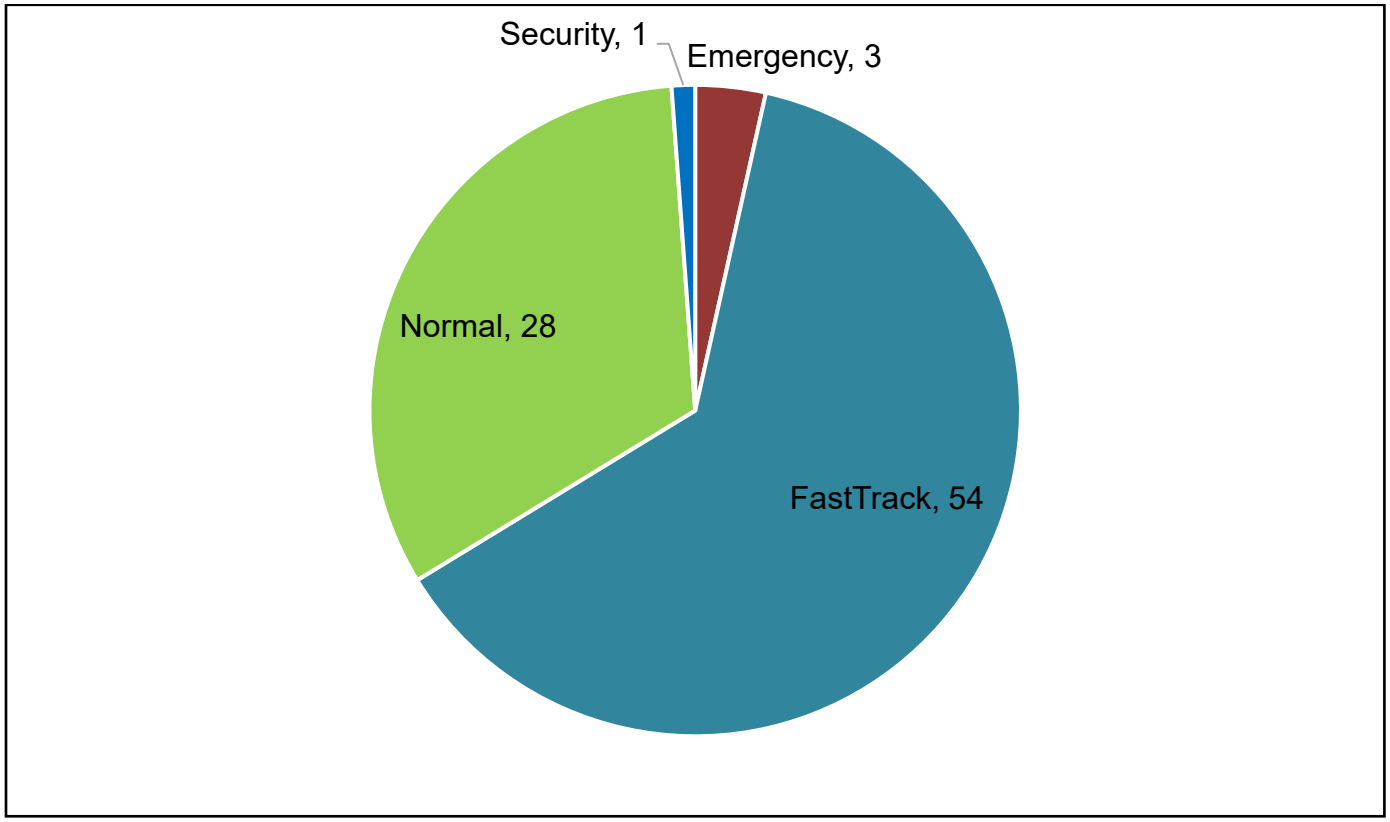
Change Management Key Performance Indicator (KPI)

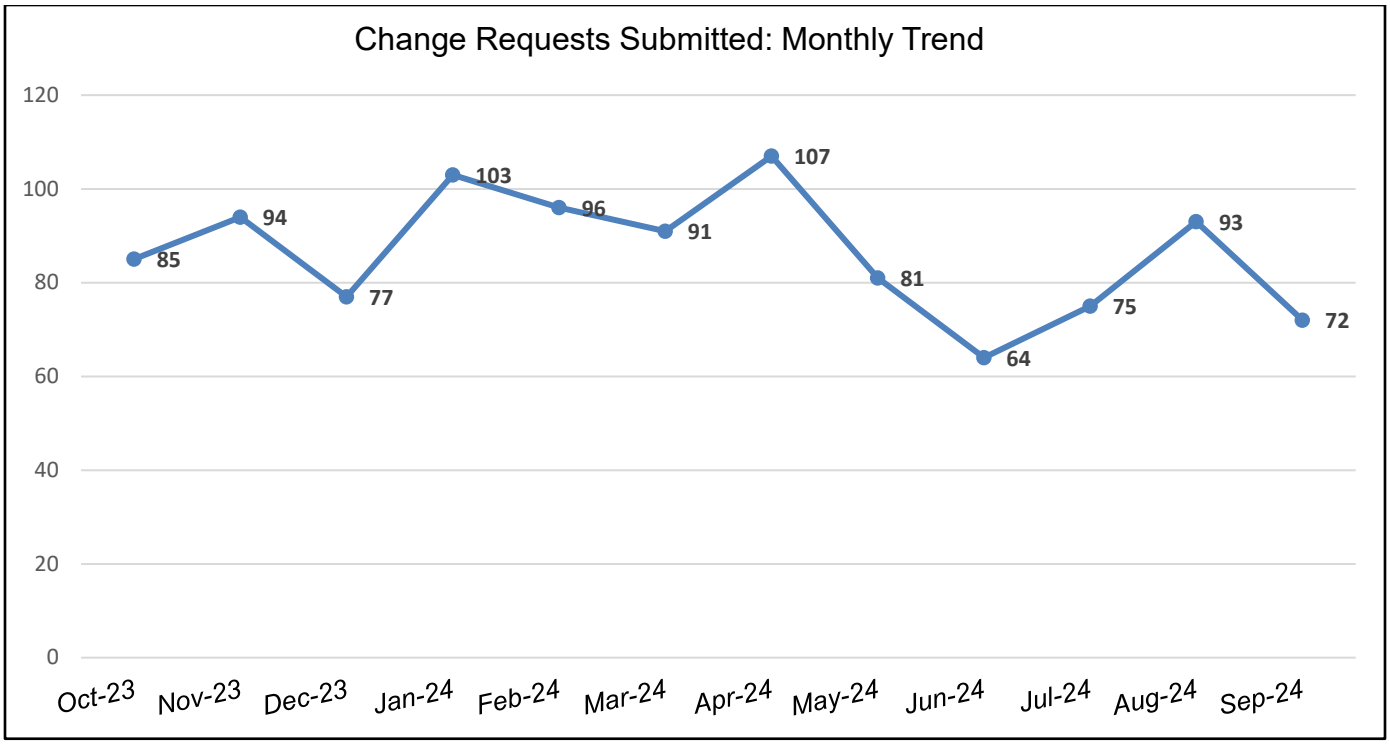
- Change Request Overall Summary in the month of September 2024 KPI:
  - 72 Changes Submitted.
  - 86 Changes Completed and Closed.
  - 107 Active Change Requests in pipeline.
  - 6 Change Requests Cancelled or Rejected.

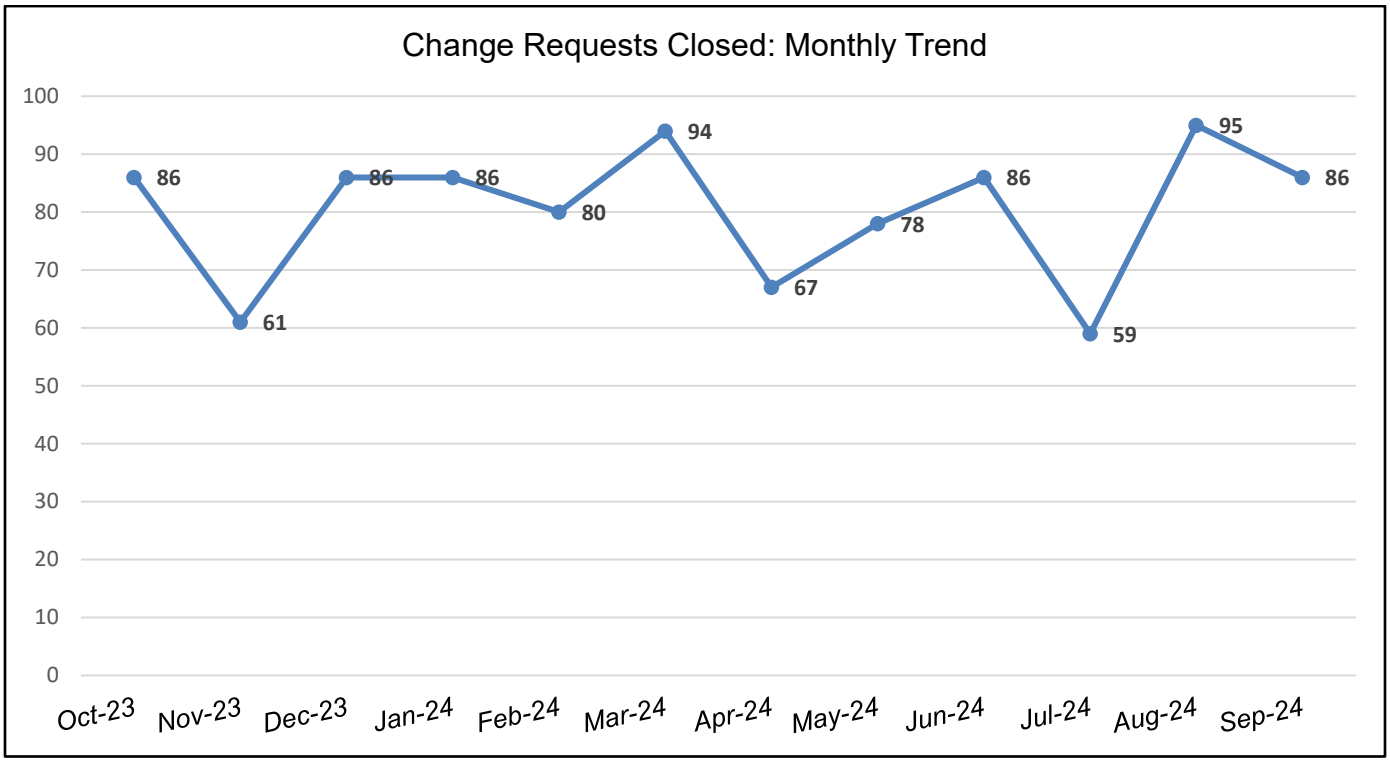
- 72 Change Requests Submitted/Logged in the month of September 2024



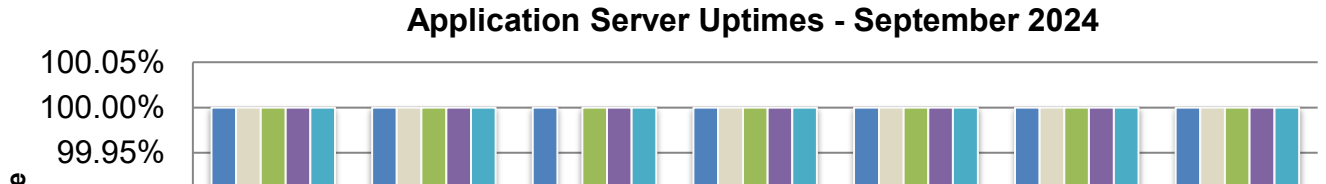
- 86 Change Requests Closed in the month of September 2024




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
85
94
77
103
96
91
107
81
64
75
93
72
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24


Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
86
61
86
86
80
94
67
78
86
59
95
86
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24

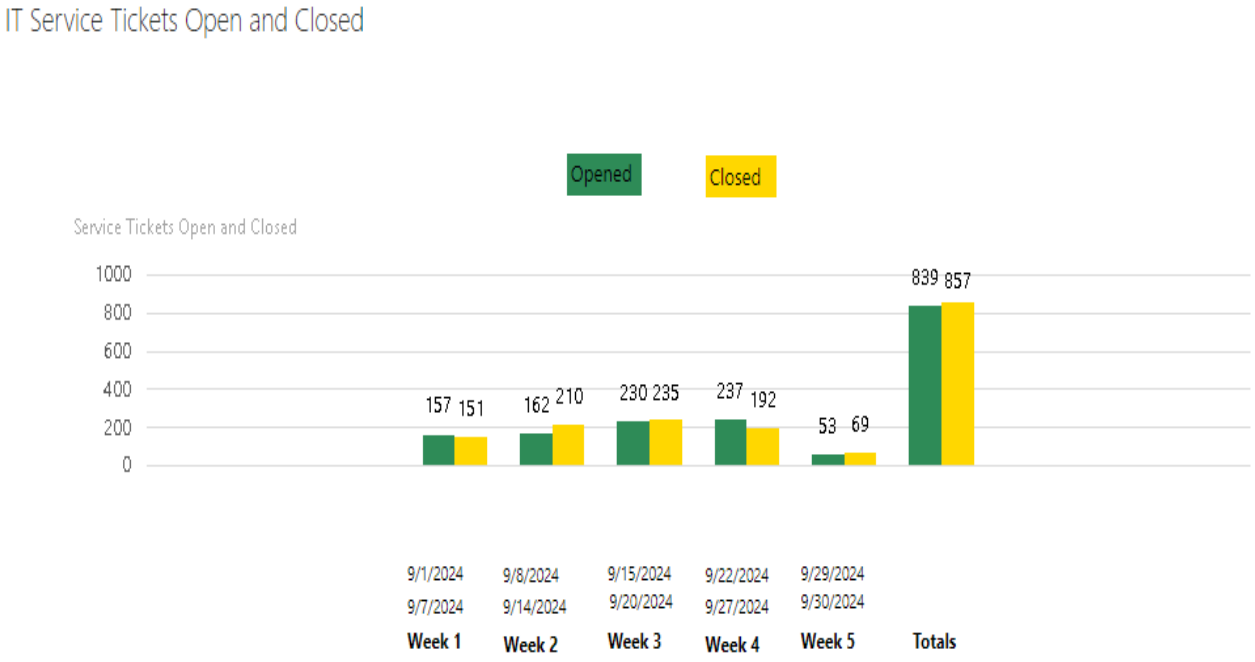
IT Stats: Infrastructure



	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%	99.77%	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.

IT Stats: Service Desk



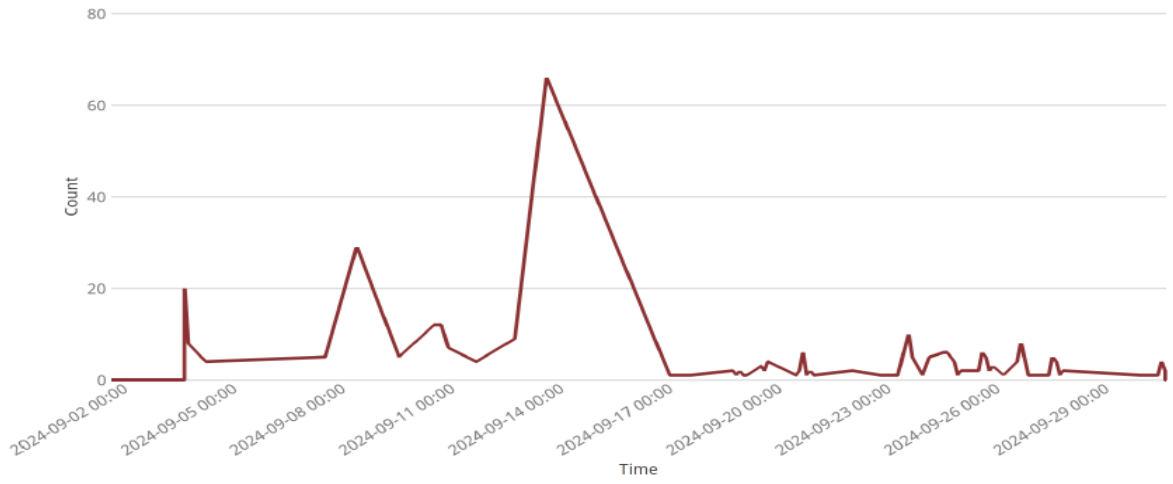
- 839 Service Desk tickets were opened in the month of September 2024, which is 33.17% lower than the previous month (1257) and 23.84% lower than the previous 3-month average of 1,103.

- 857 Service Desk tickets were closed in the month of September 2024, which is 20.35% lower than the previous month (1161) and 19.90% lower than the previous 3-month average of 1,070.

IT Stats: Network

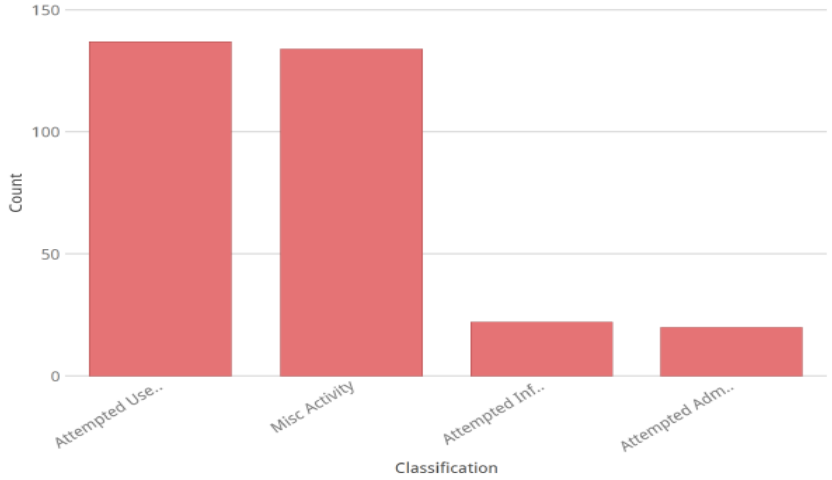
All Intrusion Events

Time Window: *2024-09-01 09:29:00 - 2024-09-30 09:29:00*



Dropped Intrusion Events

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



Classification	Count
Attempted User Privilege Gain	137
Misc Activity	134
Attempted Information Leak	22
Attempted Administrator Privilege Gain	20

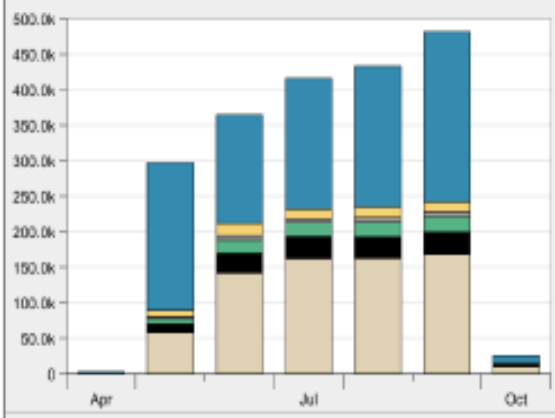
My Email Reports

sma1.hc6375-48.iphmx.com

01 Apr 2024 00:00 to 01 Oct 2024 22:59 (GMT -07:00)

View Data for: Group: Hosted_Cluster
Data in time range: 100.0 % complete

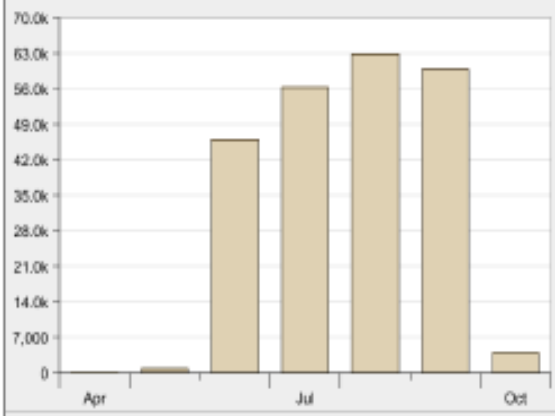
Overview > Incoming Mail Graph



Overview > Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	50.0%	994,814
Stopped by Domain Reputation Filtering	0.0%	413
Stopped as Invalid Recipients	0.0%	837
Spam Detected	3.3%	66,232
Virus Detected	0.0%	12
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	496
Stopped by Content Filter	0.0%	796
Stopped by DMARC	1.5%	29,151
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**53.4%**	**1,063,600**
Marketing Messages	4.5%	89,568
Social Networking Messages	0.2%	3,770
Bulk Messages	6.6%	130,589
Total Graymails:	**11.2%**	**223,927**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	35.3%	703,849
Total Attempted Messages:		**1,991,376**

Overview > Outgoing Mail Graph



Overview > Outgoing Mail Summary

Message Processing	%	Messages
Spam Detected	0.0%	0
Virus Detected	0.0%	6
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	0
Stopped by Content Filter	0.0%	1
Stopped by DLP	0.0%	0
Clean Messages	100.0%	229,608
Total Messages Processed:		**229,615**

Message Delivery	%	Messages
Hard Bounces	3.7%	8,499
Delivered	96.3%	219,317
Total Messages Delivered:		**227,816**

- 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 198.7k.

- Attempted information leaks detected and blocked at the firewall is at 0 for the month of September 2024.

- Network scans returned a value of 0, which is in line with previous month’s data.

- Attempted User Privilege Gain is at 8 from a previous six-month average of 358.

Analytics

Tiffany Cheang

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

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

Date: **October 11th, 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: July 2023 – June 2024 dates of service
Prior reporting period: July 2022 – June 2023 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 8.9% of members account for 88.2% of total costs.
- In comparison, the Prior reporting period was slightly higher at 9.9% 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 54.5% of the members, with SPDs accounting for 21.6% and ACA OE's at 32.9%.
    - The percent of members with costs >= $30K slightly decreased from 2.6% to 2.4%.
    - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.7%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 33.9%.
    - Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
    - However, the age distribution of the top 8.9% is more concentrated in the 45-66 year old category (37.3%) compared to the overall population (20.8%).

Analytics

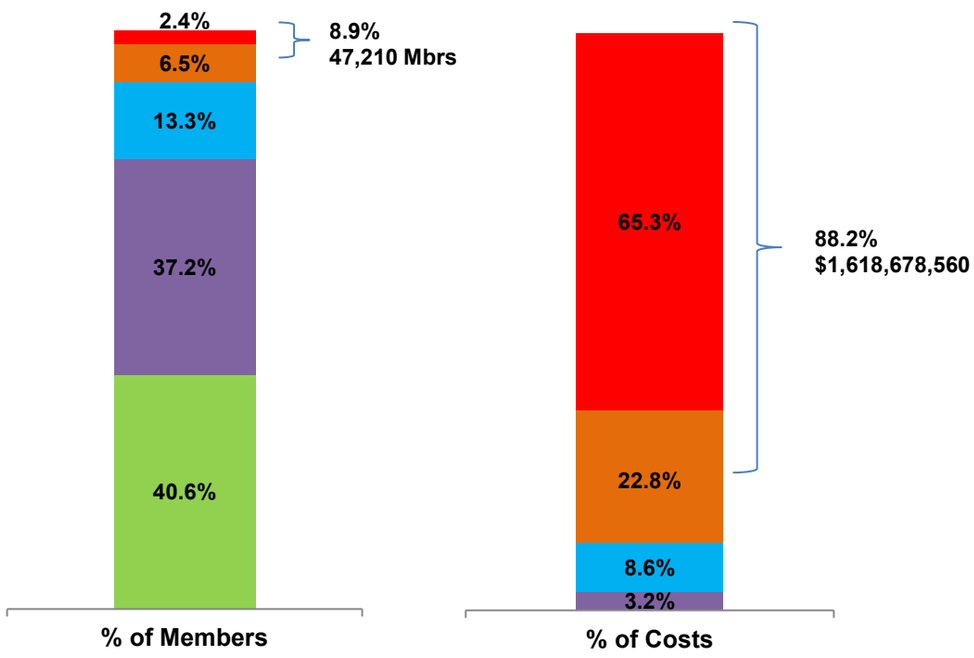
Supporting Documents

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

Note: Data incomplete due to claims lag

Run Date: 09/30/2024

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	12,621	2.4%	$ 1,199,394,777	65.3%
$5K - $30K	34,589	6.5%	$ 419,283,784	22.8%
$1K - $5K	70,752	13.3%	$ 158,224,365	8.6%
< $1K	197,745	37.2%	$ 58,523,522	3.2%
$0	215,808	40.6%	$ -	0.0%
Totals	**531,515**	**100.0%**	**$ 1,835,426,447**	**100.0%**

Top 8.9% of Members = 88.2% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	3,498	0.7%	$ 702,485,533	38.3%
$75K to $100K	1,589	0.3%	$ 138,331,424	7.5%
$50K to $75K	2,960	0.6%	$ 180,430,737	9.8%
$40K to $50K	1,931	0.4%	$ 86,368,271	4.7%
$30K to $40K	2,643	0.5%	$ 91,778,812	5.0%
SubTotal	***12,621***	***2.4%***	***$ 1,199,394,777***	***65.3%***
$20K to $30K	4,896	0.9%	$ 119,189,283	6.5%
$10K to $20K	12,931	2.4%	$ 180,889,312	9.9%
$5K to $10K	16,762	3.2%	$ 119,205,189	6.5%
SubTotal	***34,589***	***6.5%***	***$ 419,283,784***	***22.8%***
Total	**47,210**	***8.9%***	**$ 1,618,678,560**	***88.2%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Jun 2024	404,362	$ 1,640,726,185
Dis-Enrolled During Year	127,153	$ 194,700,263
Totals	**531,515**	**$ 1,835,426,447**

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
8.9% of Members = 88.2% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jul 2023 - Jun 2024
Note: Data incomplete due to claims lag
Run Date: 09/30/2024

8.9% of Members = 88.2% of Costs
21.6% of members are SPDs and account for 27.5% of costs.
32.9% of members are ACA OE and account for 32.0% of costs.
10.1% of members disenrolled as of Jun 2024 and account for 10.8% of costs.

Highest Cost Members; Cost Per Member >= $100K
30.9% of members are SPDs and account for 31.9% of costs.
28.4% of members are ACA OE and account for 33.4% of costs.
9.1% of members disenrolled as of Jun 2024 and account for 9.4% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	169	763	932	2.0%
MCAL	MCAL - ADULT	1,017	6,157	7,174	15.2%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	504	3,086	3,590	7.6%
	MCAL - ACA OE	3,733	11,814	15,547	32.9%
	MCAL - SPD	3,520	6,657	10,177	21.6%
	MCAL - DUALS	907	2,819	3,726	7.9%
	MCAL - LTC	184	9	193	0.4%
	MCAL - LTC-DUAL	1,029	83	1,112	2.4%
Not Eligible	Not Eligible	1,558	3,201	4,759	10.1%
Total		**12,621**	**34,589**	**47,210**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	40	1.1%
MCAL	MCAL - ADULT	227	6.5%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	70	2.0%
	MCAL - ACA OE	995	28.4%
	MCAL - SPD	1,081	30.9%
	MCAL - DUALS	286	8.2%
	MCAL - LTC	109	3.1%
	MCAL - LTC-DUAL	372	10.6%
Not Eligible	Not Eligible	318	9.1%
Total		**3,498**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 13,373,528	$ 8,698,008	$ 22,071,536	1.4%
MCAL	MCAL - ADULT	$ 93,608,293	$ 72,731,165	$ 166,339,459	10.3%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 36,805,600	$ 34,548,422	$ 71,354,021	4.4%
	MCAL - ACA OE	$ 376,669,099	$ 142,056,010	$ 518,725,109	32.0%
	MCAL - SPD	$ 358,032,302	$ 86,295,871	$ 444,328,174	27.5%
	MCAL - DUALS	$ 73,490,652	$ 33,421,763	$ 106,912,415	6.6%
	MCAL - LTC	$ 22,757,777	$ 147,318	$ 22,905,095	1.4%
	MCAL - LTC-DUAL	$ 90,302,850	$ 1,396,834	$ 91,699,684	5.7%
Not Eligible	Not Eligible	$ 134,354,676	$ 39,988,392	$ 174,343,069	10.8%
Total		**$ 1,199,394,777**	**$ 419,283,784**	**$ 1,618,678,560**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 6,811,965	1.0%
MCAL	MCAL - ADULT	$ 52,811,520	7.5%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 16,020,968	2.3%
	MCAL - ACA OE	$ 234,847,573	33.4%
	MCAL - SPD	$ 224,067,036	31.9%
	MCAL - DUALS	$ 37,746,731	5.4%
	MCAL - LTC	$ 18,017,536	2.6%
	MCAL - LTC-DUAL	$ 46,184,791	6.6%
Not Eligible	Not Eligible	$ 65,977,413	9.4%
Total		**$ 702,485,533**	**100.0%**

% of Total Costs By Service Type

Breakout by Service Type/Location

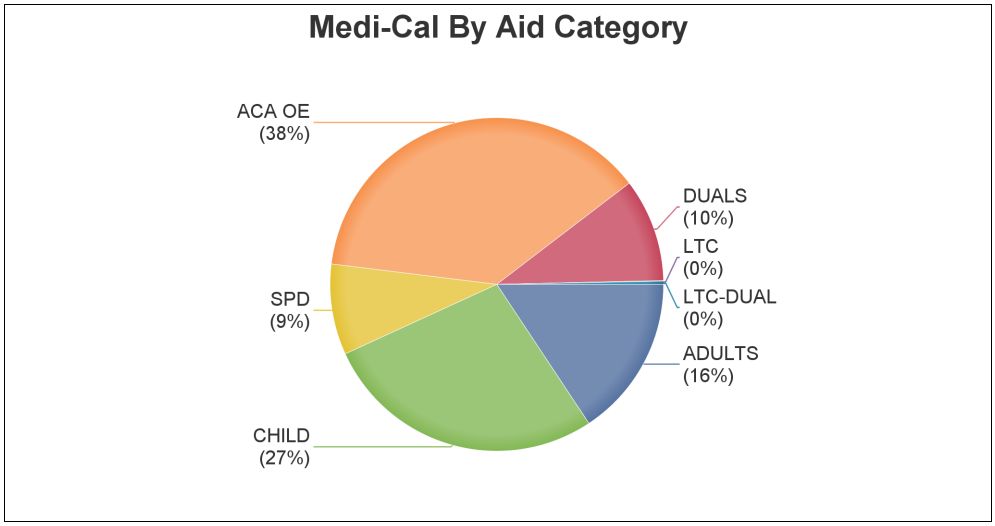
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	6%	0%	1%	15%	41%	1%	11%	3%	2%	27%
$75K to $100K	4%	0%	1%	18%	25%	2%	5%	4%	4%	42%
$50K to $75K	4%	0%	1%	20%	24%	3%	5%	4%	3%	41%
$40K to $50K	5%	0%	1%	30%	27%	6%	5%	6%	1%	25%
$30K to $40K	10%	1%	3%	33%	21%	13%	5%	6%	2%	19%
$20K to $30K	3%	1%	5%	37%	24%	7%	7%	6%	1%	18%
$10K to $20K	0%	0%	11%	35%	25%	6%	9%	9%	2%	15%
$5K to $10K	0%	0%	6%	33%	14%	10%	12%	13%	1%	18%
Total	**5%**	**0%**	**3%**	**23%**	**31%**	**4%**	**9%**	**5%**	**2%**	**27%**

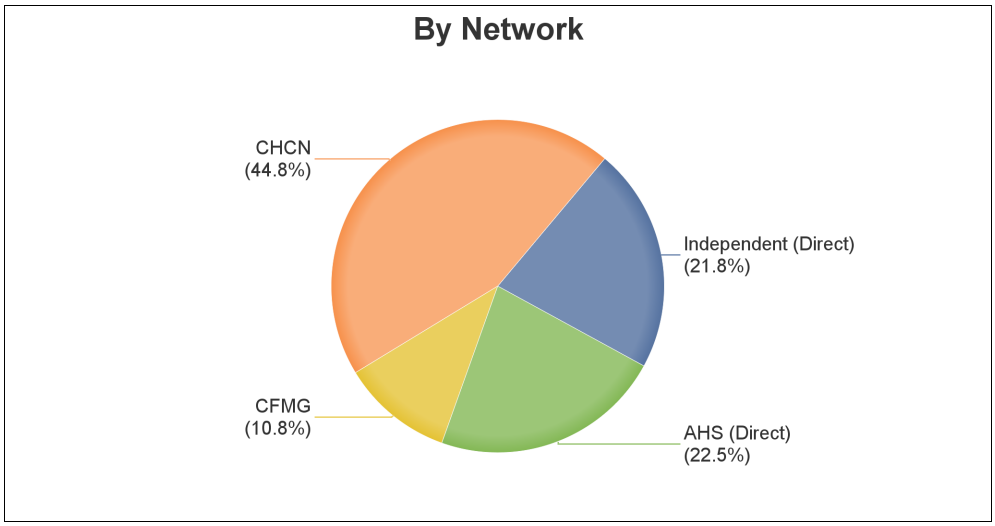
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Aug 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,671	16%	12,681	14,466	5	35,519
CHILD	109,803	27%	8,842	13,705	41,006	46,250
SPD	35,177	9%	11,437	5,581	1,426	16,733
ACA OE	150,482	38%	25,736	53,678	1,516	69,552
DUALS	40,030	10%	26,279	2,841	6	10,904
LTC	226	0%	210	8	0	8
LTC-DUAL	1,247	0%	1,245	0	0	2
Medi-Cal	399,636		86,430	90,279	43,959	178,968
Group Care	5,686		2,120	903	0	2,663
Total	**405,322**	**100%**	**88,550**	**91,182**	**43,959**	**181,631**
Medi-Cal %	98.6%		97.6%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.4%	1.0%	0.0%	1.5%
	Network Distribution		**21.8%**	**22.5%**	**10.8%**	**44.8%**
			% Direct:	**44%**	**% Delegated:**	**56%**

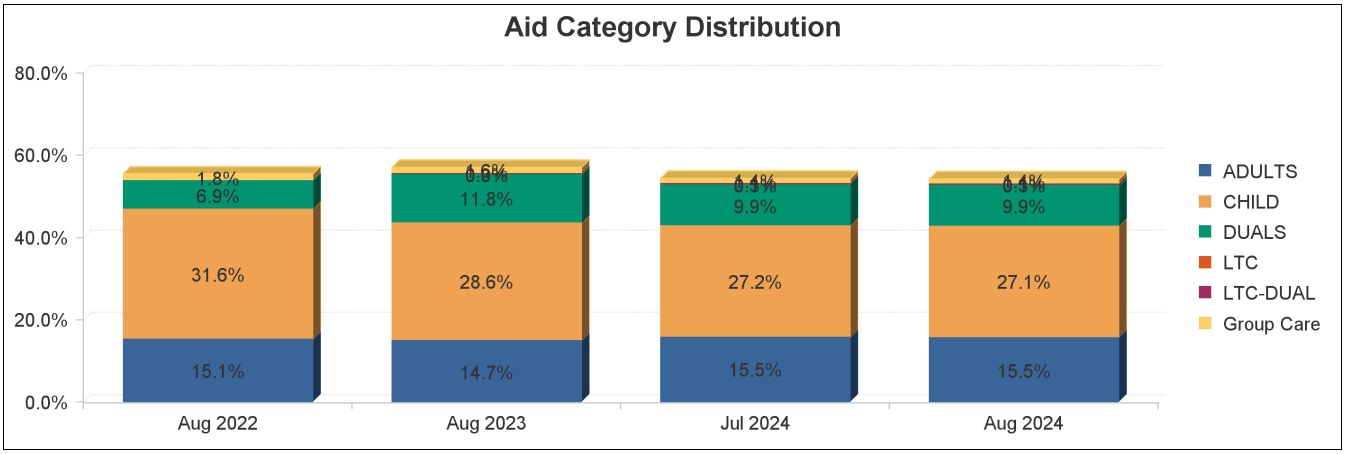




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

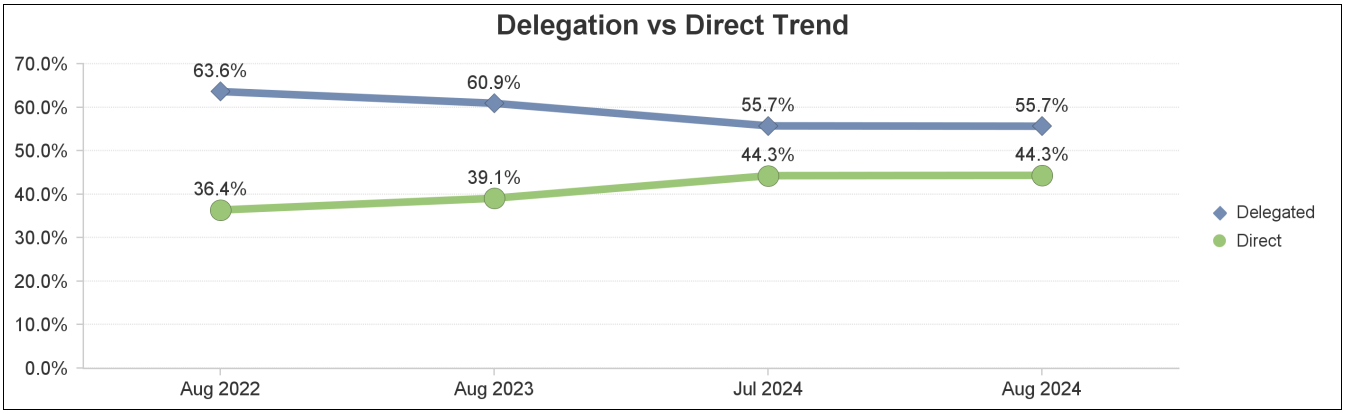
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
ADULTS	48,112	52,176	62,739	**62,671**	15.1%	14.7%	15.5%	15.5%	8.4%	20.1%	-0.1%
CHILD	100,977	101,555	109,962	**109,803**	31.6%	28.6%	27.2%	27.1%	0.6%	8.1%	-0.1%
SPD	28,079	30,864	35,018	**35,177**	8.8%	8.7%	8.7%	8.7%	9.9%	14.0%	0.5%
ACA OE	114,208	121,928	149,801	**150,482**	35.8%	34.3%	37.0%	37.1%	6.8%	23.4%	0.5%
DUALS	22,077	41,722	39,896	**40,030**	6.9%	11.8%	9.9%	9.9%	89.0%	-4.1%	0.3%
LTC	0	138	222	**226**	0.0%	0.0%	0.1%	0.1%	0.0%	63.8%	1.8%
LTC-DUAL	0	1,020	1,241	**1,247**	0.0%	0.3%	0.3%	0.3%	0.0%	22.3%	0.5%
Medi-Cal	313,453	349,403	398,879	**399,636**	98.2%	98.4%	98.6%	98.6%	11.5%	14.4%	0.2%
Group Care	5,803	5,645	5,675	**5,686**	1.8%	1.6%	1.4%	1.4%	-2.7%	0.7%	0.2%
Total	**319,256**	**355,048**	**404,554**	405,322	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.2%**	**14.2%**	**0.2%**



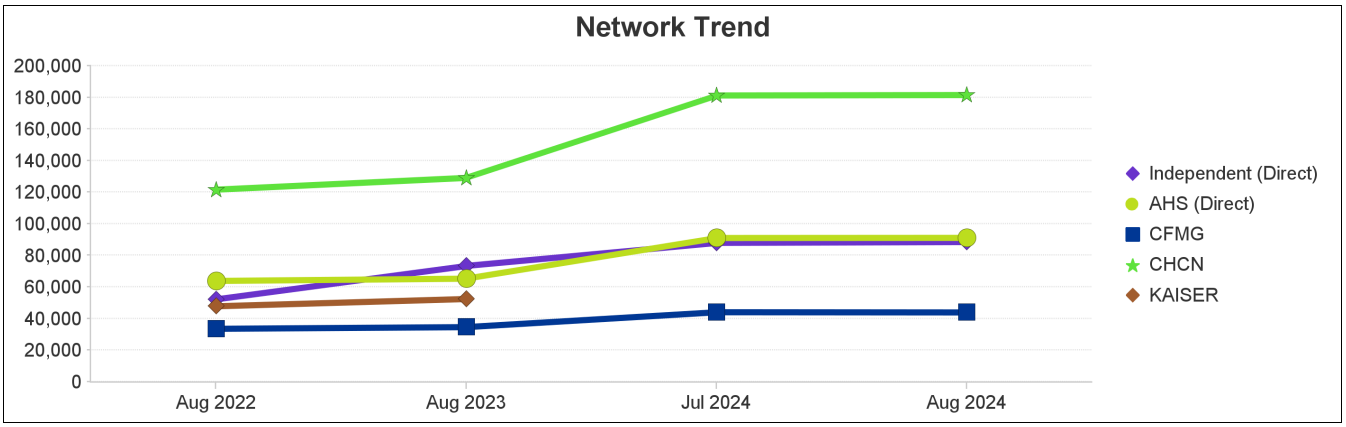
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
Delegated	203,148	216,300	225,445	**225,590**	63.6%	60.9%	55.7%	55.7%	6.5%	4.3%	0.1%
Direct	116,108	138,748	179,109	**179,732**	36.4%	39.1%	44.3%	44.3%	19.5%	29.5%	0.3%
Total	**319,256**	**355,048**	**404,554**	405,322	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.2%**	**14.2%**	**0.2%**



Network Trend

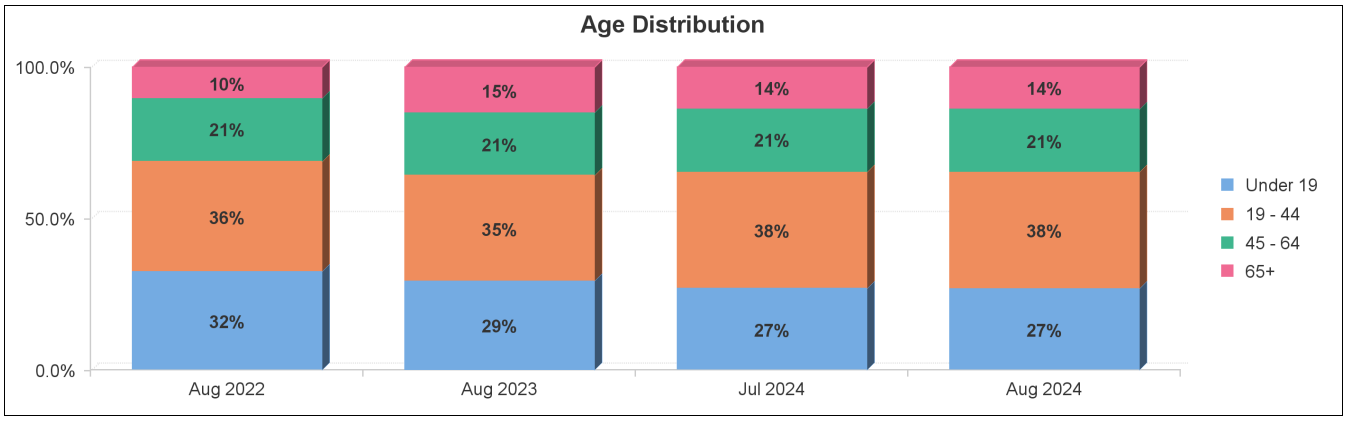
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
Independent (Direct)	52,198	73,404	88,010	**88,550**	16.3%	20.7%	21.8%	21.8%	40.6%	20.6%	0.6%
AHS (Direct)	63,910	65,344	91,099	**91,182**	20.0%	18.4%	22.5%	22.5%	2.2%	39.5%	0.1%
CFMG	33,594	34,649	44,090	**43,959**	10.5%	9.8%	10.9%	10.8%	3.1%	26.9%	-0.3%
CHCN	121,703	129,183	181,355	**181,631**	38.1%	36.4%	44.8%	44.8%	6.1%	40.6%	0.2%
KAISER	47,851	52,468	0	**0**	15.0%	14.8%	0.0%	0.0%	9.6%	-100.0%	0.0%
Total	**319,256**	**355,048**	**404,554**	**405,322**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.2%**	**14.2%**	**0.2%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

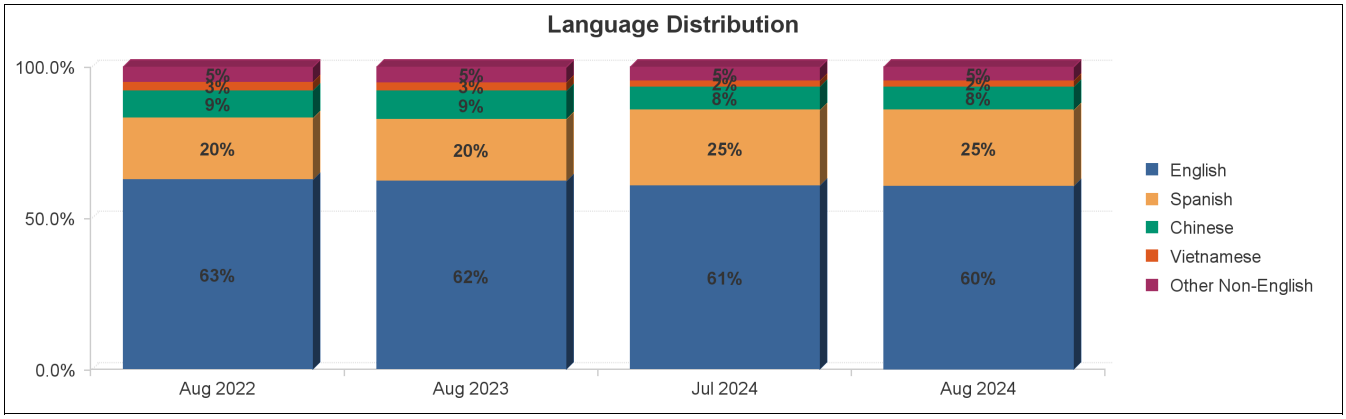
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
Under 19	103,223	103,911	108,451	**108,349**	32%	29%	27%	27%	1%	4%	0%
19 - 44	116,003	123,789	155,339	**155,686**	36%	35%	38%	38%	7%	26%	0%
45 - 64	66,526	73,289	84,037	**84,199**	21%	21%	21%	21%	10%	15%	0%
65+	33,504	54,059	56,727	**57,088**	10%	15%	14%	14%	61%	6%	1%
Total	**319,256**	**355,048**	**404,554**	**405,322**	**100%**	**100%**	**100%**	**100%**	**11%**	**14%**	**0%**



Language Trend

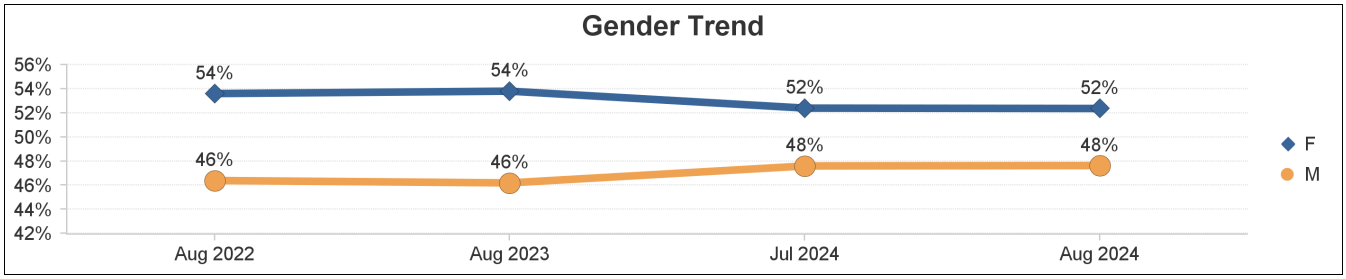
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Aug 2022	Aug 2023	Jul 2024	Aug 2024	ug 2022	ug 2023	Jul 2024	ug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
English	199,798	220,565	245,137	**245,150**	63%	62%	61%	60%	10%	11%	0%
Spanish	64,967	72,596	101,314	**102,034**	20%	20%	25%	25%	12%	41%	1%
Chinese	28,938	33,152	30,651	**30,695**	9%	9%	8%	8%	15%	-7%	0%
Vietnamese	8,869	9,609	8,353	**8,310**	3%	3%	2%	2%	8%	-14%	-1%
Other Non-English	16,684	19,126	19,099	**19,133**	5%	5%	5%	5%	15%	0%	0%
Total	**319,256**	**355,048**	**404,554**	**405,322**	**100%**	**100%**	**100%**	**100%**	**11%**	**14%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

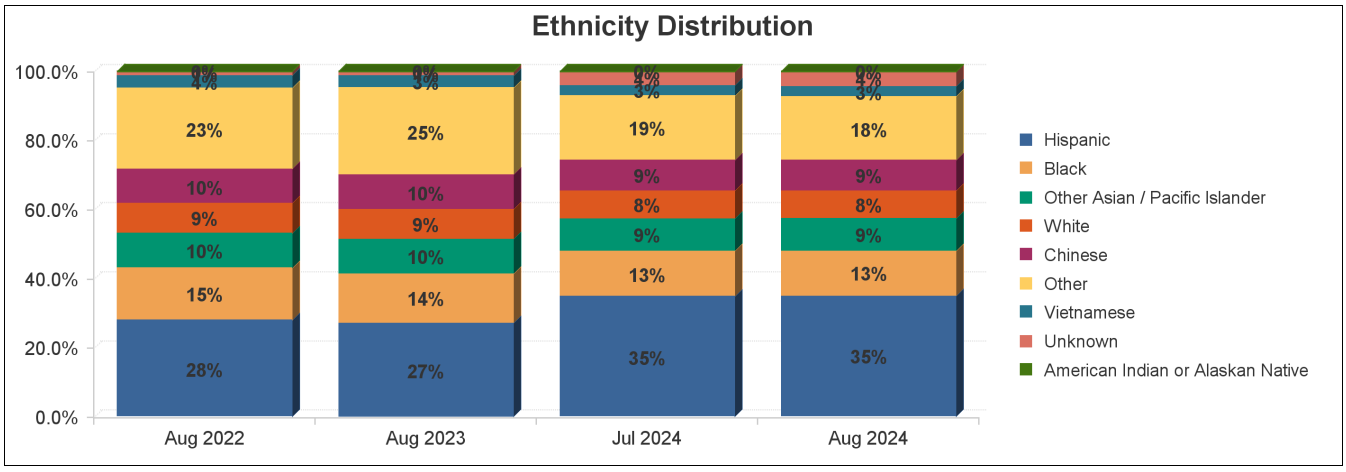
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
F	171,141	191,038	211,979	**212,258**	54%	54%	52%	52%	12%	11%	0%
M	148,115	164,010	192,575	**193,064**	46%	46%	48%	48%	11%	18%	0%
Total	**319,256**	**355,048**	**404,554**	**405,322**	**100%**	**100%**	**100%**	**100%**	**11%**	**14%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022	Aug 2023	Jul 2024	Aug 2024	Aug 2022 to Aug 2023	Aug 2023 to Aug 2024	Jul 2024 to Aug 2024
Hispanic	88,998	95,902	140,570	**141,075**	28%	27%	35%	35%	8%	47%	0%
Black	48,133	50,614	53,042	**52,860**	15%	14%	13%	13%	5%	4%	0%
Other Asian / Pacific Islander	32,123	35,566	37,878	**38,062**	10%	10%	9%	9%	11%	7%	0%
White	27,887	30,577	32,713	**32,586**	9%	9%	8%	8%	10%	7%	0%
Chinese	31,586	35,715	35,841	**35,869**	10%	10%	9%	9%	13%	0%	0%
Other	74,839	89,524	75,541	**74,954**	23%	25%	19%	18%	20%	-16%	-1%
Vietnamese	11,428	12,104	11,830	**11,804**	4%	3%	3%	3%	6%	-2%	0%
Unknown	3,579	4,327	16,341	**17,310**	1%	1%	4%	4%	21%	300%	6%
American Indian or Alaskan Native	683	719	798	**802**	0%	0%	0%	0%	5%	12%	1%
Total	**319,256**	**355,048**	**404,554**	**405,322**	**100%**	**100%**	**100%**	**100%**	**11%**	**14%**	**0%**



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

Medi-Cal By City

City	Aug 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	160,557	40%	23,274	42,818	17,444	77,021
HAYWARD	64,039	16%	12,797	17,316	7,482	26,444
FREMONT	37,151	9%	15,368	6,647	2,143	12,993
SAN LEANDRO	33,087	8%	8,103	5,711	4,270	15,003
UNION CITY	14,674	4%	5,513	2,630	873	5,658
ALAMEDA	13,850	3%	3,296	2,496	2,085	5,973
BERKELEY	15,025	4%	4,039	2,314	1,752	6,920
LIVERMORE	12,894	3%	1,825	625	2,231	8,213
NEWARK	9,387	2%	2,744	4,122	525	1,996
CASTRO VALLEY	9,486	2%	2,520	1,639	1,403	3,924
SAN LORENZO	7,320	2%	1,473	1,664	835	3,348
PLEASANTON	7,536	2%	1,751	416	819	4,550
DUBLIN	7,465	2%	1,971	439	882	4,173
EMERYVILLE	2,826	1%	631	623	456	1,116
ALBANY	2,514	1%	654	294	565	1,001
PIEDMONT	470	0%	104	198	51	117
SUNOL	87	0%	27	14	6	40
ANTIOCH	23	0%	2	13	2	6
Other	1,245	0%	338	300	135	472
Total	399,636	100%	**86,430**	**90,279**	**43,959**	**178,968**

Group Care By City

City	Aug 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,792	32%	355	334	0	1,103
HAYWARD	645	11%	300	155	0	190
FREMONT	639	11%	424	71	0	144
SAN LEANDRO	603	11%	235	93	0	275
UNION CITY	295	5%	186	44	0	65
ALAMEDA	295	5%	90	24	0	181
BERKELEY	155	3%	50	11	0	94
LIVERMORE	100	2%	29	4	0	67
NEWARK	133	2%	79	29	0	25
CASTRO VALLEY	191	3%	84	29	0	78
SAN LORENZO	134	2%	40	25	0	69
PLEASANTON	68	1%	21	3	0	44
DUBLIN	120	2%	43	5	0	72
EMERYVILLE	32	1%	11	4	0	17
ALBANY	20	0%	11	2	0	7
PIEDMONT	10	0%	2	1	0	7
SUNOL	2	0%	2	0	0	0
ANTIOCH	26	0%	7	5	0	14
Other	426	7%	151	64	0	211
Total	**5,686**	**100%**	**2,120**	**903**	**0**	**2,663**

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

Total By City

City	Aug 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,349	40%	23,629	43,152	17,444	78,124
HAYWARD	64,684	16%	13,097	17,471	7,482	26,634
FREMONT	37,790	9%	15,792	6,718	2,143	13,137
SAN LEANDRO	33,690	8%	8,338	5,804	4,270	15,278
UNION CITY	14,969	4%	5,699	2,674	873	5,723
ALAMEDA	14,145	3%	3,386	2,520	2,085	6,154
BERKELEY	15,180	4%	4,089	2,325	1,752	7,014
LIVERMORE	12,994	3%	1,854	629	2,231	8,280
NEWARK	9,520	2%	2,823	4,151	525	2,021
CASTRO VALLEY	9,677	2%	2,604	1,668	1,403	4,002
SAN LORENZO	7,454	2%	1,513	1,689	835	3,417
PLEASANTON	7,604	2%	1,772	419	819	4,594
DUBLIN	7,585	2%	2,014	444	882	4,245
EMERYVILLE	2,858	1%	642	627	456	1,133
ALBANY	2,534	1%	665	296	565	1,008
PIEDMONT	480	0%	106	199	51	124
SUNOL	89	0%	29	14	6	40
ANTIOCH	49	0%	9	18	2	20
Other	1,671	0%	489	364	135	683
Total	405,322	100%	**88,550**	**91,182**	**43,959**	**181,631**

Human Resources

Anastacia Swift

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

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

Date: **October 11th, 2024**

Subject: **Human Resources Report**

Staffing

- As of October 1st, 2024, the Alliance had 639 full time employees and 1-part time employee.

- On October 1st, 2024, the Alliance had 59 open positions in which 13 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 46 positions open to date. The Alliance is actively recruiting for the remaining 46 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by division:

Division	Open Position October 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	12	5	7
Operations	27	3	24
Healthcare Analytics	2	1	1
Information Technology	6	1	5
Finance	8	3	5
Compliance	3	0	3
Human Resources	1	0	1
Health Equity	0	0	0
Executive	0	0	0
Total	59	13	46

- Our current recruitment rate is 8%.

Employee Recognition

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

  5 years:
  - AJ Dixon (Integrated Planning)
  - Komal Babbar (Utilization Management)
  - Ramces Cortez (Claims)
  - Monique Lester (Case & Disease Management)
  - Gabriela Figueroa (Grievance & Appeals)

  6 years:
  - Cynthia Ruiz Robledo (Claims)
  - Cynthia Catalan (Member Services)
  - Katherine Ebido (Quality Management)

  7 years:
  - Jennifer Leung (Facilities)
  - Benita Ochoa (Pharmacy Services)

  8 years:
  - Natalie McDonald (Utilization Management)
  - Sasi Karaiyan (Information Technology)
  - Ed DeOcampo (IT Infrastructure)
  - Tami Lewis (Operations Support)
  - Pandiyarajan Subburaman (IT Development)
  - Sankar Ganesh Rathnasamy (IT Development)
  - Anthony Taylor (Finance)

  9 years:
  - Smita Kaza (IT Ops & Quality Apps Management)
  - Dacheng Peng (IT Development)

  11 years:
  - Hellai Momen (Quality Management)
  - Alexandra Loza (Grievance & Appeals)
  - Catie Patrick (Case & Disease Management)

  12 years:
  - BJ Gerona (Information Technology)

  20 years:
  - Carol Van Oosterwijk (Finance)

  22 years:
  - Steve Le (Marketing & Communications)