Board of Governors

Regular Meeting

Friday, December 13th, 2024
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 South Loop Road, Alameda, CA 94502

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

AGENDA

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

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

7830 MacArthur Blvd
Oakland, CA 94605

PUBLIC COMMENTS: Public Comments can be submitted for any agendized item or for any item not listed on the agenda, by mailing your comment to: "Attn: Clerk of the Board," 1240 S. Loop Road, Alameda, CA 94502 or by emailing the Clerk of the Board at brmartinez@alamedaalliance.org. You may attend meetings in person or by computer by logging in to the following link: Click here to join the meeting. You may also listen to the meeting by calling in to the following telephone number: 1-510-210-0967 conference id 703750150#. 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 December 13th, 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) OCTOBER 8th, 2024, FINANCE COMMITTEE MEETING MINUTES

b) NOVEMBER 12th, 2024, FINANCE COMMITTEE MEETING MINUTES

c) OCTOBER 11th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

d) OCTOBER 11th, 2024, BOARD OF GOVERNORS MEETING MINUTES

e) APPROVE RESOLUTION FOR QIHEC COMMITTEE NOMINEES

f) APPROVE RESOLUTION FOR PHARMACY & THERAPEUTICS (P&T) COMMITTEE NOMINEE

g) APPROVE RESOLUTION AMENDING THE ALAMEDA ALLIANCE FOR HEALTH CONFLICT OF INTEREST CODE AND LIST OF DESIGNATED FILERS

h) APPROVE THE 2024-2025 HOURLY AND SALARY SCHEDULE

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

b) FINANCE COMMITTEE

7. CEO UPDATE

8. BOARD BUSINESS

a) BEHAVIORAL HEALTH AUDIT

b) REVIEW AND APPROVE SEPTEMBER AND OCTOBER 2024 MONTHLY FINANCIAL STATEMENTS

c) REVIEW AND APPROVE FISCAL YEAR 2025 FINAL BUDGET

d) HEALTH EQUITY UPDATE

e) REVIEW AND APPROVE STANDING COMMITTEE STIPENDS POLICY

9. UNFINISHED BUSINESS

10. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

11. PUBLIC COMMENT (NON-AGENDA ITEMS)

12. 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

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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 December 10th, 2024, by 12:00 p.m.

Brenda Martinez, Clerk of the Board

EXECUTIVE SUMMARY APPENDIX

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

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FINANCE REPORT Page 159

OPERATIONS REPORT Page 205

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COMPLIANCE REPORT Page 260

HEALTH CARE REPORT Page 316

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INFORMATION TECHNOLOGY REPORT Page 345

PERFORMANCE & ANALYTICS REPORT Page 366

HUMAN RESOURCES REPORT Page 378

PRESENTATIONS APPENDIX

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

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FISCAL YEAR 2025 FINAL BUDGET PAGE 110

HEALTH EQUITY UPDATE PAGE 126

STANDING COMMITTEE STIPENDS POLICY PAGE 155

SUPPORTING MATERIALS APPENDIX

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

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OPERATIONS SUPPORTING DOCUMENTS PAGE 230

COMPLIANCE SUPPORTING DOCUMENTS PAGE 264

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INTEGRATED PLANNING SUPPORTING DOCUMENTS PAGE 227

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Consent Calendar

Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

October 8th, 2024
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted in-person and by Teleconference.

Committee Members in-person: Dr. Rollington Ferguson, Gil Riojas
Committee Members by Teleconference: James Jackson
Committee Members Excused: Yeon Park
Board of Governor members in-person and on Conference Call: Rebecca Gebhart

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

CALL TO ORDER

Dr. Ferguson convened the Finance Committee meeting at 8:00 a.m.

ROLL CALL

Roll call was conducted, noting the absence of a quorum, which prevented any votes or actions from being taken.

INTRODUCTIONS

CFO Gil Riojas introduced the auditors from Moss Adams, Chris Pritchard, Rianne Suico, and Gordon Lam who were present to provide an update on the fiscal year 2024 financial statements.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

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

a) REVIEW AND APPROVE FISCAL YEAR 2024 ANNUAL AUDITED FINANCIAL STATEMENTS

The auditors presented their findings related to the fiscal year 2024 financial statements, highlighting an unmodified audit opinion: "Financial statements are presented fairly and in accordance with generally accepted accounting principles". This is the highest level of assurance that can be issued from the audit firm.

Discussion included assets, liabilities, and net position balance (cash balances, investment evaluations, premiums receivable, claims payable, net position, etc.), noting no significant issues.

Management and the entire team demonstrated a high level of collaboration and responsiveness in addressing all inquiries essential to substantiating the reported figures. There were no audit adjustments or disagreements with management. Notably, there is no indication of significant

instances of fraud or noncompliance with pertinent laws and regulations. From the auditor's perspective, the overall audit process proceeded seamlessly.

Question: Rebecca inquired about claims liability estimates, specifically whether they only pertained to hospital claims.

Answer: The auditors clarified that the liability balance in the financial statements encompasses both traditional medical claims liabilities and liabilities that do not go through the claim system. The latter are excluded for presentation purposes, aiming to accurately represent the claims liabilities, including fee-for-service claims liabilities. Management is tasked with estimating the ultimate payout at the end of each fiscal year.

Question: Rebecca asked why there was a historic increase in claims volume from around 7% to 11%, specifically if this increase was solely due to a higher volume of claims.

Answer: The auditors explained that the increase was not just due to the volume of claims but also to the speed at which claims were being processed and the rate at which providers submitted claims forms for the health plan to process and pay. Additionally, they mentioned that the overall increase in the acuity of the members' medical services was also a significant factor driving the increase. Gil added that over the last several months, they had observed lower completion factors for these claims, resulting in longer processing times, and the volume of claims was much higher than in the past.

b) CEO UPDATE

Matt Woodruff provided updates to the Finance committee on several key topics, which included:

Building Relocation:
The lease for the 1320 Harbor Bay office will be ending in May 2025. Additionally, in response to the Finance committee's request, the process of exploring potential building options and relocation has been initiated. CEO Matt Woodruff sought guidance from the committee, which agreed to postpone the building relocation process until the 2025 rates are received.

Question: Dr. Ferguson asked what the savings are from the lease cancellation.

Answer: Gil estimated the savings to be approximately $1 million a year but will confirm and provide the precise savings resulting from the lease cancellation.

Question: James asked if there could be any negative consequences to delaying the building relocation process.

Answer: Matt agreed with the board that the current location on the island is very isolated, with no public transportation options. He mentioned that the lack of accessibility may be a drawback, as they only have about one visitor per business day. During the transition period in January, February, and March, they saw five to six visitors per day, indicating that the current location may not be ideal for reaching their members. Additionally, Matt pointed out that the real estate market is currently down, with many vacant properties. While this could mean getting a competitive price for a new building, it may not be the best time to invest $50-60 million in a new property.

<u>Question</u>: Rebecca inquired whether there has been any consideration given to leasing a small space for member services in a location that is accessible to members as opposed to purchasing a $60 million building.

<u>Answer</u>: Matt noted that there had been previous discussions on this topic. Gil suggested exploring a small space in Oakland, and possibly one in Fremont to serve the South County area, in addition to securing a space in Oakland. James expressed interest in participating in those discussions. Dr. Ferguson encouraged having those conversations and presenting them to the board as an alternative. Matt said they will investigate this possibility and provide a report, possibly in December.

Audit:
Matt expressed his gratitude to the entire finance team for the audit, considering the various challenges we have faced with state recoupment, long-term care rates, and transitioning to the single plan model.

Financial Measures and Actions:

Matt outlined several financial measures and actions being taken to address the financial situation, including freezing travel, removing provider grants, initiating a hiring freeze, and considering delaying new initiatives like ECM and community supports.

<u>Question</u>: Rebecca asked Matt for an example of an operational efficiency initiative that will save money.

<u>Answer</u>: Matt explained that they focused on automating the manual authorization process for healthcare services to reduce hiring and increase efficiency. By automating the approval of authorizations, they aim to decrease the workload and streamline the process. They also plan to audit the automated authorizations to ensure that providers follow standard processes. Additionally, they are exploring the possibility of stationing nurses back in hospitals to assist with discharge planning.

<u>Comment</u>: Dr. Ferguson suggested inviting someone from DMHC to attend a future board meeting to address the board and hear their concerns directly, emphasizing the importance of board engagement in these discussions.

Committee Membership and Quorum Issues:

The board addressed the issue of not meeting a quorum, considering expanding the committee membership to ensure a quorum can be met in future meetings.

c) REVIEW AND APPROVE THE AUGUST 2024 MONTHLY FINANCIAL STATEMENTS

<u>AUGUST 2024 Financial Statement Summary</u>

Due to time constraints, the August 2024 Financial Statement discussion was moved to the October 11, 2024 Board meeting.

Gil acknowledged the accounting team for their excellent work on the Moss Adams Audits.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 9:00 a.m.

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

November 12th, 2024
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted in-person and by Teleconference.

Committee Members in-person: Dr. Rollington Ferguson, Rebecca Gebhart, James Jackson, Yeon Park (arrived at 8:10 a.m.), Gil Riojas
Committee Members by Teleconference: None
Committee Members Excused: None
Board of Governor members in-person and on Conference Call: Andie Martinez Patterson, Tosan Boyo

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, Shulin Lin, Carol van Oosterwijk, Linda Ly, Brenda Martinez, Felix Rodriguez, Danube Serri, Brett Kish, Christine Corpus

CALL TO ORDER

Dr. Ferguson convened the Finance Committee meeting at 8:00 a.m.

ROLL CALL

Roll call was conducted and confirmed.

INTRODUCTIONS

CEO Matt Woodruff introduced Pritika Dutt from the Department of Managed Health Care (DMHC), who joined the meeting via conference call.

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 the Finance Committee with updates on several topics, including:

Financial Meeting with DHCS:

Matt and Gil had a collaborative meeting with DHCS where they discussed financial statement results, with the State asking many good questions. There was a small net increase in preliminary Calendar Year 2025 (CY25) rates. Matt and Gil continue to advocate for higher rates for CY25.

Medical Management:

Dr. Carey outlined three approaches to medical management: preventing avoidable hospitalizations, decreasing length of stay and hospital readmissions, and managing expenses.

Preventable Hospitalizations
The team is identifying high-risk and low-risk members using a population health management strategy. High-risk members are being enrolled in the Enhanced Care Management (ECM) program to receive extensive case management and avoid preventable hospitalizations.

Decreasing length of stay and hospital readmissions
The focus is on transitional care services, including meeting members at bedside during hospital admission to assist with post-discharge planning and enrollment in the ECM network. High-risk members are linked to a provider visit within seven days after discharge, and low-risk members within 30 days. Pharmacists are also utilized for medication reconciliation for high-risk members.

Managing Expenses
Strategies include creating criteria for the use of sitters in long-term care, monitoring the necessity of sitters, and establishing criteria for community supports to ensure they are provided to those who truly need them.

Question: High risk versus low risk? How is that determined?

Answer: The determination is based on the number of emergency room visits, medical conditions, and chronic diseases. Members are stratified into high, emerging, or low risk. High-risk members are those with multiple hospitalizations and chronic diseases.

Question: Has the risk stratification tool been examined to ensure that it does not contain any inherent biases that could affect how a person is classified or defined? Specifically, has equity been considered in this evaluation?

Answer: Tiffany confirmed that the population health team is looking at the risk stratification toll through an equity lens. The tool uses the John Hopkins ACG models, which have been tested for equity.

b) REVIEW AND APPROVE THE SEPTEMBER 2024 MONTHLY FINANCIAL STATEMENTS

SEPTEMBER 2024 Financial Statement Summary

Enrollment:

Enrollment increased by 666 members since August and an overall increase of 1,943 members since June 2024.

Net Income:

For the month ending September 30th, 2024, the Alliance reported a Net Loss of $8.7 million (versus budgeted Net Loss of $215,000). For the year-to-date, the Alliance recorded a Net Loss of $34.1 million versus a budgeted Net Income of $5.4 million.

Premium Revenue:

For the month ending September 30th, 2024, actual Revenue was $170.9 million vs. our budgeted amount of $166.2 million.

Medical Expense:

Actual Medical Expenses for the month were $174.5 million, vs. budgeted amount of $159.0 million. For the year-to-date, actual Medical Expenses were $526.9 million vs. budgeted Medical Expense of $483.8 million.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 102.1%. The year-to-date MLR was 103.1%. 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 September 30th, 2024, were $8.9 million vs. our budgeted amount of $10.0 million. Our Administrative Loss Ratio (ALR) is 5.2% of our Revenue for the month, and 5.7% of Net Revenue for year-to-date.

Other Income / (Expense):

As of September 30th, 2024, our YTD interest income from investments show a gain of $10.9 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending September 30th, 2024, we reported $194.3 million unbudgeted MCO Tax Revenue, and $47.1 million unbudgeted MCO Tax Expense.

Tangible Net Equity (TNE):

For September, the DMHC requires that we have $70.2 million in TNE, and we reported $221.3 million, leaving an excess of $151.1 million. As a percentage we are at 315%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $625.4 million in cash; $442.3 million is uncommitted. Our current ratio is above the minimum required at 1.17 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired $530,000 on Capital Assets year-to-date. Our annual capital budget is $1.7 million.

Question: When actual expenses significantly exceed projections, is it correct that members are sicker than anticipated? Are we experiencing an adverse selection, or is there a combination of these two? Are there other factors?

Answer: We are observing a sicker population than anticipated in part due to redetermination. The healthier population has disenrolled, leaving behind those who are sicker. This shift is reflected in our RDT, which indicates higher acuity levels. As a result, we are experiencing higher expenses that exceed both our budget projections and the state's expectations. As the population continues to grow, it will lead to increased expenses.

Question: What is being done to address the high pharmacy expenses?

Answer: Efforts are being made to manage the costs of physician-administered drugs and other high-cost medications, particularly those related to weight loss and diabetes management.

Question: In our last meeting, we discussed that our denial rate is not aligned with some other plans. What steps have been taken to address this issue and bring our denial rate more in line with those plans?

Answer: We are currently reviewing our criteria and identifying the requests we consistently approve. We are implementing some auto-approvals for these standard requests to streamline our process. At the same time, we are focusing on cases where we have encountered issues.

At this stage, our goal is to analyze high-cost items and understand the various criteria that need to be met for approval. We have assessed our automation processes to determine what can be automated. Dr. Carey's team is then tasked with ensuring that the remaining requests meet all necessary criteria.

Motion: A motion was made by Rebecca Gebhart, and seconded by Yeon Park, to accept and approve the September 2024 Financial Statements.

Motion Passed

No opposed or abstained.

c) DHCS FINANCIAL PRESENTATION

Gil shared the presentation recently delivered to DHCS to advocate for necessary rate increases and to emphasize the financial challenges being faced.

Updated Year to Date Numbers

- Removed prior period revenue adjustment related to CY23 acuity and any gains from investment income.
- Medical Loss Ratio above 100% from April through August and beyond.
- Year to date MLR at 102%.
- Total Net Loss of $91 million.
- Tangible Net Equity near 200%.
- Community support costs are estimated to be $33.6 million for the fiscal year, representing a 54% increase from the fiscal year 2024.
- There was a significant negative variance in Community Supports revenue ($7.3 million) compared to expenses for FY24 ($21.8 million) and this negative variance is expected to increase for FY25.
- Draft CY25 rates represent only a 3.9% increase from CY24.

CY24 Financial Trends

- Medical Loss Ratio above 100% from April through August.
- Material Net Loss continues even with the removal of prior period revenue adjustments.

DHCS Rate Support Needed

- Material rate increases for CY25 across most COAs are needed to support increasing volume and expense trends.
- Core business impacted by Community Supports costs.
- DSNP line of business ramp up includes significant expense outlay (labor, consulting, vendor) without supporting revenue.
- Positive returns from investment income will diminish as interest rates are lowered.
- Safety net system impacts will be experienced with our County partnership and safety net hospitals (AHS/St. Rose).
- Network adequacy concerns (provider groups closing to our members).

Motion: A motion was made by James Jackson and seconded by Yeon Park to extend the meeting by five minutes.

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 9:04 a.m.

Compliance Advisory Committee Meeting Minutes

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

COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes
Friday, October 11th, 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

Approved

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

None

5. CONSENT CALENDAR

a) September 13th, 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: Motion passed

6. COMPLIANCE MEMBER REPORTS

a) Compliance Activity Report

i Plan Audits and State Regulatory Oversight

1. 2024 DHCS Audit Draft Findings Status:

    a. The 2024 DHCS routine medical survey was held from June 17 – June 28th of this year

    b. DHCS has now scheduled our exit conference for October 16, 2024 and we expect to receive the preliminary report by October 14th, in time for the exit conference.

    c. After the exit conference we will then receive the final audit report. We expect this before the end of October.

    d. We have 30 days to provide our initial corrective action plan (CAP) response to DHCS after the final audit report is received.

2. 2024 Network Adequacy Validation Audit Close Out:

    a. The virtual network adequacy validation audit with Health Services Advisory Group (HSAG) was on July 15th, 2024 to July 17th, 2024.
    b. This Audit evaluated the Plan's data, systems and methods used to calculate results for each network adequacy indicator, to the state's standards.
    c. HSAG specifically validated network related data reported to DHCS in November 2023.
    d. 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.

3. 2024 PCP Facility Site Review and Medical Record Review Completed:

    a. DHCS conducted the required random full scope Facility Site Review and Medical Record Review for Alameda County, consistent with APL 22-017 from September 17th to September 19th 2024.
    b. DHCS selected 10 of our PCPs to review. Our Facility Site Review Team then provided guidance to the selected PCPs in preparation for the audit.
    c. A nurse reviewer was onsite during the reviews to assist in the process as it can be complicated.
    d. There were eight providers identified with the findings. The providers submitted a CAP and evidence of corrections to the Plan's facility site review team, we submitted it to DHCS on October 4th, 2024.

Question: Individual PCPs were identified with compliance issues within their documentation, The CAP involved edits in the records or some other type of improvement?

Answer: Different improvements that they saw when they went on-site. These were issues with the facility itself, not with medical records.

Question: In the facility site review were there things that were found that weren't safe?

Answer: There were some noted improvements needed with needlestick safety precautions, airway management, infectious materials collection, qualified personnel administering vaccines, ER kits, timely referral procedures.

ii **2024 Behavioral Health Comparison Audit Preliminary Report**

1. The Behavioral Health Comparison Audit's aim is to compare Alameda Alliance behavioral health services to the Kaiser Settlement agreement to identify areas of improvement and compliance for the Alliance.
2. The goal of the audit is to Identify potential area of improvement, mitigate risk and reduce audit findings form the state.
3. The Alliance Internal Audit Team developed 66 Review Criteria. Internal Audit reviewed documents and processes for nine Alliance Departments.
4. Preliminary findings and observations were shared with audited departments on September 11, 2024.
    a. Internal Audits met and reviewed preliminary findings and observations.
    b. Audited Departments provided written responses to preliminary findings and observations.
    c. Internal Audits has preliminary findings and observations for 16 Review Criteria.
    d. The Alliance is fully compliant with 45 review criteria.
    e. Five review criteria were not applicable, the Alliance does not delegate behavioral health services.
    f. This review did not include behavioral health treatment and did not include Kaiser as an Alliance delegate because our relationship with Kaiser had ended prior to the review period.

- The following preliminary findings were identified. Alliance internal departments will have time to review these findings and provide any feedback or supporting documentation before final findings are determined and issued.
    - Behavioral Health Preliminary Findings**:**
        - The behavioral health team did not pass an audit of notice of action letters in Q4 2023.
            - Issues included decision timeliness, letter content, and translation.
            - Process improvements were implemented in early 2024.
    - Grievance and Appeals Preliminary Findings**:**
        - The grievance and appeals team did not pass an audit of grievance resolution letters in Q4 2023.
            - Issues included capturing all issues, writing at a 6th-grade reading level, and fully resolving grievances.
            - A quality assurance process was implemented.
    - Quality Improvement Preliminary Findings**:**

- The quality improvement team did not have a follow-up on missed or canceled appointments policy for all network providers, as required by the DHCS contract.

- Preliminary Observations**:**

Question: If you could point out the significance of providing observational improvements that aren't based in contract?

Answer: These can improve our members' access to services. This one specifically would help with better referrals. Some are best practices in general for all of the observations, or to align our policies with our workflows or to make sure we have supporting documentation. To show we are doing the work. They are meant to serve ideas as areas for improvement for the Alliance.

Question: As we go through this audit process are we keeping track of existing conditions by which we are making improvements but have not met the goal or are we fulling owning it to meet the goal?

Answer: We're fully owning it. It's on us to fix it.

- Cross Functional Preliminary Observations:
  - Behavioral Health Providers:
    - The Alliance collected behavioral health provider expertise information but did not have a process to maintain it or incorporate it into the provider repository.
      - Internal stakeholder meetings have started to address this.
      - Conducting validation audits to ensure process improvements are effective.
      - Developing desktop procedure or policy for the behavioral health initial evaluation form.
      - Incorporating behavioral health provider expertise information.
  - Timely Access Grievances**:**
    - The Alliance addresses timely access grievances through the grievance process and potential quality issue process, but these processes take longer than timely access standards.
      - Standard grievances must be resolved within 30 calendar days
      - Quality of Access Potential Quality Issues are reviewed by Quality Improvement within 120 days
      - Regulations require health plans to have providers that can offer members non-urgent appointments within 10 business days
      - One thing to note is the Alliance was compliant with behavioral health timely access standards based on the 2023 provider appointment availability survey.

- Access and Availability Preliminary Observations**:**
  - Access and Availability reviews medical records, but it does not document its review unless a corrective action is issued against a provider
  - CG CAHPS captures behavioral health provider compliance with non-urgent appointments, however, this information is not yet reported to committees.
  - Behavioral health providers had limited response rates to the DHCS timely access study, impacting the assessment of timely access standards.
    - The access and availability team is working to improve response rates.

Question: Does this also include working with the county access number as an option?

Answer: They were supposed to include information on the county access phone number but it did not happen. This process is done initially by member services. When the member calls, if they can't access an appointment or they're not satisfied with the education that they're provided, then it's sent over to the Grievance and appeals department. Sometimes we do not get a doctor to agree and that could be part of the problem.

Question: The database would help with that?

Answer: Yes, it helps but even when we have the information, it could be two or three days old, and it may change. The focus is not on the process, it’s the documentation of the process. From member to member, service to service, provider to provider.

- Behavioral Health Preliminary Observations**:**
  - The behavioral health initial evaluation form:
    - This form was developed to facilitate care coordination, but there are no desktop procedures or policies for its use
    - There is no incentives for providers to submit the form, however discussions around an incentive payment for providers have started
    - This form is not available for out-of-network providers
  - Behavioral Health GroupCare Workflows do not specify or include information on scheduling appointments or arranging for the admission with out-of-network providers for inpatient services
    - The Alliance has two established policies with this information, BH-001 and UM-057

Question: This is a clinical behavioral health service. That is described in many different ways, so a provider might make a referral and request a set of services and then a member may call in and say, actually I want this service plus X or actually only want a portion of the services for which I was referred. How are we resolving those?

Answer: Overall, for our medical services, the member has to consent for the purpose. We will provide what the member desires and then document it.

- Grievance and Appeals Preliminary Observations**:**
    - The grievance and appeals process does not have documented steps to ensure members are informed about alternative ways to access services immediately.
        - Member services initially handles these calls, and if unresolved, they are sent to grievance and appeals.
        - Documenting steps to ensure members are informed about alternative ways to access services immediately.
        - Ensuring grievance resolution letters capture all issues and are written at a 6th grade reading level.
        - Ensuring grievance resolution letters fully resolve members' grievances.
        - Educating members on how to access services immediately through urgent care, Teladoc, or emergency services.
        - A validation Audit will be conducted.

Question: I'm curious about fully resolving member grievances. What is the metric by which we say we are resolving that? Is it by the Members report or by accountability within the organization?

Answer: Internal audit reviews the letters and the grievance file. If there are three issues the member called in about, we are reviewing to see if the resolution letter addresses all three of those issues. For DHCS, the resolution of a grievance means that the Member has been made whole, so if the Member is looking to access care and needs to make an appointment, resolution would be that the appointment has been facilitated and that the Member was seen.

- Provider Services Preliminary Observations**:**
    - Ensure all Alliance departments are aware of the process for updating provider status on accepting patients.
        - Provider services has a process for updating provider status on accepting patients, but some Alliance departments may not be aware of this process.
        - Ensuring awareness will contribute to the accuracy of the provider repository.
        - The request goes to the provider team so they have the information and it is done consistently.
        - Documentation will be more standardized in the future.

- **Next Steps for Audit:**
    - The audit team will revise the audit findings and observations, meet with audited departments, review final drafts, issue final reports, and present the findings to the board in December.

Question: Will we hear a preliminary report today at the board on this audit?

Answer: No, we will wait until December. An abbreviated version, the full version will be in December.

Question: Going back to the findings that were about the 6th grade reading level, does that include the medical director terminology.

Answer: Yes, it's the same as the NOA. On the appeals side, we do need to meet that 6th grade reading level, but the 6th grade reading level is a DHCS specific requirement. DMHC is more lenient on that requirement but yes our notice of appeal resolutions do have to meet the 6th grade reading lever requirement.

Question: Does the plan have a standardized process for all letters that need to be at the 6th grade reading level? Despite the software we have in place we have issues? Is that a preliminary finding?

Answer: Yes, we have software. We need better software. It's a handoff and we will get better. There are multiple areas that work on this and we are continuing to improve the process.

b) MEDI-CAL PROGRAM UPDATES

- **i** No Updates

2. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a) Stipend Policy-Review & Discussion

1. The California Constitution Public Section specifically prohibits the giving or lending of public funds to any person or entity, whether it be public or private.
2. Expenditures need to serve a primary purpose; it is not a gift even if it incidentally benefits an individual. However, the utilization of public funds can rise to the level of a "gift" if the amount is unreasonable or unconscionable, even if there is a public purpose.
3. An area in which had seen amounts that raised questions was the stipends the Alliance pays for some of our standing committees.
   - **a)** In determining whether the amount is unreasonable, we looked to similar organizations within the region.
   - **b)** We reached out to sister plans in the Bay Area. Upon receiving average numbers, we realized that we are paying excessively more than similarly situated sister plans.
     - i QIHEC & PRCC: $450;
     - ii P&T: $600.
   - **c)** In order not to trigger a violation of the misuse of public funds, we believe it is necessary to reduce these amounts to more reasonable numbers.
   - **d)** A policy was drafted to streamline these numbers and provide a consistent and reasonable amount.
     - i Note that the $250.00 would apply to QIHEC, PRCC, and P&T.

ii We would keep the amount for our community advisory committee the same, which is $150.00 for reimbursement of travel to the meeting and $75.00 for virtual attendance.

Question: Is there anything about the time commitment that's very different amongst the committees or is one flat rate for that committee?

Answer: It's just a flat rate.

Question: Is this informational or asking for a decision and/or feedback?

Answer: This is for feedback. The goal is to take this to the Board in the future.

3. STAFF UPDATES

a) None

4. UNFINISHED BUSINESS

a) None

5. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

a) None

6. ADJOURNMENT

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

Board of Governors Meeting Minutes

Alameda Alliance for Health
Health care you can count on.
Service you can trust.

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, October 11th, 2024
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford (arrived at 1:02 p.m.) James Jackson, Byron Lopez, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam

Board of Governors Remote: Tosan Boyo, Andie Martinez-Patterson, Jody Moore, Andrea Schwab-Galindo

Board of Governors Excused: Dr. Noha Aboelata (Vice-Chair), Dr. Marty Lynch, Natalie Williams

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

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

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL

There were no modifications to the agenda.

4. INTRODUCTIONS

Matt Woodruff introduced the Moss Adams auditors, who reviewed the financial reports. Matt also introduced and welcomed two new board members, Tosan Boyle, CEO of Sutter East Bay, and Wendy Peterson, CEO of the Senior Services Coalition.

5. CONSENT CALENDAR

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)

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

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Tosan Boyo, Colleen Chawla, Dr. Rollington Ferguson, James Jackson, Byron Lopez, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Chair Rebecca Gebhart.

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

Dr. Kelley Meade provided an update on the Compliance Advisory Committee meeting held on October 11th. At the meeting, several informational updates were discussed. We are awaiting the 2024 DHCS audit draft findings, which are expected next week and will be discussed at the next board meeting. Additionally, a network adequacy validation audit was recently completed with no formal findings, which is a commendable achievement.

The bulk of the meeting focused on a preliminary internal report comparing behavioral health services between our plan and other company audit results. This report highlights the strengths developed within our plan, particularly in managing provider expertise and access to grievance and appeal processes. More details of this report will be provided to the board as it progresses.

b) FINANCE COMMITTEE

During the Finance Committee update on October 8th, Dr. Ferguson reviewed the August financials and the Moss Adams report. Moss Adams found no inconsistencies in our financial reports over the past year and provided a positive assessment. However, since the quorum was not met, the meeting was informational only.

Dr. Ferguson highlighted concerns about our financial health. Our Tangible Net Equity (TNE) continues to decline, and our Medical Loss Ratio (MLR) is consistently over 100%, nearing 110%. This high MLR indicates that we are spending significantly more on medical expenses than anticipated. Matt and the team will present options to address these financial challenges.

7. REVIEW AND APPROVE MOSS ADAMS FINANCIAL AUDIT REVIEW

Chris Pritchard, Rianne Suico, and Gordon Lam from Moss Adams presented their findings related to the fiscal year 2024 financial statements, highlighting an unmodified audit opinion: "Financial statements are presented fairly and in accordance with generally accepted accounting principles." This is the highest level of assurance that can be issued from the audit firm.

Discussion included assets, liabilities, and net position balance (cash balances, investment evaluations, premiums receivable, claims payable, net position, etc.), noting no significant issues.

Management and the entire team demonstrated a high level of collaboration and responsiveness in addressing all inquiries essential to substantiating the reported figures. There were no audit adjustments or disagreements with management. Notably, there is no indication of significant instances of fraud or noncompliance with pertinent laws and regulations. From the auditor's perspective, the overall audit process proceeded seamlessly.

Chair Gebhart expressed gratitude to CFO Gil Riojas and the entire finance team for their continuous preparedness for audits. She also acknowledged CEO Matt Woodruff for his leadership in finance as well.

Motion: A motion was made by Dr. Rollington Ferguson and seconded by James Jackson to accept the Moss Adams Financial Audit review.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Tosan Boyo, Colleen Chawla, Dr. Rollington Ferguson, James Jackson, Byron Lopez, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Chair Rebecca Gebhart.

No opposition or abstentions.

8. CEO UPDATE

CEO Matt Woodruff provided important updates regarding the financials. He highlighted a scheduled meeting with the Department of Health Care Services (DHCS) to discuss current financials and the cost of care.

<u>Key Highlights</u>:

DHCS Meeting: A meeting with DHCS is scheduled to address current financials.

Financial Losses: Matt reported financial losses of $18 million for August and $23 million for the first two months of the fiscal year. This situation underscores the urgent need for financial measures. Several strategies to mitigate these losses were discussed, including a hiring freeze, postponing contract changes with providers, freezing community, and recovering funds from claims overpayment, with $600,000 already recouped.

Regulatory Metrics: Key regulatory metrics were reviewed, showing an increase in the Medical Loss Ratio (MLR) and issues related to missed claims payments. This prompted the need for additional Finance Committee meetings.

Rate Adjustments: Matt mentioned that the final rates for the calendar year 2024 include a 0.1% increase, amounting to approximately $1.2 million.

Risk Adjustment: The process of risk adjustment was discussed, particularly the impact of the state's removal of the COVID acuity adjustment, which has resulted in a 0.5% decrease in long-term care rates.

<u>Question</u>: What process will you use to determine where to scale back community support and ECM?
<u>Answer</u>: Matt explained the process of determining whether to scale back existing offerings, including the need for state approval and potential impacts on the model of care.

<u>Question</u>: James Jackson asked about the impact of changes on Financial Metrics
<u>Answer</u>: Matt estimated that the changes could save about $10-$20 million, with the potential for more savings depending on the duration of the hiring freeze and other factors.

<u>Question</u>: Tosan Boyo had a question concerning capacity constraints with new enrollments.
<u>Answer</u>: Matt explained the State's stance on health plan responsibilities and the need to increase access by adding new providers.

<u>Question</u>: Dr. Seevak asked what data is being used to support access issues.
<u>Answer</u>: Matt mentioned using data on provider closures and ER visit rates to argue for increased access and efforts to bring new providers into the network.

<u>Question</u>: Do we have a contingency plan if the State denies relief?
<u>Answer</u>: Matt outlined the potential actions, including extending the hiring freeze, layoffs, and cutting community support programs.

9. BOARD BUSINESS

a) REVIEW AND APPROVE AUGUST 2024 MONTHLY FINANCIAL STATEMENTS

During the meeting, Gil Riojas, the Chief Financial Officer, presented a general overview of the financial statements for August 2024. 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 what is required but remained above minimum requirements.

Enrollment:

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

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

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

Medical Expense

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

Medical Loss Ratio (MLR)

- The Medical Loss Ratio 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

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.

Tangible Net Equity (TNE)

- Required TNE - $71.5 million
- Actual TNE - $230.0 million
- Excess TNE - $158.5 million
- TNE% of Required TNE – 322%

Capital Investment

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

<u>Question</u>: What is the zone of TNE that is most ideal?
<u>Answer</u>: The ideal TNE should be between 300% to 700%. The state requires monthly reporting if TNE goes below 150%, and it should always be above 100%.

<u>Question</u>: When you drill down on the medical expenses, what are the drivers within those categories?
<u>Answer</u>: Inpatient expenses, long-term care, and ER visits are the main drivers. Trends show higher utilization and unit costs, particularly in the SPD and optional expansion categories.

<u>Question</u>: What is the status of the campaign to educate patients on alternatives to ER visits, such as telehealth and urgent care?
<u>Answer</u>: The plan is to use case managers and frontline staff to inform members about alternative access options. A campaign to send notifications to members is also being considered.

<u>Motion:</u> A motion was made by Yeon Park and seconded by Dr. Evan Seevak to approve the August 2024 monthly financial statements.

<u>Vote</u>: The motion was passed unanimously.

<u>Ayes</u>: Aarondeep Basrai, Tosan Boyo, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Chair Rebecca Gebhart.

No opposition or abstentions.

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

<u>Motion:</u> A motion was made by Aarondeep Basrai and seconded by Supervisor Lena Tam to approve adding the November Finance subcommittee meeting on November 12, 2024.

<u>Vote</u>: The motion was passed unanimously.

<u>Ayes</u>: Aarondeep Basrai, Tosan Boyo, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Yeon

Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Chair Rebecca Gebhart.

No opposition or abstentions.

c) APPROVE RESOLUTION ADDING REBECCA GEBHART TO THE FINANCE COMMITTEE

Motion: A motion was made by Yeon Park and seconded by Dr. Evan Seevak to approve adding Rebecca Gebhart to the Finance Committee.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Tosan Boyo, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Chair Rebecca Gebhart.

Abstention: Chair Rebecca Gebhart

No opposition.

d) BEHAVIORAL HEALTH UPDATE

Ruth Watson, Dr. Carey & Dr. Currie presented an update on Behavioral Health.

Highlights:

Lessons Learned:

- Significant pent-up demand and care coordination needs were identified post-insourcing.
- Specialized staff were added to address specific issues.
- New regulatory requirements were implemented, and care coordination with primary care and co-treating providers is still under development.
- A stronger relationship with Alameda County Behavioral Health (ACBH) was developed.

Utilization Increase:

- Unique utilizers increased by 175%, indicating more people are using the benefit.
- The penetration rate improved from 3.6% to 5.2%.

Behavioral Health Therapy (BHT) for Autism:

- Challenges in getting Comprehensive Diagnostic Evaluations (CDE) providers are crucial for appropriate treatment.
- A 97% increase in unique utilizers from June 2023 to May 2024.
- Authorization volume increased significantly, with an average of 328 prior authorizations per month in 2024.

Successes:

- Doubled member utilization from pre-launch.
- Strong regulatory compliance and timely grievance handling.
- Expanded network with a 53% increase in mental health providers and improved language-specific services.

Challenges:

- Only 35% of authorized ABA services are provided, indicating a need for stability in the BHT network.
- Addressing grievances related to timely callbacks and provider attitudes.

Question: What contributed to the increase in unique utilizers for behavioral health services?
Answer: Increased community outreach, listening sessions, and member notifications about the insourcing of behavioral health services contributed to the increase.

Question: How has the relationship with Alameda County Behavioral Health (ACBH) evolved?
Answer: The relationship has strengthened significantly, with regular meetings to address individual cases and broader service responsibilities.

Question: What caused the spike in grievances in May?
Answer: The spike was due to concerns about not receiving timely callbacks and issues with provider attitudes. These have been addressed, leading to a decrease in complaints.

Informational item only.

e) CYBER SECURITY UPDATE

Chief Information Officer Sasi Karaiyan delivered a concise presentation on cybersecurity, which included an overview of the following topics: Security Strategies, Accomplishments, Ongoing Initiatives, Healthcare Incidents, Security Training and Awareness, Effectiveness of End User Training, AAH Network Intrusion Detection, the IT Security Roadmap, and Alliance's Cybersecurity Score.

Informational Item only.

f) REPORT OUT OF BEHAVIORAL HEALTH AUDIT

Due to time constraints, the Behavioral Health Audit was postponed to December 13, 2024, Board meeting.

10. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE

Due to time constraints, the Behavioral Health Audit was postponed to December 13, 2024, Board meeting.

b) PHARMACY & THERAPEUTICS COMMITTEE

Due to time constraints, the Behavioral Health Audit was postponed to December 13, 2024, Board meeting.

c) STRATEGIC PLANNING COMMITTEE

Due to time constraints, the Behavioral Health Audit was postponed to December 13, 2024, Board meeting.

11. STAFF UPDATES

There were no staff updates.

12. UNFINISHED BUSINESS

Motion: A motion was made by James Jackson and seconded by Aarondeep Basrai to postpone the Behavioral Health Audit Update and Standing Committee Updates to December 13, 2024, Board meeting.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Andie Martinez Patterson, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Chair Rebecca Gebhart.

13. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

14. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

15. ADJOURNMENT

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

Resolution for QIHEC Committee Nominees

RESOLUTION NO. 2024-XX

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH APPOINTING NOMINEES TO QUALITY IMPROVEMENT AND HEALTH EQUITY 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, the Alliance Board of Governors (the "Board") on September 8, 2023, passed Resolution 2023-07, creating the Quality Improvement and Health Equity Committee (the "QIHEC") as a standing committee of the Board; and

WHEREAS, pursuant to Resolution 2023-07 appointments to the QIHEC shall be for two (2) year terms, and members may be reappointed to additional terms by Board approval; and

WHEREAS, the QIHEC currently would benefit from additional members.

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 the following individuals to serve as members of the QIHEC for two (2) year terms:

Dr. Anchita Venkatesh, Dental Provider at Highland Hospital;

Ms. Kristin Nelson, Alameda County Office of Education;

Dr. Chaunise "Chaun" Powell, Alameda County Office of Education;

Mr. Anthony Guzman, Native Health Services;

Ms. Deka Dike, Omotochi;

Dr. Beth Mahler, Alameda Health System (AHS)

PASSED AND ADOPTED by the Board at a meeting held on the 13th day of December 2024.

____
CHAIR, BOARD OF GOVERNORS

ATTEST:

____
Secretary

Resolution for Pharmacy & Therapeutic (P&T) Committee Nominee

RESOLUTION NO. 2024-XX

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH APPOINTING NOMINEE TO THE PHARMACY AND THERAPEUTICS 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, the Pharmacy and Therapeutics "P&T" Committee was established through Resolution #2005-02 on October 27, 2005; and

WHEREAS, pursuant to Resolution #2005-02, appointments to P&T shall be for a term of two years, and that members may be reappointed to additional terms by the Board of Governors;

WHEREAS, the P&T Committee would benefit from additional member(s);

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 Dr. Charles Raynard – Alameda Behavioral Health, Director of Pharmacy Services to a two (2) year term to the Alameda Alliance for Health P&T Committee.

PASSED AND ADOPTED by the Board at a meeting held on the 13th day of December 2024.

____
CHAIR, BOARD OF GOVERNORS

ATTEST:

____
Secretary

Resolution Amending Conflict of Interest Code and List of Designated Filers

RESOLUTION NO. 2024-XX

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH AMENDING THE ALAMEDA ALLIANCE FOR HEALTH CONFLICT OF INTEREST CODE AND LIST OF DESIGNATED FILERS

WHEREAS, the Political Reform Act of 1974, Government Code Section 81000 *et seq*., requires every state or local government agency to adopt a Conflict-of-Interest Code ("Conflict of Interest Code"), and to conduct a biennial review of the code and list of designated positions; and

WHEREAS, Alameda Alliance for Health ("Alliance") is deemed a public entity for purposes of the Political Reform Act; and

WHEREAS, the Alliance has previously prepared a Conflict-of-Interest Code, and the Political Reform Act requires the Conflict-of-Interest Code to be reviewed to determine its accuracy; and

WHEREAS, the Alliance Board of Governors ("Board") has reviewed the prior Conflict of Interest Code and determined that it is appropriate to amend and restate the Conflict-of-Interest Code.

NOW, THEREFORE, BE IT RESOLVED, the Board of Governors of the Alliance hereby resolves as follows:

SECTION 1. Pursuant to the Political Reform Act of 1974, Government Code Section 87300 *et seq*., and Section 18730 of Title 2 of the California Code of Regulations, the Board adopts the model conflict of interest code promulgated by the Fair Political Practices Commission of the State of California as set forth in Section 18730 of Title 2 of the California Code of Regulations, which model conflict of interest code is incorporated herein by reference, and which, together with the list of designated positions and the disclosure categories applicable to each designated position as set forth in Appendix A and B of this Resolution, collectively constitutes the Alliance's Conflict of Interest Code. As the model conflict of interest code set forth in Section 18730 of Title 2 of the California Code of Regulations is amended from time to time by State law, regulatory action of the Fair Political Practices Commission, or judicial determination, the portion of the Board's conflict of interest code comprising the model conflict of interest code shall be deemed automatically amended without further action to incorporate by reference all such amendments to the model conflict of interest code so as to remain in compliance therewith. Nothing in this Resolution shall supersede the independent applicability of Government Code Section 87200.

SECTION 2. The definitions contained in the Political Reform Act of 1974 and in the regulations of the Fair Political Practices Commission, and any amendments to either of the foregoing, are incorporated by reference into this Conflict-of-Interest Code.

SECTION 3. The Board finds and determines that the persons who hold the designated positions set forth in Appendix A, attached to and made part of this resolution, make or participate in the making of decisions which may foreseeably have a material effect on their financial interests, and shall file Statements of Economic Interest pursuant to the requirements of the Alliance's Conflict of Interest Code.

SECTION 4. The persons holding designated positions shall disclose their economic interests according to the assigned disclosure categories set forth in Appendix B, attached to and made part of this resolution. The place of filings for the Members of the Board and for the Chief Executive Officer shall be the Board of Supervisors, Alameda County, 1221 Oak Street, Room 536, Oakland, CA 94612, attention to Clerk of the Board. The place of filing for all other designated positions set forth in Appendix A shall be the Alameda Alliance for Health, 1240 South Loop Road, Alameda, CA 94502, attention to the *Legal Department*.

SECTION 5. Any prior resolution or action of the Board designated positions of persons required to file Statements of Economic Interests and their assigned disclosure categories are hereby repealed.

SECTION 6. The Alliance Secretary is hereby instructed to forward such amended Conflict of Interest Code and revised Appendices A and B to the County of Alameda Board of Supervisors for review and approval as required by Government Code Section 87303.

PASSED AND ADOPTED by the Board at a meeting held on the 13th day of December 2024.

____
CHAIR, BOARD OF GOVERNORS

ATTEST:

____
SECRETARY

APPENDIX "A"

Designated Positions

Division	Position	Disclosure Category
N/A	Member, Board of Governors	**I, II**
Administration	Chief Executive Officer	**I, II**
Analytics	Chief Analytics Officer	**I, II**
Analytics	Senior Director, Analytics	**I**
Analytics	Manager, Quality Analytics	**I**
Compliance	Chief Compliance Officer & Chief Privacy Officer	**I, II**
Compliance	Director, Compliance & Special Investigations	**I**
Compliance	Senior Director, Enterprise Risk Management & Operational Oversight	**I**
Finance	Assistant Controller	**I**
Finance	Chief Financial Officer	**I**
Finance	Strategic Account Representative	**I**
Finance	Controller	**I**
Finance	Director, Vendor Management	**I**
Finance	Manager, Vendor Account Management	
Finance	Manager, Vendor Management	**I**
Finance	Director, Financial Planning & Analysis, Healthcare	**I**
Finance	Senior Director, Financial Planning & Analysis	**I**
Health Care Services	Chief Medical Officer	**I, II**
Health Care Services	Director, Long Term Services and Supports	**I**
Health Care Services	Director of Population Health & Equity	**I**
Health Care Services	Director, Quality Assurance	**I**
Health Care Services	Director, Social Determinants of Health	**I**
Health Care Services	Director, Utilization Management	**I**
Health Care Services	Executive Director, Medicare Programs	**I**
Health Care Services	Medical Director, Case Management	**I**
Health Care Services	Medical Director, Community Health	**I**

Health Care Services	Medical Director, Long Term Supportive Services	**I**
Health Care Services	Medical Director, Utilization Management	**I**
Health Care Services	Senior Director, Health Care Services	**I**
Health Care Services	Senior Director, Quality	**I**
Health Care Services	Senior Director, Behavioral Health	**I**
Health Care Services	Senior Director, Pharmacy Services	**I**
Health Care Services	Senior Medical Director	**I**
Health Equity	Chief Health Equity Officer	**I, II**
Health Equity	Director, Health Equity	**I**
Human Resources	Chief Human Resources Officer	**I, II**
Human Resources	Director, Human Resources	**I**
Human Resources	Human Resources Manager	**I**
Human Resources	Senior Director, Workforce Development	**I**
Human Resources	Director, Diversity, Equity, Inclusion	**I**
Information Technology	Chief Information Officer & Chief Security Officer	**I, II**
Information Technology	Director, IT Applications Management	**I**
Information Technology	Director, Applications Management, Quality & Process Improvement	**I**
Information Technology	Director, Data Exchange & Interoperability	**I**
Information Technology	Director, Data Integration & Application Development	**I**
Information Technology	Director, IT Infrastructure	**I**
Information Technology	Manager, IT Service Desk	**I**
Legal	Supervising Associate Counsel	**I, II**
Operations	Chief Operating Officer	**I, II**
Operations	Director, Claims	**I**
Operations	Director, Housing & Community Services Program	**I,II**
Operations	Director, Incentives & Reporting	**I**
Operations	Director, Provider Services & Provider Contracting	**I**

Operations	Director, Stars Strategy & Program Management	**I**
Operations	Executive Director, Medicare Programs	**I**
Operations	Executive Director, Operations	**I**
Operations	Manager, Networks & Contracting	**I**
Operations	Senior Director, Behavioral Health Services & Long Term Care Operations	**I**
Operations	Senior Director, Portfolio Management & Service Excellence	**I**
Operations	Senior Director, Facilities	**I, II**
Operations	Senior Director, Integrated Planning	**I**
Operations	Senior Director, Member Services	**I**
Operations	Senior Manager, Public Affairs & Media Relations	**I**
Operations	Senior Manager, Communications & Outreach	**I**
Operations	Senior Manager, Peer Review & Credentialing	**I**
All	Consultants[1]	**I**

[1] Consultants shall be included in the list of designated positions and shall disclose pursuant to the broadest disclosure category in the code subject to the following limitation. The Chief Executive Officer may determine in writing that a particular consultant, although a "designated person," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements described in this section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. The Chief Executive Officer's determination is a public record and shall be retained for public inspection in the same manner and location as this Conflict of Interest Code.

APPENDIX “B”

Disclosure Categories

CATEGORY I

Persons in this category shall disclose all investments, income (including compensation for consulting work, loans (including bank loans, gifts, and travel payments) and business positions in:

a. Health care providers or other businesses under contract with or under consideration to contract with the Alliance.
b. Businesses engaged in the delivery of health care services or supplies, or services or supplies ancillary thereto of a type to be provided or arranged for by the Alliance.
c. Businesses that manufacture, provide, or sell services, supplies, materials, machinery, or equipment of a type purchased or leased by the Alliance.
d. Businesses subject to the regulatory, permitting or licensing authority of the Alliance.

CATEGORY II

Persons in this category shall disclose all interests in real property in Alameda County if the property or any part of it is located within or not more than two miles outside the boundaries of Alameda County or within two miles of any land owned or used by the Alliance.

Persons are not required to disclose a residence, such as a home or vacation cabin, used exclusively as a personal residence; however, a residence in which a person rents out a room or for which a person claims a business deduction may be reportable.

2024-2025 Hourly and Salary Schedule

Alameda Alliance for Health
Salary Schedule
Effective: 12/22/2024 (first day of pay period after 12/13/2024 BOG meeting)

Pay Grade	Job	Job Title Creation Date	Hourly HMin	Hourly HMid	Hourly HMax	Annual SMin	Annual SMid	Annual SMax
Grade 1			**20.01**	**25.01**	**30.01**	**41,620.80**	**52,020.80**	**62,420.80**
	Administrative Assistant	1/4/2005						
	Claims Customer Service Representative	9/24/2004						
	Claims Processor	10/13/2000						
	Facilities Clerk	4/12/2012						
	Information Support Clerk	9/7/2011						
	Member Services Representative	3/2/2007						
	Member Services Support Services Specialist	6/27/2016						
	MS Support Services Specialist	6/27/2016						
	Provider Data Clerk	4/28/2016						
	Provider Data Entry Clerk	9/16/2014						
	Provider Data Entry Clerk Lead	9/16/2014						
	Provider Network Data Clerk	4/28/2016						
	Receptionist / MS Support Specialist	4/2/2019						
	Receptionist Office Support	6/11/2012						
Grade 2			**22.88**	**28.61**	**34.33**	**47,590.40**	**59,498.40**	**71,406.40**
	Authorization Unit Specialist	1/15/2002						
	CM Coordinator	12/22/2024						
	Community Health Worker HHWP	9/1/2017						
	Facilities Coordinator	2/14/2006						
	Facilities Coordinator I	8/11/2020						
	Grievance & Appeals Clerk	11/28/2016						
	Member Services Rep I	6/14/2016						
	Member Services Representative I	6/14/2016						
	Member Services Representative I - Bilingual Arabic	6/1/2017						
	Member Services Representative I - Bilingual Cantonese	6/1/2017						
	Member Services Representative I - Bilingual Cantonese/Manda	6/1/2017						
	Member Services Representative I - Bilingual Farsi	6/1/2017						
	Member Services Representative I - Bilingual Mandarin	6/1/2017						
	Member Services Representative I - Bilingual Spanish	6/1/2017						
	Member Services Representative I - Bilingual Tagalog	6/1/2017						
	Member Services Representative I - Bilingual Vietnamese	6/1/2017						
	Member Services Representative I Bilingual	6/1/2017						
	MS Rep I Bilingual	6/1/2017						
	Provider Data Coordinator I	4/28/2016						
	Provider Dispute Resolution Clerk	6/7/2017						
	Provider Dispute Resolution Coordinator	3/12/2019						
	Provider Dispute Rsltn Clerk	6/7/2017						
	Provider Relations Rep I	6/11/2015						
	Provider Relations Representative	8/3/2000						
	Provider Relations Representative I	6/11/2015						
	Senior Claims Processor	7/1/2003						
	Support Services Clerk	3/17/2016						
	Third Party Liability/Other Health Coverage Coordinator	9/30/2021						
Grade 3			**27.11**	**33.89**	**40.66**	**56,388.80**	**70,480.80**	**84,572.80**
	Accounts Receivable Clerk	7/17/2001						
	Claims Coordinator	4/7/1997						
	Claims Processor I	10/28/2016						
	Claims Recovery Specialist	4/1/2015						
	Credentialing Coordinator	5/1/2014						
	Data Specialist	9/17/2015						
	Facilities Coordinator II	3/17/2023						
	Grievance and Appeals Coord	8/2/2006						
	Grievance and Appeals Coordinator	8/2/2006						
	Grievance and Appeals Coordinator I	11/28/2016						
	Health Assessment Coordinator	7/12/2013						
	Lead Facilities Coordinator	4/12/2012						
	Lead Member Services Representative	1/21/2011						
	Member Care Advisor	8/9/2007						
	Member Services Rep II	10/1/2007						
	Member Services Rep II – Bilingual Cantonese/Vietnamese	10/1/2007						
	Member Services Representative II	10/1/2007						
	Member Services Representative II - Bilingual Cantonese	6/14/2016						
	Member Services Representative II - Bilingual Cantonese/Mandarin	6/14/2016						
	Member Services Representative II – Bilingual Cantonese/Vietnamese	6/14/2016						
	Member Services Representative II - Bilingual Vietnamese	6/14/2016						
	Member Services Representative II Bilingual Spanish	6/14/2016						
	Member Services Representative II Bilingual Tagalog	6/14/2016						
	MSR II	10/1/2007						

	Title	Date						
	MSR Rep II Bilingual	10/1/2007						
	Pharmacy Services Specialist	10/17/2001						
	Provider Data Coordinator II	1/11/2016						
	Provider Relations Coordinator	7/29/2013						
	Provider Relations Rep II	5/27/2015						
	Provider Relations Representative II	5/27/2015						
	Provider Relations Representative Lead Call Center	9/4/2018						
	Staff Accountant	1/20/2004						
	Support Services Coordinator I	10/21/2022						
	Utilization Management Data Entry Specialist	11/10/2014						
Grade 4			**30.26**	**37.83**	**45.40**	**62,940.80**	**78,686.40**	**94,432.00**
	Accountant-Payroll	5/29/2020						
	C&L Services Specialist	12/22/2024						
	Claims Analyst	11/15/2004						
	Claims Auditor	3/30/2005						
	Claims Lead	9/23/2002						
	Claims Processor II	10/28/2016						
	CompleteCare Specialist	8/4/2008						
	Compliance Analyst	9/10/2014						
	Compliance Coordinator	9/10/2014						
	Compliance Delegation Oversight Specialist	4/16/2021						
	Contract Analyst	3/1/2002						
	Coordination of Benefits Coordinator	2/15/2006						
	Education Specialist	12/22/2024						
	Facilities Maintenance Spclst	1/1/2017						
	Facilities Maintenance Specialist	1/1/2017						
	Facility Site Rev QI Coordinat	3/16/2015						
	Facility Site Review Quality Improvement Coordinator	3/16/2015						
	GL Accountant	1/31/2005						
	Grievance and Appeals Coordinator II	8/31/2023						
	Health Education Coordinator	7/1/2016						
	Health Programs Coordinator	12/22/2024						
	Inpatient Util Mgmt Coord	12/22/2024						
	Intake Coordinator	1/27/2012						
	Lead Authorization Unit Specialist	1/15/2002						
	Lead Claims Processor	4/1/2015						
	Lead Data Coordinator	3/29/2018						
	Lead Grievance and Appeals Coo	12/22/2024						
	Lead Staff Accountant	6/1/2010						
	Member Services Rep III	6/14/2016						
	Member Services Rep III - Bilingual Cantonese/Mandarin	6/14/2016						
	Member Services Representative III	6/14/2016						
	Member Services Representative III - Bilingual Cantonese	6/14/2016						
	Member Services Representative III - Bilingual Spanish	6/14/2016						
	Member Services Representative III - Bilingual Tagalog	6/14/2016						
	Member Services Representative III - Bilingual Vietnamese	6/14/2016						
	Member Services Representative III Bilingual Cantonese Vietn	6/14/2016						
	Member Services Representative III Bilingual Cantonese Vietnamese	6/14/2016						
	Member Services Representative III - Bilingual Cantonese/Mandarin	6/14/2016						
	Outreach Coordinator	6/3/1998						
	Outreach Coordinator - Bilingual Cantonese/Mandarin	3/15/2016						
	Outreach Coordinator - Bilingual Spanish	6/3/1998						
	Outreach Coordinator - Bilingual Vietnamese	6/3/1998						
	Outreach Coordinator I - Bilingual Arabic	7/1/2017						
	Outreach Coordinator I - Bilingual Spanish	3/15/2016						
	Outreach Supervisor	12/22/2024						
	Peer Review Credentialing Coordinator	1/14/2013						
	Pharmacy Technician	2/28/2017						
	Provider Data Coordinator III	4/28/2016						
	Provider Data QA Specialist	10/4/2017						
	Provider Data Quality Assurance Specialist	10/4/2017						
	Provider Relations Rep III	6/11/2015						
	Provider Relations Representative III	6/11/2015						
	Quality Assurance and Training Specialist	10/1/2007						
	Quality Programs Coordinator	8/10/2017						
	Regulatory/Legal Assistant	10/1/2018						
	Senior Provider Data Analyst	9/30/2014						
	Service Desk Coordinator	12/5/2012						
	Transition of Care Utilization Management Coordinator	9/1/2013						
	Utilization Management Coordinator	7/7/2016						
	Utilization Mgmnt Coordinator	7/7/2016						
	Vendor Analyst I	2/20/2020						
	Vendor Management Analyst	12/29/2016						
	Vendor Management Analyst I	12/22/2024						
Grade 5			**34.80**	**43.51**	**52.21**	**72,384.00**	**90,490.40**	**108,596.80**

Accreditation and Regulatory Compliance Specialist	5/21/2015
Application Software QA Spcst	11/7/2011
Assistant to the CEO and Board of Governors	12/22/2024
Behavioral Health Case Management Navigator	3/1/2022
Behavioral Health Navigator	3/1/2022
Behavioral Health Navigator - Bilingual	3/1/2022
Behavioral Health Navigator - Bilingual Spanish	3/1/2022
Behavioral Health Quality Improvement Navigator	3/1/2022
Behavioral Health Quality Improvement Navigator - Bilingual	3/1/2022
Behavioral Health Quality Improvement Navigator - Bilingual Spanish	3/1/2022
Benefits Specialist, Member Services	6/23/2014
BH Quality Improvement Navigator – Bilingual Spanish	3/1/2022
Business Operations Support Specialist	2/1/2012
Case Management Coordinator	6/13/2022
Claims Auditor Trainer	6/8/2011
Claims Outreach Specialist	6/8/2011
Claims Oversight Specialist	6/20/2013
Claims Processor III	10/28/2016
Claims Quality Auditor Specialist	10/27/2023
Claims Specialist	10/28/2016
Claims Specialist - Provider Services	3/30/2018
Claims Specialist Lead	9/18/2018
Clinical Quality Programs Coordinator	10/1/2022
Communications & Content Specialist	7/1/2016
Communications & Content Splst	7/1/2016
Community Support Coordinator	9/1/2021
Compliance Specialist	2/15/2006
Contract Specialist	12/22/2011
Credentialing Quality Assurance Specialist	6/11/2024
Disease Management Health Educator	8/28/2019
Executive Administrator	12/22/2024
Executive Assist Chief Medical Officer/Credentialing Auditor	7/1/2011
Grievance and Appeals Coordinator III	8/31/2023
Health Educator	4/2/1999
Health Navigator	11/7/2011
Health Navigator (Bilingual Preferred)	1/27/2012
Health Navigator, ECM	2/28/2017
Health Navigator, Enhanced Care Management	2/28/2017
HEDIS Retriever - Seasonal	2/8/2019
Hospital Access Coordinator	5/7/2007
Housing Navigator Health Homes	2/28/2017
Interpreter Services Coordinator	4/14/2022
IT Service Desk Coordinator	7/9/2014
IT Service Desk Technician	1/1/2007
Lead Claims Analyst	9/23/2002
Lead Credentialing Coordinator	8/8/2022
Lead Grievance & Appeals Coordinator	1/24/2017
Lead Pharmacy Technician	9/25/2018
Marketing Outreach Coordinator	6/3/1998
Member Services Quality Assurance Specialist	1/31/2017
Operations Support Specialist	7/1/2011
Outreach Coordinator – Bilingual Tagalog	7/1/2017
Outreach Coordinator II - Bilingual Cantonese/Mandarin	7/1/2017
Outreach Coordinator II - Bilingual Spanish	7/1/2017
Outreach Coordinator II - Bilingual Vietnamese	7/1/2017
Oversight Specialist	4/2/2015
Production and Traffic Manager	6/9/2010
Provider Billing Prcss Spclst	12/15/2016
Provider Billing Process Specialist	12/15/2016
Provider Dispute Resolution Analyst	11/28/2016
Provider Relations Quality Assurance Specialist	7/20/2023
Quality Assurance Specialist	10/1/2013
Quality Assurance Specialist - Bilingual Spanish	1/31/2017
Quality Assurance Specialist - Bilingual Tagalog	1/31/2017
Quality Engagement Coordinator	12/21/2023
Quality Improvement Analyst	10/27/2006
Quality Improvement Project Specialist	8/1/2023
Quality Specialist	4/2/2015
Recruiter	4/20/2018
Respite Specialist	7/20/2023
Senior California Children's Services Specialist	10/12/2012
Senior Human Resources Specialist Training	1/1/2020
Senior Payroll Accountant	12/23/2015
Senior Utilization Management Project Specialist	6/25/2012
Senior Utilization Management Specialist	9/25/2014

	Service Coordinator Commercial Product	9/12/2013						
	Service Desk Support Technician	9/17/2014						
	Sr Service Desk Technician	12/22/2024						
	Sr Util Management Specialist	9/25/2014						
	Supervisor Data Entry Unit	8/31/2015						
	Supervisor Facilities	9/8/2016						
	Supervisor Grievance & Appeals and Care Advisor Unit	6/1/2010						
	Supervisor Health Assessment Unit	9/3/2013						
	Support Services Spvsr	12/22/2024						
	Support Services Supervisor	11/23/2015						
	Talent & Quality Development Specialist	1/31/2017						
	Talent & Quality Dvlpmnt Spcls	1/31/2017						
	Technical Analyst I	6/16/2015						
	TOC Health Navigator	9/5/2017						
	Training Specialist	10/1/2013						
	Transition of Care Health Navigator	9/5/2017						
	Utilization Management Specialist	1/9/2017						
	Utilization Mgmt Specialist	1/9/2017						
	Vendor Analyst II	2/21/2020						
Grade 6			**40.02**	**50.03**	**60.03**	**83,241.60**	**104,052.00**	**124,862.40**
	Accounting Analyst II	7/20/2023						
	Administrative Coordinator	4/8/1999						
	Analyst Healthcare	4/17/2019						
	Authorization Process Manager	12/15/2014						
	Business Operations Support Analyst	4/26/2012						
	California Children’s Services (CCS) Coordinator	7/1/2022						
	Care Management Coordinator	5/25/2010						
	Claims Operations Trainer	4/2/2015						
	Communications & Media Spec	10/1/2015						
	Communications & Media Specialist	10/1/2015						
	Communications Copywriter Editor	9/1/2023						
	Community Base Adult Services Utilization Management Coordinator	11/23/2022						
	Community Base Adult Services Utilization Mgmt. Coordinator	11/23/2022						
	Community Outreach Supervisor - Bilingual Spanish	7/1/2021						
	Community Supports Supervisor	9/1/2021						
	Compliance Auditor	11/21/2012						
	Compliance Auditor - Delegation Oversight	4/16/2021						
	Compliance Auditor – Internal Audit	4/16/2021						
	Compliance Auditor - Internal Audit, SIU and FWA	4/16/2021						
	Compliance Auditor - Internal Audit, Special Investigations Unit and Fraud,	4/16/2021						
	Compliance Special Investigator	8/15/2021						
	Configuration Analyst	2/25/2015						
	Contract Management Administrator	2/20/2020						
	Coordinator, Long Term Care	7/26/2022						
	Executive & Credentialing Assistant	3/28/2013						
	Executive Assistant	10/22/2001						
	Executive Assistant to Chief Operating Officer	12/16/2016						
	Financial Analyst	10/22/2001						
	Government Relations Coordinator	10/13/2011						
	Health Education Specialist	12/29/2017						
	Health Policy and Planning Specialist	7/19/2011						
	HealthCare Analyst	4/1/2010						
	Housing and Community Services Program Coordinator	6/24/2024						
	Inpatient Util Mgmt LVN	9/14/2014						
	Inpatient Utilization Management LVN	9/17/2014						
	Interim Manager, Claims Recovery and Resolution	7/1/2019						
	IT Service Desk Support Technician	6/21/2013						
	Lead Interpreter Services Coordinator	7/15/2022						
	Learning Development and Quality Supervisor	12/11/2020						
	Licensed Clinical Social Worker	3/29/2019						
	Long Term Care Health Navigator	6/1/2024						
	Manager Claims Operations	4/1/2015						
	Manager Claims Recovery and Resolution	4/2/2015						
	Medical Coder	9/9/2014						
	Member Liaison Specialist, Beh Health Bilingual Vietnamese	4/22/2022						
	Member Liaison Specialist, Behavioral Health	4/22/2022						
	Member Liaison Specialist, Behavioral Health – Bilingual Cantonese/Manda	4/22/2022						
	Member Liaison Specialist, Behavioral Health – Bilingual Spanish	4/22/2022						
	Member Liaison Specialist, Behavioral Health Bilingual Vietnamese	4/22/2022						
	Member Liaison Specialist, BH – Bilingual Cantonese/Mandarin	4/22/2022						
	Member Liaison Specialist, BH – Bilingual Spanish	4/22/2022						
	Mgr Claims Recvry and Resln	12/22/2024						
	Privacy Compliance Specialist	10/14/2020						
	Provider Dispute Resolution Supervisor	11/13/2019						
	Provider Relations Call Center Supervisor	9/2/2015						

	Title	Date						
	Provider Relations Rep IV	6/11/2015						
	Provider Relations Representative IV	6/11/2015						
	Provider Reln Call Ctr Spv	12/22/2024						
	Quality Improvement Project Specialist I	8/1/2023						
	Recruiting Supervisor	6/22/2020						
	Regulatory Compliance Specialist	6/4/2015						
	Regulatory Compliance Specialist, Legislative Policy & Analy	1/15/2021						
	Regulatory Compliance Specialist, Legislative Policy and Ana	1/15/2021						
	Senior Communications and Content Specialist	3/24/2023						
	Senior GL Accountant	3/14/2006						
	Senior HR Specialist	2/16/2016						
	Senior Human Resources Specialist	2/16/2016						
	Senior Member Care Advisor	5/9/2013						
	Senior Payroll Analyst	3/11/2022						
	Sr GL Accountant	3/14/2006						
	Strategic Communications Coordinator	1/1/2020						
	Sup UM Operations	7/19/2016						
	Supervisor Claims	2/15/2006						
	Supervisor Claims Processing	10/18/2016						
	Supervisor Claims Resolution	7/8/2008						
	Supervisor Claims Support Services	10/18/2016						
	Supervisor Intake Unit	5/31/2013						
	Supervisor Network Data Management	3/9/2016						
	Supervisor Network Data Mgt	3/9/2016						
	Supervisor Prior Authorization Unit	3/5/2013						
	Supervisor Utilization Management Operations	7/19/2016						
	Supervisor, Community Supports	9/1/2021						
	Supervisor, Grievance and Appeals	8/31/2023						
	Supervisor, Network Data Validation	6/2/2020						
	Supervisor, Provider Relations Call Center	8/2/2018						
	Transition of Care Program Specialist	9/1/2013						
	Transportation Coordinator	12/27/2022						
Grade 7			**46.03**	**57.54**	**69.04**	**95,742.40**	**119,672.80**	**143,603.20**
	Behavioral Health Quality Improvement Specialist	6/29/2023						
	Business System Analyst	12/2/2024						
	Care Management Operations Support Analyst	5/30/2013						
	Case Manager	3/11/2004						
	Claims Specialist Supervisor	10/18/2016						
	Clinical RN Specialist	2/20/2014						
	Communications Initiative Specialist	7/1/2022						
	Comp Benefits Manager	11/18/2015						
	Compensation Benefits Manager	11/18/2015						
	Compliance Project Specialist	5/7/2021						
	Contract Drafter and Negotiator	10/31/2022						
	Copywriter Content Manager	6/6/2010						
	Data Quality Analyst	9/25/2014						
	Facilities Manager	7/1/2018						
	Grievance & Appeals Manager	5/1/2012						
	Healthcare Services Specialist	3/22/2023						
	HR Generalist	2/15/2006						
	HRIS Analyst	5/28/2021						
	Human Resources Generalist	2/15/2006						
	Human Resources Information System (HRIS) Analyst	5/28/2021						
	Inpatient Utilization Management Coordinator	9/17/2014						
	Interim Case Manager	7/1/2019						
	Interim Compliance Manager	7/1/2019						
	Interim Facilities Manager	7/1/2019						
	Interim Manager, Communications & Outreach	7/1/2019						
	Interim Manager, Grievance and Appeals	7/1/2019						
	Interim Manager, Peer Review and Credentialing	7/1/2019						
	Interim Public Affairs Manager	4/10/2019						
	IT Service Desk Tech Network	6/1/2010						
	Jr. Business Analyst	12/30/2016						
	Jr. Systems Administrator	1/22/2016						
	Jr. Systems Administrator Telecom	7/6/2016						
	Jr. Systems Administrator Telecom	12/22/2024						
	Lead Accountant	8/25/2019						
	Lead Outpatient Utilization Management Coordinator	6/10/2020						
	Lead Quality Specialist	2/28/2023						
	Lead Service Desk Technician	6/1/2010						
	Legal Analyst	7/1/2017						
	Legal Analyst I	9/23/2019						
	Long Term Services & Supports (LTSS) Nurse Care Coordinator	11/1/2012						
	Manager Care Advisor Unit	5/24/2007						
	Manager Care Coordination	1/18/2011						

	Manager Care Management Applications	11/10/2011						
	Manager Community Relations	5/2/2016						
	Manager Customer Service	9/30/2014						
	Manager Grievance & Appeals Care Advisor Unit	5/24/2007						
	Manager Medicare Compliance	10/27/2011						
	Manager Medicare Initiatives	2/19/2013						
	Manager Peer Review Credentialing	5/25/2012						
	Manager, Public Relations	4/12/2018						
	Medical Social Worker	3/15/2018						
	Member Services Outbound Supervisor	8/8/2023						
	Member Services Supervisor	7/1/2013						
	Member Services Supervisor Behavioral Health	5/4/2022						
	Member Services Training and Development Supervisor	9/19/2023						
	Mgr Peer Review Credentialing	5/25/2012						
	Non Clinical Supervisor, Case Management	8/1/2023						
	Non-Clinical Supervisor, Case Management	8/1/2023						
	Nurse Liaison for Community Care Management	10/11/2017						
	OB Case Manager	8/8/2016						
	Operations Support Analyst	6/1/2010						
	Operations Technical Analyst	11/17/2011						
	Outpatient Utilization Management Coordinator	7/7/2016						
	Population Health and Equity Specialist	6/22/2022						
	Program Manager	12/1/1994						
	Provider Relations Education and Claims Advisor	3/4/2015						
	Public Affairs Manager	4/10/2019						
	Quality Improvement Project Specialist II	8/1/2023						
	Quality Improv Nurse Specialist	6/1/2002						
	Quality Improvement Nurse Specialist	6/1/2002						
	Retrospective UM Nurse	7/20/2016						
	Retrospective Utilization Management Nurse	7/20/2016						
	Senior Accountant	4/4/1997						
	Senior Analyst Operations	12/22/2024						
	Senior Analyst, Healthcare	9/12/2014						
	Senior Communications & Media Specialist	6/1/2023						
	Senior Contract Specialist	2/1/2021						
	Senior Data Analyst Healthcare	1/17/2018						
	Senior Financial Analyst	12/1/2004						
	Senior Financial Analyst HealthCare	11/28/2011						
	Senior Financial Analyst Planning	3/8/2012						
	Senior Government Relations Specialist	10/21/2010						
	Senior HealthCare Analyst	3/16/2015						
	Senior Provider Relations Representative	12/15/2012						
	Senior Quality Assurance and Reporting Analyst	8/13/2021						
	Senior Service Desk Technician	5/15/2015						
	Social Worker, Long Term Care	9/29/2022						
	Sr Financial Analyst HealthCare	11/28/2011						
	Sr Financial Analyst Planning	3/28/2012						
	Sr. Quality Assurance and Reporting Analyst	8/13/2021						
	Strategic Account Representative	2/20/2020						
	Supervisor, Health Plan Audits	8/9/2022						
	Supervisor, Health Plan Investigations	4/16/2021						
	Supervisor, Provider Relations	8/2/2023						
	Supervisor, Provider Services Call Center	8/2/2018						
	Supervisor, Regulatory Affairs and Compliance	11/11/2022						
	Technical Writer	7/25/2017						
	TOC Case Manager	12/1/2016						
	TOC Social Worker	7/17/2017						
	TOC UM Nurse Care Coordinator	2/8/2013						
	Transition of Care Case Manager	12/1/2016						
	Transition of Care Coach RN	6/26/2013						
	Transition of Care Social Worker	7/17/2017						
	Transition of Care Utilization Management Nurse Care Coordinator	2/8/2013						
	Utilization Management Nurse Care Coordinator	8/7/2003						
	Utilization Nurse Care Coordinator	3/24/2003						
	Whole Person Care Data Analyst	4/7/2017						
	Workforce Development Trainer	7/21/2024						
Grade 8			**52.93**	**66.16**	**79.39**	**110,094.40**	**137,612.80**	**165,131.20**
	Accreditation Manager	12/27/2022						
	Applications Systems Analyst	8/10/2008						
	Behavioral Health Triage Specialist	3/1/2022						
	Business Analyst	10/27/2010						
	Business Analyst, Incentives & Reporting	1/4/2023						
	Business Analyst, Integrated Planning	9/14/2021						
	Business Analyst, Project Management Office (PMO)	2/14/2023						
	Business Intelligence Analyst	7/1/2006						

Business Process Analyst	4/25/2024
Clerk of the Board	4/1/2021
Clinical Nurse Specialist	12/22/2024
Clinical Nurse Specialist, G&A Unit	7/20/2016
Clinical Nurse Specialist, Grievance & Appeals Unit	7/20/2016
Clinical Nurse Specialist, PDR Unit	7/1/2016
Clinical Nurse Specialist, Provider Dispute Resolution Unit	7/1/2016
Clinical Review Nurse	8/15/2018
Clinical Supervisor Utilization Management	6/12/2020
CM RN Supervisor	12/22/2024
Community Supports, Nurse	7/20/2023
Complex Case Manager, Nurse	6/6/2018
Compliance Manager	6/29/2005
Diversity, Equity and Inclusion Program Trainer	12/13/2023
EDI (Electronic Data Interchange) Analyst	2/26/2015
EDI (Electronic Data Interchange) Data Analyst	4/29/2020
EDI (Electronic Data Interchange) Report Developer	5/12/2020
EDI (Electronic Data Interchange) Support Analyst	6/29/2023
EDI Analyst	2/26/2015
EDI Data Analyst	4/29/2020
EDI Report Developer	5/12/2020
ETL Developer	6/23/2013
Inpatient Util Mgmt Reviewer	3/20/2015
Inpatient Utiliz Mgmt RN	9/17/2014
Inpatient Utilization Management Reviewer	3/20/2015
Inpatient Utilization Management RN	9/17/2014
Interim Complex Case Manager, Nurse	7/1/2019
Interim Manager, Claims Production	7/1/2019
Interim Manager, Compliance Audits and Investigations	12/1/2020
Interim Manager, Health Education	9/28/2017
Interim Manager, Member Services	7/1/2019
Interim Manager, Regulatory Affairs & Compliance	7/15/2021
IT Service Desk Supervisor	7/21/2022
Jr. Application Developer	12/22/2024
Jr. ETL Developer	12/22/2024
Lead Financial Analyst Payroll	7/1/2024
Lead Financial Analyst, Revenue	12/22/2024
Lead HealthCare Analyst	9/12/2014
Lead Quality Improvement Project Specialist	8/12/2022
Lead Technical Analyst	2/16/2022
Long Term Services and Supports (LTSS) Liaison	2/21/2024
Manager Applications and Configuration	5/29/2013
Manager Claims Operations Support	11/5/2019
Manager Contract Operations	11/29/2005
Manager Quality Perf Improvement	5/20/2016
Manager, Claims Production	10/18/2016
Manager, Community Supports	12/11/2023
Manager, Compliance Audits and Investigations	7/8/2016
Manager, Compliance Audits, and Investigations	7/8/2016
Manager, Health Education	4/2/1999
Manager, Networks and Contracting	8/3/2021
Manager, Provider Services	2/15/2006
Manager, Provider Services Call Center	6/23/2022
Manager, Regulatory Affairs & Compliance	1/15/2021
Manager, Vendor Account Management	7/22/2024
Member Services Manager	4/6/2005
Out of Plan Nurse Specialist	10/17/2018
Out of Plan Services Nurse Specialist	10/17/2018
Outpatient Non-Clinical Utilization Management Supervisor	6/12/2020
Outpatient Utilization Management Organ Transplant Nurse	9/22/2021
Project Manager Business	3/20/2015
Quality Assurance Analyst	8/14/2023
Quality Improvement Review Nurse	5/16/2006
Quality Review Nurse	1/20/2017
Senior Analyst, Healthcare Finance	7/20/2023
Senior Configuration Analyst (IT)	12/22/2024
Senior ETL Analyst	8/26/2016
Senior Financial Analyst, Healthcare Finance	4/27/2022
Senior Financial Planning Analyst	4/27/2023
Senior HR Generalist	9/26/2014
Senior Human Resources Generalist	9/26/2014
Senior Human Resources Generalist Trainer	2/6/2020
Senior Legal Analyst	7/10/2023
Senior Technical QA Engineer	4/27/2023
Sr. ETL Analyst	12/22/2024

Grade	Job Title	Date						
	Sr. Technical QA Engineer	12/22/2024						
	Supervisor Applications and Configuration	8/31/2016						
	Supervisor Outpatient Utilization Management	9/19/2014						
	Supervisor, Autism	5/13/2024						
	Supervisor, Behavioral Health	5/13/2024						
	Supervisor, Health Plan Privacy	7/10/2023						
	System Administrator	3/12/2015						
	System Administrator Communications	7/21/2016						
	Systems Administrator	2/28/2014						
	Technical Analyst II	6/12/2015						
	Technical Business Analyst	8/23/2012						
	Technical PMO Business Analyst	4/7/2017						
	Technical Project Management (PMO) Business Analyst	4/7/2017						
	Technical QA Analyst	3/16/2015						
Grade 9			**60.96**	**76.20**	**91.43**	**126,796.80**	**158,485.60**	**190,174.40**
	Applied Behavioral Analysis Analyst	3/1/2022						
	Applied Behavioral Analysis Analyst, Behavioral Health	3/1/2022						
	Applied Behavioral Analysis Supervisor	6/5/2024						
	Behavioral Health Case Management Nurse	3/1/2022						
	Behavioral Health Quality Improvement Nurse	3/1/2022						
	Behavioral Health Supervisor	5/13/2024						
	California Children's Services Outpatient Utilization Management Nurse	7/20/2022						
	CCS Outpatient Utilization Management Nurse	7/20/2022						
	Clinical Manager of Enhanced Care Management (ECM)	4/20/2019						
	Clinical Manager, Health Homes	4/20/2019						
	Clinical Quality Manager	6/1/2018						
	Clinical Supervisor, Long Term Care	6/1/2024						
	Clinical Supervisor, Outpatient Utilization Management	6/12/2020						
	Data Steward Lead	8/23/2012						
	EDI (Electronic Data Interchange) Lead	9/1/2020						
	EDI (Electronic Data Interchange) Lead Role	9/1/2020						
	EDI (Electronic Data Interchange) Software Developer	1/16/2020						
	EDI Lead	9/1/2020						
	EDI Software Developer	1/16/2020						
	Enhanced Care Management, Nurse	6/23/2022						
	Grants and Incentives Program Manager	6/4/2024						
	Housing Program Manager	5/31/2023						
	Human Resources Manager	2/27/2008						
	Interim Clinical Manager, Health Homes	7/1/2019						
	Interim Clinical Quality Manager	7/1/2019						
	Interim Human Resources Manager	6/1/2020						
	Interim Lead Complex Case Manager	7/1/2019						
	Interim Manager, Healthcare Analytics	7/1/2019						
	Interim Manager, Service Desk	4/4/2017						
	Interim Manager, Transition of Care	7/1/2019						
	Interim Manager, Vendor Management	7/1/2019						
	Interim Program Manager / Senior Project Manager Managed Care	2/15/2018						
	IT Project Manager	12/16/2011						
	IT Security Analyst	7/19/2023						
	Lead Complex Case Manager	11/9/2016						
	Lead Data Analyst, Healthcare Finance	4/26/2021						
	Lead Financial Analyst Healthcare	8/15/2019						
	Lead Financial Analyst Planning	10/2/2019						
	Lead Financial Analyst, Reporting	10/3/2022						
	Lead Financial Analyst, Treasury	7/1/2024						
	Lead Financial Planning Analyst, Healthcare	4/27/2023						
	Lead Long Term Care Nurse Specialist	7/25/2023						
	Lead System Administrator	2/20/2019						
	Lead System Administrators	2/20/2019						
	Liaison, Clinical Initiatives and Leadership Development	11/2/2020						
	Manager Clinical Review Utilization Management Operations	12/9/2016						
	Manager eHealth Business Operations	5/23/2011						
	Manager Financial Analysis	3/17/2008						
	Manager HealthCare Analytics	9/1/2009						
	Manager Healthcare Analytics Network Performance	3/16/2015						
	Manager IT Operations	1/21/2011						
	Manager Technical Support	3/12/2015						
	Manager Transition of Care	2/8/2013						
	Manager Utilization and Care Coordination	6/8/2011						
	Manager Vendor Management	8/24/2016						
	Manager, Applications	2/23/2015						
	Manager, Community Health Worker	6/4/2024						
	Manager, Cultural and Linguistic Services	7/15/2022						
	Manager, Health Plan Privacy & Privacy Operations	10/24/2024						
	Manager, IT Service Desk	4/4/2017						

	Title	Date						
	Manager, Population Health and Equity	12/2/2024						
	Mgr Clinical Review UM Ops	12/9/2016						
	Mgr eHealth Business Ops	5/23/2011						
	Nurse Specialist, Long Term Care	7/26/2022						
	Outpatient Utilization Management Nurse	9/20/2016						
	Program Manager/Senior Project Manager, Managed Care	3/15/2017						
	Program Mgr/Sr. PM, Mngd Care	3/15/2017						
	Project Manager	5/18/2000						
	Quality Improvement Manager	6/1/2018						
	Senior Analyst of Health Equity	3/23/2023						
	Senior Application Analyst Release Management & Shared Services	7/18/2022						
	Senior Business Intelligence Analyst	9/1/2008						
	Senior Business Intelligence Engineer	10/31/2008						
	Senior Data Quality Analyst	12/7/2016						
	Senior EDI (Electronic Data Interchange) Analyst	7/24/2023						
	Senior EDI Analyst	7/24/2023						
	Senior ETL Developer	9/10/2014						
	Senior Healthcare Business Analyst	7/31/2012						
	Senior IT Project Manager	3/20/2015						
	Senior Manager HealthCare Analytics	3/16/2015						
	Senior Manager Quality Oversight	3/16/2015						
	Senior Quality Improvement Nurse Specialist	2/15/2006						
	Sharepoint Developer	2/18/2015						
	Software Development Engineer in Test	1/2/2024						
	Sr Qlty Improv Nurse Spclst	2/15/2006						
	Sr. Application Analyst Release Management & Shared Services	7/18/2022						
	Supervisor Case Management	11/1/2015						
	Supervisor Data Integration	2/25/2015						
	Supervisor QA and Analysis	2/25/2015						
	Supervisor, IT Applications	11/11/2020						
	Technical Business Data Analyst Data Integration	12/23/2012						
	Technical Quality Assurance Analyst	3/16/2015						
Grade 10			**68.29**	**85.37**	**102.44**	**142,043.20**	**177,559.20**	**213,075.20**
	Application Architect	3/12/2015						
	Applications Development Supervisor	12/22/2024						
	Behavioral Health Manager	6/14/2023						
	Business Intelligence Administrator/Developer	10/7/2022						
	Business Objects Adm Developer	1/24/2017						
	Business Objects Administrative Developer	1/24/2017						
	Change Control Process Improvement Manager	9/13/2016						
	Clinical Pharmacist	4/23/2007						
	Compensation Manager	12/12/2023						
	Data Architect	1/9/2012						
	Database & Applications Architect	12/15/2021						
	Database Administrator	6/1/2010						
	Director Accreditation	7/1/2016						
	Director Accreditation Reports Audit and Training	3/10/2015						
	Director Administration	5/30/2014						
	Director Case Management	9/11/2013						
	Director Clinical Services	1/14/2014						
	Director Complaints and Reslns	11/9/2015						
	Director Complaints and Resolutions	11/9/2015						
	Director Delegated Oversight	2/1/2014						
	Director Member Services	3/12/2007						
	Director Network Management	3/20/2015						
	Director Qtly Msr Prg Impv	3/13/2016						
	Director Quality Measurement Program Improvement	3/13/2016						
	Director, Compliance Privacy & Special Investigations	8/28/2020						
	Director, Health Care Services	7/10/2018						
	Director, Incentives & Reporting	7/29/2022						
	Director, Quality Analytics	12/21/2017						
	Finance Program Manager	12/31/2021						
	Interim Change Control & Process Improvement Manager	7/1/2019						
	Interim Director of Accreditation	7/1/2019						
	Interim Director, Clinical Services	7/1/2019						
	Interim Director, Complaints and Resolutions	7/1/2019						
	Interim Director, Health Care Services	7/1/2019						
	Interim Director, Member Services	7/1/2019						
	Interim Director, Quality Analytics	7/1/2019						
	Interim Manager Financial Planning & Analysis - Healthcare	7/1/2017						
	Interim Manager Financial Planning & Analysis Healthcare	7/1/2017						
	Interim Manager, Access to Care	7/1/2019						
	Interim Manager, Accounting	7/1/2019						
	Interim Manager, Analytics	12/22/2024						
	Interim Manager, Applications	7/1/2019						

Interim Manager, Case Management	7/1/2019
Interim Manager, Corporate Planning	1/24/2017
Interim Manager, Data Integration	7/19/2022
Interim Manager, Inpatient Utilization Management	7/1/2019
Interim Manager, Legal Services	12/22/2024
Interim Manager, Outpatient Utilization Management	12/22/2024
Interim Manager, Quality Analytics	12/22/2024
Interim Program Reimbursement Manager	4/23/2019
Interim Senior Project Manager	12/22/2024
IT Solution Designer	1/10/2024
Lead Applied Behavioral Analysis Analyst	7/14/2023
Manager Accounting	2/14/2006
Manager Analytics	4/2/2019
Manager Applications	2/23/2015
Manager Case Management	3/17/2015
Manager Corporate Planning	9/16/2013
Manager Data Integration	12/22/2024
Manager Financial Planning and Analysis Healthcare	11/26/2012
Manager Financial Planning and Analysis Planning	7/14/2013
Manager HealthCare Business Analytics	9/23/2013
Manager Healthcare Business Analytics Network Performance	7/25/2013
Manager Inpatient Utilization Management	9/19/2014
Manager IT Infrastructure	7/26/2016
Manager Outpatient Utilization Management	9/19/2014
Manager, Access to Care	10/10/2018
Manager, Accounting	7/1/2019
Manager, Analytics	4/2/2019
Manager, Financial Planning and Analysis - Healthcare	11/26/2012
Manager, Legal Services	7/29/2021
Manager, Long Term Care	7/26/2022
Manager, Medicare Marketing, Communications and Branding	7/12/2024
Manager, Payroll	4/17/2013
Manager, Quality Analytics	9/2/2021
Manager, Quality Assurance Release Management Shared Services	3/11/2022
Manager, Quality Assurance Release Mgmt Shared Services	12/22/2024
Mgr Fin Pln and Analys HlthCar	11/26/2012
Mgr Fn Pln and Analys Planning	7/14/2013
Mgr Inpatient Utilization Mgmt	9/19/2014
Mgr Outpatient Utiliz Mgmt	9/19/2014
Network Architect	8/17/2021
Pharmacy Program Manager	12/23/2012
Product Lead	10/19/2023
Program Reimbursement Manager	4/23/2019
Quality Assurance and Regulatory Reporting Manager	8/14/2023
Quality Improvement Supervisor	8/11/2017
Senior .Net Developer	1/24/2017
Senior BPMS Developer	1/15/2008
Senior Business Analyst	12/30/2016
Senior Business Analyst/Integrated Planning	8/8/2022
Senior Database Administrator	9/17/2014
Senior EEO and Employee Relations Liaison	8/30/2024
Senior Facilities Manager	9/20/2023
Senior Infrastructure Engineer	1/8/2018
Senior Lead Business Analyst	12/8/2021
Senior Manager Healthcare Business Analytics	9/10/2014
Senior Manager, Applications	2/20/2020
Senior Manager, Claims Operations Support	11/5/2019
Senior Manager, Grievance and Appeals	4/7/2023
Senior Manager, Provider Services	5/24/2022
Senior Net Developer	4/6/2012
Senior Network Analyst	5/1/2015
Senior Project Manager	10/17/2008
Senior System Administrator	11/30/2020
Senior Technical Project Manager	1/15/2021
Sr Database Administrator	9/17/2014
Sr Project Manager	10/17/2008
Sr. Business Analyst/Integrated Planning	8/8/2022
Sr. Lead Business Analyst	12/8/2021
Sr. Manager, Provider Services	5/24/2022
Sr. Technical Project Manager	1/15/2021
Supervisor, Accounting	6/1/2022
Systems & Security Engineer	2/27/2020
Systems Engineer	7/20/2007
Transitions of Care Pharmacist	2/10/2017
Voice Engineer	6/14/2019

Grade 11		80.50	100.63	120.75	167,440.00	209,300.00	251,160.00
Assistant Controller	10/15/2014						
Associate Counsel	6/14/2022						
Associate Director, Applications	12/11/2020						
Associate Director, Infrastructure	10/8/2018						
Associate Director, IT Infrastructure & Service Desk	10/8/2018						
Associate Director, IT Operations & Quality Applications Management	10/28/2021						
Data Architect and Delivery Manager	7/22/2019						
Data Integration Manager	7/22/2019						
Development and Data Integration Director	12/22/2024						
Director Claims	5/10/2013						
Director Clinical Initiatives and Clinical Leadership Development	4/16/2019						
Director Compliance	4/12/2010						
Director Compliance, Privacy & Special Investigations	8/28/2020						
Director of Population Health and Equity	8/8/2022						
Director of Portfolio Management & Service Excellence	7/16/2020						
Director of Vendor Management	2/21/2020						
Director Pharmacy Services	2/5/2010						
Director PMO	9/10/2014						
Director Project Management Office	9/10/2014						
Director Provider Contracting	5/18/2015						
Director, Long Term Services and Supports	7/20/2023						
Director, Quality Assurance	7/10/2018						
Director, Social Determinants of Health	10/8/2021						
Director, Utilization Management	9/13/2022						
EDI Manager	3/30/2017						
Enterprise Architect	1/22/2008						
ETL Lead	4/12/2022						
Executive Director Duals Programs	5/1/2012						
Information Security Director	4/17/2017						
Interim Assistant Controller	7/1/2019						
Interim Associate Director, Applications	12/11/2020						
Interim Associate Director, Infrastructure	7/1/2019						
Interim Associate Director, IT Infrastructure & Service Desk	10/8/2018						
Interim Data Architect and Delivery Manager	7/22/2019						
Interim Director of Portfolio Management & Service Excellence	7/16/2020						
Interim Director of Vendor Management	2/21/2020						
Interim Director, Claims	7/1/2019						
Interim Director, Clinical Initiatives and Clinical Leadership Development	7/1/2019						
Interim Director, Compliance	7/1/2019						
Interim Director, Financial Planning & Analysis	1/24/2017						
Interim Director, Pharmacy Services	7/1/2019						
Interim Director, Provider Services	7/1/2019						
Interim Director, Quality Assurance	7/10/2019						
Interim Director, Social Determinants of Health	10/8/2021						
Interim EDI Manager	7/1/2019						
Interim Senior Manager, Communications & Outreach	12/8/2021						
Interim Sr. Manager, Peer Review and Credentialing	12/1/2021						
IT Security Manager	7/19/2023						
IT Server Core Manager, IT Infrastructure	9/1/2023						
Lead Clinical Pharmacist	9/20/2018						
Lead Clinical Pharmacist, Medical Drug Management	6/30/2023						
Manager Development and Data Integration	4/30/2015						
Manager Financial Forecasting and Modeling	3/1/2023						
Manager, IT Governance and Incident Management	4/5/2024						
Pharmacy Supervisor	8/8/2022						
Senior Database Administrator Lead	4/22/2022						
Senior Director HealthCare Analytics	3/16/2015						
Senior Director Healthcare Business Analytics	12/17/2012						
Senior Director IT	4/27/2007						
Senior Director Medical Services	10/20/2006						
Senior Director Quality Improvement and Compliance Officer	1/15/2013						
Senior Finance Program Manager	7/29/2024						
Senior Manager – Project Management Office (PMO)	1/30/2023						
Senior Manager Analytics	7/1/2016						
Senior Manager Financial Planning & Analysis	2/13/2019						
Senior Manager of Health Equity	3/23/2023						
Senior Manager, Communications & Outreach	12/8/2021						
Senior Manager, Financial Planning and Analysis - Healthcare	2/13/2019						
Senior Manager, IT Applications	2/20/2020						
Senior Manager, Member Services	10/21/2022						
Senior Manager, Outpatient Utilization Management	7/21/2022						
Senior Manager, Payroll	7/1/2024						
Senior Manager, Peer Review and Credentialing	12/1/2021						
Senior Manager, Public Affairs and Media Relations	11/2/2022						

Grade	Title	Date						
	Senior Manager, Quality Analytics	9/2/2021						
	Senior Program Manager - Portfolio Programs	7/5/2022						
	Senior Program Manager – State Directed and Special Programs	7/5/2022						
	Sr. Manager, Member Services	10/21/2022						
	Sr. Manager, Peer Review and Credentialing	12/1/2021						
	Staff Attorney	7/29/2021						
Grade 12			**93.26**	**116.58**	**139.89**	**193,980.80**	**242,476.00**	**290,971.20**
	Director Applications Development	7/14/2016						
	Director Applications Management	7/14/2016						
	Director Applications Management and Configuration	12/19/2017						
	Director Data Integration & Application Development	3/6/2020						
	Director Fin Plan and Analysis	12/23/2012						
	Director Financial Planning and Analysis	12/23/2012						
	Director Health Equity	3/23/2023						
	Director Healthcare Analytics	12/7/2016						
	Director Infrastructure	3/20/2017						
	Director IT Applications Management	12/11/2020						
	Director Provider Services	6/29/2004						
	Director, Application Management	7/14/2016						
	Director, Applications Management, Quality & Process Improve	12/19/2017						
	Director, Applications Management, Quality & Process Improvement	12/19/2017						
	Director, Compliance & Special Investigations	8/28/2020						
	Director, Data Exchange and Interoperability	12/1/2020						
	Director, Diversity, Equity, Inclusion	4/19/2023						
	Director, Financial Planning and Analysis - Healthcare	7/29/2024						
	Director, Housing & Community Services Program	1/18/2023						
	Director, Human Resources	5/30/2014						
	Director, IT Infrastructure	1/7/2017						
	Director, Stars Strategy and Program Management	4/15/2024						
	Executive Director Government Relations and Program Oversight	11/11/2015						
	Executive Director HR	3/24/2017						
	Executive Director Human Resources	3/24/2017						
	Interim Director, Application Management	7/1/2019						
	Interim Director, Application Management & Configuration	7/1/2019						
	Interim Director, Applications Management, Quality & Process Improve	12/19/2017						
	Interim Director, Compliance & Special Investigations	8/28/2020						
	Interim Director, Data Exchange and Interoperability	12/1/2020						
	Interim Director, Healthcare Analytics	12/7/2016						
	Interim Director, Infrastructure	7/1/2019						
	Interim Executive Director, Human Resources	7/1/2019						
	Interim Senior Director Facilities	7/1/2019						
	Interim Senior Director of Quality	7/1/2019						
	Interim Senior Director, Behavioral Health	3/1/2021						
	Interim Senior Director, Member Services	11/30/2021						
	Interim Senior Director/Pharmacy Services	7/1/2019						
	Senior Director Facilities	9/15/2015						
	Senior Director Integrated Planning	4/9/2020						
	Senior Director of Behavioral Health Services & Long Term Care Operations	3/1/2021						
	Senior Director of Behavioral Health Services & LTC Ops	3/1/2021						
	Senior Director Pharmacy Services	7/28/2018						
	Senior Director Quality	7/1/2018						
	Senior Director, Behavioral Health	3/1/2021						
	Senior Director, Enterprise Risk Management & Operational Oversight	7/15/2024						
	Senior Director, Member Services	11/30/2021						
	Senior Director, Portfolio Management & Service Excellence	7/1/2022						
	Senior Manager, Financial Reporting	3/9/2022						
	Senior Program Director	12/22/2024						
	Supervising Associate Counsel	6/14/2022						
	Utilization Management Physician Reviewer	4/29/2019						
Grade 13			**126.14**	**157.68**	**189.21**	**262,371.20**	**327,964.00**	**393,556.80**
	Associate Medical Director	6/17/2004						
	Controller	8/19/2003						
	Director, Provider Services and Provider Contracting	7/1/2016						
	Executive Director Information Technology	9/6/2018						
	Interim Controller	1/24/2017						
	Interim Executive Director, IT	7/1/2019						
	Interim Senior Director of Financial Planning and Analysis	2/13/2019						
	Interim Senior Director of Health Care Services	4/23/2020						
	Senior Director Analytics	7/14/2013						
	Senior Director of Health Care Services	4/23/2020						
	Senior Director of Workforce Development	2/14/2023						
	Senior Director, Financial Planning & Analysis	12/7/2020						
	Senior Director, Health Care Services	7/1/2016						
	Sr. Director of Workforce Development	2/14/2023						
Grade 14			**130.22**	**162.80**	**195.37**	**270,857.60**	**338,613.60**	**406,369.60**

Grade	Title	Date						
Grade 15			**134.31**	**167.89**	**201.47**	**279,364.80**	**349,211.20**	**419,057.60**
	CCO/General Counsel	7/1/2014						
	Executive Director Healthcare Analytics	7/1/2016						
	Executive Director, Medicare Programs	9/8/2023						
	Executive Director, Operations	5/20/2014						
	Interim Medical Director	7/1/2019						
	Interim Quality Improvement Medical Director	7/1/2019						
	Medical Director	11/29/2000						
	Medical Director Long Term Supportive Services	10/22/2023						
	Quality Improvement Medical Director	8/14/2017						
Grade 16			**146.97**	**183.72**	**220.46**	**305,697.60**	**382,127.20**	**458,556.80**
	Chief Administrative Officer	4/1/2012						
	Chief Analytics Officer	3/1/2018						
	Chief Compliance Officer	5/18/2015						
	Chief Compliance Officer & Chief Privacy Officer	8/2/2020						
	Chief Financial Officer	10/22/2001						
	Chief Human Resources Officer	7/1/2020						
	Chief Information Officer	10/23/2001						
	Chief Information Officer & Chief Security Officer	8/26/2020						
	Chief of Health Equity	6/24/2022						
	Chief Performance Officer	6/1/2013						
	Chief Projects Officer	4/9/2020						
	Chief Strategy Officer	4/1/2012						
	Interim Chief Analytics Officer	7/1/2019						
	Interim Chief Compliance Officer	8/2/2020						
	Interim Chief Compliance Officer & Chief Privacy Officer	8/2/2020						
	Interim Chief Financial Officer	6/1/2016						
	Interim Chief Human Resources Officer	7/1/2020						
	Interim Chief Information Officer	8/26/2020						
	Interim Chief Information Officer & Chief Security Officer	8/26/2020						
	Interim Chief Projects Officer	4/9/2020						
	Interim Senior Medical Director	11/9/2021						
	Senior Medical Director	11/9/2021						
Grade 17			**171.75**	**214.69**	**257.62**	**357,240.00**	**446,544.80**	**535,849.60**
	Chief Medical Officer	3/31/2017						
	Chief Operating Officer	7/9/2003						
	General Counsel	7/17/2013						
	Interim Chief Medical Officer	3/31/2017						
	Interim Chief Operating Officer (COO)	7/1/2019						
	Interim General Counsel	12/22/2024						
Grade 18			**206.04**	**257.56**	**309.07**	**428,563.20**	**535,714.40**	**642,865.60**
Grade 19			**229.02**	**308.60**	**388.17**	**476,361.60**	**641,878.30**	**807,395.00**
	Chief Executive Officer	7/9/2001						
	Interim Chief Executive Officer	7/1/2019						

CEO Update

Matthew Woodruff

To: Alameda Alliance for Health Board of Governors

From: Matthew Woodruff, Chief Executive Officer

Date: December 13th, 2024

Subject: CEO Report

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

	October	YTD
Medi-Cal	($25.9M)	($58.5M)
Group Care	$238K	($156K)
Medicare	($1.4K)	($2.4K)
Total	($27M)	($61M)

  - **Revenue was $158.2 million in October 2024 and $669.3 million Year-to-Date (YTD)**.
    - Medical expenses were $177.2 million in October and $704.1 million for the fiscal year-to-date; the medical loss ratio is 112.0% for the month and 105.2% for the fiscal year-to-date.
    - Administrative expenses were $10.0 million in October and $39.2 million for the fiscal year-to-date; the administrative loss ratio is 6.3% of net revenue for the month and 5.9% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 252% of the required DMHC minimum, representing $117.1 million in excess TNE.
  - **Total enrollment in October 2024 was 406,153**, an increase of 220 Medi-Cal members compared to September 2024.

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - Nothing to report
  - **Non-Regulatory Metrics:**
    - Nothing to report

- **Alliance Updates:**
  - **Demographics**
    - Please see the attached PowerPoint 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. Currently, there are 17 different departmental workstreams and a total of 113 projects, of which 56 are active, 51 are requested, and 6 are on hold.
    - Notice of Intent to Apply (NOIA) was completed on November 8th, 2024, and the AAH H contract with CMS is H2035.
    - For supplemental benefit vendors, AAH is moving forward with finalizing contracting with dental, vision, and hearing. RFP/RFQ scoring is still in progress for Flex Card and Medication Therapy Management (MTM).
    - The Creative Department consultant group has completed a refresh of the AAH logo and names to modernize and elevate the brand identity. The logo and names are being brought to the Consumer Advisory Committee (CAC) for feedback on Thursday, December 5th.
    - Continuing to collaborate with IT in updating Core Claims / Medical Management Systems and identified 321 requirements collected within Microsoft List.

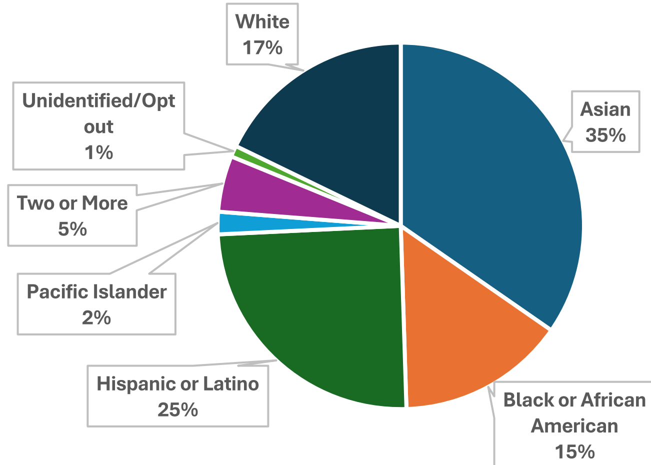
- **Financial Review**
    - Calling a special finance meeting in January to discuss the updated budget and forecast
    - Potential good news on calendar year 2024 rates
    - Good news for calendar year 2025 rates and forecast
    - Medicare decision no later than February 3, 2025

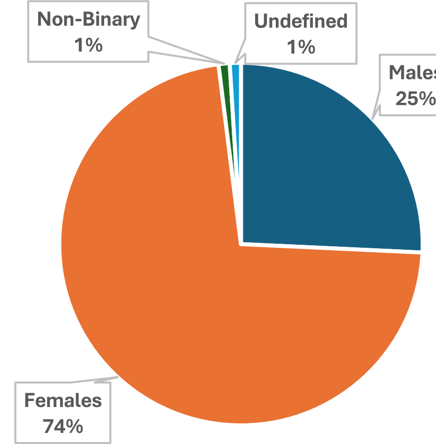
The purpose of this report is to conduct a comparative analysis of the demographic composition of Alameda Alliance for Health's workforce and the population distribution of Alameda Count. The primary focus of this comparison will be on key metrics, including race/ethnicity, gender, and age distribution. Through the analysis of these data points, our objective is to evaluate the extent to which our workforce reflects the county's population and to pinpoint areas for enhancing diversity, equity, and inclusion.

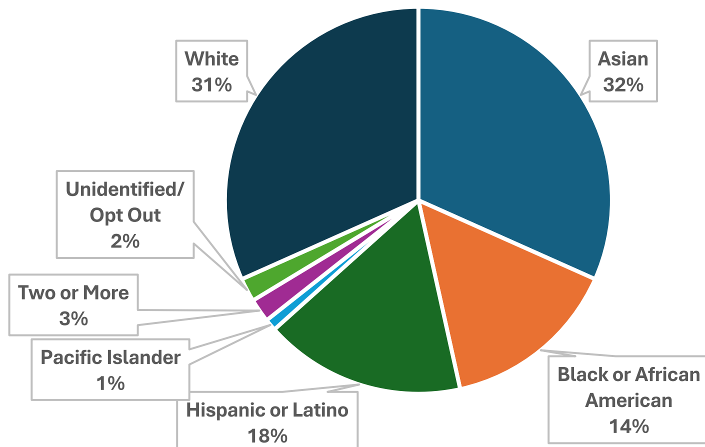
The demographic data for the county, including the total population and demographic breakdown, is sourced from Healthy Alameda County, which is sponsored by the Alameda County Public Health Department. This site serves as a central repository of information related to Alameda County, providing the most current data and over 250 community wellbeing indicators (Healthy Alameda County :: Demographics :: County :: Alameda. The information presented in this report was last updated in April 2024. Additionally, the data used for Alameda Alliance for Health was last updated in November 2024 and is collected and maintained monthly by the Human Resources Department internally.

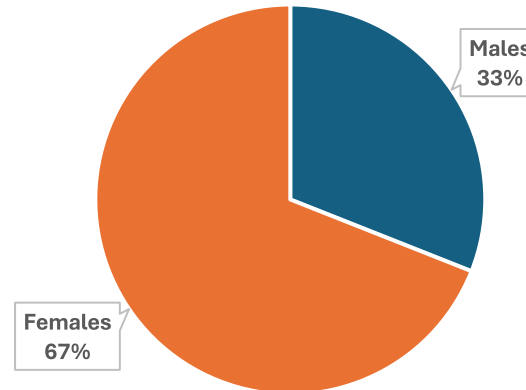
Category	**Alameda Alliance for Health** (Workforce information last updated November 2024)	**Alameda County** (Population Information last updated in April 2024)
Population/Total Employees	646	1,634,785
Race & Ethnicity		
Asian	35%	34.68%
Hispanic	25%	23.95%
White	17%	28.75%
Black/African American	15%	9.27%
Native Hawaiian/Pacific Islander	2%	0.85%
Two or More Races	5%	11.68%
Unidentified/Opt Out	1%	
Gender		
Male	26%	48.98%
Female	74%	51.02%
Non-Binary	1%	
Undefined	1%	
Age Distribution		
Under 25	1%	12.47%
25-34	22%	14.34%
35-44	34%	15.89%
45-54	25%	13.44%
55-Older	18%	27.65%

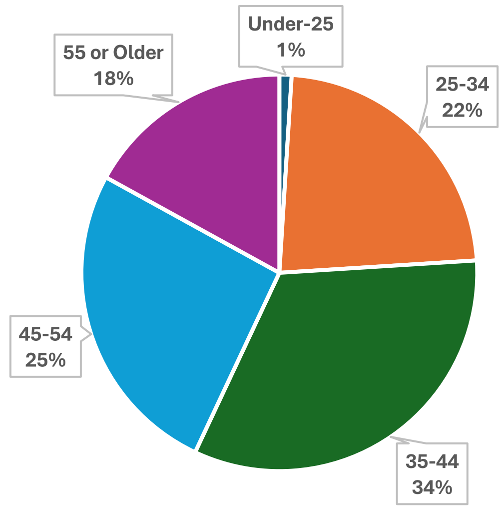
AAH Employee Demographics Data Report November 2024










Employee Age Demographics - 646
November 2024
Under-25
1%
25-34
22%
35-44
34%
45-54
25%
55 or Older
18%

Executive Dashboard

12/4/2024 1:34:18 PM

Financials

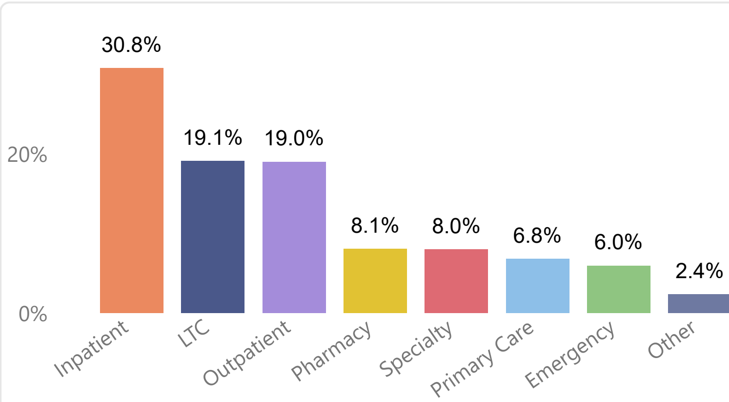
Income & Expenses

	OCTOBER 2024	FISCAL YTD
REVENUE	$ 221.7 M	$ 1.0 B
MEDICAL EXPENSE	$ (177.2) M	$ (704.1) M
ADMIN EXPENSE	$ (10.0) M	$ (39.2) M
OTHER/TAX	$ (61.5) M	$ (338.8) M
NET INCOME	$ (27.0) M	$ (61.0) M

Medical Loss % (Fiscal YTD)

105.2%

Medical Expenses



Liquid Reserves

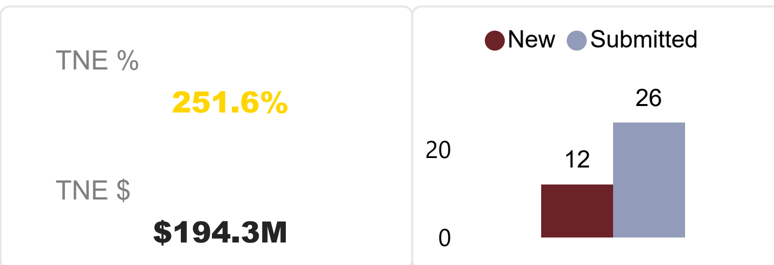
TNE %

251.6%

TNE $

$194.3M

Reinsurance Cases



Balance Sheet

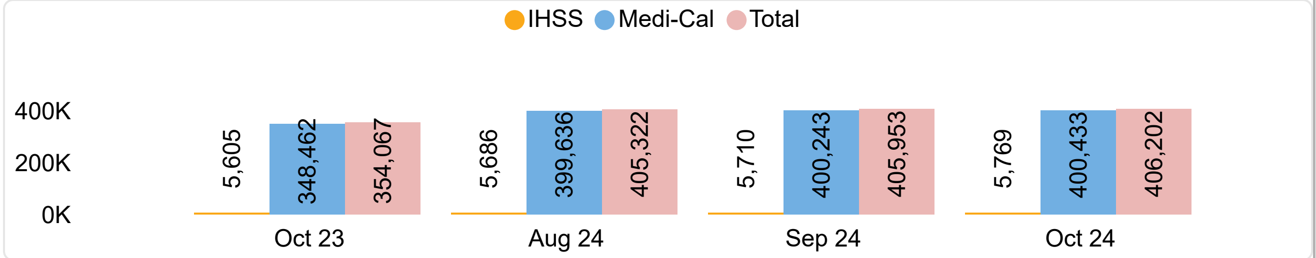
Cash Equivalents	$448.2M
Pass-Through Liabilities	$115.6M
Uncommitted Cash	$332.6M
Working Capital	$135.6M

Current Ratio

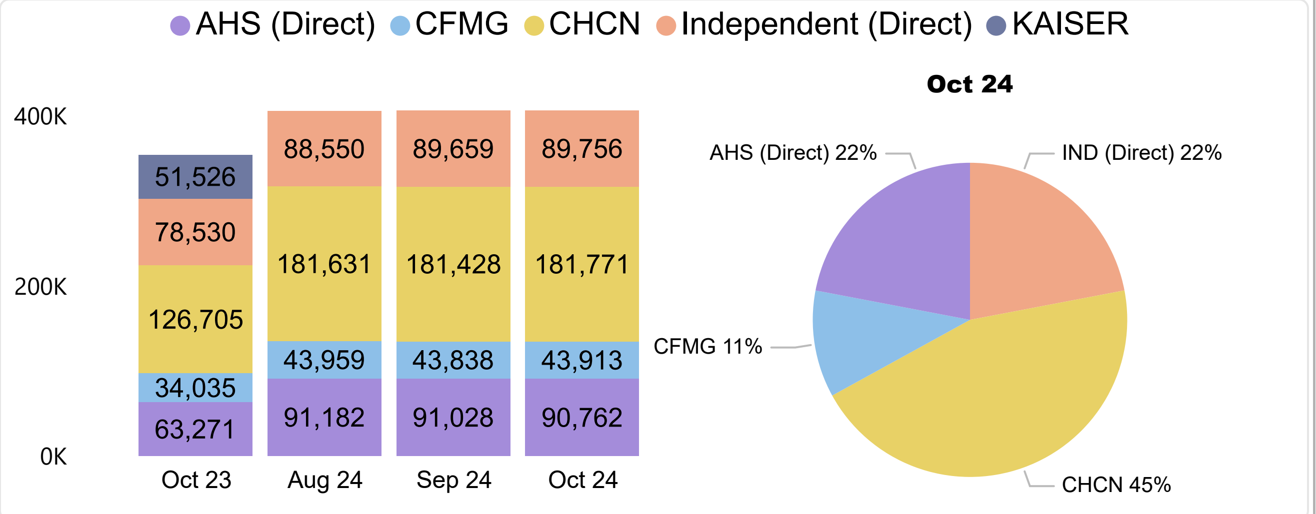
1.17

Membership

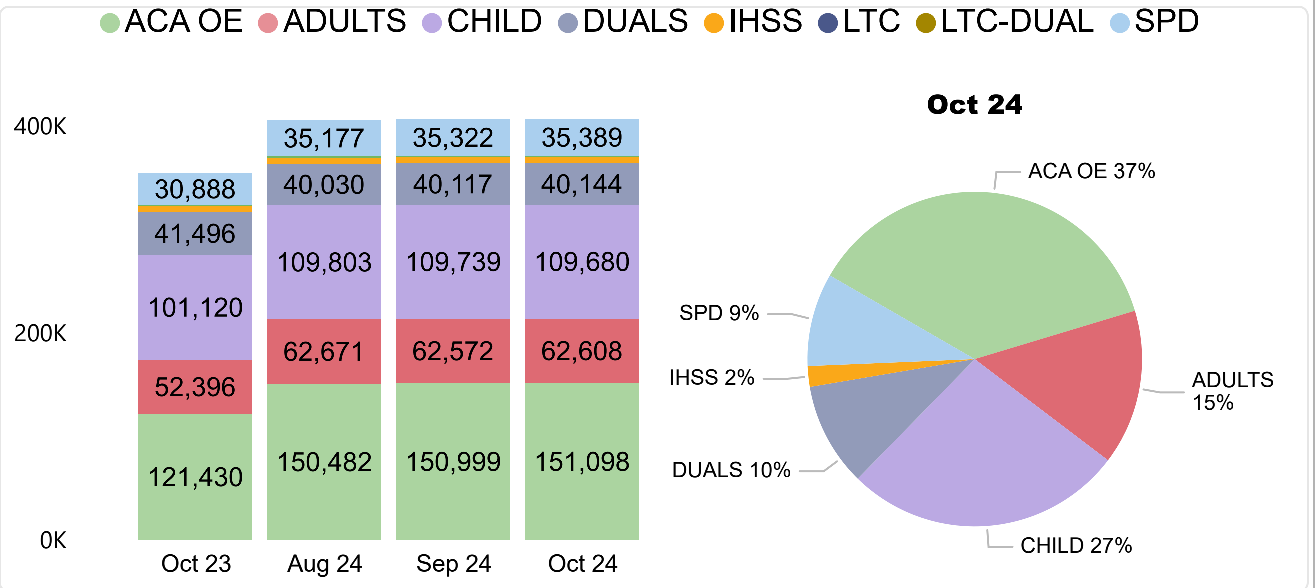
By Plan



By Network

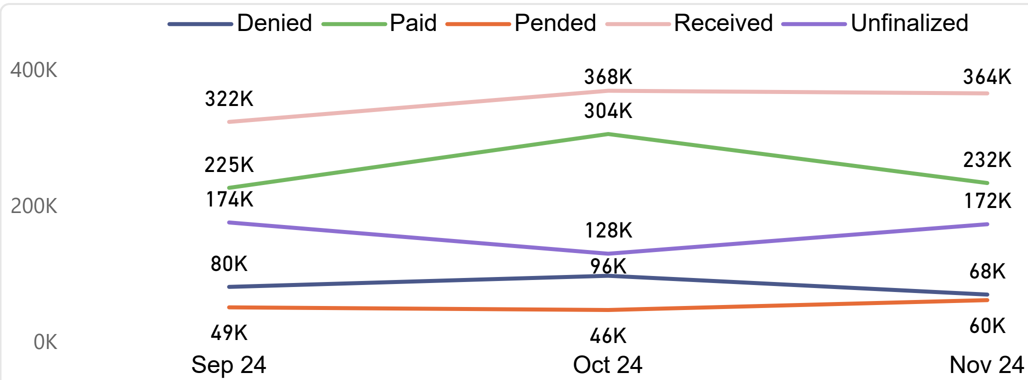


By Category

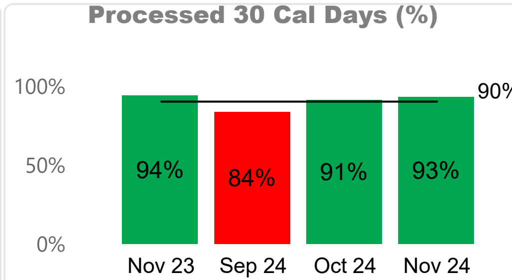


Claims

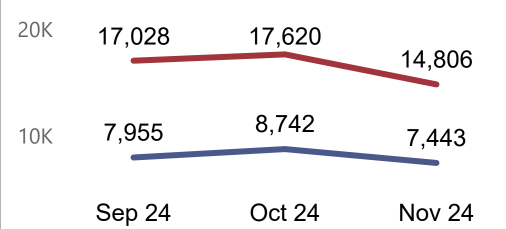
Claims Processing

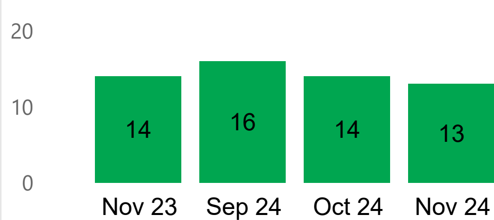


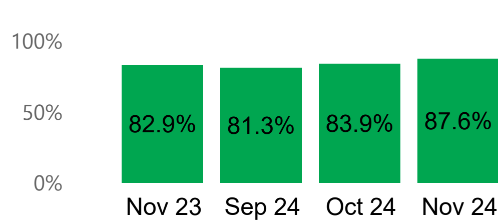
Claims Compliance

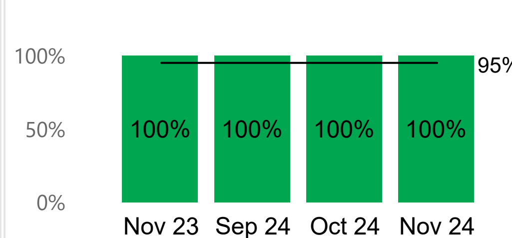


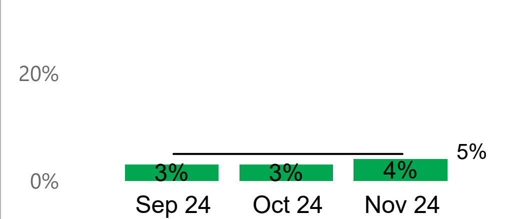
Member Services

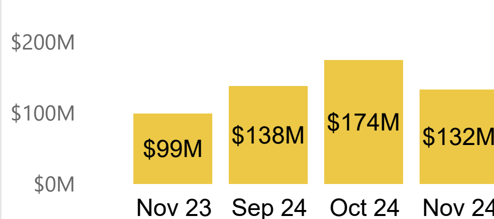


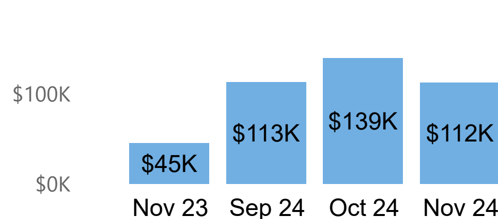




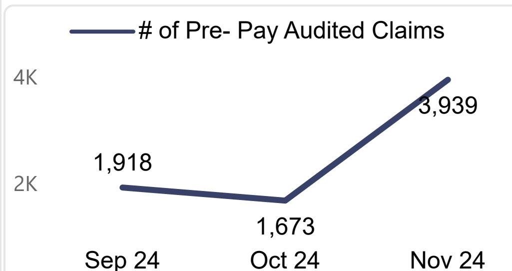


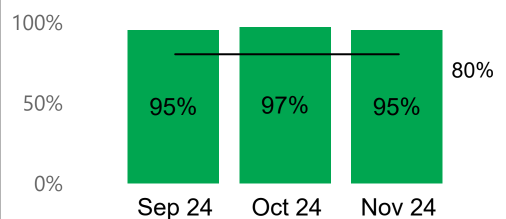






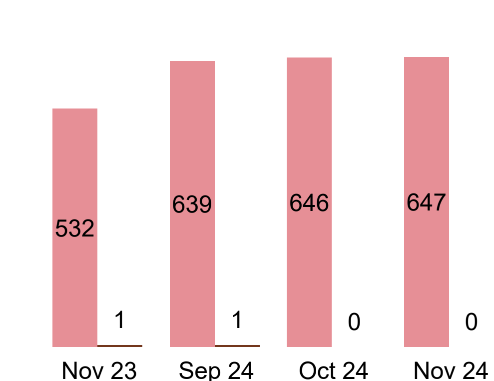
Claims Auditing

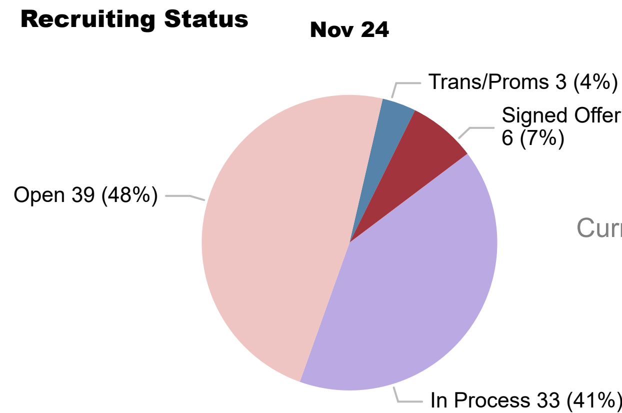




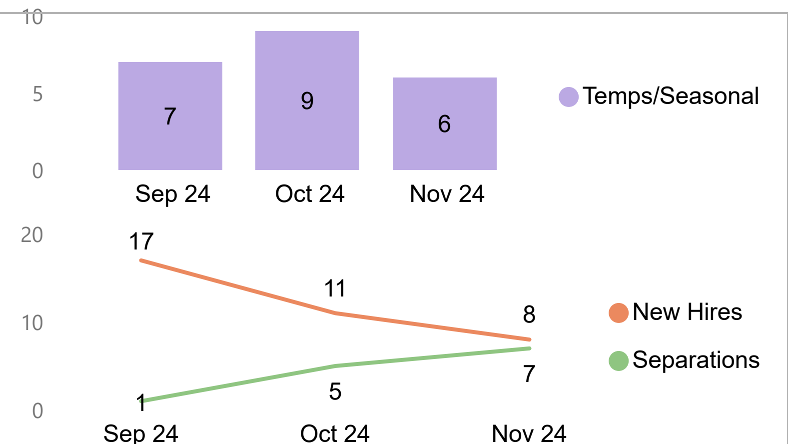
Average Call Times	Sep 24	Oct 24	Nov 24
Wait Time	00:14	00:9	00:12
Call Duration	07:11	07:08	07:13

Human Resources





Current Vacancy
5%



Provider Services

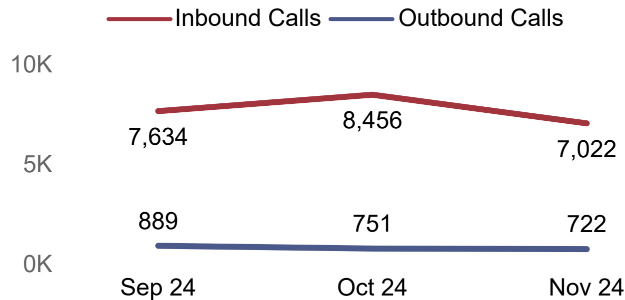
Provider Network

Hospital	17
Specialist	11,219
Primary Care Physician	771
Skilled Nursing Facility	106
Urgent Care	15
Health Centers (FQHCs and Non-FQHCs)	83
TOTAL	**12,211**

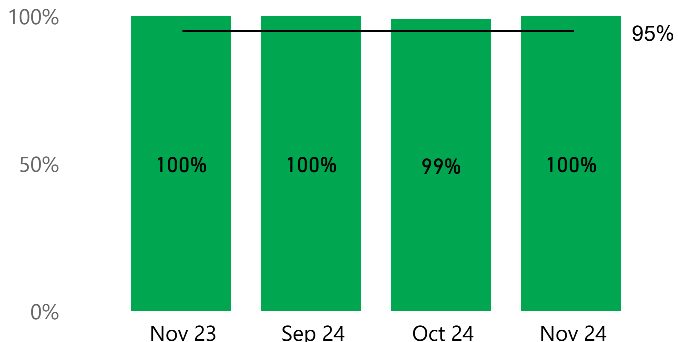
Provider Credentialing

4,199

Provider Call Center

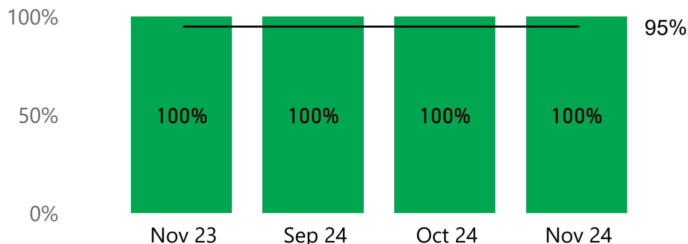


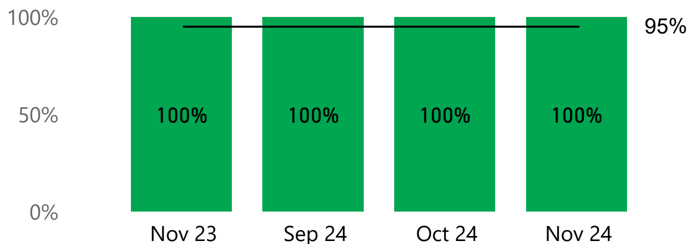
Provider Disputes & Resolutions



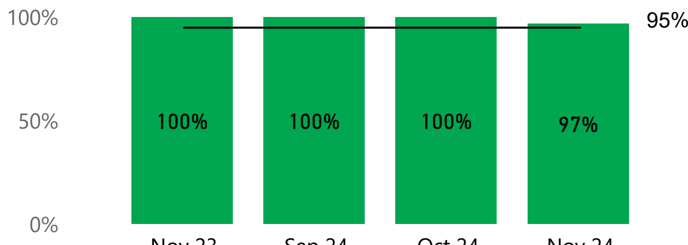
Compliance

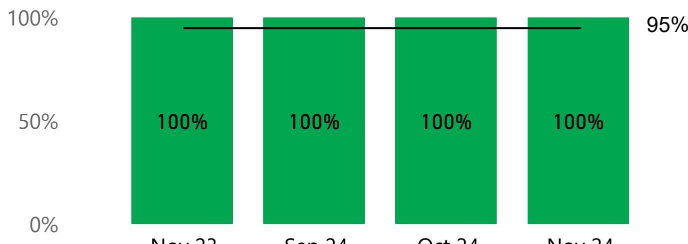
Member Grievances



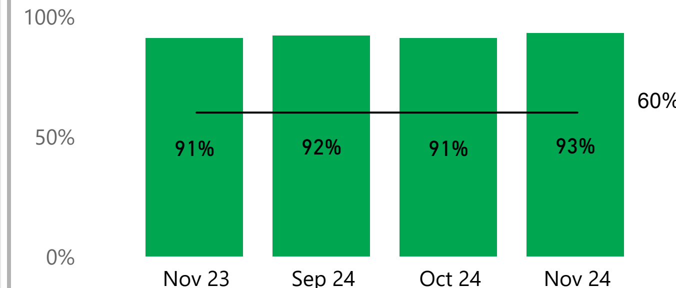


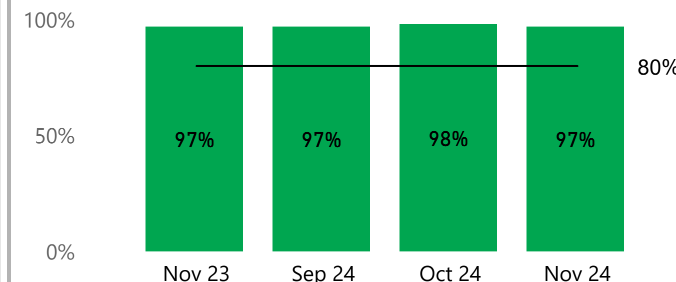
Member Appeals

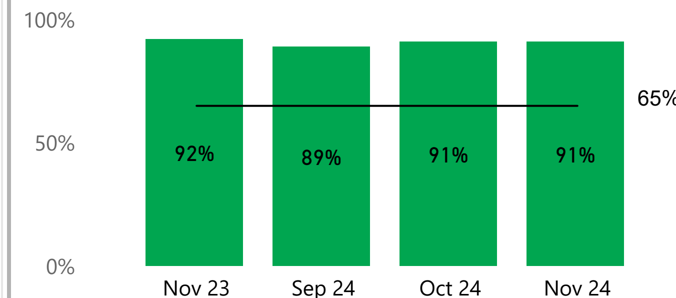


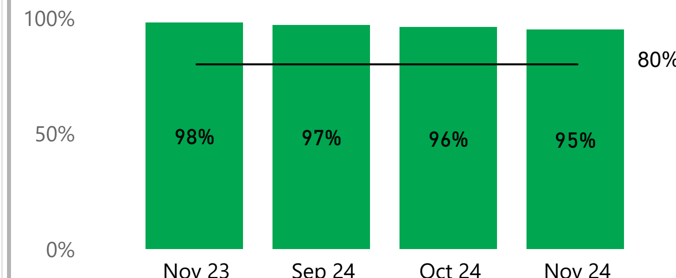


Encounter Data



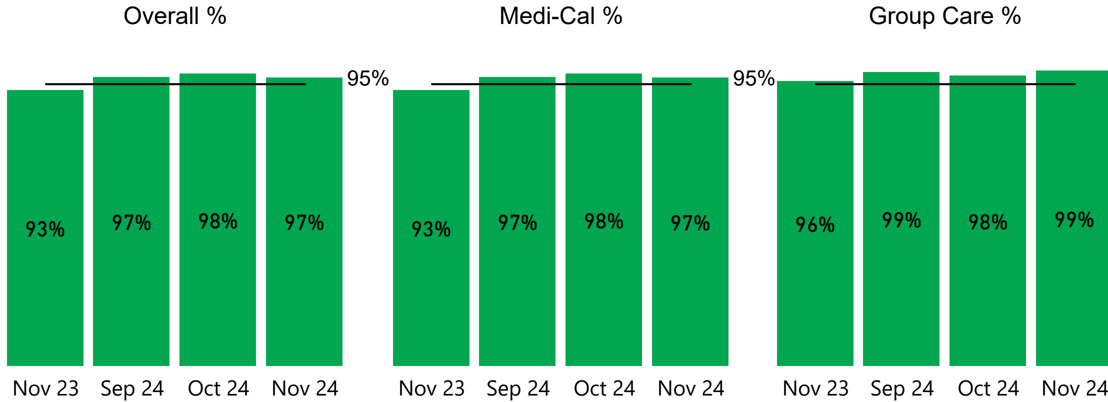




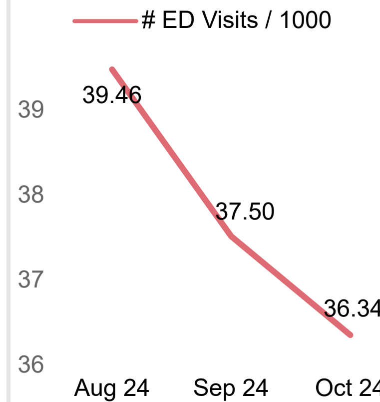


Health Care Services

Authorization Turnaround

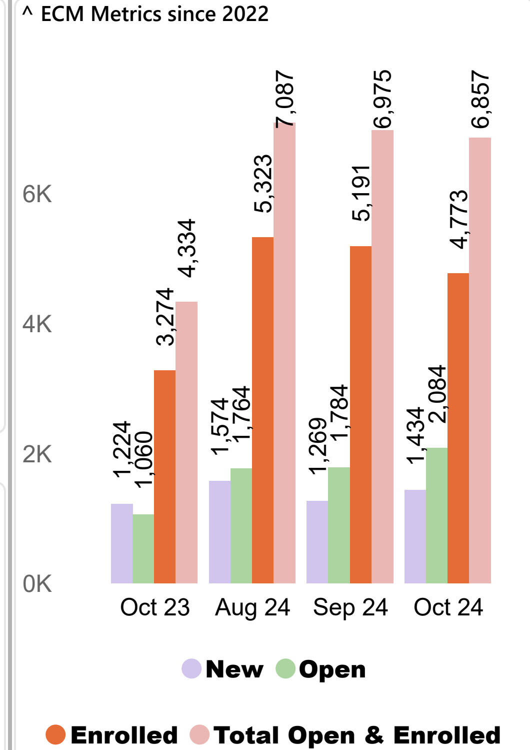


ED Utilization

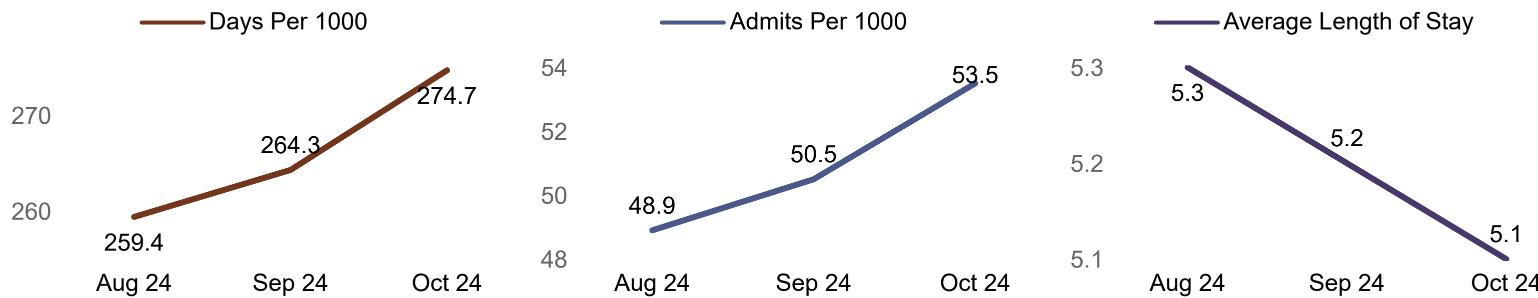


Case Management

Total Cases^



Inpatient Utilization

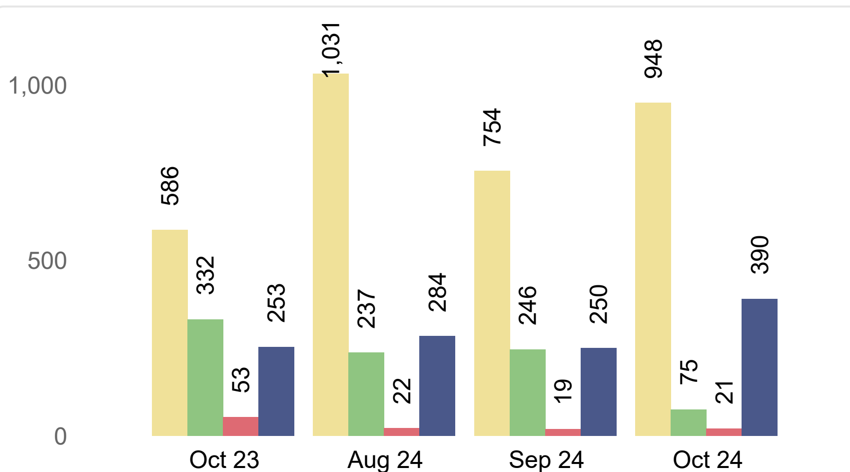


Case Management^

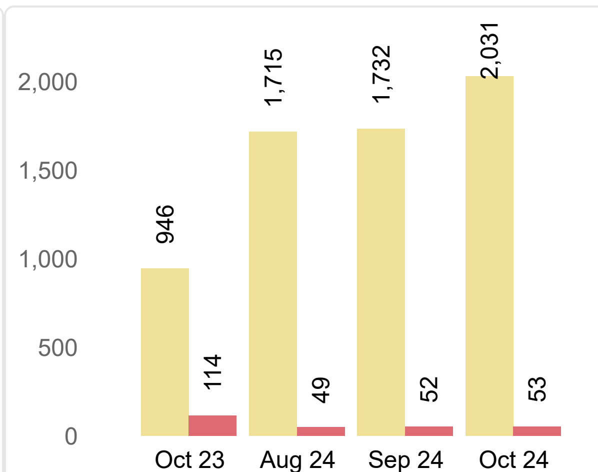
Care Coordination · Community Supports · Complex Cases · Enhanced Case Management

^ ECM Metrics since 2022

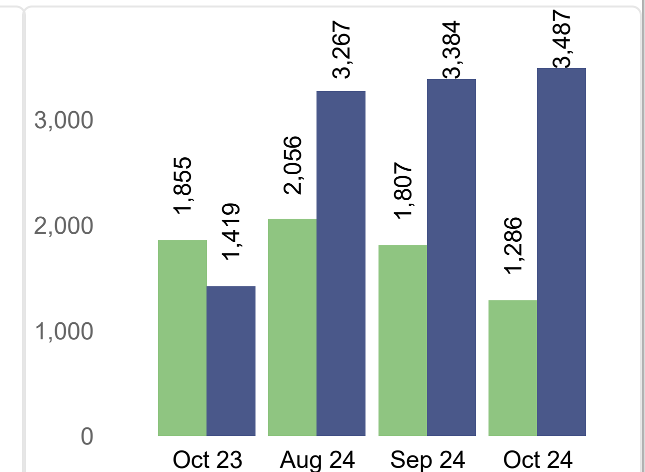
New Cases



Open Cases



Enrolled Cases



Technology (Business Availability)

Applications	Nov 23	Sep 24	Oct 24	Nov 24
HEALTHsuite System	100.0%	100.0%	99.9%	99.8%
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	Nov 23	Sep 24	Oct 24	Nov 24
Denial Rate Excluding Partial Denials (%)	4.5%	2.9%	2.8%	2.8%
Overall Denial Rate (%)	4.7%	3.1%	3.1%	3.1%
Partial Denial Rate (%)	0.3%	0.2%	0.3%	0.3%

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

Pharmacy Authorizations

Authorizations	Nov 23	Sep 24	Oct 24	Nov 24
Approved Prior Authorizations	37	39	55	34
Closed Prior Authorizations	67	74	115	85
Denied Prior Authorizations	39	57	50	62
Total Prior Authorizations	143	170	220	181

Legislative Tracking

Alliance Public Affairs Department

ALAMEDA Alliance FOR HEALTH

Complete list of enacted State bills that the Alliance tracked in 2024

ALAMEDA
Alliance
FOR HEALTH

2024 Tracked Legislation

ALAMEDA Alliance FOR HEALTH

Enacted Bills

- AB 1282 – Mental health: impacts of social media
- AB 1316 – Emergency services: psychiatric emergency medical conditions
- AB 1842 – Health care coverage: Medication-assisted treatment
- AB 1936 – Maternal mental health screenings
- AB 2063 – Health care coverage
- AB 2105 – Coverage for PANDAS and PANS
- AB 2115 – Controlled substances: clinics
- AB 2129 – Immediate postpartum contraception
- AB 2132 – Health care services: tuburculosis
- AB 2198 – Health information
- AB 2258 – Health care coverage: cost sharing
- AB 2319 – California Dignity in Pregnancy and Chilbirth Act
- AB 2376 – Chemical dependency recovery hospitals
- AB 2556 – Behavioral health and wellness screenings: notice
- AB 2630 – Pupil health: oral health assessment
- AB 2703- Federally qualified health centers and rural health clinics: psychological associates..
- AB 2843 – Health care coverage: rape and sexual assault

2024 Tracked Legislation

ALAMEDA Alliance FOR HEALTH

Enacted Bills

- AB 3030 – Health care services: artificial intelligence
- AB 3059 – Human milk
- AB 3221 – Department of Managed Health Care: review of records
- AB 3275 – Health care coverage: claim reimbursement
- AB 729 – Health care coverage: treatment for infertility and fertility services
- SB 120 – Health care coverage: utilization review
- SB 339 - HIV preexposure prophylaxis and postexposure prophylaxis
- SB 729 – Health care coverage: treatment for infertility and fertility services
- SB 1120 – Health care coverage: utilization reivew
- SB 1131 – Medi-Cal providers: family planning
- SB 1180 – Health care coverage: emergency medical services
- SB 1300 – Health facility closure: public notice: inpatient psychiatric and perinatal services.
- SB 1320 – Mental health and substance use disorder treatment
- SB 1354 – Long-term health care facilities: payment source and resident census

Summary of enacted State bills that impact the Alliance and its members

ALAMEDA Alliance FOR HEALTH

Alameda Alliance for Health

AB 1842 (Reyes) Health care coverage: Medication-assisted treatment

- Requires a group or individual health plan or health insurer to provide coverage without prior authorization or step therapy, or utilization review for at least one medication approved by the United States Food and Drug Administration (FDA) in each of four specified categories
  - Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist;
  - Medication for the detoxification or maintenance treatment of a substance use disorder (SUD), including a daily oral buprenorphine product;
  - A long-acting buprenorphine product; and
  - A long-acting injectable naltrexone product.

Source: Bill Text – AB 1842 – Health care coverage: Medication- assisted treatment

AB 1936 (Cervantes) Maternal mental health screenings

- Requires a health plan or insurer's existing maternal mental health (MMH) program to include at least one MMH screening during pregnancy, and at least one additional screening during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the treating provider's judgement.

Source: Bill Text – AB 1936 Maternal mental health screenings

Alameda Alliance for Health

AB 2105 (Lowenthal) Coverage for PANDAS and PANS

- Requires a health plan contract 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) as prescribed or ordered by the treating physician and surgeon and is medically necessary.
- Medially necessary will be defined by current nationally recognized clinical practice guidelines by expert treating physicians published in peer-reviewed medical literature.

Source: Bill Text – AB 2105 Coverage for PANDAS and PANS.

Alameda Alliance for Health

AB 2129 (Petrie-Norris) Immediate postpartum contraception

- Authorizes a health care provider, in a contract between a health plan or insurer, to separately bill for devices, implants, or professional services, or a combination thereof, associated with immediate postpartum contraception (IPPC) if the birth takes place in a general acute care hospital or licensed birth center.
- Prohibits the provider contract from considering those devices, implants, or services to be part of a payment for a general obstetric procedure.

Source: Bill Text – AB 2129 Immediate postpartum contraception

Alameda Alliance for Health

AB 2198 (Flora) Health information

- Requires the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI), commencing January 1, 2027, or when final federal rules are implemented, whichever occurs later, to require health plans and insurers to establish and maintain patient access application programming interfaces (API), provider access API, payer-to-payer API, and prior authorization API.
- Authorizes DMHC and CDI, until January 1, 2027, to issue guidance not subject to the Administrative Procedure Act.

Source: Bill Text – AB 2198 Health information

ALAMEDA Alliance FOR HEALTH

AB 2258 (Flora) Health care coverage: cost sharing

- Prohibits a group or individual nongrandfathered health plan contract or insurance policy from imposing a cost-sharing requirement for items or services integral to the provision of specified preventative care services and screenings.
- Prohibits a health plan contract or insurance policy from imposing cost sharing for office visits associated with the preventive care services if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.
- Prohibits a civil penalty from exceeding $5,000 for each violation, or, if a violation was willful, from exceeding $10,000 for each violation in the Insurance Code.

Source: Bill Text – AB 2258 Health care coverage: cost sharing

ALAMEDA Alliance FOR HEALTH

AB 2556 (Jackson) Behavioral health and wellness screenings: notice

- Requires a health plan or insurer to provide annual notices to enrollees or insureds regarding the benefits of a behavioral health and wellness screening for children and adolescents eight to 18 years of age.
- Exempts Medi-Cal managed care contracts from the provision of this bill.

[Source: Bill Text – AB 2556 Behavioral health and wellness screenings: notice]

ALAMEDA Alliance FOR HEALTH

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

- Requires a health plan or insurer to provide coverage for emergency room medical care and follow-up treatment for an enrollee or insured who is treated following a rape or sexual assault without cost sharing for the first nine months after the enrollee or insured initiates treatment.
- Requires the waiver of the imposition of cost sharing to only apply if the enrollee's treatment provider submits all requests for claims payments using accurate diagnosis codes specific to rate or sexual assault.
- Defines follow-up health care treatment to include medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault. Specifies that for a health plan contract that meets the definition of a high deductible health plan, requires this bill to only apply once an enrollee's deductible has been satisfied for the year.
- Delays implementation to July 1, 2025.

Source: Bill Text – AB 2843 Health care coverage: rape and sexual assault

Alameda Alliance for Health

AB 3059 (Weber) Human milk

- Requires coverage of medically necessary pasteurized donor human milk (DHM) under existing basic health care services, as specified.
- Exempts from tissue bank licensure by the Department of Public Health (DPH), the storage or distribution of human milk that was obtained from a tissue bank, by a general acute care hospital.
- Requires hospitals that collect, process, store, or distribute human milk in any other circumstance to obtain a tissue bank license.

Source: Bill Text – AB 2059 Human milk

AB 3221 (Pellerin) Department of Managed Health Care: review of records

- Requires the records, books, and papers of a health plan and other specified entities to be open to inspection by the Department of Managed Health Care (DMHC) Director, including through electronic means
- Enforcement actions specified in this bill is declaratory and existing law with respect to the DMHC Director's enforcement authority.

Source: Bill Text – AB 3221 Department of Managed Health Care: review of records

AB 3275 (Perellin) Health care coverage: claim reimbursement

- Requires a health plan, including a Medi-Cal managed care plan, including specialized health plans or insurers, commencing January 1, 2026, 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 is contested or denied.
- Authorizes the Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) to issue guidance and regulations related to this bill. Exempts the guidance and amendments from the Administrative Procedure Act until December 31, 2027.
- Requires a complaint made by an enrollee to a health plan about a delay or denial of a payment of a claim to be treated as a grievance subject to that grievance process.

Source: Bill Text – AB 3275 Health care coverage: claim reimbursement

Alameda Alliance for Health

SB 339 (Wiener) HIV preexposure prophylaxis and postexposure prophylaxis

- This bill authorizes a pharmacist to furnish up to a 90-day course of preexposure prophylaxis (PrEP), or beyond 90-days if specified conditions are met, and requires the Board of Pharmacy (Board) to adopt emergency regulations to implement these provisions by July 1, 2024.
- This bill requires a health care service plan and health insurer to cover PrEP and postexposure prophylaxis (PEP) furnished by a pharmacist, including costs for the pharmacist's services and related testing ordered by the pharmacist.
- Excludes Medi-Cal managed care plans contracting with the Department of Health Care Services (DHCS) from the coverage provisions of the measure.

Source: Bill Text – SB 339 HIV preexposure prophylaxis and postexposure prophylaxis

SB 729 (Menjivar) Health care coverage: treatment for infertility and fertility services

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- This bill requires a health plan contract or policy of disability insurance sold in the large group market (employers with more than 100 covered individuals) to provide coverage for the diagnosis and treatment of infertility and fertility services, including services of a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM) using single embryo transfer when recommended and medically appropriate.
- Delays implementation to July 1, 2025, and exempts CalPERS until July 1, 2027, deletes the individual market requirement to offer to cover the diagnosis and treatment of infertility, and adds an exemption for religious employers.

Source: Bill Text – SB 729 Health care coverage: treatment for infertility and fertility services

SB 1120 (Becker) Health care coverage: utilization reivew

- This bill establishes requirements on health plans and insurers applicable to their use of Artificial Intelligence (AI) for utilization review (UR) and utilization management (UM) decisions, including, that the use of AI, algorithm, or other software must be based upon a patient's medical or other clinical history and individual clinical circumstances as presented by the requesting provider and not supplant health care provider decision making.

Source: Bill Text – SB 1120 Health care coverage: utilization review

SB 1180 (Ashby) Health care coverage: emergency medical services

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- This bill requires a health plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2025, to establish a process to reimburse services provided by a community paramedicine program, triage to alternative destination program, or mobile integrated health program.
- Makes these services a covered Medi-Cal benefit and requires the Department of Health Care Services to establish Medi-Cal rates for these services.
- Requires the Medi-Cal provisions to be implemented only to the extent federal financial participation is available and the Legislature appropriates funding.

Source: Bill Text – SB 1180 Health care coverage: emergency medical services

SB 1320 (Wahab) Mental health and substance use disorder treatment

Alameda Alliance for Health

- This bill requires a health plan or insurer and its delegate to establish a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services.
- The bill allows the reimbursement process to be based on federal rules or guidance issued for the Medicare program.

Source: Bill Text – SB 1320 Mental health and substance use disorder treatment

State bills tracked by the Alliance that were vetoed by the Governor

ALAMEDA Alliance FOR HEALTH

ALAMEDA Alliance FOR HEALTH

2024 Tracked Legislation

Tracked Bills Vetoed by Governor

- AB 1975 – Medi-Cal: medically supportive food and nutrition services
- AB 1977 – Health care coverage: behavioral diagnoses
- AB 2446 – Medi-Cal: diapers
- SB 966 – Pharmacy benefits
- SB 1213 – Health care programs: cancer
- SB 1220 – Public benefits contracts: phone operator jobs
- Medi-Cal: Rural Hospital Technical Advisory Group

Board Business

Behavioral Health Audit

As Presented By: Richard Golfin III, FACHE JD MBA
Chief Compliance & Privacy Officer
December 13th, 2024

ALAMEDA Alliance FOR HEALTH

ALAMEDA Alliance FOR HEALTH

Background

- The Behavioral Health Comparison Audit (BHCA) is an audit review comparing the Behavioral Health Clinical Operations at the Alameda Alliance to the findings in the DMHC settlement agreement with Kaiser Foundation Health Plan & its associated companies (The Settlement Agreement).
- Specific Goals of the Review:
  - Identify potential areas for improvement;
  - Mitigate risk, and;
  - Reduce potential and future findings and/or sanctions as a result of State Oversight.
- The BHCA provides an opportunity for the Alliance to evaluate its behavioral health services through the same lens as the DMHC within the context of Kaiser's expansive and robust clinical operations.

Methodology

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- The Alliance Internal Audit Department developed 66 Review Criteria based on the DMHC Settlement Agreement.
- BHCA Details & Procedure:
  - The BHCA review criteria excludes analysis of both Behavioral Health Treatment and Kaiser delegation.
  - The BHCA included review of current policies, procedures, workflows, and program documents.
  - The BHCA Analyzed data for Q4 2023 (October 1, 2023, through December 31, 2023).
  - The Internal Audit Department conducted in-depth meetings with subject matter experts (from April 23, 2024, through August 20, 2024).

Audit Milestones

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Milestone	Complete/Due
Board of Governors delegated responsibility to the Internal Audit team to conduct BHCA.	November 2023
Develop audit scope and questions.	December 2023 – March 2024
Engage with audit stakeholders.	April 2024 – August 2024
Issue preliminary audit findings, observations, and report.	September 2024 – October 2024
Revise audit findings, observations, and report.	November 2024
Meet with audited departments to review final draft of audit findings, observations, and report.	December 2024
Present audit to the Board of Governors.	December 2024
Issue final audit report and collaborate on internal corrective actions and process improvements.	TBD

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Summary

- 66 Review Criteria
- 11 Criteria: Findings and/or observations identified.
- 47 Criteria: Fully compliant with review parameters.
- 8 Criteria: Not applicable due to de-delegation of behavioral health services.

Strengths

- When compared to the review criteria under the Settlement Agreement, the Alliance exemplifies strong compliance in the following areas:
  - 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 limitations on visits.
  - Facilitating out-of-network referrals when in-network services are unavailable.

Summary of Findings

- The Plan Follow-up on Missed or Canceled Appointments policy is only applicable to Primary Care Physicians. However, the DHCS contract requires this for all Network Providers.
  - DHCS Contract Exhibit A, Attachment III, Section 5.2.5 (A)(2)(c)

Summary of Observations

ALAMEDA Alliance FOR HEALTH

- Access & Availability Department reviews medical records, but it does not document its review unless a corrective action is issued against a provider.
- Member Services' operational resources do not provide documented steps to ensure members are informed about alternative ways to access immediate services relative to the review.
- Behavioral Health Department implemented a form to aid in care coordination and monitoring, but there are no policies or desktop procedures for the form.
  - There is no incentive for providers to submit the form.
- Behavioral health provider expertise was collected to maximize utilization of the Alliance's existing network, but the information has not been maintained nor incorporated into the Provider Repository.
- Processes to address timely access grievances and provider compliance with timely access standards take longer than timely access standards allow.

Next Steps

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- Meet with stakeholders for Plan of action on findings and observations, and generate the final report.
- Issue the final report and action plans by December 27, 2024.

Fiscal Year 2025 Final Budget

FY 2025 Final Budget

Presented to the Alameda Alliance Board of Governors

December 13th, 2024

ALAMEDA Alliance FOR HEALTH

Budget Process

ALAMEDA Alliance FOR HEALTH

- Preliminary Budget presented to Finance Committee on June 11th and to the Board of Governors on June 14th.
- Draft 2025 Medi-Cal rates were received on October 21st. They were in line with the estimates in the Preliminary Budget but did not support the Alliance's most recent expense experience.
- The Plan shared data with the State, and had multiple conversations with DHCS leadership, sharing findings regarding medical expense trends and the Alliance's financial challenges.
- High-level final Medi-Cal base rates were received on December 2nd. The rates were favorable to those received on October 21st .
- Final Budget presented to Finance Committee on December 10th and to the Board of Governors on December 13th.

Risks and Opportunities

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- Details for the high-level CY 2025 Final Medi-Cal rates received on December 2nd are not yet available and may differ from assumptions that were made based on Preliminary rates.
- DHCS informed the Plans on November 27th that revised Medi-Cal rates will be sent for CY 2024. The revised rates will include changes to the population acuity and TRI adjustments.
- It is unclear whether the significant increase in utilization trends will continue.
- The ratio of members with Satisfactory versus Unsatisfactory Immigration Status may vary from DHCS projections.
- Contract changes for hospitals and delegated providers in projections have not been finalized.

Summary of Proposed Budget

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Highlights

- 2025 Projected Net Loss of $65.3 million.
- Projected TNE excess at 6/30/25 of $26.6 million is 134% of required TNE.
- Year-end enrollment is slightly lower than the Preliminary Budget.
- Revenue is $2.1 billion in FY 2024, $86 million higher than Preliminary, due favorable new rates.
- PMPM Fee-for-Service and Capitated Medical Expense increases by 6.2%.
- Administrative expenses represent 5.6% of revenue, $7.8 million higher than Preliminary. Increases include Purchased & Professional Services($ 9.2 million), Licenses, Insurance & Fees ($600K), and Other Expense ($400K). These were offset by reductions in Employee Expense ($2.4 million).
- Clinical expenses comprise 2.8% of revenue, $8.7 million higher than Preliminary. CalAIM Incentives ($5.2 million), Community Relations ($2.1 million), Purchased & Professional Services ($2.3 million), Licenses, Insurance & Fees ($500K), other ($900K).
- A CY 2024 Major Organ Transplant Risk Corridor Payment to DHCS of $21.0 million is planned for December 2024.

Budget Assumptions

Staffing:

- Staffing includes 718 full-time equivalent employees by June 30, 2025. This includes 480 Administrative employees and 238 Clinical employees.
- There are 87 new positions requested for FY 2025, a reduction of 13 from the Preliminary Budget. The new positions are in Operations (40), Healthcare Services (21), Compliance (7), Analytics (6), Finance/Vendor Management (6), Information Technology (5), Integrated Planning (3), and a decrease in Executive/Legal (-1).

Enrollment:

- Enrollment at year-end is 409,000, 1,100 lower than in the Preliminary Budget.
- Member Months of 4,885,000 are 8,800 lower than in the Preliminary Budget.
- As a Single Plan County, Alameda will have responsibility for Foster Children and Youth as of January 2025.
- LTC and LTC Duals will be combined by DHCS with the SPD and SPD Duals COAs beginning January 2025.
- Total Medi-Cal enrollment is projected to grow very slightly throughout the year.
- Group Care enrollment is projected to be virtually unchanged.

Budget Assumptions (con't)

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Revenue:

- 98% of Revenue for Medi-Cal, 2% for Group Care.
- High-level final Medi-Cal base rates were received 12/2/24. The rates were favorable compared to the previous draft rates.
- Details for ECM, MOT, GEMT, Community Supports etc., are not yet available.
- Final PMPM Medi-Cal base rates are 5.8% higher than Preliminary Budget. This is driven by higher rates for SIS members in the SPD and ACA OE Categories of Aid.
- The Supplemental Maternity Kick payment per delivery was reduced by 4.4%.
- Per-member-per-month Group Care rates are unchanged.

Medical Expense:

- 98% of Expense for Medi-Cal, 2% for Group Care.
- Medical loss ratio is 97.9%, an increase of 2.0% over the Preliminary Budget.
- Material increases in the Inpatient and Long-term Care Categories of Service were partially offset by decreases in Capitated Expense.
- $3.0 million has been added to the Provider Incentive Pool.

Hospital and Provider Rates:

- FY 2025 Hospital and SNF contract rates increase by $3.3 million compared to the Preliminary Budget.
- Professional capitation decreased by $26.8 million, as current rates will be largely sufficient to cover the new TRI fee schedule.

FY 2025 Final Budget

Comparison to Preliminary Budget

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$ in Thousands	FY 2025 Final Budget				FY 2025 Preliminary Budget				Variance F/(U)			
	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total
Enrollment at Year-End	403,393	5,769	0	409,162	404,574	5,643	0	410,217	(1,181)	126	0	(1,055)
Member Months	4,815,809	68,992	0	4,884,801	4,825,926	67,716	0	4,893,642	(10,117)	1,276	0	(8,841)
Premium Revenue	$2,085,255	$37,724	$0	$2,122,979	$1,999,833	$37,020	$0	$2,036,854	$85,422	$703	$0	$86,125
MCO Tax Revenue	$862,224	$0	$0	$862,224	$567,818	$0	$0	$567,818	$294,406	$0	$0	$294,406
Total Revenue	2,947,480	37,724	0	2,985,203	2,567,652	37,020	0	2,604,672	379,828	703	0	380,531
Medical Expense	2,043,579	35,347	366	2,079,292	1,923,598	30,443	371	1,954,412	(119,981)	(4,904)	5	(124,880)
Gross Margin	903,901	2,376	(366)	905,911	644,054	6,577	(371)	650,260	259,847	(4,201)	5	255,651
Administrative Expense	109,431	1,835	8,676	119,942	104,729	1,670	4,826	111,226	(4,702)	(165)	(3,850)	(8,717)
Operating Margin	794,470	541	(9,042)	785,969	539,325	4,907	(5,197)	539,034	255,145	(4,366)	(3,845)	246,934
MCO Tax Expense	877,224	0	0	877,224	567,818	0	0	567,818	(309,406)	0	0	(309,406)
Other Income / (Expense)	25,620	361	0	25,981	28,770	390	0	29,160	(3,150)	(29)	0	(3,179)
Net Income / (Loss)	($57,135)	$902	($9,042)	($65,275)	$277	$5,296	($5,197)	$376	($57,411)	($4,394)	($3,845)	($65,651)
Admin. Expense % of Revenue	5.2%	4.9%		5.6%	5.2%	4.5%		5.5%	0.0%	-0.4%		-0.2%
Medical Loss Ratio	98.0%	93.7%		97.9%	96.2%	82.2%		96.0%	-1.8%	-11.5%		-2.0%
TNE at Year-End				$105,123				$317,414				($212,292)
TNE Percent of Required at YE				134%				439%				(305%)

Operating Performance: 2019 to 2025

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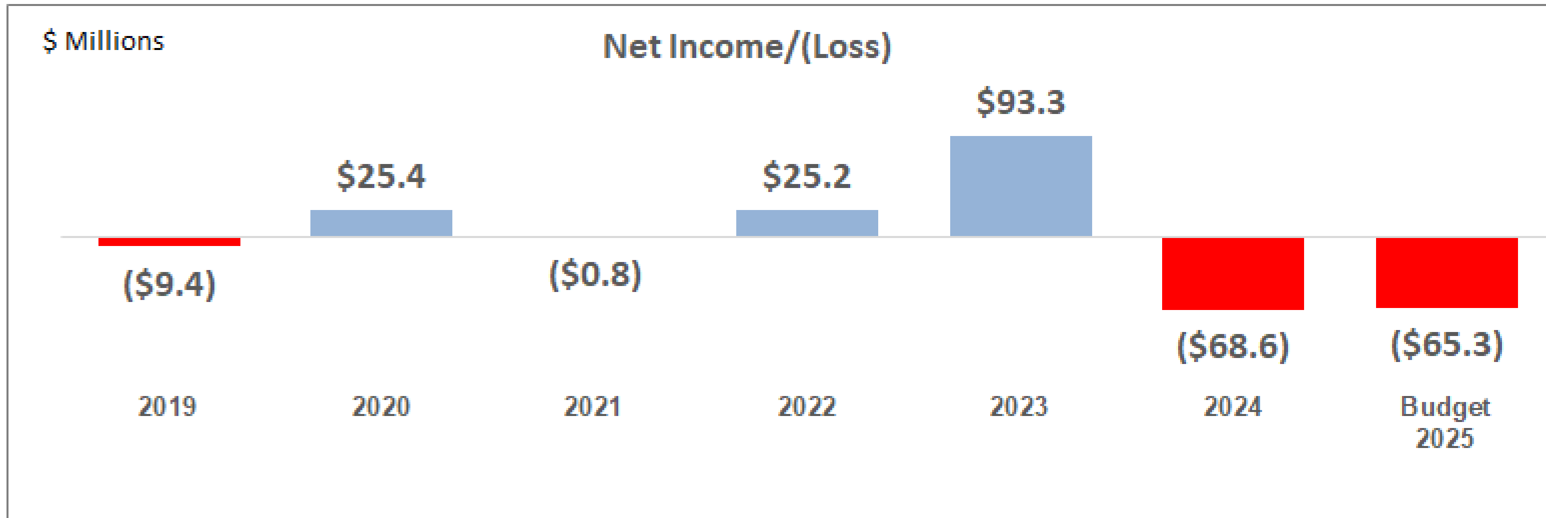
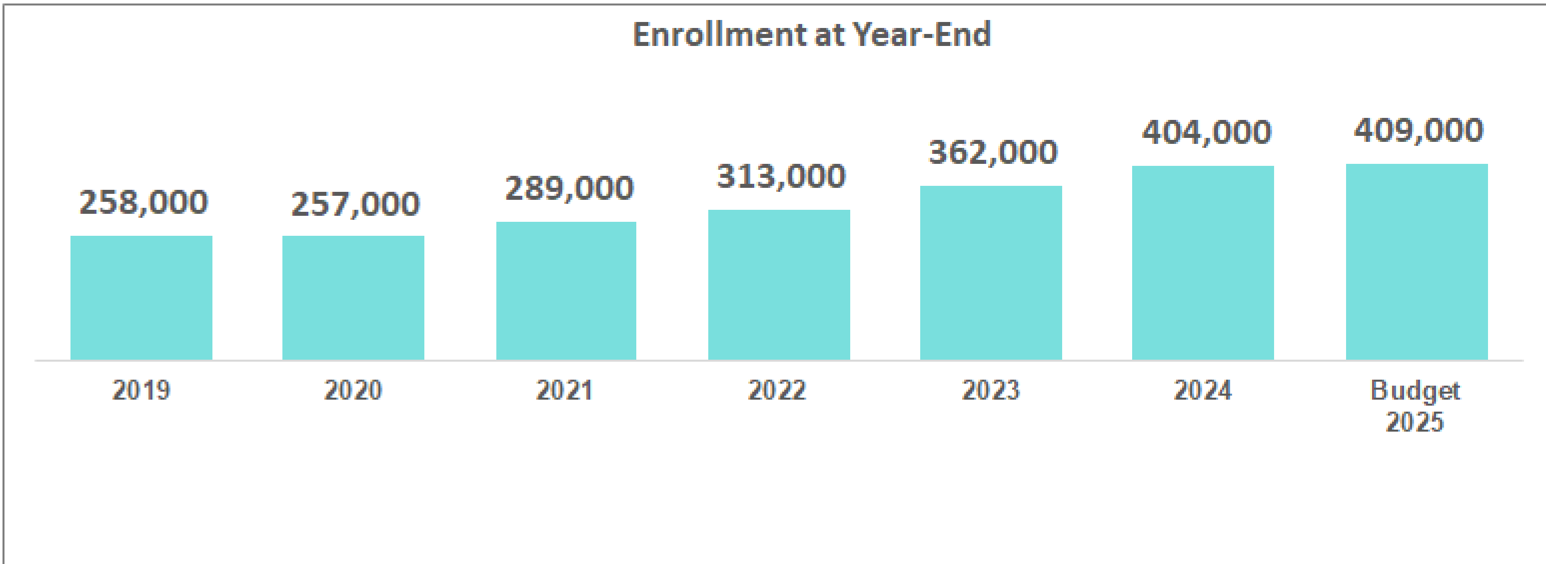
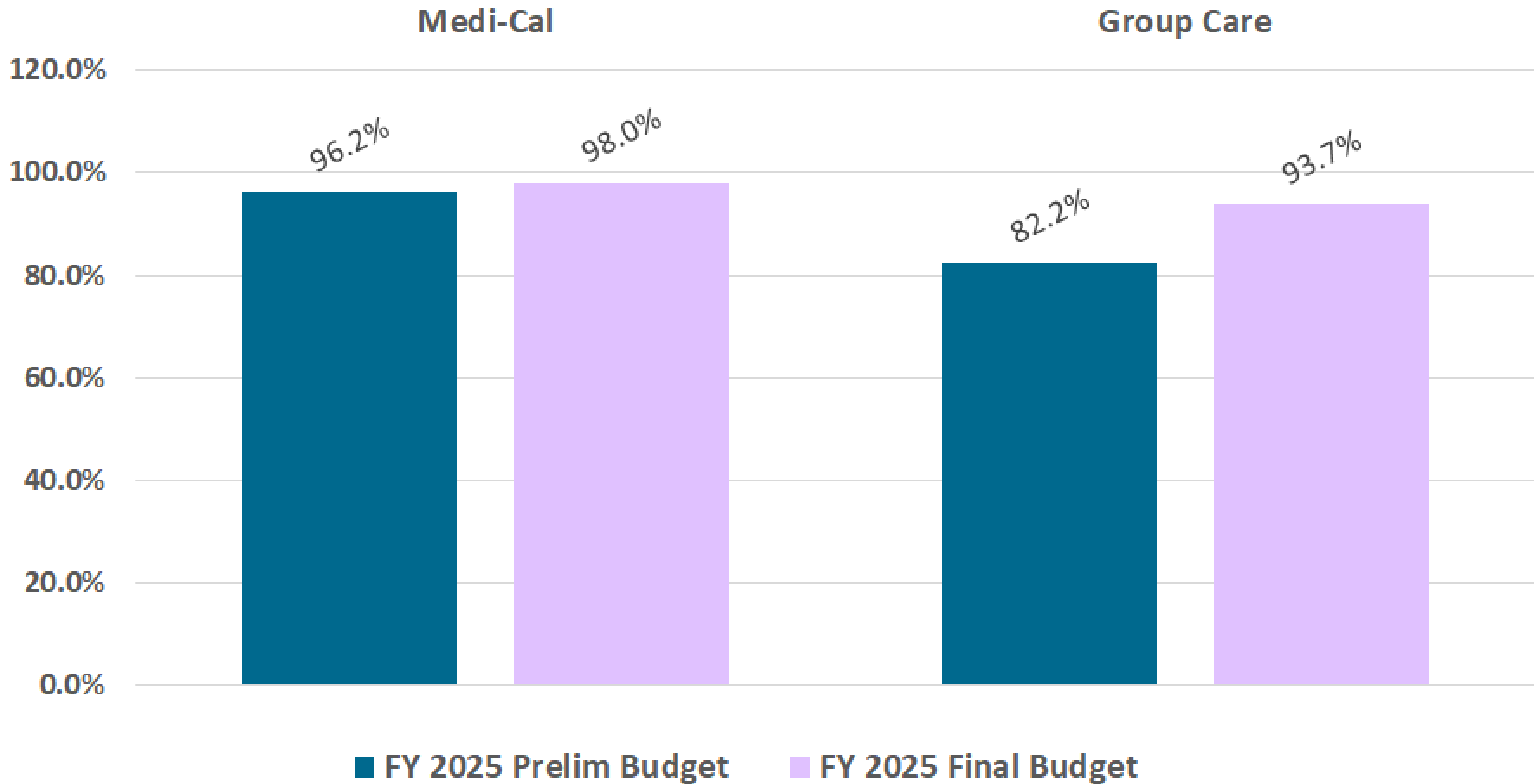




FY 2025 Final Budget

Medical Loss Ratio by Line of Business



Medi-Cal Loss Ratio by Category of Aid

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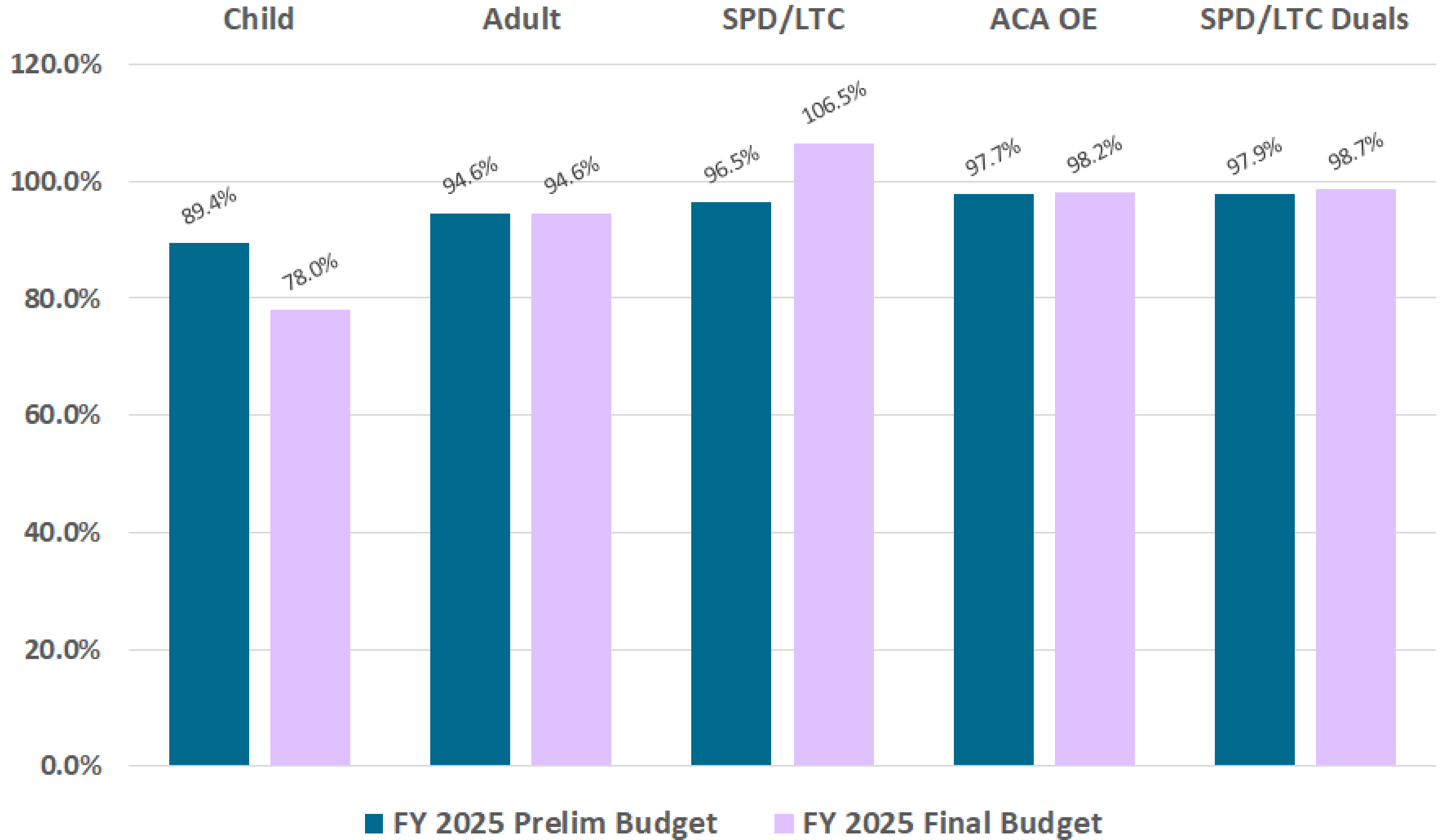
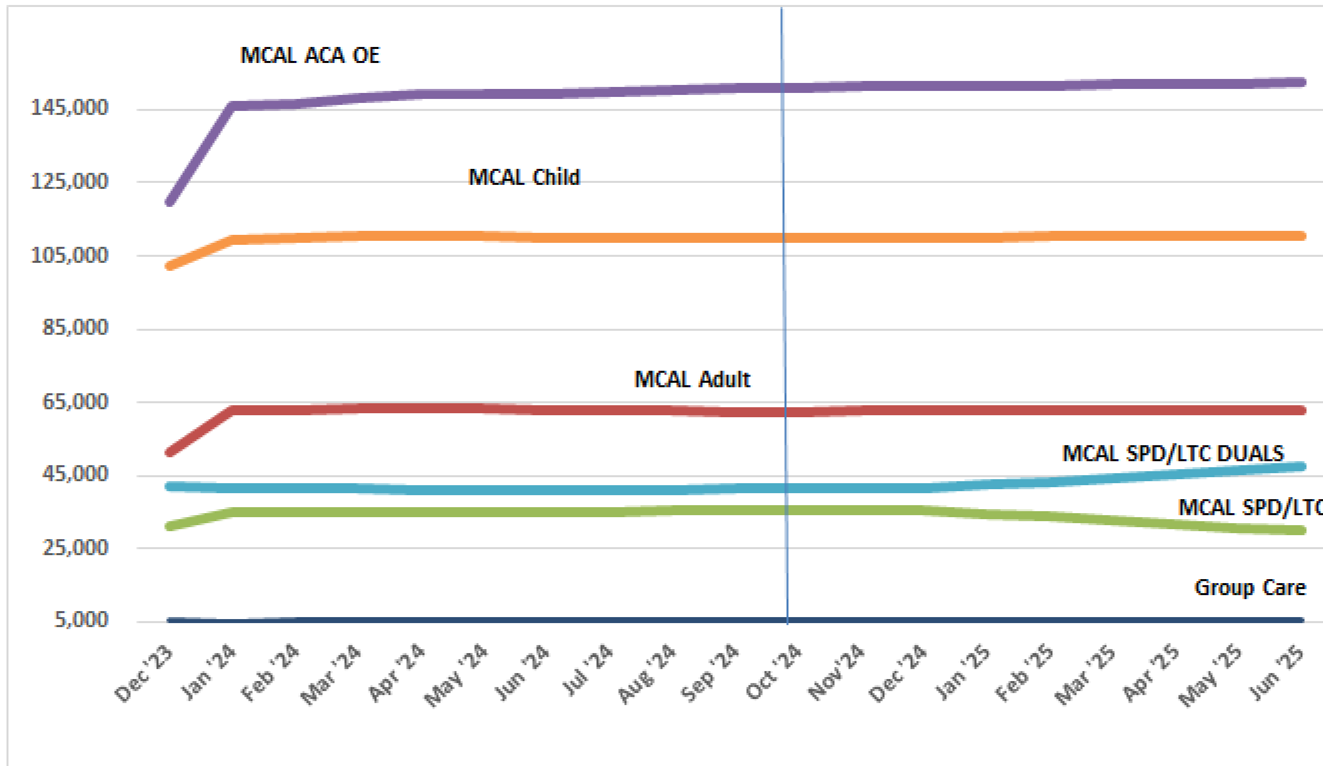


FY 2025 Final Budget

Enrollment by Month and Population



- Medi-Cal disenrollments started in July 2023, on the member's anniversary date, effective over 12 months. The Final Budget assumes that disenrollments are virtually complete.
- In January 2025, California will have a Medicare Part A Buy-In Agreement. The projection assumes that 1,000 members will transition from the SPD to the SPD Dual Category of Aid each month.
- New responsibility for Foster Children and Youth, causing a very slight uptick in the Child COA.
- Other Categories of Aid are projected to be virtually flat.
- LTC and LTC Duals will be combined by DHCS with the SPD and SPD Duals COAs beginning January 2025.

Community Supports

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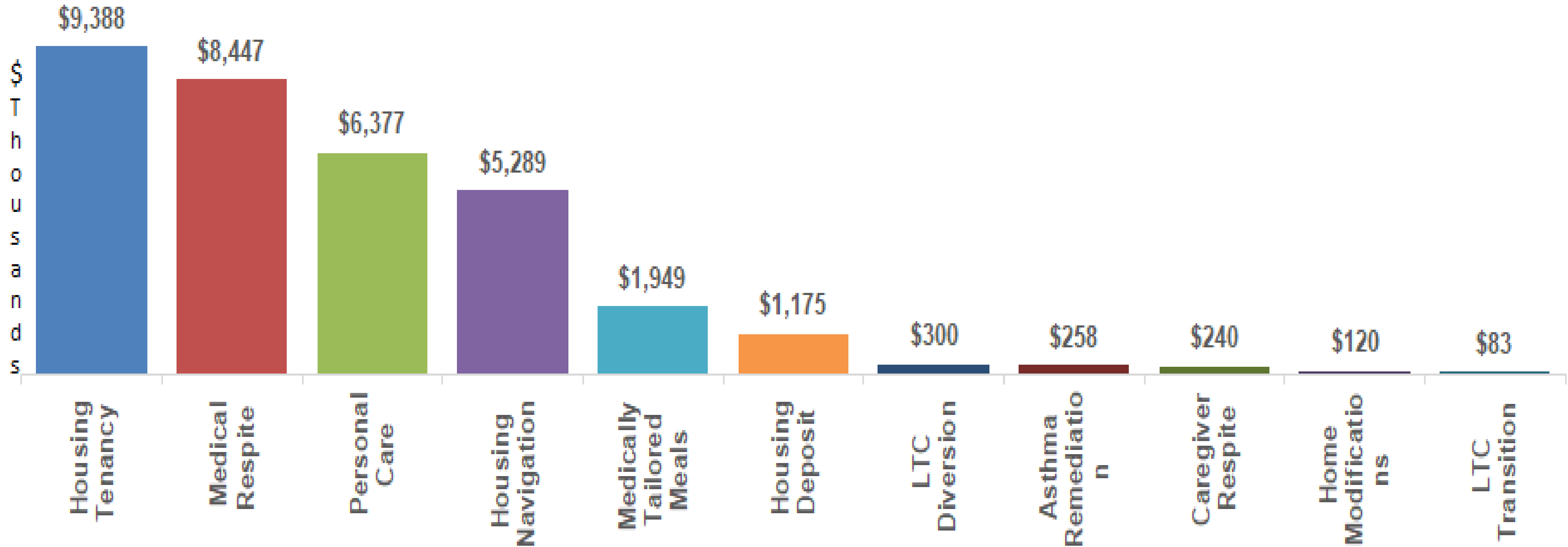

- The Alliance anticipates spending $33.6 million for Community Supports in FY25.
- CS Revenue is included in FY 2025 Medi-Cal Base Rates is $11.5 million.

Department Expenses by Line of Business

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$ In Thousands

FY 2025 Final	Administrative Departments				Clinical Departments				
	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total	Total
Employee Expense	$63,587	$911	$6,223	$70,721	$37,657	$541	$368	$38,566	109,287
Member Benefits Admin.	$625	$280	$0	$905	$5,693	$0	$0	$5,693	6,598
Purchased & Prof. Svcs.	$25,865	$333	$2,448	$28,646	$7,741	$1,158	($2)	$8,898	37,544
Other	$19,354	$310	$6	$19,670	$6,445	$73	$0	$6,518	26,188
Total	**$109,431**	**$1,835**	**$8,676**	**$119,942**	**$57,537**	**$1,771**	**$366**	**$59,675**	**$179,617**

Variance vs Prelim F/(U)	Administrative Departments				Clinical Departments				Total
	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total	
Employee Expense	$5,575	$25	($3,204)	$2,397	$178	($28)	$3	$153	2,550
Member Benefits Admin.	$2	($10)	$0	($8)	($4,580)	$0	$0	($4,580)	(4,588)
Purchased & Prof. Svcs.	($8,478)	($115)	($640)	($9,234)	($2,750)	$9	$2	($2,740)	(11,973)
Other	($961)	($65)	($6)	($1,032)	($1,527)	($26)	$0	($1,553)	(2,585)
Total	**($3,862)**	**($165)**	**($3,850)**	**($7,877)**	**($8,680)**	**($46)**	**$5**	**($8,720)**	**($16,597)**

Capital Expenditures

Full Year budget is $2.0 million for capitalized purchases, compared to the Preliminary Budget of $1.7 million.

Information Technology:

- Hardware $1,948,700

Facilities:

- Building Improvements $30,000

FY 2025 Final Budget

Staffing: Full-time Employees at Year-end

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Administrative FTEs	FY25 Final	FY25 Prelim	Increase/ Decrease
Administrative Vacancy	(59.0)	(65.5)	6.5
Operations	8.0	9.0	(1.0)
Medicare Operations	18.0	17.0	1.0
Executive	2.0	2.0	0.0
Finance	37.0	37.0	0.0
Healthcare Analytics	20.0	20.0	0.0
Claims	53.0	53.0	0.0
Information Technology	15.0	15.0	0.0
IT Infrastructure	9.0	9.0	0.0
Apps Mgmt., IT Quality & Process Imp.	23.0	23.0	0.0
IT Development	17.0	18.0	(1.0)
IT Data Exchange	10.0	11.0	(1.0)
IT-Ops and Quality Apps Mgt.	14.0	15.0	(1.0)
Member Services	108.0	110.0	(2.0)
Provider Services	42.0	45.0	(3.0)
Credentialing	11.0	11.0	0.0
Health Plan Operations	1.0	1.0	0.0
Human Resources	13.0	12.0	1.0
Vendor Management	10.0	10.0	0.0
Legal Services	4.0	7.0	(3.0)
Facilities & Support Services	8.0	9.0	(1.0)
Marketing & Communication	12.0	14.0	(2.0)
Privacy and SIU	17.0	17.0	0.0
Regulatory Affairs & Compliance	11.0	11.0	0.0
Risk Mgmt. & Operations Oversite	4.0	4.0	0.0
Grievance and Appeals	27.0	27.0	0.0
Integrated Planning	23.0	23.0	0.0
State Directed & Special Programs	9.0	9.0	0.0
Portfolio Mgmt. & Svc Excellence	0.0	0.0	0.0
Workforce Development	9.0	10.0	(1.0)
Health Equity	4.0	4.0	0.0
Total Administrative FTEs	**480.0**	**487.5**	**(7.5)**

Clinical FTEs	FY25 Final	FY25 Prelim	Increase/ Decrease
Clinical Vacancy	(6.0)	(5.1)	(0.9)
Utilization Management	7.0	8.0	(1.0)
Case/Disease Management	28.0	28.0	0.0
Medical Services	67.0	68.9	(1.8)
Quality Management	56.0	54.0	2.0
HCS Behavioral Health	8.0	6.0	2.0
Pharmacy Services	39.0	39.0	0.0
Regulatory Readiness	27.0	27.0	0.0
Total Clinical FTEs	8.0	9.0	(1.0)
0.0	4.0	4.0	0.0
Total Clinical FTEs	**238.0**	**238.8**	**(0.8)**

Total FTEs	**718.0**	**726.3**	**(8.3)**

**FTE = Full-Time Equivalent Personnel working approximately 2,080 hours per year. Includes Temporary Employees.*

Health Equity Update

Board of Governor's Meeting
HEALTH EQUITY DEPARTMENT

Lao Paul Vang, Chief Health Equity Officer
Dr. Yen Ang, Director of Health Equity

December 13th, 2024

ALAMEDA Alliance FOR HEALTH

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Agenda

1. Health Equity Division's Vision and Mission
2. 4 Quadrants of Priority
   - Internal Stakeholders, Members, Providers, CBOs and downstream networks
   - Intersectoral Collaboration and Partnerships
3. Short, Mid, and Long-term Action Plans
   - DHCS-APL 23-025 (DEI Training)
   - Health Equity Data (Alameda Alliance for Health & Alameda County Data)
   - Health Equity & DEIB Roadmap
4. Health Equality vs Health Equity
5. Our MOTTO

Vision:

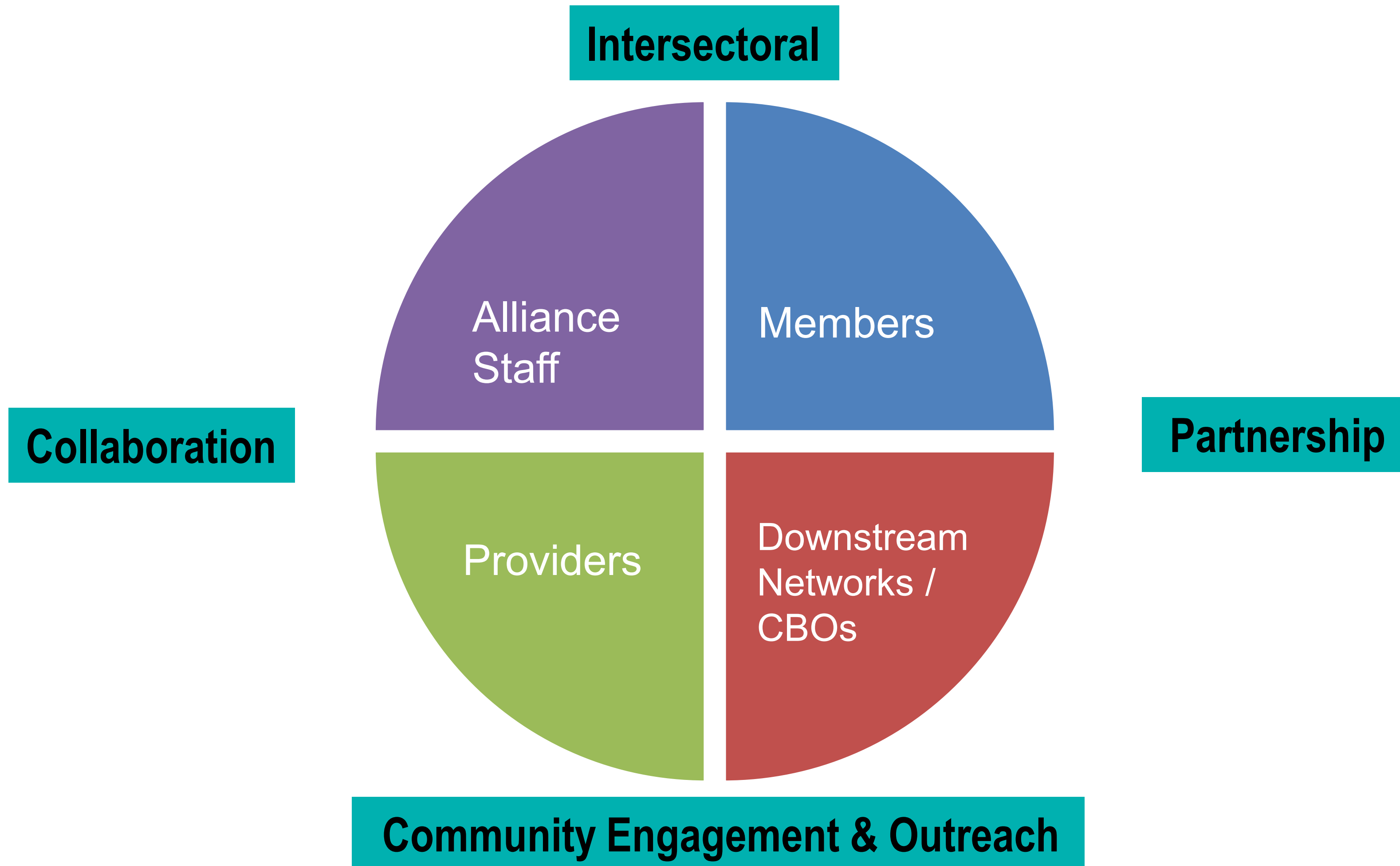
A world where every Alliance member, regardless of race, ethnicity, religion, gender-sexual identity, or social economic status, has equal access to gender-informed and culturally responsive care.

Mission:

To dismantle institutional racism and systemic inequities in healthcare practices, strengthen intersectoral collaboration and community engagement to achieve and sustain health equity for all members.

Health Equity Division's 4 Quadrants of Priority – Key Stakeholders

ALAMEDA Alliance FOR HEALTH



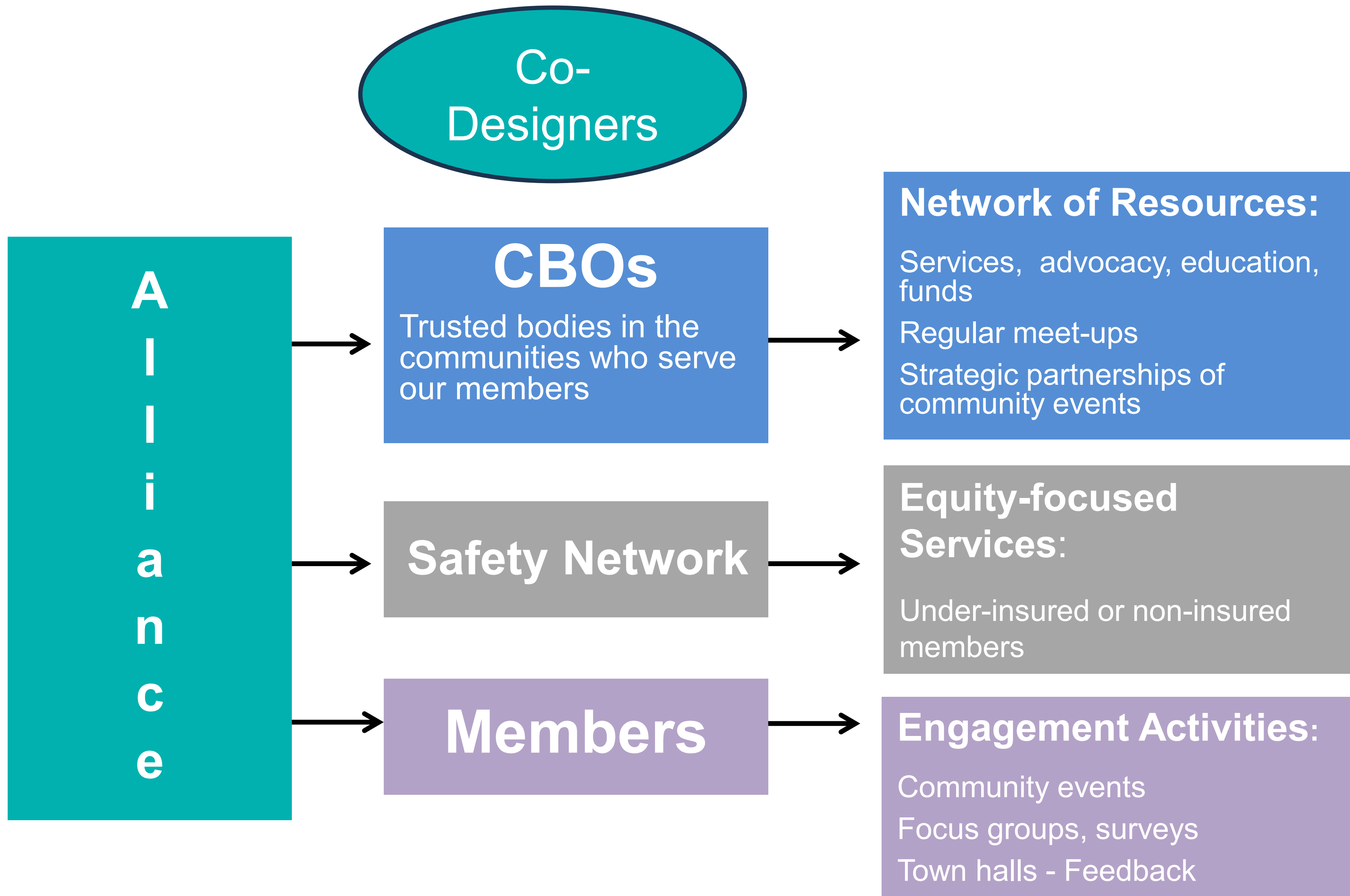
Health Equity Engagement Strategy: Co-Design

ALAMEDA Alliance FOR HEALTH

- Participatory approach to designing solutions in which community members are treated as equal collaborators in the design process.
- Active collaboration between users and designers.
- Engage, Validate, Adjust.
- Core concept: users are experts in their own experience.
- Gain trust from our members; particularly those historically marginalized communities, so they will trust the healthcare system that serve them.
- Three critical CO-DESIGN-Partners:

    1. CBOs
    2. Safety Network
    3. Members

Health Equity Engagement Strategy



Short-Term Action Plans

ALAMEDA Alliance FOR HEALTH

DHCS 23-025 DEI Training Requirements

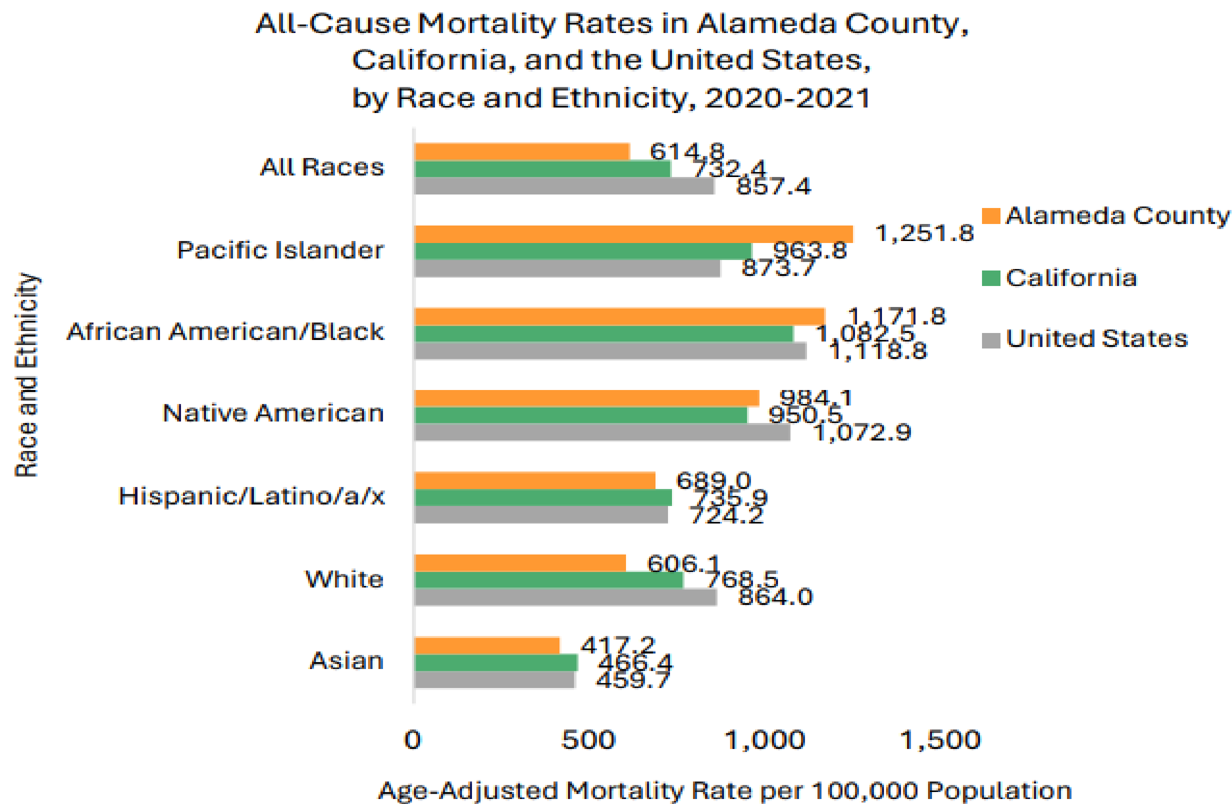
1. DHCS 23-025 implemented this All-Plan Letter on 09/14/2023 that represents DHCS' multi-pronged vision:
   - Data collection and stratification
   - Workforce diversity and cultural responsiveness
   - Eliminating health disparities
2. Comprehensive DEI training includes three modules:
   - Health Equity
   - Cultural Sensitivity
   - Diversity, Equity, Inclusion & Belonging (DEIB)
3. Timeline:
   - Submission for DHCS approval: December 2024
   - Rollout of Pilot Training: January 2025
   - General Rollout Training: Summer 2025

Mid-Term Action Plans

ALAMEDA Alliance FOR HEALTH

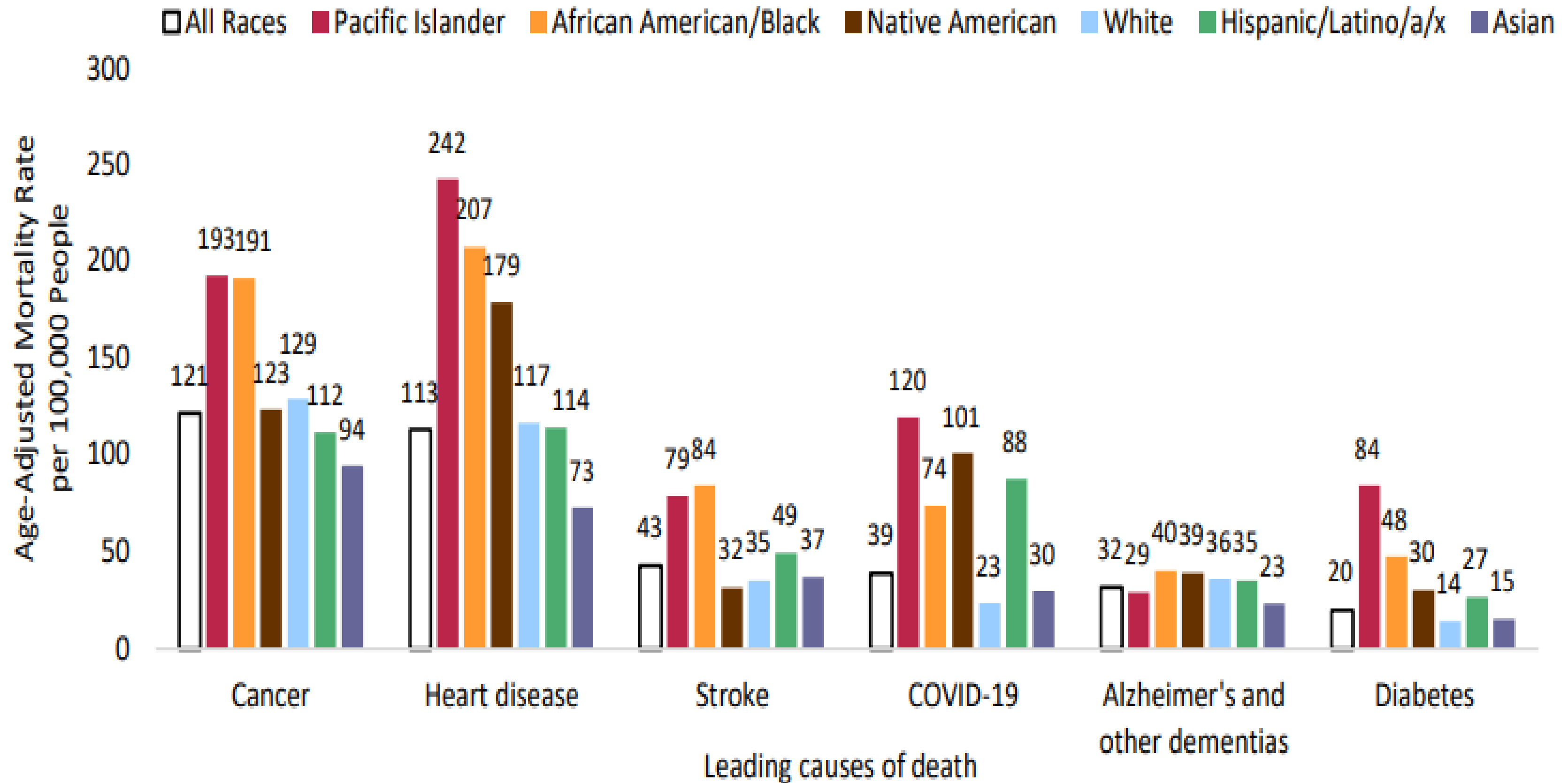
Goal: Data-Driven Health Equity Designs & Strategies

All-Cause Mortality Rates in Alameda County Compared To California State and The Nation



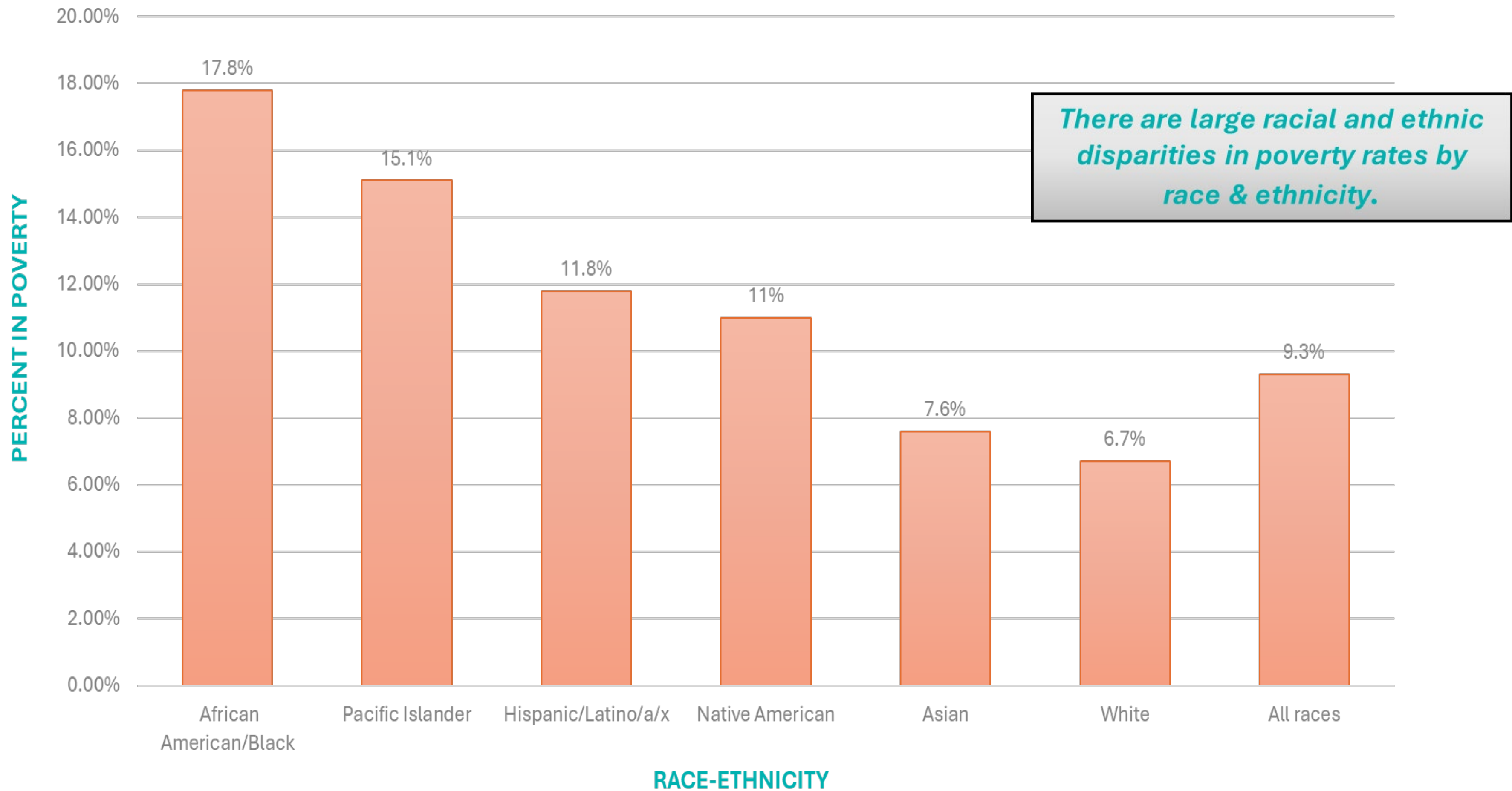
- Pacific Islanders and African Americans in Alameda County face higher all-cause mortality rates than their counterparts in CA and the nation
- Native Americans in Alameda County face higher all-cause mortality rates than their counterparts in CA

Alameda County



- Pacific Islanders, African Americans, and Native Americans experience the highest mortality due to cancer heart disease, stroke, COVID-19, Alzheimer's and diabetes.

Racial and Ethnic Poverty Rates



Data from the Alameda County Public Health Dept
Source: American Community Survey (ACS)
Notes: The ACS does not break out the races mutually exclusive Hispanic/Latino/a/x except for White

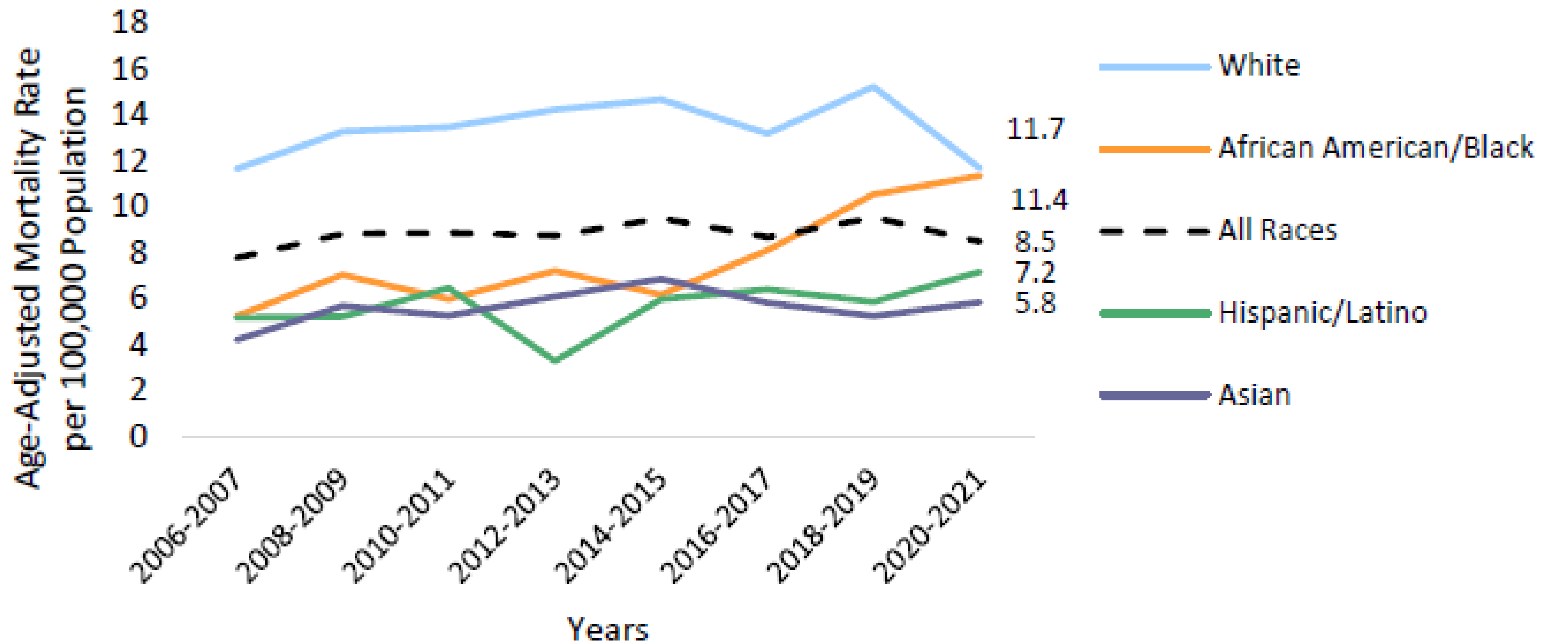
Social Justice Statistics in Alameda County: Homicide Rate

ALAMEDA Alliance FOR HEALTH

* Since there are few homicide deaths among Native Americans and Pacific Islanders, we had to aggregate eight years of data for each. For 2014-2021, the Native American rate was 16.2/100,000 and the Pacific Islander rate was 9.2/100,000.

Source: Examining increases in Mortality and Disparities from 2018-2019 to 2020-2021. Alameda County Health Care Agency and Public Health Department

Social Justice Statistics in Alameda County: Suicide rates



Source: Examining increases in Mortality and Disparities from 2018-2019 to 2020-2021. Alameda County Health Care Agency and Public Health Department

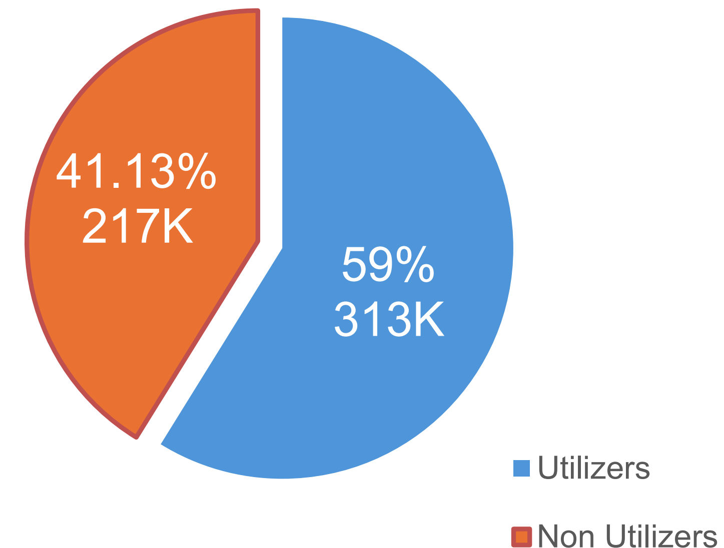
Mid-Term Action Plans

Non-Utilization Equity Project

Goal: Understanding Alliance Non–utilizer data to close the disparity gap

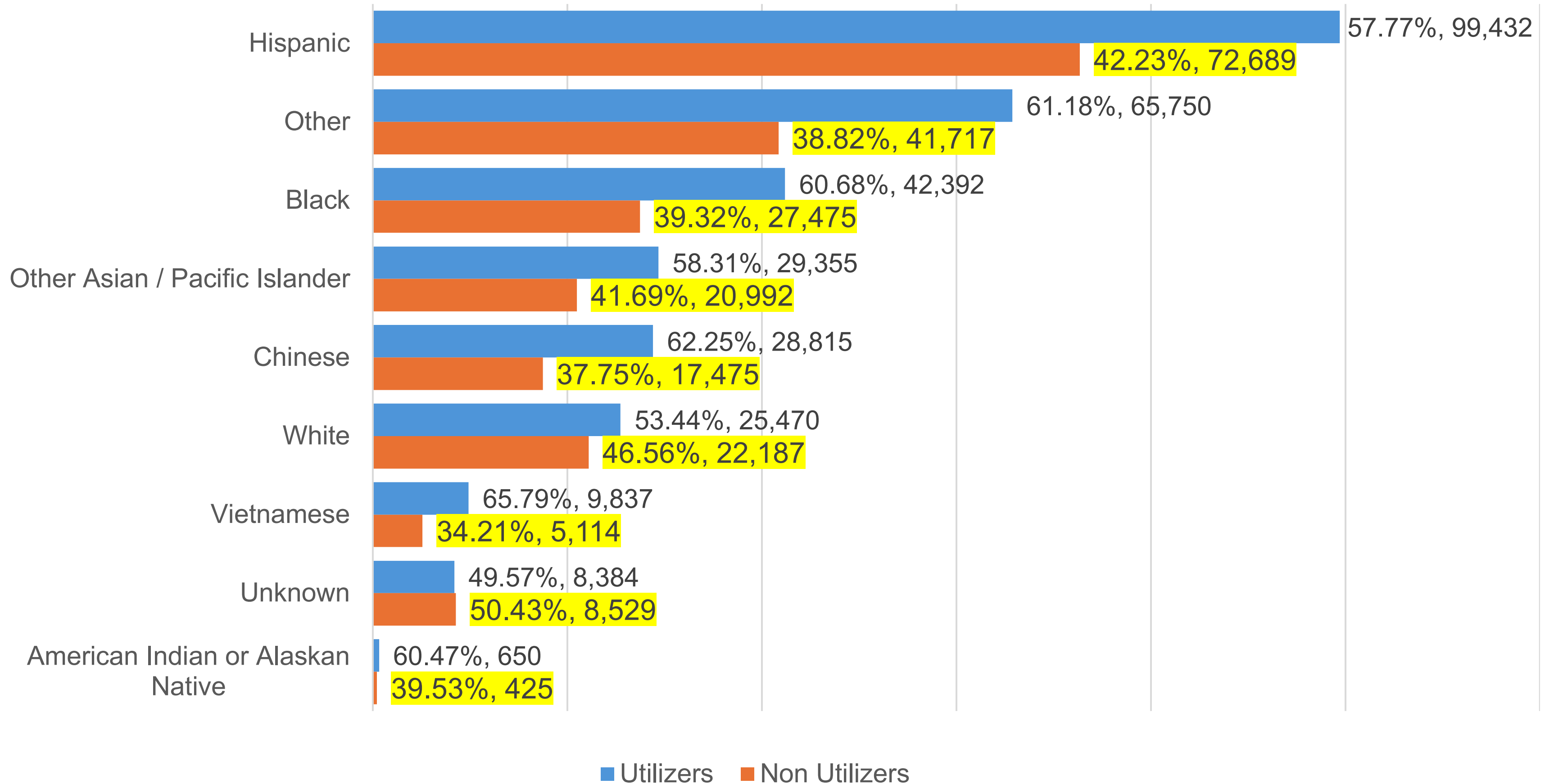
- About 2 in every 5 of the Alliance members (41%) or 217,000 non-utilizers do not use healthcare services in the past 12 month.
- Analyze and understand the "WHO'" and "WHY" of non-utilization to identify potential health disparities.
- Take corrective actions to resolve any identified health disparity issues.
- Holistically and proactively assess non-utilization data on an annual basis to prevent health disparities.

Total Alliance Members – Utilizers vs. Non–Utilizers
(N=527,000)
April 2024



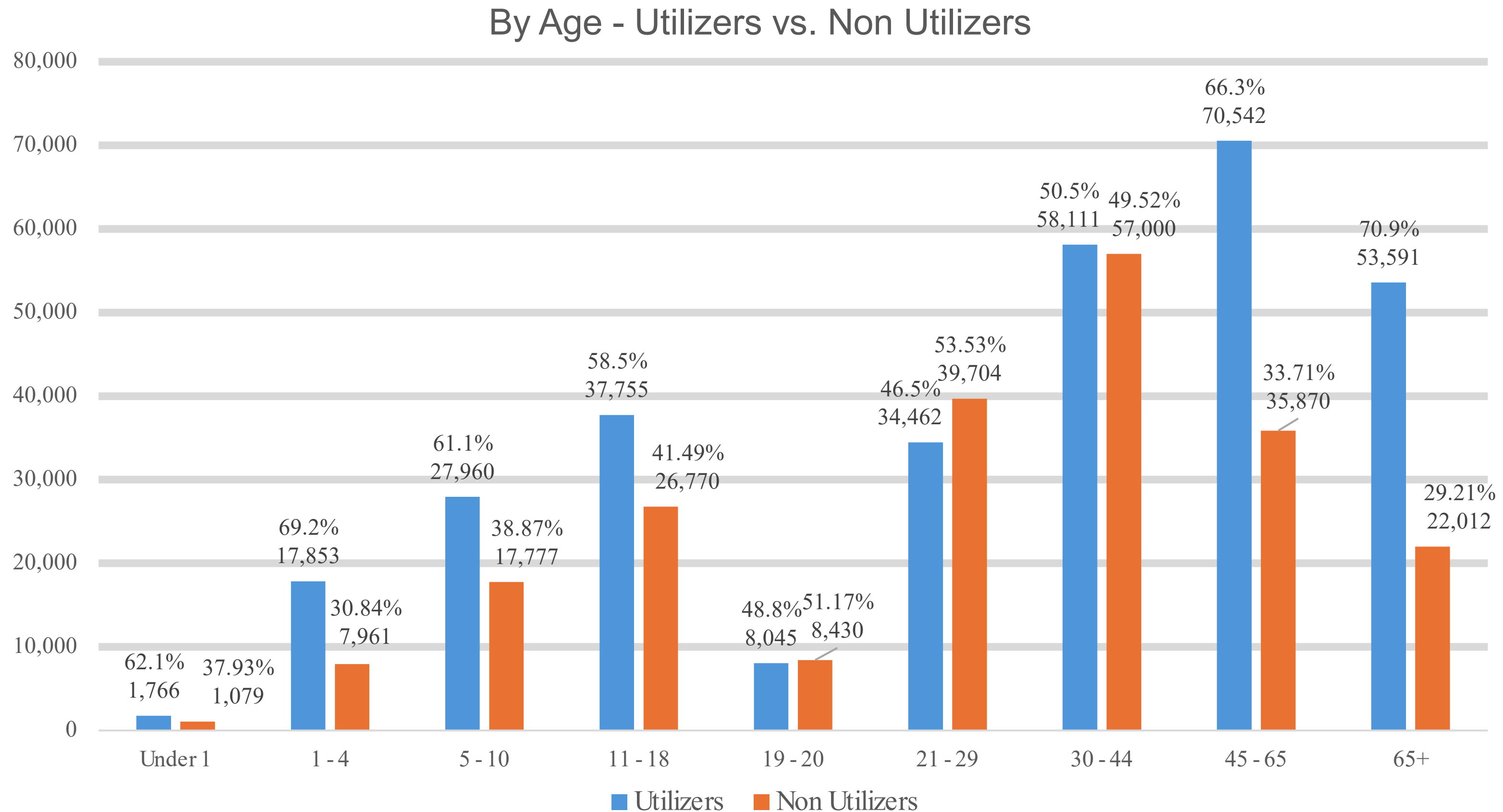
Source: Alliance –13521_UtilizerSummarybyCategory - Power BI

By Ethnicity – Utilizers vs Non-Utilizers



Source: Alliance – 13521_UtilizerSummarybyCategory - Power BI

By Age – Utilizers vs Non-Utilizers



- Almost 1 in 3 older adults (age 45-65 and age 65+) are non-utilizers, which causes concern for they are also more at risk for diseases.
- More analyses (e.g., equity markers such as ethnicity, zip codes, and language) are needed to provide insight into potential SDOH faced by the vulnerable populations.

ALAMEDA Alliance FOR HEALTH

Mid-Term Action Plans

Non-Utilization Equity Project: Alliance Data

- The macro and micro data will guide us to develop priorities and targeted interventions for specific vulnerable populations who need help the most.
- Alliance Utilization vs Non-utilization data stratified by race, ethnicity, neighborhood, etc., will help explain variance.
- The equity-based information might provide indication into potential SDOHs, thereby allowing more effective and targeted intervention.

Mid & Long-Term Plans Health Equity & DEIB Roadmap (3 yr. Milestones)

ALAMEDA Alliance FOR HEALTH

HE & DEIB Roadmap Committee

- Stakeholders Committee's Meetings & Discussions
- Identify and create milestones
- Rollout 2025 – 2028

Strategic Roadmap

Committee Overview

- A strategic planning committee was formed to represent a diverse cross-section of the Alliance workforce, and external stakeholders. Bringing together employees from various backgrounds, departments, and organizations.
- By intentionally including voices from different roles - from junior staff to senior leadership – and different organizations, it ensured a rich diversity of thought, experience, and perspective in the planning process.
- This approach allowed the team to capture a holistic view of the organization's needs and opportunities for advancing health equity and DEIB

Strategic Roadmap Committee

- Linda Ayala (PHM)
- Allison Lam (HCS-UM)
- Michelle Stott (QI and Health Equity)
- Krystaniece Wong (Compliance)
- Shatae Jones (Housing & Community Support, Ops)
- Jennifer Karmelich (Quality Assurance/NCQA/ Grievances & Appeals)
- Michelle Lewis (C&O)
- Darryl Crowder (Provider Services)
- Jorge Rosales (DEIBC member)

Additional Consultations:

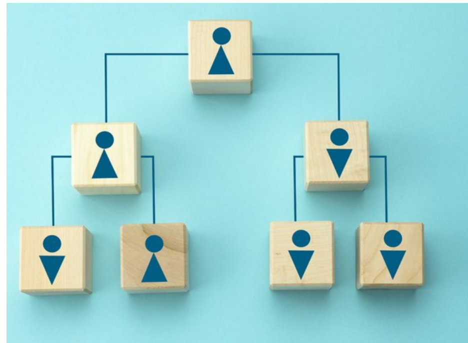
- Alliance Senior Leadership
- CEO Providers
- Alliance MAC Members

- Taumaoe Gaoteote (DEI HR)
- Tiffany Cheang (Analytics)
- Gia DeGrano (Member Services)
- Dr. Sanjay Bhatt (Behavioral Health, Health Equity, and QI)
- Karina Rivera (Public Affairs and Media Relations)
- Renan Ramirez (Finance)
- Shava K. Walters (Vendor Management)
- Peter Currie (Behavioral Health)
- Jeanette Murray (Health Equity)
- Yen Ang (Health Equity)
- Yemaya Teague (Health Equity)
- Anthony Guzman (NAHC)
- Tangerine Bingham (AHS)

Six Milestones of the Health Equity Roadmap

ALAMEDA Alliance FOR HEALTH

❶ Organization



❹ Communication

❷ Data Driven

❺ Community Engagement

❸ Education

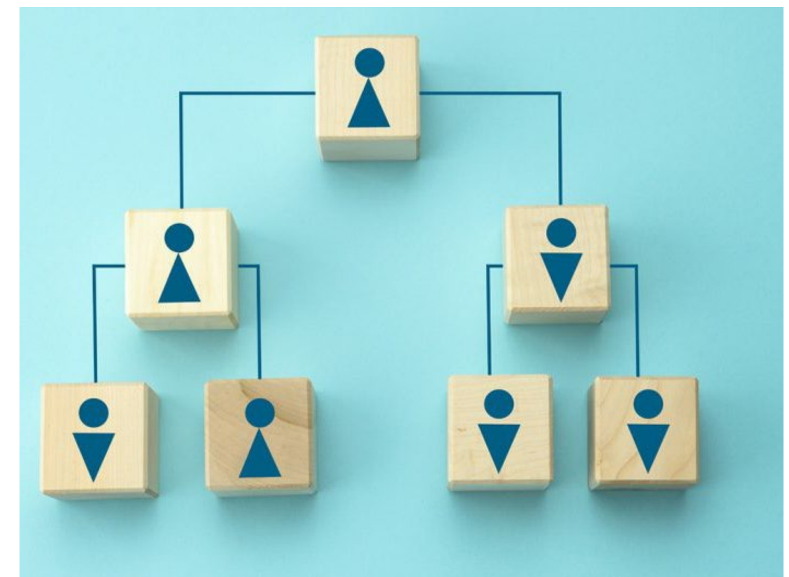
❻ SDOH Mitigation Measures

Milestone # 1: Organization

Alameda Alliance for Health

Health Equity Roadmap

- Top-down system-wide alignment by ensuring our organization on core concepts and foundation in Health equity work.
- Organization mission and vision that embrace Health Equity & DEIB
- Embed Health Equity across the organizational, departmental goals, objectives, policies, processes, services, and products.
- Health Equity and DEIB principles in organization cultures and HR practices
- Interdepartmental collaboration within the organization to prevent silo operations and duplication of efforts

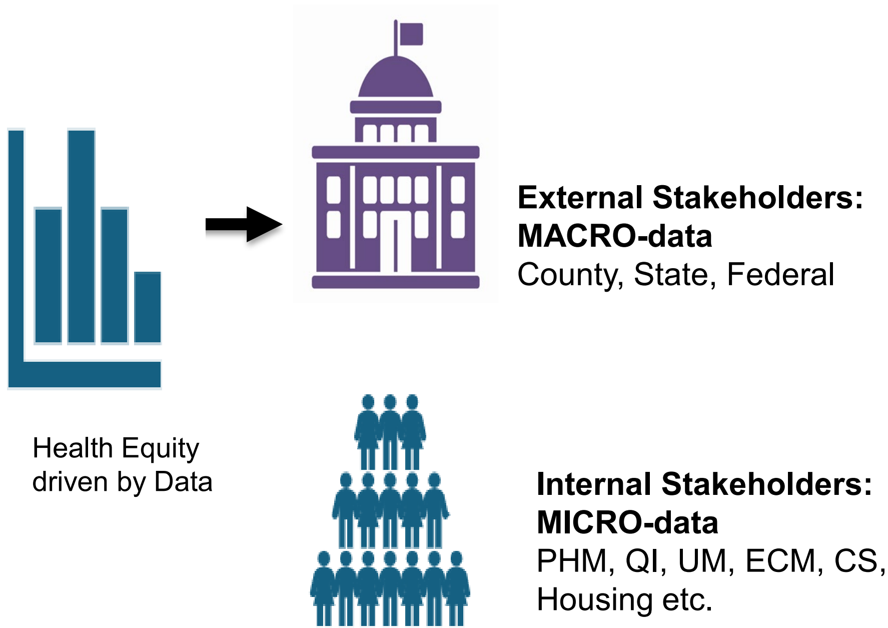


Stakeholders include BOG, CEO, and SLT

Alameda Alliance for Health

Milestone # 2: Data-Driven

Health Equity Roadmap



Stakeholders include but not limited to PHM, QI, QA, UM, ECM, CS

Goals

1. The work of Health Equity must be data-driven to ensure all our interventions, services, policies, and funding are directed at populations that need help the most.
2. Utilizing data to identify pain points, alleviate suffering and injustice, remove systemic discrimination, and reduce health disparities.
3. Refer, integrate, and synergize Macro-Micro data sources from internal and external stakeholders across multiple sectors to develop health equity-based services and products that are relevant to our members.
4. Establish data governance and conduct organizational data inventory. Foster collaborative effort in data utilization for equity-related projects.

Milestone # 3: Education

ALAMEDA Alliance FOR HEALTH

Health Equity Roadmap

Stakeholders include but not limited to C&O, HR, PHM, CLS, QI, HCS

Goals

1. Provide ongoing training and education relating to health equity and DEIB to the Alliance staff, contracted organizations, vendors, and all downstream network providers.

2. In partnership with internal stakeholders, e.g., PHM, QI, Compliance, NCQA, to implement Health Equity Accreditation and all other HE-related metrics.

3. In partnership and collaboration with HR to provide health equity and DEIB training to staff as part of their professional development activities.

4. Constant alignments of concepts and key deliverables with various internal stakeholders to ensure the Alliance is on one accord regarding health equity.

ALAMEDA Alliance FOR HEALTH

Milestone # 4: Communications

Health Equity Roadmap

Goals

1. Collaborate with the Communication Team to brand Alliance as the **Health Equity Champion** in the community.
2. Communicate and Engage internal and external stakeholders to identify barriers to care and create "**safe spaces**" for our internal organization to discuss inequitable practices and policies.
3. Communicate, report and provide updates on health equity and DEIB initiatives to relevant stakeholders.

Stakeholders include but not limited to CS, PR, C&O, CLS

ALAMEDA Alliance FOR HEALTH

Milestone # 5: Community Engagement

Health Equity Roadmap

Co-DESIGN model

Three -tiers Community

- CBOs
  - Building strategic and intentional partnerships with trusted bodies in the community who serve directly or indirectly our members, eg faith-based originations, schools or social justice organizations
- Safety Network
  - Partnering with equity-focused care providers for the under-insured, non-insured populations or under-served members.
- Members
  - Getting members voices heard via community events, focus groups, town halls or surveys

Dismantling SDOHs requires intersectoral collaboration that builds a network of resources and arsenals. Co-DESIGN approach ensures we have collective solutions that meet the complex needs of our disenfranchised communities.

Milestone# 6: SDOH Mitigations

ALAMEDA Alliance FOR HEALTH

Health Equity Roadmap

Top 3 High-Value-High-Impact
SDOH Mitigation Measures

Goals

1. **Members' Health Disparities (Non-utilization Study)**
   Disaggregating AAH Non-utilizer data to develop targeted interventions and close disparity gaps.

2. **Housing Disparities**
   Address the destabilizing SDOH that has the most cascading impacts on the health outcomes of the Medi-Cal population.

3. **Women's Health Disparities**
   Data shows preventive care is a barrier for women of color. Targeted interventions will be designed to remove high–impact SDOHs.

How to Achieve Health Equity?

ALAMEDA Alliance FOR HEALTH

- Health Equity cannot be achieved in silos.
- It takes a multi, inter-sectoral collaboration to take down systemic and structural barriers combined with mitigations of Social Determinant of Health to achieve and sustain health equity.
- The ultimate goal of Health Equity is justice where all structural and systemic barriers are removed within the integrity of the law.

Equality

Equity

Justice

ALAMEDA Alliance FOR HEALTH

Health Equality VS Health Equity

- **Health Equality** is to provide the same level of healthcare to everyone regardless of their ability to pay, whereas
- **Health Equity** is to level the playing field by examining and understanding why underserved and marginalized populations are at greater risk of illness, injury, and death and make a commitment to the allocation of sustainable resources to support and address those populations' healthcare needs.

OUR MOTTO

BUILD
BRIDGES

NOT
WALLS

We "Build bridges, not walls."

Our work, "Matters to this one."

Standing Committee Stipends Policy

POLICY AND PROCEDURE

Policy Number	
Policy Name	**Standing Committee Stipends**
Department Name	Legal Services
Department Officer	
Policy Owner	Senior Legal Analyst
Lines of Business	Medi Cal, Medicare
Effective Date	
Subcommittee Name	
Subcommittee Approval Date	
Administrative Oversight Committee Approval Date	

POLICY STATEMENT

This policy governs the payment of stipends to members of certain standing committees of the Alameda Alliance for Health (AAH) Governing Board for purposes of meeting participation. This policy is only applicable to the following standing committees of the Governing Board: Quality Improvement and Health Equity Committee (QIHEC); Peer Review and Credentialing Committee (PRCC); Pharmacy and Therapeutics Committee (P&T); Community Advisory Committee (CAC); Selection Committee (SC).

PROCEDURE

I. The Governing Board authorizes payment of stipends to the specific standing committee members for meeting attendance and participation as follows:

i. QIHEC: $300
ii. PRCC: $300
iii. P&T: $300
iv. CAC: $150 for all members, except those who are not permitted to receive stipends in accordance with Fair Political Practices Commission "FPPC" guidelines. (This stipend covers in person attendance and reimbursement); $75 (virtual Brown Act compliant attendance). Qualified CAC member(s) serving on the Community Advisory Selection Committee shall also receive this stipend for participation in the Community Advisory Selection Committee.

II. To qualify for the stipend, the members of the committees stated above must be voting members and apply when the following conditions are present:

a) The voting committee member be physically present for the meeting or must timely provide (in advance of 72 hours or when the agenda is publicly posted, whichever is sooner) of a publicly posted ADA compliant address for remote participation.
b) Alternatively, committee members may participate in accordance with Assembly Bill 2449 under "just cause" or "emergency circumstances" so long as there is a quorum of committee members attending in person.

The stipends outlined in this policy are on a per-meeting attended basis when serving as a committee member, which is to be defined as either (1) physically present at AAH, or (2) attendance through "traditional" Brown Act which includes a timely RSVP with a publicly available, ADA-compliant alternative address, or remote participation through Assembly Bill 2449.

No stipend shall be provided if:

(1) the committee member's attendance does not count for quorum, thereby rendering the member unable to vote for the meeting; and
(2) If the committee member's attendance does not fall under physical presence or an alternative under the Brown Act (traditional or under Assembly Bill 2449).

A *committee stipend* shall ***not*** be provided to an AAH employee, in any circumstances.

This policy shall be reviewed every 2 years from its effective date.

DEFINITIONS

Place all definitions and acronyms used in the policy here

AFFECTED DEPARTMENTS/PARTIES

RELATED POLICIES AND PROCEDURES

Any policies referred to in the policy, and any policies that will be affected by this policy

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REVISION HISTORY

TBD

REFERENCES

California Government Code, § 54950 et seq
California Assembly Bill 2449

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draft

MONITORING

AAH's Legal Services Department will monitor any changes in the law (at the state and federal level) that would warrant any changes to this policy. Absent state and federal law changes, this policy shall be reviewed every 2 years.

draft

Finance

Gil Riojas

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

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

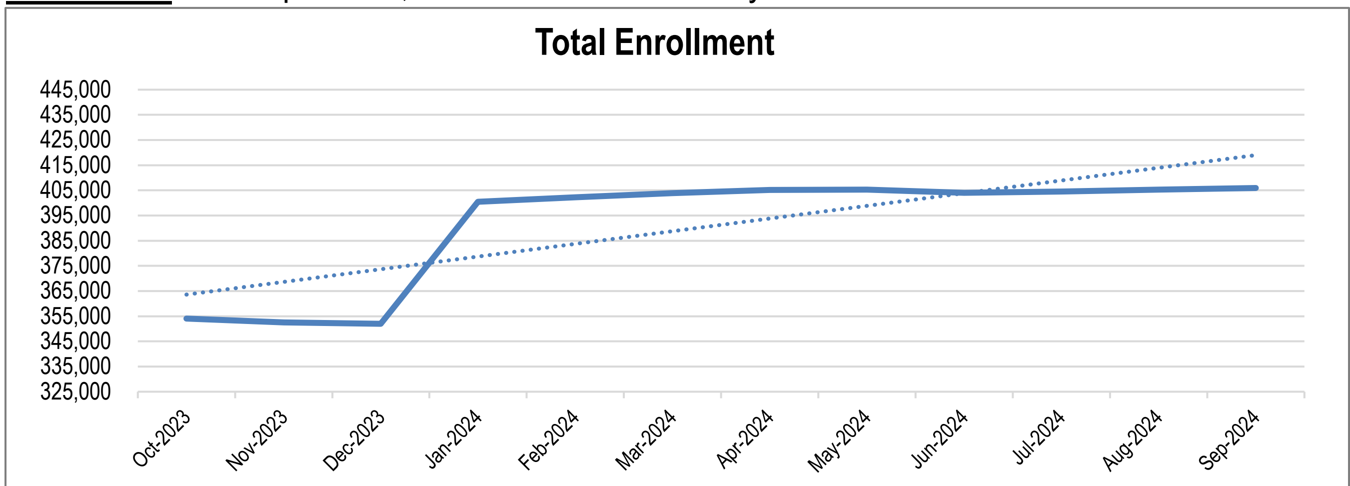
Date: **November 15th, 2024**

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

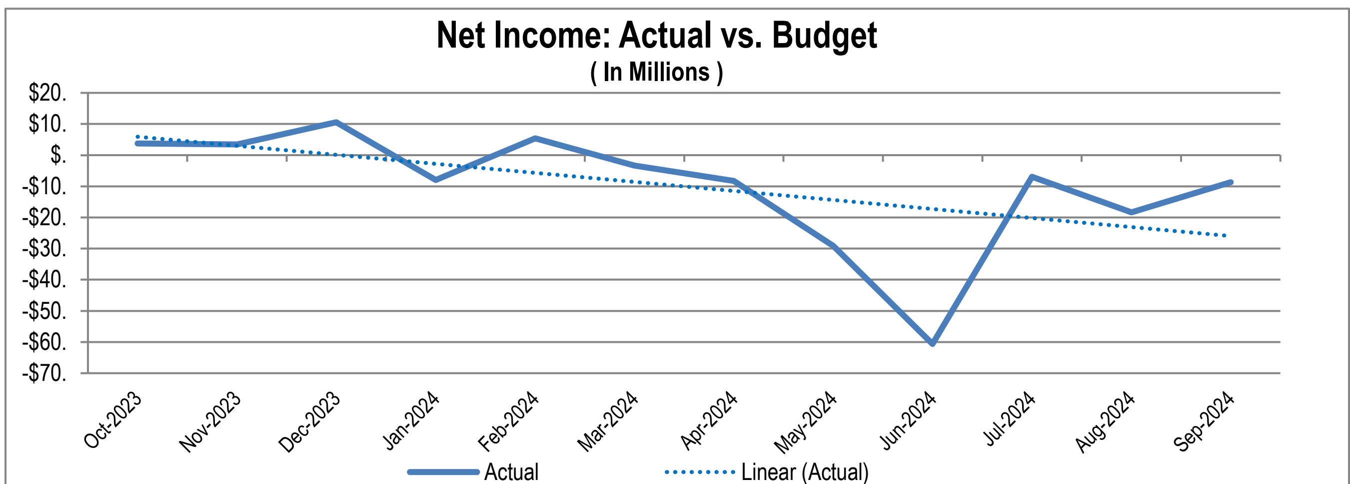
Executive Summary

For the month of September, the Alliance continued to see slight increases in enrollment, reaching 405,933 members. A Net Loss of $8.7 million was reported, and the Plan's Medical Expenses represented 102.1% of revenue. Alliance reserves decreased to 315% of required but continue to remain above minimum requirements.

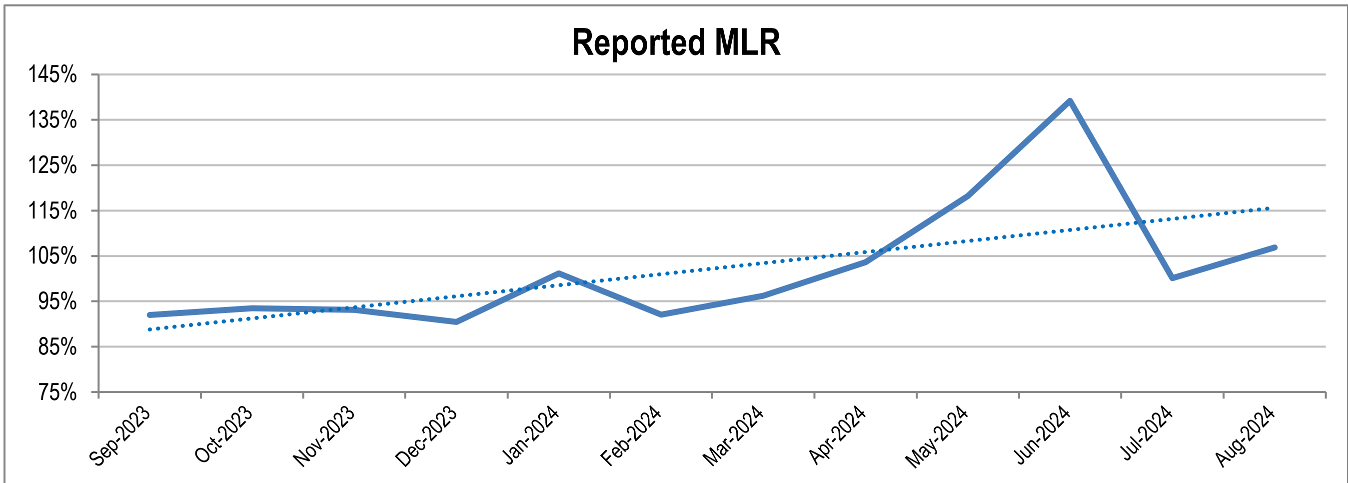
Enrollment – In September, Enrollment increased by 666 members.



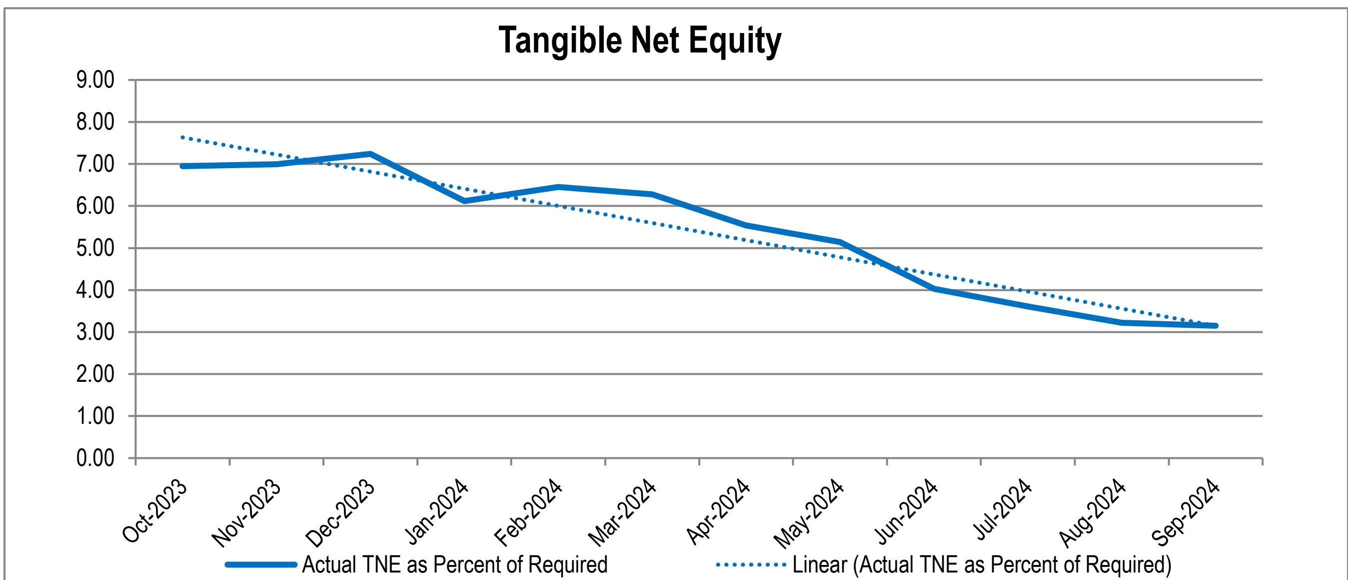
Net Income – For the month ended September 30th, 2024, actual Net Loss was $8.7 million vs. budgeted Net Loss of $215,000. For the fiscal YTD, actual Net Loss was $34.1 million vs. budgeted Net Loss of $5.4 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $170.9 million vs. budgeted Revenue of $166.2 million.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 102.1% for the month, and 103.1% for fiscal YTD. The major variances include unfavorable Emergency Expense, Inpatient/SNF, Pharmacy, and Long-Term Care expenses.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $70.2M in reserves, we reported $221.3M. Our overall TNE remains above DMHC requirements at 315%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, we reported returns of $10.9M, in the investment portfolio. Capital assets acquired FYD is $530k.

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

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

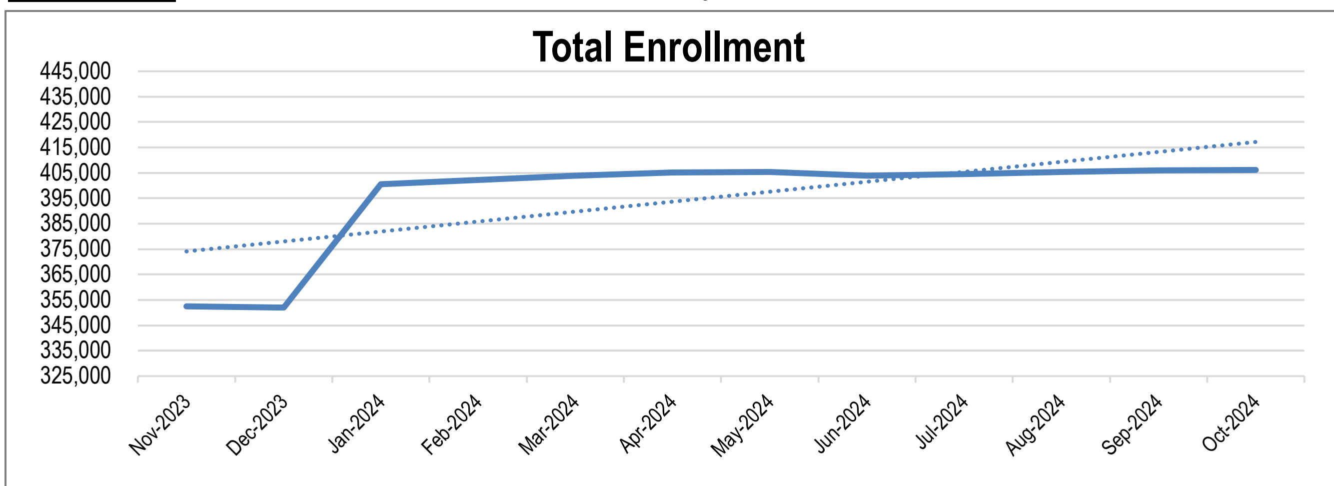
Date: **December 13th, 2024**

Subject: Finance Report – October 2024 Financials

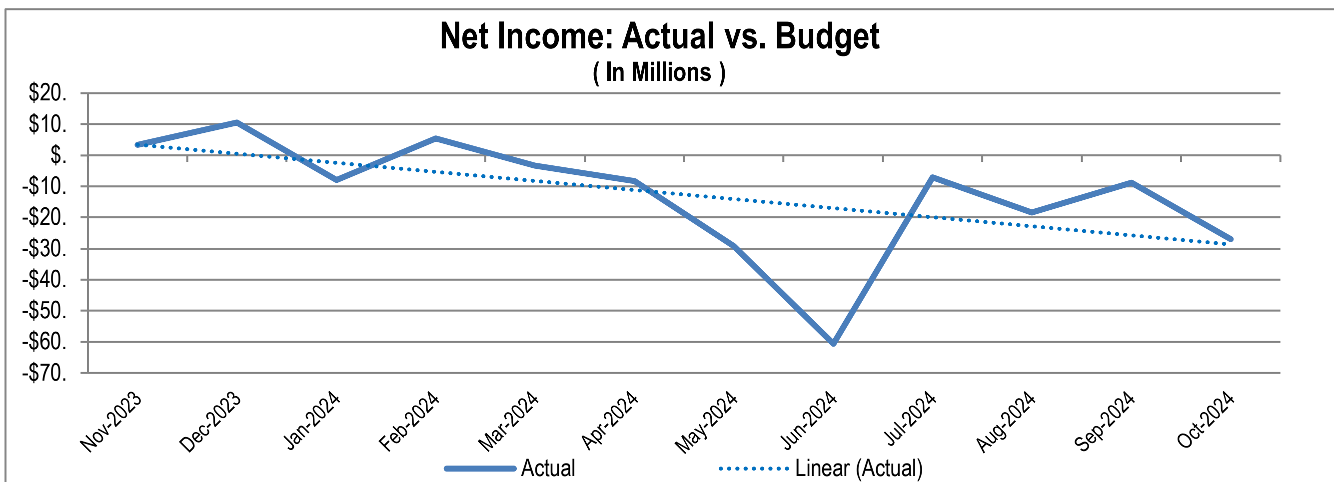
Executive Summary

For the month of October, the Alliance continued to see slight increases in enrollment, reaching 406,153 members. A Net Loss of $27.0 million was reported, and the Plan's Medical Expenses represented 112.0% of revenue. Alliance reserves decreased to 252% of required but continue to remain above minimum requirements.

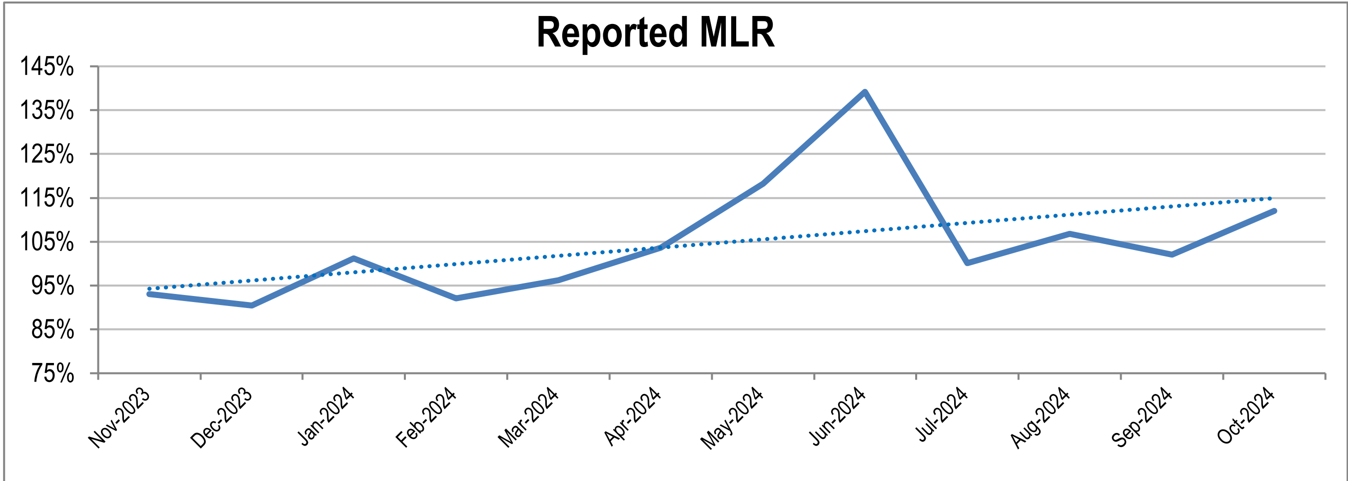
Enrollment – In October, Enrollment increased by 220 members.



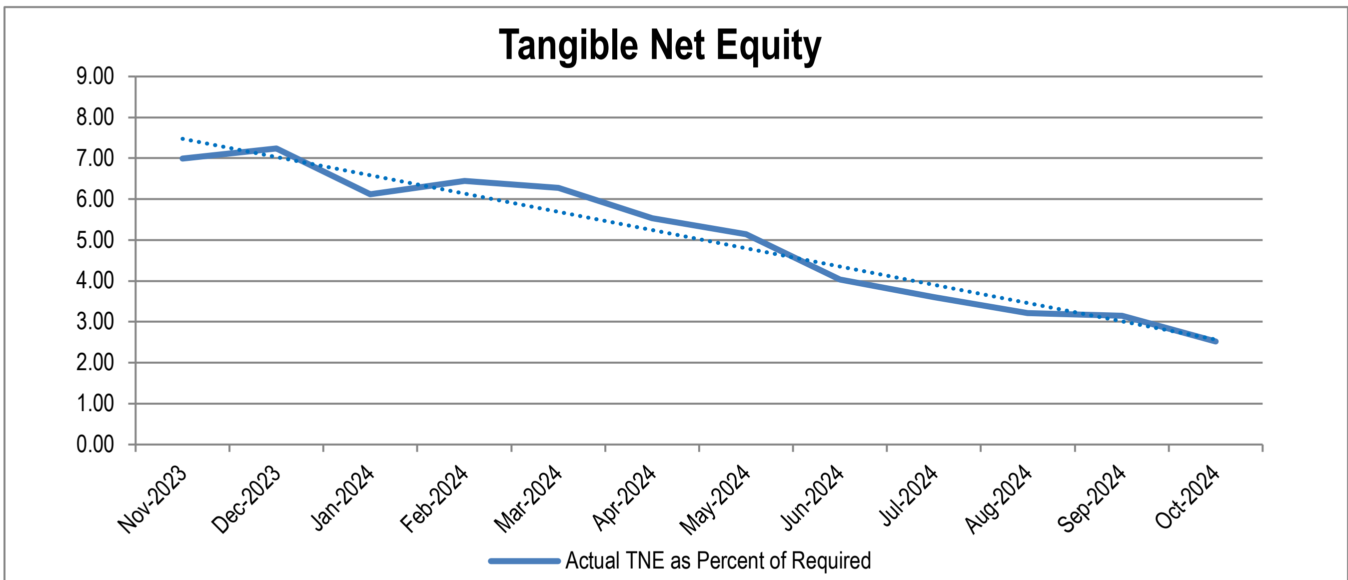
Net Income – For the month ended October 31st, 2024, actual Net Loss was $27.0 million vs. budgeted Net Loss of $4.9 million. For the fiscal YTD, actual Net Loss was $61.0 million vs. budgeted Net Loss of $10.3 million. For the month, Premium Revenue was unfavorable to budget, actual Revenue was $158.2 million vs. budgeted Revenue of $166.3 million.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 112.0% for the month, and 105.2% for fiscal YTD. The major variances include unfavorable Emergency Expense, Inpatient/SNF, Pharmacy, and Long-Term Care expenses.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $77.2M in reserves, we reported $194.3M. Our overall TNE remains above DMHC requirements at 252%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date investments show a gain of $13.0M. Capital assets acquired so far are $530k.

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: December 13th, 2024

Subject: Finance Report – October 2024

Executive Summary

- For the month ended October 31st, 2024, the Alliance had enrollment of 406,153 members, a Net Loss of $27.0 million and 252% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$221,702	$1,021,011
Medical Expense	177,222	704,112
Admin. Expense	9,983	39,175
MCO Tax Expense	63,537	351,752
Other Inc. / (Exp.)	2,056	12,981
Net Income	**($26,984)**	**($61,048)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	($25,864)	($58,491)
Group Care	238	(156)
Medicare	(1,358)	(2,401)
	($26,984)	**($61,048)**

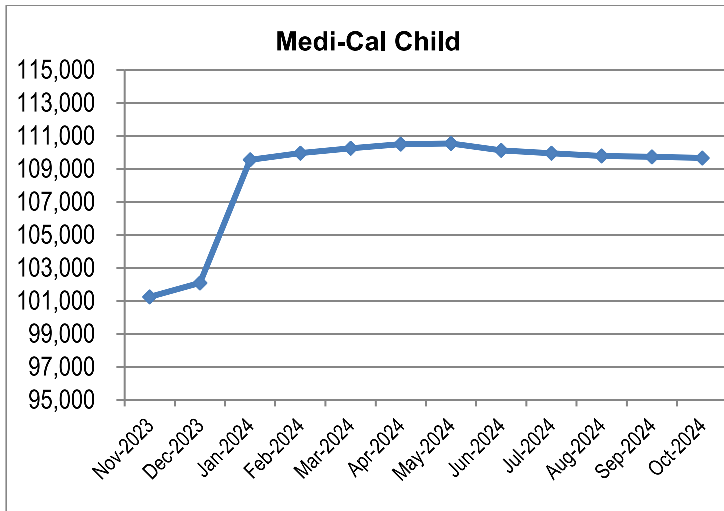
Enrollment

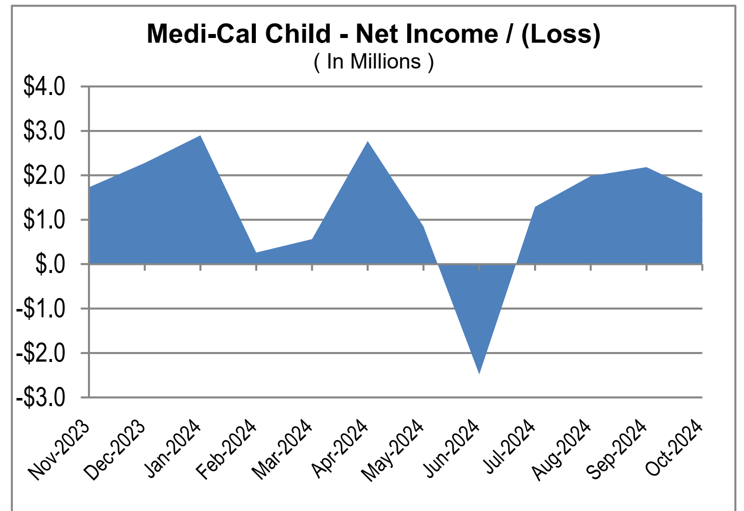
- Total enrollment increased by 220 members since September 2024.
- Total enrollment increased by 2,163 members since June 2024.

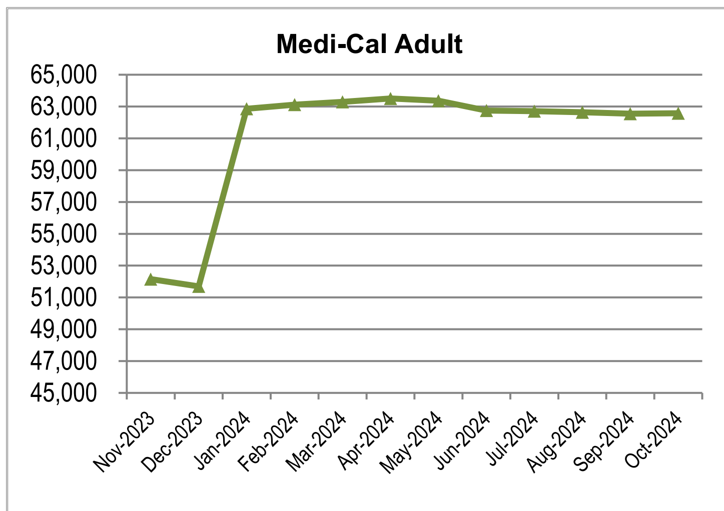
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

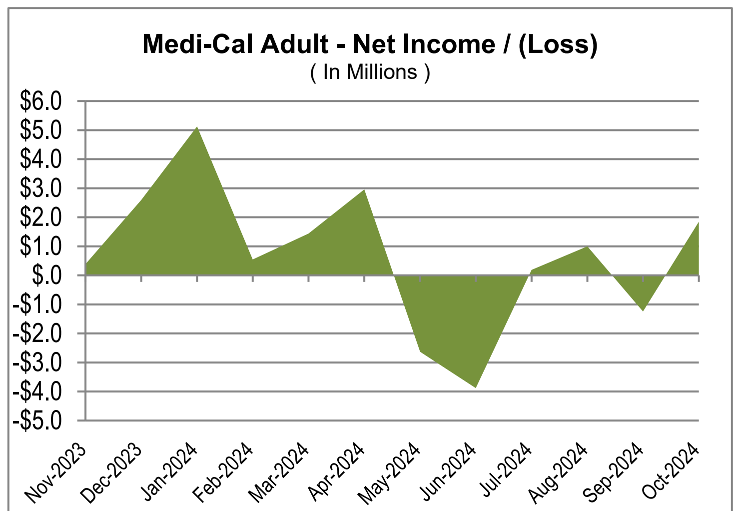
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
62,578	63,763	(1,185)	-1.9%	Adult	250,477	254,668	(4,191)	-1.6%
109,662	111,388	(1,726)	-1.5%	Child	439,128	444,221	(5,093)	-1.1%
35,388	34,848	540	1.5%	SPD	140,902	139,392	1,510	1.1%
40,144	39,791	353	0.9%	Duals	160,184	159,164	1,020	0.6%
151,098	149,765	1,333	0.9%	ACA OE	602,386	598,163	4,223	0.7%
249	224	25	11.2%	LTC	937	896	41	4.6%
1,265	1,285	(20)	-1.6%	LTC Duals	5,007	5,140	(133)	-2.6%
400,384	**401,064**	**(680)**	**-0.2%**	**Medi-Cal Total**	**1,599,021**	**1,601,644**	**(2,623)**	**-0.2%**
5,769	5,643	126	2.2%	Group Care	22,840	22,572	268	1.2%
406,153	**406,707**	**(554)**	**-0.1%**	**Total**	**1,621,861**	**1,624,216**	**(2,355)**	**-0.1%**

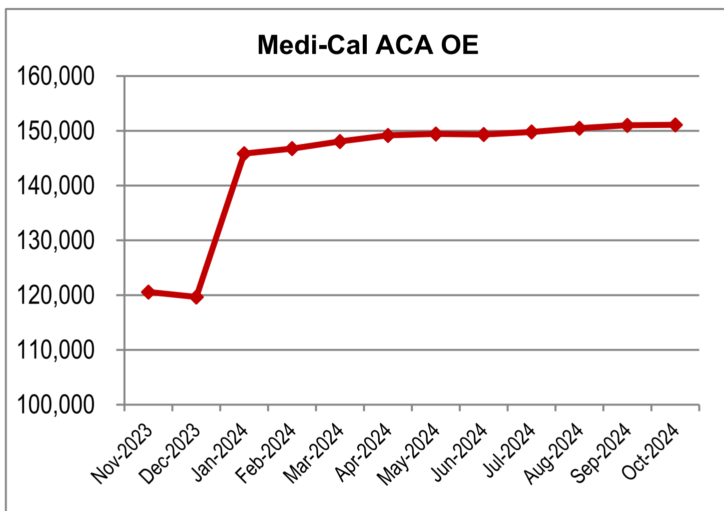
Enrollment and Profitability by Program and Category of Aid

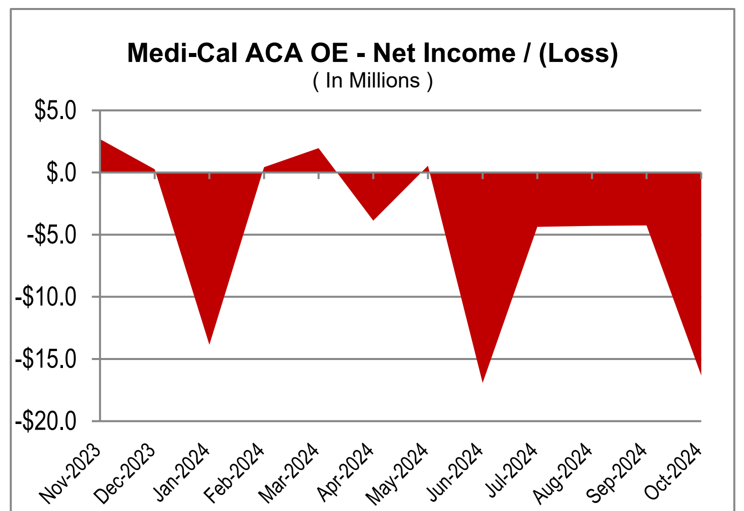




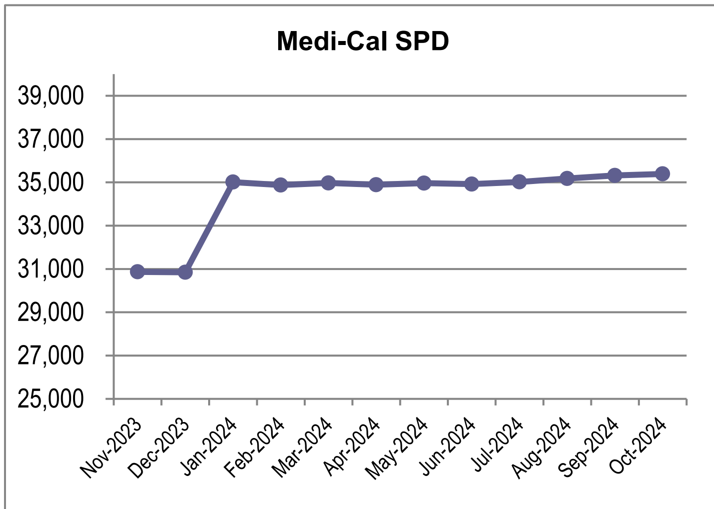


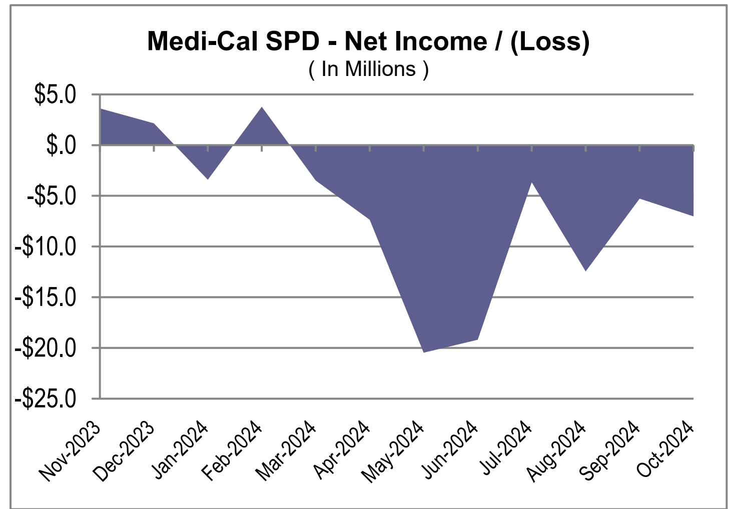


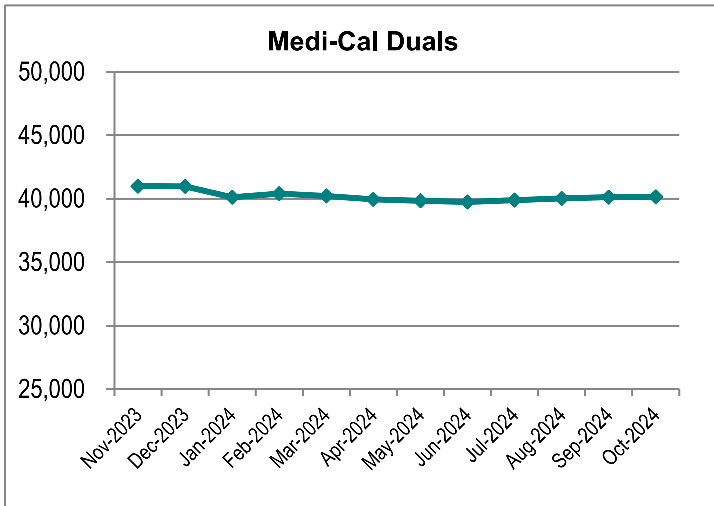


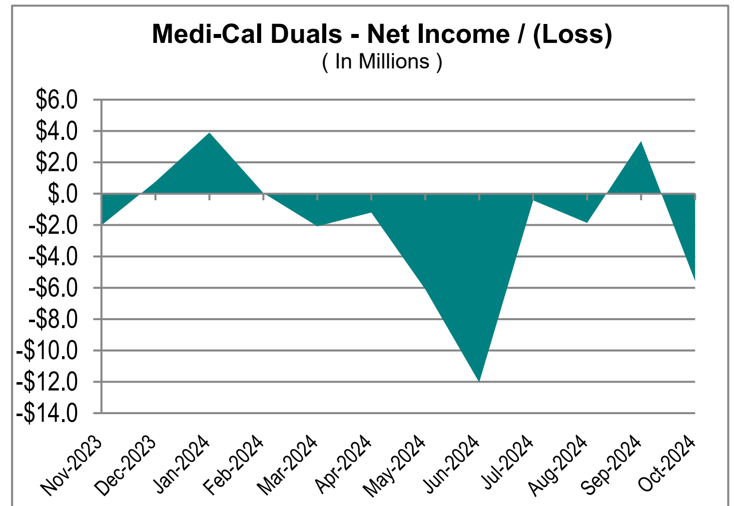


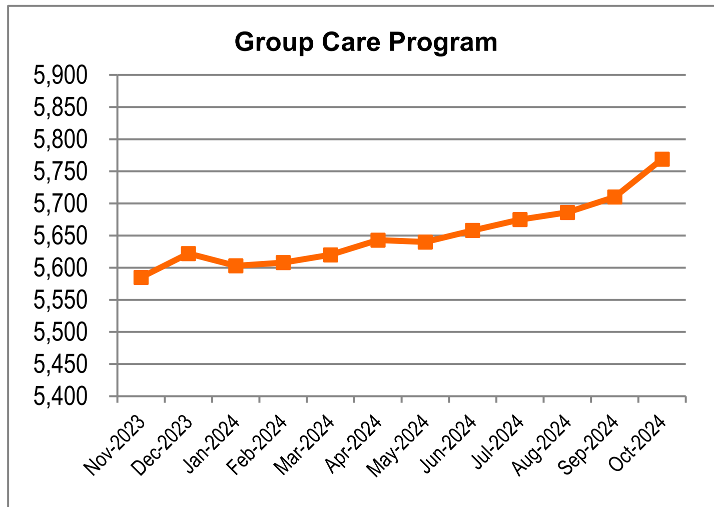
Enrollment and Profitability by Program and Category of Aid

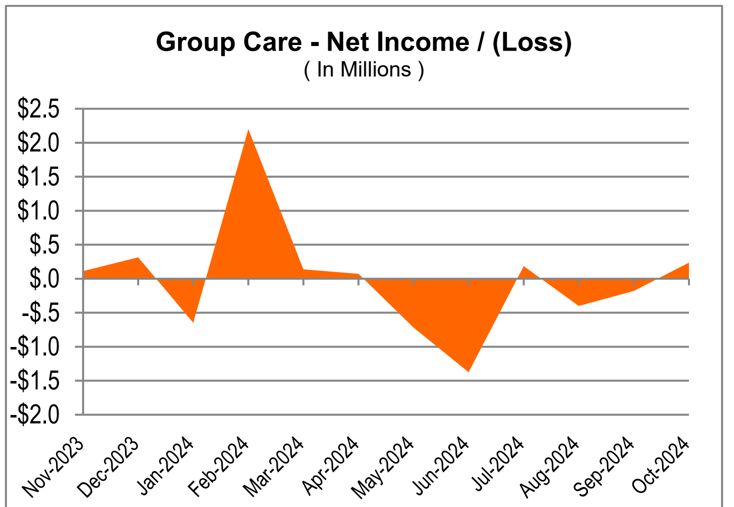




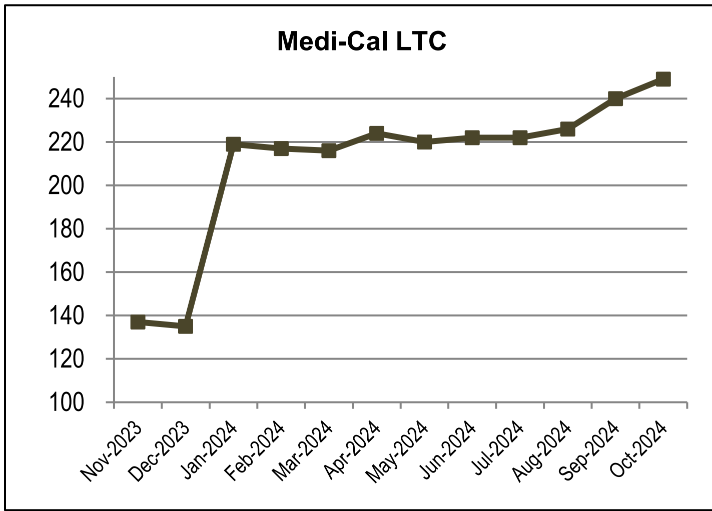


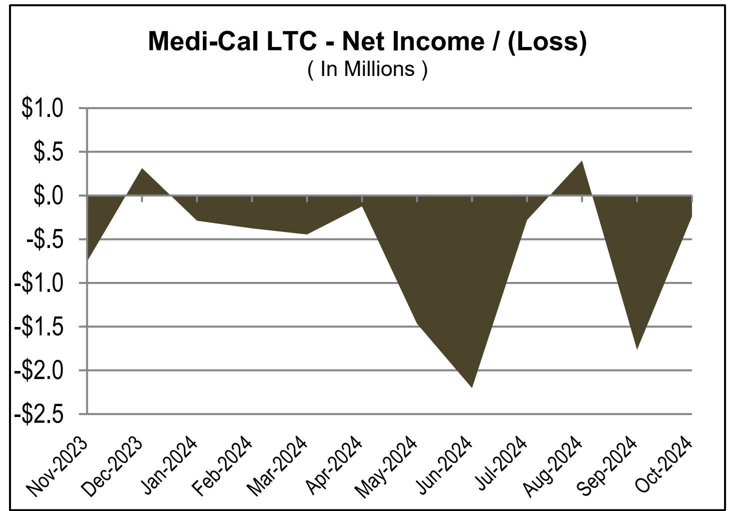


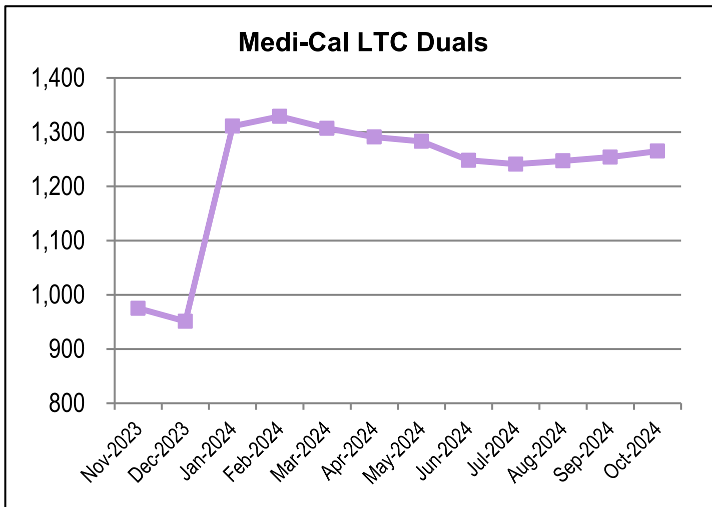


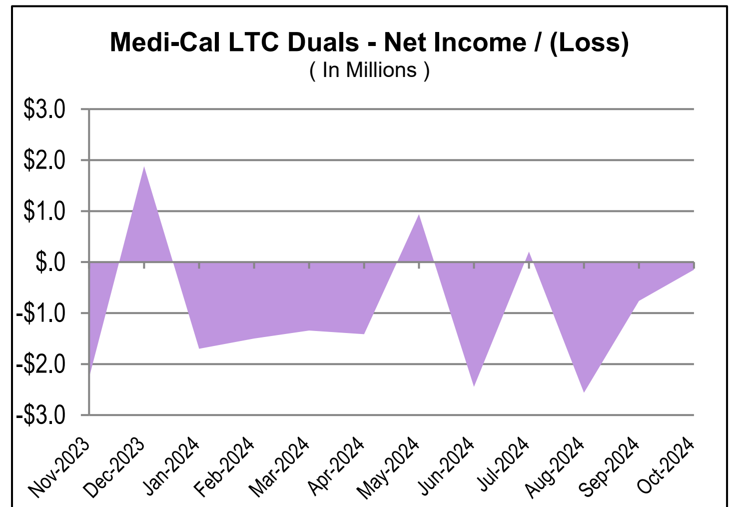


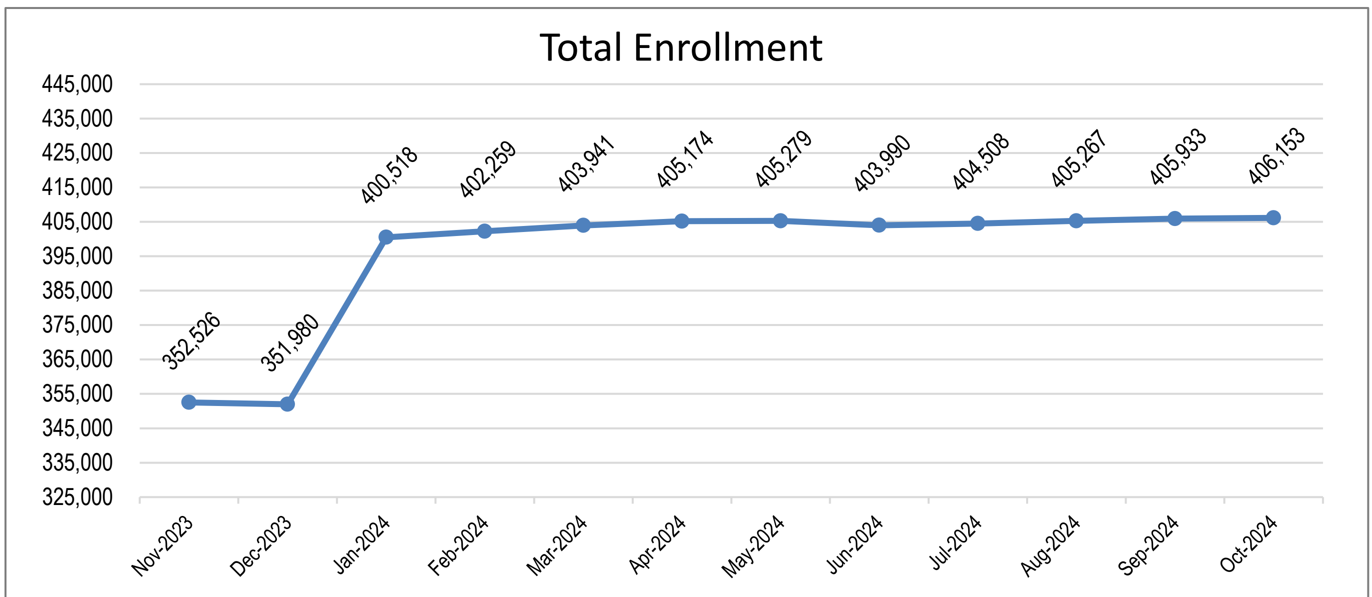
Enrollment and Profitability by Program and Category of Aid

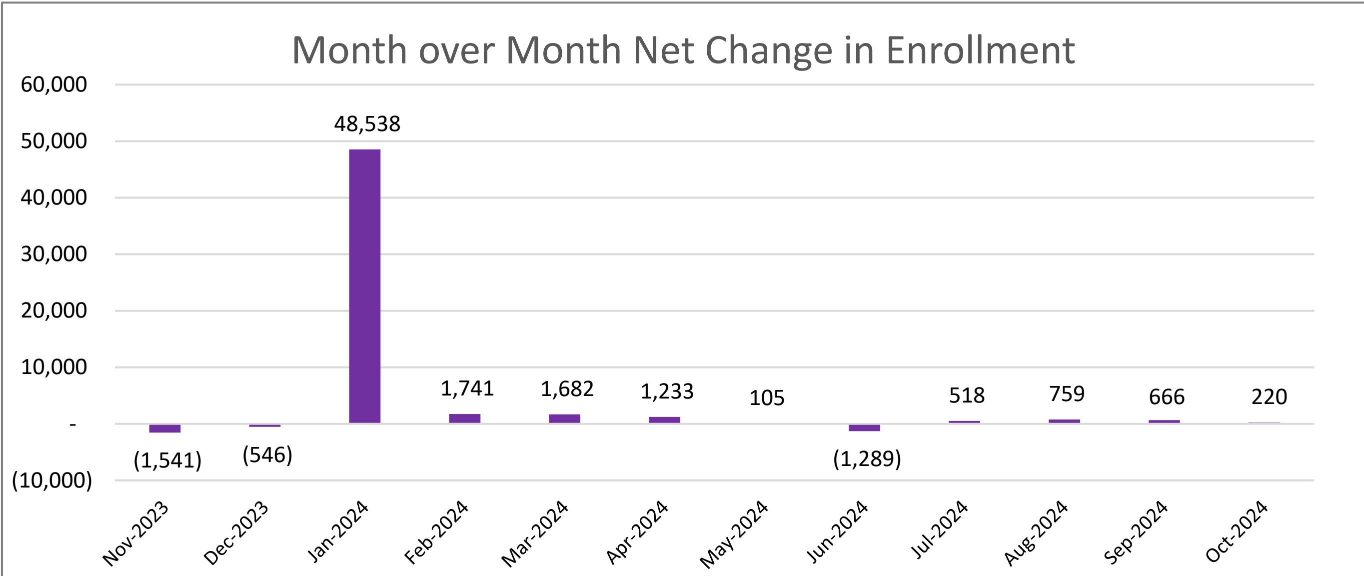








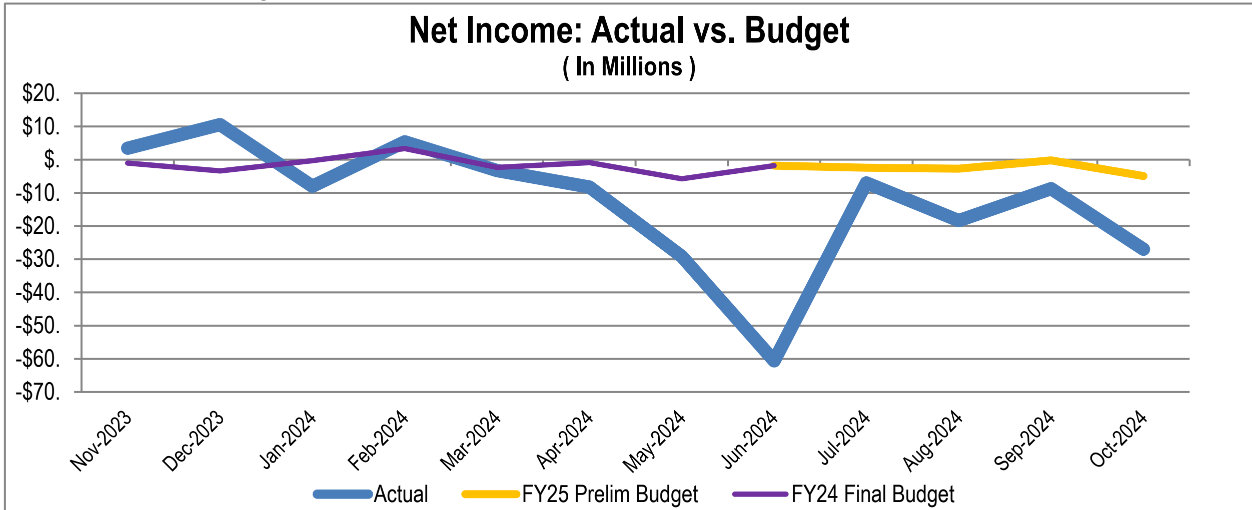




- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and ended May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the Alliance.
- In January 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 October 31st, 2024:
  - Actual Net Loss $27.0 million.
  - Budgeted Net Loss $4.9 million.
- For the fiscal YTD ended October 31st, 2024:
  - Actual Net Loss $61.0 million.
  - Budgeted Net Loss $10.3 million.

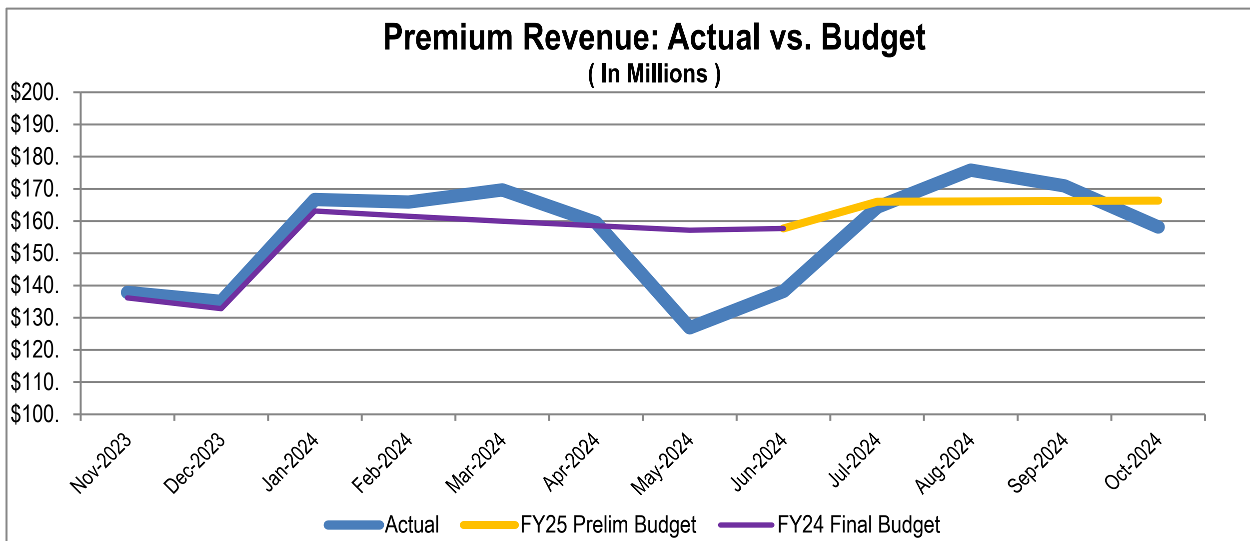


- The unfavorable variance of $22.1 million in the current month is primarily due to:
    - Unfavorable $13.0 million higher than anticipated Medical Expense.
    - Unfavorable $8.2 million lower than anticipated Premium Revenue.

Premium Revenue

- For the month ended October 31st, 2024:
    - Actual Revenue: $158.2 million.
    - Budgeted Revenue: $166.3 million.

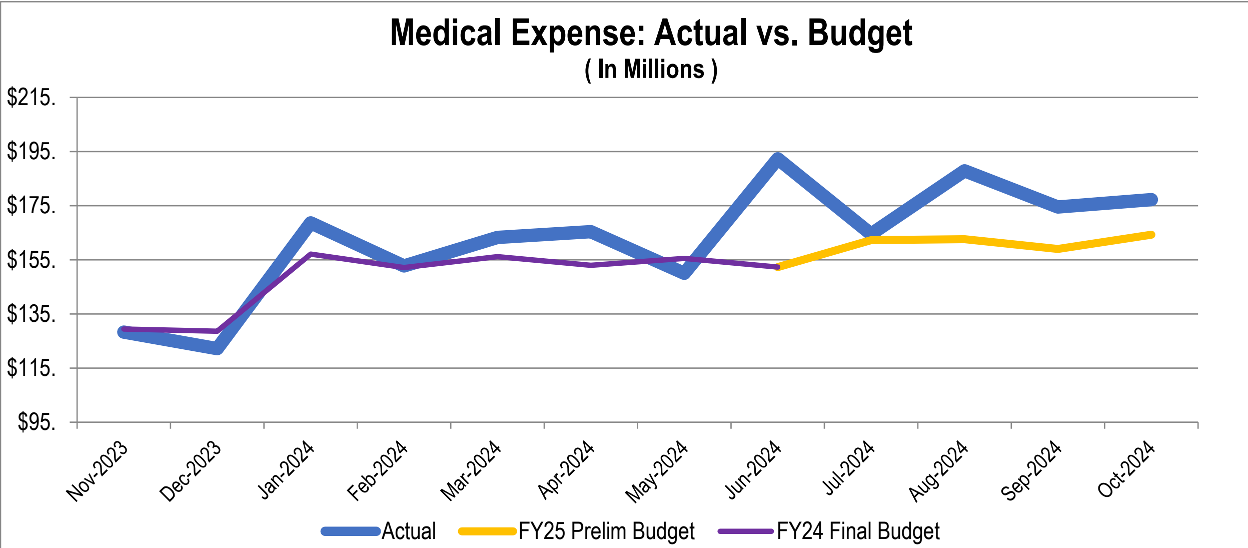
- For the fiscal YTD ended October 31st, 2024:
    - Actual Revenue: $669.3 million
    - Budgeted Revenue: $664.7 million.



- For the month ended October 31st, 2024, the unfavorable Premium Revenue variance of $8.2 million is primarily due to the following:
    - Unfavorable $11.6 million reduction in CY2022 Prop56 revenue via MEP (Medical Expenditure Percentage) reconciliation.
    - Partially offset by $1.2 million in Medi-Cal capitation volume variance for the current month.

Medical Expense

- For the month ended October 31st, 2024:
    - Actual Medical Expense: $177.2 million.
    - Budgeted Medical Expense: $164.3 million.
- For the fiscal YTD ended October 31st, 2024:
    - Actual Medical Expense: $704.1 million.
    - Budgeted Medical Expense: $648.1 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 October, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $8.9 million. Year to date, the estimate for prior years increased by $24.8 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	$72,340,775	$0	$72,340,775	$79,345,342	$7,004,567	8.8%
Primary Care FFS	$8,524,550	$100,267	$8,624,817	$24,369,731	$15,845,181	65.0%
Specialty Care FFS	$31,925,503	$1,251,545	$33,177,048	$31,889,871	($35,632)	-0.1%
Outpatient FFS	$48,581,626	$741,132	$49,322,759	$45,656,575	($2,925,052)	-6.4%
Ancillary FFS	$71,513,814	$3,044,387	$74,558,201	$67,599,332	($3,914,482)	-5.8%
Pharmacy FFS	$55,156,320	$1,526,119	$56,682,439	$48,198,887	($6,957,433)	-14.4%
ER Services FFS	$41,122,546	$809,700	$41,932,246	$34,889,170	($6,233,376)	-17.9%
Inpatient Hospital & SNF FFS	$202,390,858	$14,201,921	$216,592,779	$181,495,417	($20,895,441)	-11.5%
Long Term Care FFS	$131,152,702	$3,137,751	$134,290,453	$116,104,135	($15,048,568)	-13.0%
Other Benefits & Services	$16,305,188	$0	$16,305,188	$17,004,914	$699,726	4.1%
Net Reinsurance	$285,638	$0	$285,638	$1,543,478	$1,257,840	81.5%
Provider Incentive	$0	$0	$0	$0	$0	-
	$679,299,520	**$24,812,823**	**$704,112,343**	**$648,096,852**	**($31,202,668)**	**-4.8%**

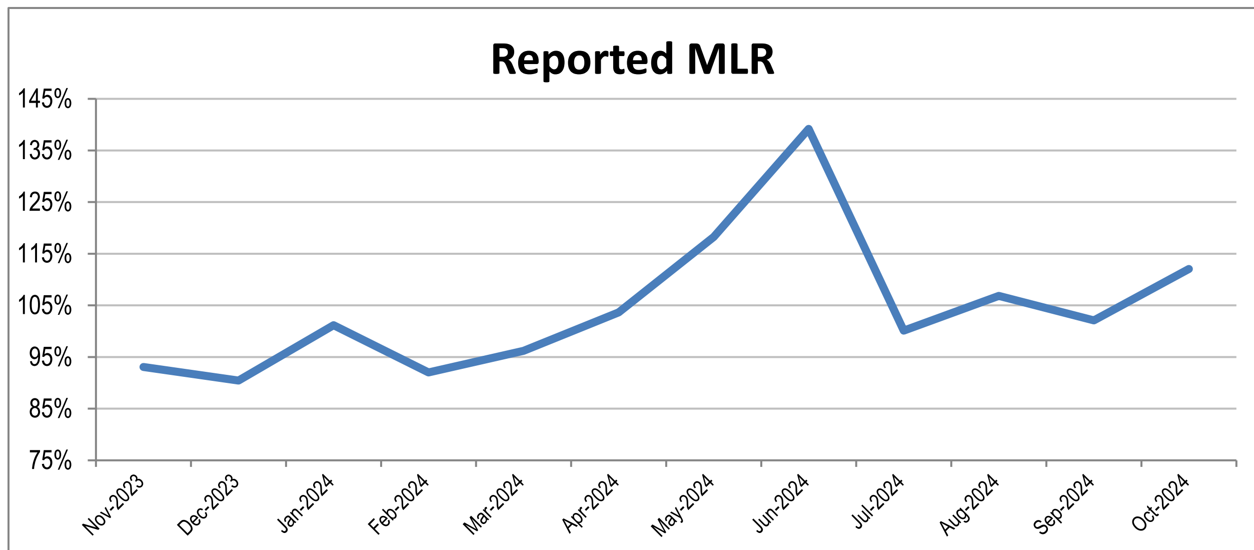
Medical Expense - Actual vs. Budget (Per Member Per Month) Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			**Budget**	**Variance Actual vs. Budget Favorable/(Unfavorable)**	
	Adjusted	**Change in IBNP**	**Reported**		**$**	**%**
Capitated Medical Expense	$44.60	$0.00	$44.60	$48.85	$4.25	8.7%
Primary Care FFS	$5.26	$0.06	$5.32	$15.00	$9.75	65.0%
Specialty Care FFS	$19.68	$0.77	$20.46	$19.63	($0.05)	-0.3%
Outpatient FFS	$29.95	$0.46	$30.41	$28.11	($1.84)	-6.6%
Ancillary FFS	$44.09	$1.88	$45.97	$41.62	($2.47)	-5.9%
Pharmacy FFS	$34.01	$0.94	$34.95	$29.68	($4.33)	-14.6%
ER Services FFS	$25.36	$0.50	$25.85	$21.48	($3.87)	-18.0%
Inpatient Hospital & SNF FFS	$124.79	$8.76	$133.55	$111.74	($13.05)	-11.7%
Long Term Care FFS	$80.87	$1.93	$82.80	$71.48	($9.38)	-13.1%
Other Benefits & Services	$10.05	$0.00	$10.05	$10.47	$0.42	4.0%
Net Reinsurance	$0.18	$0.00	$0.18	$0.95	$0.77	81.5%
Provider Incentive	$0.00	$0.00	$0.00	$0.00	$0.00	-
	$418.84	**$15.30**	**$434.14**	**$399.02**	**($19.82)**	**-5.0%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $31.2 million unfavorable to budget. On a PMPM basis, medical expense is 5.0% unfavorable to budget. For per-member-per-month expense:
  - Capitated Expense is slightly under budget, mostly due to favorable FQHC PCP Capitation expense.

- Primary Care Expense is under budget due to a reduction in Prop56 expense in the SPD, ACA OE, Child and Adult aid code categories.
- Specialty Care Expense is below budget, driven by lower than expected Dual and ACA OE unit cost and utilization offset by higher utilization in the SPD and Group Care populations.
- Outpatient Expense is over budget mostly driven by utilization and unit cost in the SPD, ACA OE, LTC Duals and Group Care populations.
- Ancillary Expense is over budget mostly due to higher lab and radiology, Behavioral Health, Home Health, DME and CBAS expense in the Child and Dual aid code categories.
- Pharmacy Expense is above budget due to Non-PBM expense driven by high unit cost and utilization in the SPD and ACA OE aid code categories and to a lesser degree the Adult and Group Care populations.
- Emergency Room Expense is over budget driven by high utilization and unit cost in the SPD and ACA OE aid code categories.
- Inpatient Expense is over budget driven by higher utilization and unit cost in the SPD and ACA OE aid code categories.
- Long Term Care Expense is over budget due to high utilization in the SPD, ACA OE and Duals aid code categories.
- Other Benefits & Services is under budget, due to lower than expected community relations expense.
- Net Reinsurance 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 112.0% for the month and 105.2% for the fiscal year-to-date.



Administrative Expense

- For the month ended October 31st, 2024:
  - Actual Administrative Expense: $10.0 million.
  - Budgeted Administrative Expense: $9.5 million.

- For the fiscal YTD ended October 31st, 2024:
  - Actual Administrative Expense: $39.2 million.
  - Budgeted Administrative Expense: $36.9 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 %**
$5,971,370	$6,072,836	$101,466	1.7%	Employee Expense	$23,030,935	$23,140,731	$109,797	0.5%
77,643	74,625	(3,017)	-4.0%	Medical Benefits Admin Expense	304,856	298,162	(6,694)	-2.2%
2,470,858	1,796,098	(674,761)	-37.6%	Purchased & Professional Services	8,844,117	6,849,139	(1,994,977)	-29.1%
1,463,117	1,565,373	102,256	6.5%	Other Admin Expense	6,994,901	6,647,684	(347,219)	-5.2%
$9,982,988	$9,508,932	($474,056)	-5.0%	Total Administrative Expense	$39,174,808	$36,935,715	($2,239,093)	-6.1%

The year-to-date variances include:

- Unfavorable in Purchased & Professional Services, primarily for the timing for Consulting Services, Other Purchased Services, Legal Fees, and HMS Recovery Fees.
- 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 in Supplies & Other Expenses
- Favorable Employee and Temporary Services and delayed training, travel, and other employee-related expenses.
- Favorable Building Occupancy costs.
- Favorable Printing/Postage/Promotion and Supplies & Other Expenses.

The Administrative Loss Ratio (ALR) is 6.3% of net revenue for the month and 5.9% 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 $553,000.

Other Income / (Expense)

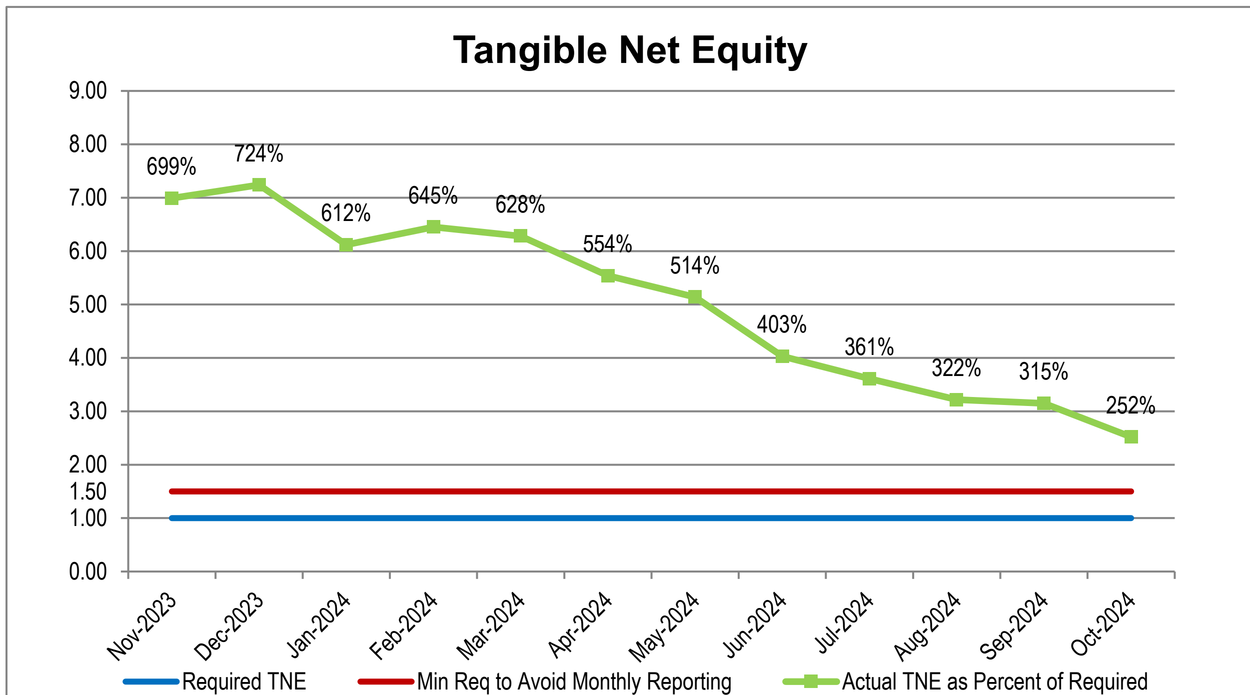
Other Income & Expense is comprised of investment income and claims interest. Fiscal year-to-date net investments show a gain of $13.0 million.

Managed Care Organization (MCO) Provider Tax

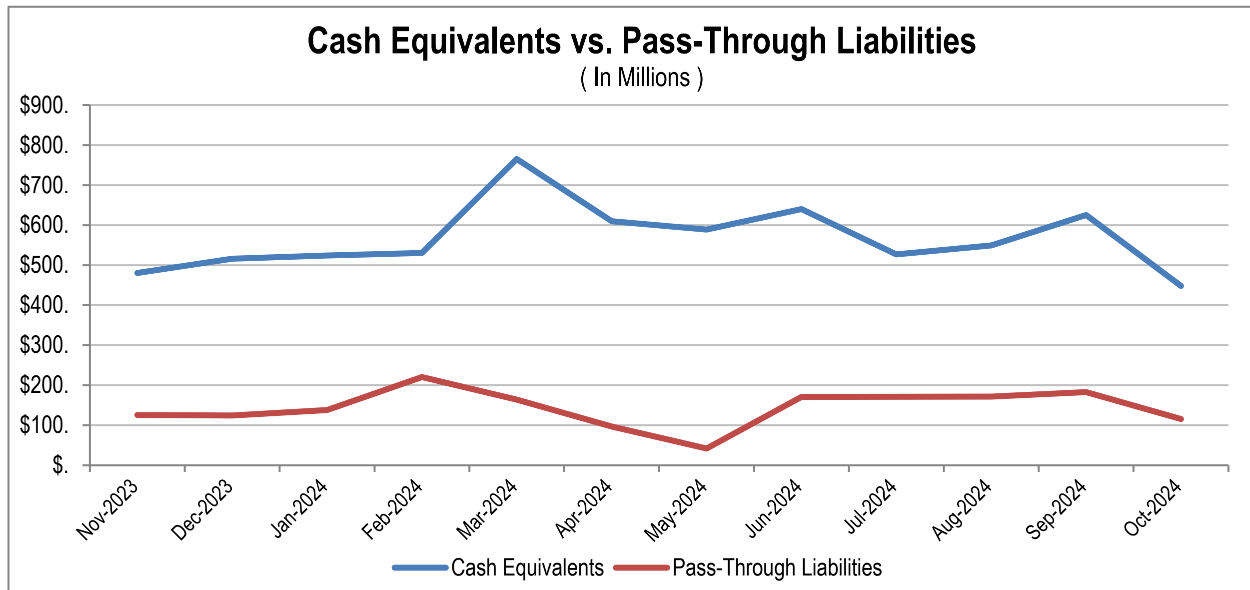
- Revenue:
  - For the month ended October 31st, 2024:
    - Actual: $63.5 million.
    - Budgeted: $47.2 million.
  - For the fiscal YTD ended October 31st, 2024:
    - Actual: $351.8 million.
    - Budgeted: $188.4 million.
- Expense:
  - For the month ended October 31st, 2024:
    - Actual: $63.5 million.
    - Budgeted: $47.2 million.
  - For the fiscal YTD ended October 31st, 2024:
    - Actual: $351.8 million.
    - Budgeted: $188.4 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 $77.2 million
  - Actual TNE $194.3 million
  - Excess TNE $117.1 million
  - TNE % of Required TNE 252%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $448.2 million
    - Pass-Through Liabilities $115.6 million
    - Uncommitted Cash $332.6 million
    - Working Capital $135.6 million
    - Current Ratio 1.17 (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 OCTOBER 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
400,384	401,064	(680)	(0.2%)	1. Medi-Cal	1,599,021	1,601,644	(2,623)	(0.2%)
5,769	5,643	126	2.2%	2. GroupCare	22,840	22,572	268	1.2%
406,153	**406,707**	**(554)**	**(0.1%)**	**3. TOTAL MEMBER MONTHS**	**1,621,861**	**1,624,216**	**(2,355)**	**(0.1%)**
				REVENUE				
$158,165,425	$166,343,156	($8,177,731)	(4.9%)	4. Premium Revenue	$669,258,396	$664,719,815	$4,538,581	0.7%
$63,536,937	$47,189,190	$16,347,747	34.6%	5. MCO Tax Revenue AB119	$351,752,408	$188,449,433	$163,302,975	86.7%
$221,702,362	**$213,532,346**	**$8,170,016**	**3.8%**	**6. TOTAL REVENUE**	**$1,021,010,804**	**$853,169,248**	**$167,841,556**	**19.7%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$19,050,817	$19,868,598	$817,781	4.1%	7. Capitated Medical Expense	$72,340,775	$79,345,343	$7,004,567	8.8%
				Fee for Service Medical Expenses				
$55,151,176	$46,259,484	($8,891,692)	(19.2%)	8. Inpatient Hospital Expense	$216,592,779	$181,495,417	($35,097,362)	(19.3%)
($6,170,677)	$6,151,615	$12,322,292	200.3%	9. Primary Care Physician Expense	$8,624,817	$24,369,731	$15,744,914	64.6%
$9,027,183	$8,061,119	($966,064)	(12.0%)	10. Specialty Care Physician Expense	$33,177,048	$31,889,871	($1,287,177)	(4.0%)
$21,777,951	$17,128,250	($4,649,701)	(27.1%)	11. Ancillary Medical Expense	$74,558,201	$67,599,332	($6,958,869)	(10.3%)
$12,489,328	$11,588,104	($901,224)	(7.8%)	12. Outpatient Medical Expense	$49,322,759	$45,656,575	($3,666,184)	(8.0%)
$10,109,923	$8,867,764	($1,242,158)	(14.0%)	13. Emergency Expense	$41,932,246	$34,889,170	($7,043,076)	(20.2%)
$15,044,760	$12,219,602	($2,825,158)	(23.1%)	14. Pharmacy Expense	$56,682,439	$48,198,887	($8,483,552)	(17.6%)
$36,003,205	$29,332,395	($6,670,810)	(22.7%)	15. Long Term Care Expense	$134,290,453	$116,104,135	($18,186,318)	(15.7%)
$153,432,849	$139,608,333	($13,824,516)	(9.9%)	16. Total Fee for Service Expense	$615,180,741	$550,203,117	($64,977,624)	(11.8%)
$5,020,702	$4,403,259	($617,443)	(14.0%)	17. Other Benefits & Services	$16,305,188	$17,004,915	$699,727	4.1%
($281,983)	$386,239	$668,222	173.0%	18. Reinsurance Expense	$285,638	$1,543,478	$1,257,840	81.5%
$177,222,385	**$164,266,429**	**($12,955,957)**	**(7.9%)**	**20. TOTAL MEDICAL EXPENSES**	**$704,112,343**	**$648,096,853**	**($56,015,490)**	**(8.6%)**
$44,479,977	**$49,265,918**	**($4,785,941)**	**(9.7%)**	**21. GROSS MARGIN**	**$316,898,461**	**$205,072,394**	**$111,826,067**	**54.5%**
				ADMINISTRATIVE EXPENSES				
$5,971,370	$6,072,837	$101,467	1.7%	22. Personnel Expense	$23,030,935	$23,140,731	$109,797	0.5%
$77,643	$74,625	($3,017)	(4.0%)	23. Benefits Administration Expense	$304,856	$298,162	($6,694)	(2.2%)
$2,470,858	$1,796,098	($674,760)	(37.6%)	24. Purchased & Professional Services	$8,844,117	$6,849,139	($1,994,977)	(29.1%)
$1,463,117	$1,565,372	$102,255	6.5%	25. Other Administrative Expense	$6,994,901	$6,647,682	($347,219)	(5.2%)
$9,982,988	**$9,508,932**	**($474,056)**	**(5.0%)**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$39,174,808**	**$36,935,715**	**($2,239,093)**	**(6.1%)**
$63,536,937	**$47,189,190**	**($16,347,747)**	**(34.6%)**	**27. MCO TAX EXPENSES**	**$351,752,408**	**$188,449,433**	**($163,302,975)**	**(86.7%)**
($29,039,948)	**($7,432,205)**	**$21,607,743**	**(290.7%)**	**28. NET OPERATING INCOME / (LOSS)**	**($74,028,755)**	**($20,312,754)**	**$53,716,001**	**(264.4%)**
				OTHER INCOME / EXPENSES				
$2,055,610	**$2,500,000**	**($444,390)**	**(17.8%)**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$12,981,002**	**$10,000,000**	**$2,981,002**	**29.8%**
($26,984,338)	**($4,932,205)**	**($22,052,133)**	**(447.1%)**	**30. NET SURPLUS (DEFICIT)**	**($61,047,753)**	**($10,312,754)**	**($50,734,999)**	**(492.0%)**
112.0%	98.8%	-13.2%	-13.4%	31. Medical Loss Ratio	105.2%	97.5%	-7.7%	-7.9%
6.3%	5.7%	-0.6%	-10.5%	32. Administrative Expense Ratio	5.9%	5.6%	-0.3%	-5.4%
-12.2%	-2.3%	-9.9%	-430.4%	33. Net Surplus (Deficit) Ratio	-6.0%	-1.2%	-4.8%	-400.0%

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

	10/31/2024	9/30/2024	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$8,277,790	$367,885	$7,909,905	2,150.10%
CNB Short-Term Investment	439,944,665	625,052,479	(185,107,814)	-29.61%
Interest Receivable	5,190,880	5,107,654	83,227	1.63%
Premium Receivables	476,503,745	464,364,872	12,138,873	2.61%
Reinsurance Recovery Receivable	6,581,946	7,223,012	(641,067)	-8.88%
Other Receivables	4,916,251	4,922,657	(6,406)	-0.13%
Prepaid Expenses	788,964	797,015	(8,051)	-1.01%
TOTAL CURRENT ASSETS	**942,204,241**	**1,107,835,574**	**(165,631,333)**	**-14.95%**
OTHER ASSETS				
CNB Long-Term Investment	44,106,913	47,159,283	(3,052,370)	-6.47%
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)	543,269	609,183	(65,913)	-10.82%
GASB 96-SBITA Assets (Net)	3,563,561	3,792,137	(228,577)	-6.03%
TOTAL OTHER ASSETS	**56,739,142**	**60,086,003**	**(3,346,861)**	**-5.57%**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.00%
Furniture And Equipment	13,071,003	13,071,003	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	38,640,099	38,640,099	0	0.00%
Less: Accumulated Depreciation	(32,900,631)	(32,836,374)	(64,258)	0.20%
PROPERTY AND EQUIPMENT (NET)	**5,739,467**	**5,803,725**	**(64,258)**	**-1.11%**
TOTAL ASSETS	**1,004,682,851**	**1,173,725,302**	**(169,042,451)**	**-14.40%**
CURRENT LIABILITIES				
Trade Accounts Payable	7,057,073	5,257,431	1,799,642	34.23%
Incurred But Not Reported Claims	300,812,101	315,432,746	(14,620,645)	-4.64%
Other Medical Liabilities	109,795,018	108,836,933	958,085	0.88%
Pass-Through Liabilities	115,603,841	183,131,713	(67,527,872)	-36.87%
MCO Tax Liabilities	260,598,240	322,530,053	(61,931,813)	-19.20%
GASB 87 and 96 ST Liabilities	2,425,565	3,016,225	(590,660)	-19.58%
Payroll Liabilities	10,358,458	10,500,034	(141,575)	-1.35%
TOTAL CURRENT LIABILITIES	**806,650,296**	**948,705,135**	**(142,054,838)**	**-14.97%**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	377,634	380,908	(3,275)	-0.86%
Deferred Inflow	3,327,530	3,327,530	0	0.00%
TOTAL LONG TERM LIABILITIES	**3,705,163**	**3,708,438**	**(3,275)**	**-0.09%**
TOTAL LIABILITIES	**810,355,460**	**952,413,573**	**(142,058,113)**	**-14.92%**
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)	(61,047,753)	(34,063,414)	(26,984,338)	79.22%
TOTAL NET WORTH	**194,327,391**	**221,311,730**	**(26,984,338)**	**-12.19%**
TOTAL LIABILITIES AND NET WORTH	**1,004,682,851**	**1,173,725,302**	**(169,042,451)**	**-14.40%**
Cash Equivalents	448,222,455	625,420,363	(177,197,908)	-28.33%
Pass-Through	115,603,841	183,131,713	(67,527,872)	-36.87%
Uncommitted Cash	332,618,614	442,288,650	(109,670,036)	-24.80%
Working Capital	135,553,945	159,130,439	(23,576,495)	-14.82%
Current Ratio	116.8%	116.8%	0.0%	0.0%

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,152,819	$9,389,125	$17,659,539	$12,492,384
GroupCare Receivable	48,756	25,804	2,048,552	(3,060,536)
Total	3,201,575	9,414,929	19,708,091	9,431,848
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	218,549,543	800,369,648	1,496,882,411	1,008,518,420
Premium Receivable	(12,187,629)	(107,458,459)	(236,133,062)	(106,499,689)
Total	206,361,914	692,911,189	1,260,749,349	902,018,731
Investment & Other Income Cash Flows				
Other Revenues	(1,057,676)	617,359	1,136,327	1,481,407
Interest Income	3,124,799	8,383,557	17,838,233	11,548,018
Interest Receivable	(83,227)	(1,677,516)	(3,988,550)	(3,274,817)
Total	1,983,896	7,323,400	14,986,010	9,754,608
Medical & Hospital Cash Flows				
Total Medical Expenses	(177,222,386)	(539,601,688)	(1,046,455,661)	(704,112,349)
Other Health Care Receivables	648,270	(1,383,927)	(6,470,885)	(535,750)
Capitation Payable	-	-	-	-
IBNP Payable	(14,620,645)	31,524,752	38,935,490	4,507,842
Other Medical Payable	(66,568,788)	(133,931,152)	20,221,880	(110,441,897)
Risk Share Payable	(1,000)	(2,680,192)	(2,680,192)	(2,680,192)
New Health Program Payable	-	-	-	-
Total	(257,764,549)	(646,072,207)	(996,449,368)	(813,262,346)
Administrative Cash Flows				
Total Administrative Expenses	(9,994,502)	(28,390,733)	(57,649,412)	(39,223,233)
Prepaid Expenses	8,052	(512,664)	241,852	(550,347)
Other Receivables	(797)	(3,484)	(27,421)	32,095
CalPERS Pension	-	-	637,208	-
Trade Accounts Payable	1,799,641	2,227,777	594,352	566,777
Payroll Liabilities	(141,576)	1,632,278	(642,107)	2,259,233
GASB Assets and Liabilities	(299,445)	(983,675)	(444,277)	(802,146)
Depreciation Expense	64,258	187,413	(190,841)	237,959
Total	(8,564,369)	(25,843,088)	(57,480,646)	(37,479,662)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(63,536,937)	(304,825,717)	(580,237,512)	(351,752,408)
MCO Tax Liabilities	(61,931,813)	179,356,967	203,817,763	100,814,726
Total	(125,468,750)	(125,468,750)	(376,419,749)	(250,937,682)
Net Cash Flows from Operating Activities	**(180,250,283)**	**(87,734,527)**	**(134,906,313)**	**(180,474,503)**

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	3,052,374	9,032,659	(26,929,335)	(11,114,658)
Total	3,052,374	9,032,659	(26,929,335)	(11,114,658)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	(264,510)	214,393	(529,610)
Purchases of Property and Equipment	-	(264,510)	214,393	(529,610)
Net Cash Flows from Investing Activities	**3,052,374**	**8,768,149**	**(26,714,942)**	**(11,644,268)**
Net Change in Cash	**(177,197,909)**	**(78,966,378)**	**(161,621,255)**	**(192,118,771)**
Rounding	-	-	-	-
Cash @ Beginning of Period	625,420,363	527,188,832	609,843,709	640,341,225
Cash @ End of Period	**$448,222,454**	**$448,222,454**	**$448,222,454**	**$448,222,454**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($26,984,340)	($54,058,450)	($150,826,074)	($61,047,761)
Add back: Depreciation & Amortization	64,258	187,413	(190,841)	237,959
Receivables				
Premiums Receivable	(12,187,629)	(107,458,459)	(236,133,062)	(106,499,689)
Interest Receivable	(83,227)	(1,677,516)	(3,988,550)	(3,274,817)
Other Health Care Receivables	648,270	(1,383,927)	(6,470,885)	(535,750)
Other Receivables	(797)	(3,484)	(27,421)	32,095
GroupCare Receivable	48,756	25,804	2,048,552	(3,060,536)
Total	(11,574,627)	(110,497,582)	(244,571,366)	(113,338,697)
Prepaid Expenses	8,052	(512,664)	241,852	(550,347)
Trade Payables	1,799,641	2,227,777	594,352	566,777
Claims Payable and Shared Risk Pool				
IBNP Payable	(14,620,645)	31,524,752	38,935,490	4,507,842
Capitation Payable & Other Medical Payable	(66,568,788)	(133,931,152)	20,221,880	(110,441,897)
Risk Share Payable	(1,000.00)	(2,680,192.00)	(2,680,192)	(2,680,192)
Claims Payable				
Total	(81,190,433)	(105,086,592)	56,477,178	(108,614,247)
Other Liabilities				
CalPERS Pension	-	-	637,208.00	-
Payroll Liabilities	(141,576)	1,632,279	(642,108)	2,259,233
GASB Assets and Liabilities	(299,445)	(983,675)	(444,277)	(802,146)
New Health Program	-	-	-	-
MCO Tax Liabilities	(61,931,813)	179,356,967	203,817,763	100,814,726
Total	(62,372,834)	180,005,571	203,368,586	102,271,813
Rounding	-	-	-	-
Cash Flows from Operating Activities	**(180,250,283)**	**(87,734,527)**	**(134,906,313)**	**(180,474,503)**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$206,361,914	$692,911,189	$1,260,749,349	$902,018,731
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	3,201,575	9,414,929	19,708,091	9,431,848
Other Income	(1,057,676)	617,359	1,136,327	1,481,407
Interest Income	3,041,572	6,706,041	13,849,683	8,273,201
Less Cash Paid				
Medical Expenses	(257,764,549)	(646,072,207)	(996,449,368)	(813,262,346)
Vendor & Employee Expenses	(8,564,369)	(25,843,088)	(57,480,646)	(37,479,662)
MCO Tax Expense AB119	(125,468,750)	(125,468,750)	(376,419,749)	(250,937,682)
Net Cash Flows from Operating Activities	**(180,250,283)**	**(87,734,527)**	**(134,906,313)**	**(180,474,503)**
Cash Flows from Investing Activities:				
Long Term Investments	3,052,374	9,032,659	(26,929,335)	(11,114,658)
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	0	(264,510)	214,393	(529,610)
Net Cash Flows from Investing Activities	**3,052,374**	**8,768,149**	**(26,714,942)**	**(11,644,268)**
Net Change in Cash	**(177,197,909)**	**(78,966,378)**	**(161,621,255)**	**(192,118,771)**
Rounding	-	-	-	-
Cash @ Beginning of Period	625,420,363	527,188,832	609,843,709	640,341,225
Cash @ End of Period	**$448,222,454**	**$448,222,454**	**$448,222,454**	**$448,222,454**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($26,984,340)	($54,058,449)	($150,826,075)	($61,047,761)
Add Back: Depreciation	64,258	187,413	(190,841)	237,959
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(11,574,627)	(110,497,582)	(244,571,366)	(113,338,697)
Prepaid Expenses	8,052	(512,665)	241,853	(550,347)
Trade Payables	1,799,641	2,227,777	594,352	566,777
Claims Payable, IBNP and Risk Sharing	(81,190,433)	(105,086,592)	56,477,178	(108,614,247)
Deferred Revenue	0	0	0	0
Other Liabilities	(62,372,834)	180,005,571	203,368,586	102,271,813
Total	(180,250,283)	(87,734,527)	(134,906,313)	(180,474,503)
Rounding	-	-	-	-
Cash Flows from Operating Activities	**($180,250,283)**	**($87,734,527)**	**($134,906,313)**	**($180,474,503)**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF OCTOBER 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	109,662	62,578	35,388	151,098	40,144	249	1,265	400,384	5,769	-	406,153
Revenue	$28,562,145	$30,572,143	$48,218,357	$76,500,064	$20,762,462	$2,680,650	$11,253,722	$218,549,543	$3,152,819	$0	$221,702,362
Medical Expense	$9,201,194	$17,963,192	$47,840,273	$66,614,200	$19,363,144	$2,756,415	$10,634,121	$174,372,540	$2,800,269	$49,576	$177,222,385
Gross Margin	$19,360,951	$12,608,951	$378,083	$9,885,864	$1,399,318	($75,765)	$619,601	$44,177,003	$352,550	($49,576)	$44,479,977
Administrative Expense	$468,943	$1,092,622	$2,337,150	$2,931,162	$788,254	$163,190	$750,916	$8,532,236	$142,254	$1,308,497	$9,982,988
MCO Tax Expense	$17,402,263	$9,930,503	$5,615,722	$23,977,742	$6,370,451	$39,514	$200,743	$63,536,937	$0	$0	$63,536,937
Operating Income / (Expense)	$1,489,745	$1,585,826	($7,574,789)	($17,023,039)	($5,759,387)	($278,468)	($332,058)	($27,892,171)	$210,295	($1,358,073)	($29,039,948)
Other Income / (Expense)	$103,909	$258,219	$552,316	$702,539	$188,790	$39,739	$182,646	$2,028,158	$27,451	$0	$2,055,610
Net Income / (Loss)	$1,593,654	$1,844,046	($7,022,473)	($16,320,500)	($5,570,597)	($238,730)	($149,412)	($25,864,013)	$237,747	($1,358,073)	($26,984,338)
PMPM Metrics:											
Revenue PMPM	$260.46	$488.54	$1,362.56	$506.29	$517.20	$10,765.66	$8,896.22	$545.85	$546.51	$0.00	$545.86
Medical Expense PMPM	$83.91	$287.05	$1,351.88	$440.87	$482.34	$11,069.94	$8,406.42	$435.51	$485.40	$0.00	$436.34
Gross Margin PMPM	$176.55	$201.49	$10.68	$65.43	$34.86	($304.28)	$489.80	$110.34	$61.11	$0.00	$109.52
Administrative Expense PMPM	$4.28	$17.46	$66.04	$19.40	$19.64	$655.38	$593.61	$21.31	$24.66	$0.00	$24.58
MCO Tax Expense PMPM	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$0.00	$0.00	$156.44
Operating Income / (Expense) PMPM	$13.58	$25.34	($214.05)	($112.66)	($143.47)	($1,118.35)	($262.50)	($69.66)	$36.45	$0.00	($71.50)
Other Income / (Expense) PMPM	$0.95	$4.13	$15.61	$4.65	$4.70	$159.59	$144.38	$5.07	$4.76	$0.00	$5.06
Net Income / (Loss) PMPM	$14.53	$29.47	($198.44)	($108.01)	($138.77)	($958.75)	($118.11)	($64.60)	$41.21	$0.00	($66.44)
Ratio:											
Medical Loss Ratio	82.4%	87.0%	112.3%	126.8%	134.5%	104.4%	96.2%	112.5%	88.8%	0.0%	112.0%
Administrative Expense Ratio	4.2%	5.3%	5.5%	5.6%	5.5%	6.2%	6.8%	5.5%	4.5%	0.0%	6.3%
Net Income Ratio	5.6%	6.0%	-14.6%	-21.3%	-26.8%	-8.9%	-1.3%	-11.8%	7.5%	0.0%	-12.2%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE OCTOBER 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	439,128	250,477	140,902	602,386	160,184	937	5,007	1,599,021	22,840	-	1,621,861
Revenue	$155,665,898	$141,544,288	$202,039,914	$360,336,737	$95,832,261	$10,019,472	$43,079,851	$1,008,518,421	$12,492,383	$0	$1,021,010,804
Medical Expense	$50,527,300	$81,468,658	$193,150,411	$249,468,006	$62,838,424	$11,251,639	$43,132,637	$691,837,074	$12,227,693	$47,576	$704,112,343
Gross Margin	$105,138,599	$60,075,630	$8,889,503	$110,868,731	$32,993,837	($1,232,167)	($52,786)	$316,681,347	$264,690	($47,576)	$316,898,461
Administrative Expense	$1,925,063	$4,591,109	$9,851,182	$12,492,509	$3,412,103	$699,974	$3,255,113	$36,227,053	$594,589	$2,353,165	$39,174,808
MCO Tax Expense	$96,818,320	$55,325,194	$30,959,667	$132,044,548	$35,286,740	$202,852	$1,115,087	$351,752,408	$0	$0	$351,752,408
Operating Income / (Expense)	$6,395,215	$159,328	($31,921,347)	($33,668,326)	($5,705,005)	($2,134,993)	($4,422,986)	($71,298,114)	($329,900)	($2,400,741)	($74,028,755)
Other Income / (Expense)	$656,399	$1,626,743	$3,489,025	$4,437,993	$1,192,603	$251,033	$1,153,793	$12,807,589	$173,413	$0	$12,981,002
Net Income / (Loss)	$7,051,614	$1,786,071	($28,432,321)	($29,230,333)	($4,512,402)	($1,883,960)	($3,269,193)	($58,490,525)	($156,487)	($2,400,741)	($61,047,753)
PMPM Metrics:											
Revenue PMPM	$354.49	$565.10	$1,433.90	$598.18	$598.26	$10,693.14	$8,603.92	$630.71	$546.95	$0.00	$629.53
Medical Expense PMPM	$115.06	$325.25	$1,370.81	$414.13	$392.29	$12,008.15	$8,614.47	$432.66	$535.36	$0.00	$434.14
Gross Margin PMPM	$239.43	$239.84	$63.09	$184.05	$205.97	($1,315.01)	($10.54)	$198.05	$11.59	$0.00	$195.39
Administrative Expense PMPM	$4.38	$18.33	$69.92	$20.74	$21.30	$747.04	$650.11	$22.66	$26.03	$0.00	$24.15
MCO Tax Expense PMPM	$220.48	$220.88	$219.72	$219.20	$220.29	$216.49	$222.71	$219.98	$0.00	$0.00	$216.88
Operating Income / (Expense) PMPM	$14.56	$0.64	($226.55)	($55.89)	($35.62)	($2,278.54)	($883.36)	($44.59)	($14.44)	$0.00	($45.64)
Other Income / (Expense) PMPM	$1.49	$6.49	$24.76	$7.37	$7.45	$267.91	$230.44	$8.01	$7.59	$0.00	$8.00
Net Income / (Loss) PMPM	$16.06	$7.13	($201.79)	($48.52)	($28.17)	($2,010.63)	($652.92)	($36.58)	($6.85)	$0.00	($37.64)
Ratio:											
Medical Loss Ratio	85.9%	94.5%	112.9%	109.3%	103.8%	114.6%	102.8%	105.3%	97.9%	0.0%	105.2%
Administrative Expense Ratio	3.3%	5.3%	5.8%	5.5%	5.6%	7.1%	7.8%	5.5%	4.8%	0.0%	5.9%
Net Income Ratio	4.5%	1.3%	-14.1%	-8.1%	-4.7%	-18.8%	-7.6%	-5.8%	-1.3%	0.0%	-6.0%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED October 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)				
$5,971,370	$6,072,837	$101,467	1.7%	Personnel Expenses	$23,030,935	$23,140,731	$109,797	0.5%
$77,643	$74,625	($3,017)	(4.0%)	Benefits Administration Expense	$304,856	$298,162	($6,694)	(2.2%)
$2,470,858	$1,796,098	($674,760)	(37.6%)	Purchased & Professional Services	$8,844,117	$6,849,139	($1,994,977)	(29.1%)
$523,986	$580,291	$56,305	9.7%	Occupancy	$1,984,299	$2,293,486	$309,187	13.5%
$454,498	$475,134	$20,636	4.3%	Printing Postage & Promotion	$1,531,039	$2,129,363	$598,324	28.1%
$298,479	$371,375	$72,896	19.6%	Licenses Insurance & Fees	$2,713,003	$1,688,918	($1,024,084)	(60.6%)
$186,154	$138,572	($47,581)	(34.3%)	Other Administrative Expense	$766,561	$535,915	($230,646)	(43.0%)
$4,011,618	$3,436,095	($575,522)	(16.7%)	Total Other Administrative Expenses (excludes Personnel Expenses)	$16,143,873	$13,794,983	($2,348,890)	(17.0%)
$9,982,988	$9,508,932	($474,056)	(5.0%)	Total Administrative Expenses	$39,174,808	$36,935,715	($2,239,093)	(6.1%)

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,954,379	4,288,183	333,804	7.8%	Salaries & Wages	15,050,700	15,784,133	733,434	4.6%
405,231	374,503	(30,729)	(8.2%)	Paid Time Off	1,360,898	1,410,225	49,327	3.5%
2,232	3,705	1,473	39.7%	Compensated Incentives	5,789	17,660	11,871	67.2%
0	0	0	0.0%	Severence	0	400,000	400,000	100.0%
63,459	60,385	(3,074)	(5.1%)	Payroll Taxes	246,955	237,729	(9,227)	(3.9%)
102,591	24,960	(77,631)	(311.0%)	Overtime	314,619	99,840	(214,779)	(215.1%)
312,352	289,961	(22,391)	(7.7%)	CalPERS ER Match	1,282,033	1,121,908	(160,125)	(14.3%)
938,861	681,855	(257,006)	(37.7%)	Employee Benefits	3,832,196	2,580,739	(1,251,457)	(48.5%)
(979)	0	979	0.0%	Personal Floating Holiday	3,894	0	(3,894)	0.0%
25,225	33,000	7,775	23.6%	Language Pay	86,009	116,500	30,491	26.2%
4,420	0	(4,420)	0.0%	Med Ins Opted Out Stipend	16,010	0	(16,010)	0.0%
0	0	0	0.0%	Holiday Bonus	248,810	0	(248,810)	0.0%
84,501	0	(84,501)	0.0%	Sick Leave	270,728	0	(270,728)	0.0%
59	35,275	35,216	99.8%	Compensated Employee Relations	84	90,350	90,266	99.9%
20,230	25,550	5,320	20.8%	Work from Home Stipend	78,970	96,800	17,830	18.4%
1,423	5,953	4,531	76.1%	Mileage, Parking & LocalTravel	4,992	25,229	20,237	80.2%
3,557	39,697	36,140	91.0%	Travel & Lodging	12,317	149,881	137,564	91.8%
43,393	116,738	73,345	62.8%	Temporary Help Services	112,645	702,606	589,962	84.0%
8,859	56,498	47,639	84.3%	Staff Development/Training	43,258	201,681	158,422	78.6%
1,578	36,574	34,996	95.7%	Staff Recruitment/Advertisement	60,028	105,449	45,422	43.1%
5,971,370	**6,072,837**	**101,467**	**1.7%**	**Personnel Expense**	**23,030,935**	**23,140,731**	**109,797**	**0.5%**
25,157	21,753	(3,403)	(15.6%)	Pharmacy Administrative Fees	95,132	87,014	(8,119)	(9.3%)
52,486	52,872	386	0.7%	Telemedicine Admin. Fees	209,723	211,148	1,425	0.7%
77,643	**74,625**	**(3,017)**	**(4.0%)**	**Benefits Administration Expense**	**304,856**	**298,162**	**(6,694)**	**(2.2%)**
470,697	275,494	(195,203)	(70.9%)	Consultant Fees - Non Medical	2,479,124	894,998	(1,584,126)	(177.0%)
502,891	396,830	(106,061)	(26.7%)	Computer Support Services	2,068,670	1,801,029	(267,640)	(14.9%)
26,623	15,000	(11,623)	(77.5%)	Audit Fees	68,158	60,000	(8,158)	(13.6%)
0	8	8	100.0%	Consultant Fees - Medical	(15,355)	33	15,388	46,183.4%
216,165	195,225	(20,940)	(10.7%)	Other Purchased Services	1,017,453	742,091	(275,362)	(37.1%)
0	2,454	2,454	100.0%	Maint.&Repair-Office Equipment	0	9,816	9,816	100.0%
130,848	45,067	(85,782)	(190.3%)	Legal Fees	331,286	180,267	(151,019)	(83.8%)
0	0	0	0.0%	Member Health Education	320	0	(320)	0.0%
23,714	28,133	4,419	15.7%	Translation Services	87,064	112,533	25,470	22.6%
300,690	161,698	(138,992)	(86.0%)	Medical Refund Recovery Fees	1,115,371	646,792	(468,579)	(72.4%)
664,721	524,066	(140,654)	(26.8%)	Software - IT Licenses & Subsc	1,346,856	1,951,806	604,950	31.0%
36,474	101,822	65,348	64.2%	Hardware (Non-Capital)	157,057	248,574	91,517	36.8%
98,035	50,300	(47,735)	(94.9%)	Provider Credentialing	188,113	201,200	13,087	6.5%
2,470,858	**1,796,098**	**(674,760)**	**(37.6%)**	**Purchased & Professional Services**	**8,844,117**	**6,849,139**	**(1,994,977)**	**(29.1%)**
64,258	105,504	41,246	39.1%	Depreciation	237,959	403,650	165,691	41.0%
62,638	76,371	13,733	18.0%	Lease Building	249,401	305,484	56,083	18.4%
5,761	5,960	199	3.3%	Lease Rented Office Equipment	17,965	23,840	5,875	24.6%
26,414	17,508	(8,906)	(50.9%)	Utilities	63,073	69,537	6,464	9.3%
105,467	91,065	(14,402)	(15.8%)	Telephone	347,665	364,260	16,595	4.6%
30,871	34,748	3,877	11.2%	Building Maintenance	144,455	130,173	(14,282)	(11.0%)
228,577	249,136	20,559	8.3%	GASB96 SBITA Amort. Expense	923,781	996,542	72,761	7.3%
523,986	**580,291**	**56,305**	**9.7%**	**Occupancy**	**1,984,299**	**2,293,486**	**309,187**	**13.5%**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
88,035	104,818	16,783	16.0%	Postage	276,771	277,017	246	0.1%
4,769	5,300	532	10.0%	Design & Layout	26,180	21,200	(4,980)	(23.5%)
112,076	118,935	6,859	5.8%	Printing Services	389,400	334,766	(54,634)	(16.3%)
3,924	6,910	2,986	43.2%	Mailing Services	34,383	27,640	(6,743)	(24.4%)
4,675	11,334	6,659	58.8%	Courier/Delivery Service	22,598	45,912	23,315	50.8%
29	20	(9)	(45.2%)	Pre-Printed Materials & Public	29	560	531	94.8%
6,573	10,000	3,427	34.3%	Promotional Products	43,118	10,000	(33,118)	(331.2%)
0	150	150	100.0%	Promotional Services	0	600	600	100.0%
234,417	217,667	(16,750)	(7.7%)	Community Relations	738,560	1,411,668	673,108	47.7%
454,498	**475,134**	**20,636**	**4.3%**	**Printing Postage & Promotion**	**1,531,039**	**2,129,363**	**598,324**	**28.1%**
200,000	50,000	(150,000)	(300.0%)	Regulatory Penalties	285,000	150,000	(135,000)	(90.0%)
36,686	36,000	(686)	(1.9%)	Bank Fees	132,981	144,000	11,019	7.7%
0	95,133	95,133	100.0%	Insurance Premium	976,663	385,770	(590,893)	(153.2%)
20,052	115,089	95,037	82.6%	License,Permits, & Fee - NonIT	962,873	780,476	(182,398)	(23.4%)
41,741	75,153	33,412	44.5%	Subscriptions and Dues - NonIT	355,486	228,673	(126,813)	(55.5%)
298,479	**371,375**	**72,896**	**19.6%**	**License Insurance & Fees**	**2,713,003**	**1,688,918**	**(1,024,084)**	**(60.6%)**
6,809	10,788	3,979	36.9%	Office and Other Supplies	32,375	49,102	16,728	34.1%
0	1,050	1,050	100.0%	Furniture & Equipment	0	4,200	4,200	100.0%
20,437	26,483	6,046	22.8%	Ergonomic Supplies	124,215	105,933	(18,281)	(17.3%)
15,399	30,251	14,853	49.1%	Meals and Entertainment	51,463	91,829	40,366	44.0%
4,300	0	(4,300)	0.0%	Miscellaneous	5,300	0	(5,300)	0.0%
0	0	0	0.0%	Member Incentive	0	4,850	4,850	100.0%
139,209	70,000	(69,209)	(98.9%)	Provider Interest (All Depts)	553,208	280,000	(273,208)	(97.6%)
186,154	**138,572**	**(47,581)**	**(34.3%)**	**Other Administrative Expense**	**766,561**	**535,915**	**(230,646)**	**(43.0%)**
4,011,618	**3,436,095**	**(575,522)**	**(16.7%)**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**16,143,873**	**13,794,983**	**(2,348,890)**	**(17.0%)**
9,982,988	**9,508,932**	**(474,056)**	**(5.0%)**	**TOTAL ADMINISTRATIVE EXPENSES**	**39,174,808**	**36,935,715**	**(2,239,093)**	**(6.1%)**

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			**$ 529,610**	**$ -**	**$ 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			**$ 529,610**	**$ -**	**$ 529,610**	**$ 1,713,000**	**$ 1,448,490**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 10/31/24	**$ 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-24	QTR. END Sep-24	Oct-24
Current Month Net Income / (Loss)	($60,614,028)	($6,989,303)	($18,354,879)	($8,719,232)	($26,984,338)
YTD Net Income / (Loss)	($68,581,898)	($6,989,303)	($25,344,182)	($34,063,414)	($61,047,752)
Actual TNE					
Net Assets	$255,375,144	$248,385,841	$230,030,961	$221,311,730	$194,327,391
Subordinated Debt & Interest	$0	$0	$0	$0	$0
Total Actual TNE	**$255,375,144**	**$248,385,841**	**$230,030,961**	**$221,311,730**	**$194,327,391**
Increase/(Decrease) in Actual TNE	($60,614,028)	($6,989,303)	($18,354,879)	($8,719,232)	($26,984,338)
Required TNE[1]	**$63,328,179**	**$68,750,939**	**$71,470,183**	**$70,224,330**	**$77,225,115**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$94,992,268	$103,126,409	$107,205,274	$105,336,495	$115,837,673
TNE Excess / (Deficiency)	$192,046,965	$179,634,902	$158,560,778	$151,087,400	$117,102,276
Actual TNE as a Multiple of Required	**4.03**	**3.61**	**3.22**	**3.15**	**2.52**

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

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Net Assets	$255,375,144	$248,385,841	$230,030,961	$221,311,730	$194,327,391
Fixed Assets at Net Book Value	(5,447,816)	(5,662,370)	(5,863,098)	(5,803,725)	(5,739,467)
Net Lease Assets/Liabilities/Interest	(501,485)	(319,957)	(496,877)	(1,004,186)	(1,303,630)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$249,075,843**	**$242,053,514**	**$223,320,986**	**$214,153,819**	**$186,934,294**
Liquid TNE as Multiple of Required	**3.93**	**3.52**	**3.12**	**3.05**	**2.42**

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
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,951	109,784	109,731	109,662									439,128
Adult	62,708	62,641	62,550	62,578									250,477
SPD	35,018	35,177	35,319	35,388									140,902
ACA OE	149,801	150,482	151,005	151,098									602,386
Duals	39,892	40,024	40,124	40,144									160,184
MCAL LTC	222	226	240	249									937
MCAL LTC Duals	1,241	1,247	1,254	1,265									5,007
Medi-Cal Program	398,833	399,581	400,223	400,384									1,599,021
Group Care Program	5,675	5,686	5,710	5,769									22,840
Total	**404,508**	**405,267**	**405,933**	**406,153**									**1,621,861**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(173)	(167)	(53)	(69)									(462)
Adult	(38)	(67)	(91)	28									(168)
SPD	98	159	142	69									468
ACA OE	477	681	523	93									1,774
Duals	144	132	100	20									396
MCAL LTC	0	4	14	9									27
MCAL LTC Duals	(7)	6	7	11									17
Medi-Cal Program	501	748	642	161									2,052
Group Care Program	17	11	24	59									111
Total	**518**	**759**	**666**	**220**									**2,163**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%	27.4%	27.4%									27.5%
Adult % of Medi-Cal	15.7%	15.7%	15.6%	15.6%									15.7%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%									8.8%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%									37.7%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%									10.0%
Medi-Cal Program % of Total	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%
Total	**100.0%**	**100.0%**	**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	89,634	89,724									355,856
Alameda Health System	91,091	91,170	91,024	90,756									364,041
	179,071	179,688	180,658	180,480									719,897
Delegated:													
CFMG	44,087	43,956	43,837	43,910									175,790
CHCN	181,350	181,623	181,438	181,763									726,174
Kaiser	0	0	0	0									0
Delegated Subtotal	225,437	225,579	225,275	225,673									901,964
Total	**404,508**	**405,267**	**405,933**	**406,153**									**1,621,861**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617	970	(178)									1,576
Delegated:													
CFMG	96	(131)	(119)	73									(81)
CHCN	255	273	(185)	325									668
Kaiser	0	0	0	0									0
Delegated Subtotal	351	142	(304)	398									587
Total	**518**	**759**	**666**	**220**									**2,163**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%	44.5%	44.4%									44.4%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%									10.8%
CHCN	44.8%	44.8%	44.7%	44.8%									44.8%
Kaiser	0.0%	0.0%	0.0%	0.0%									0.0%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%									55.6%
Total	**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**
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)	(1,435)	(1,726)									(5,093)
Adult	(863)	(994)	(1,149)	(1,185)									(4,191)
SPD	170	329	471	540									1,510
ACA OE	484	1,016	1,390	1,333									4,223
Duals	101	233	333	353									1,020
MCAL LTC	(2)	2	16	25									41
MCAL LTC Duals	(44)	(38)	(31)	(20)									(133)
Medi-Cal Program	(926)	(612)	(405)	(680)									(2,623)
Group Care Program	32	43	67	126									268
Total	**(894)**	**(569)**	**(338)**	**(554)**									**(2,355)**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	(1,502)	(1,021)	38	70									(2,415)
Alameda Health System	383	367	126	(238)									638
	(1,119)	(654)	164	(168)									(1,777)
Delegated:													
CFMG	306	92	(111)	(122)									165
CHCN	(81)	(7)	(391)	(264)									(743)
Kaiser	0	0	0	0									0
Delegated Subtotal	225	85	(502)	(386)									(578)
Total	**(894)**	**(569)**	**(338)**	**(554)**									**(2,355)**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED OCTOBER 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				
$4,615,273	$1,986,269	($2,629,004)	(132.4%)	PCP Capitation	$14,675,610	$7,922,903	($6,752,707)	(85.2%)
6,147,059	9,535,602	3,388,543	35.5%	PCP Capitation FQHC	24,618,289	38,080,669	13,462,380	35.4%
386,198	381,735	(4,463)	(1.2%)	Specialty Capitation	1,506,563	1,522,575	16,012	1.1%
5,415,803	5,579,633	163,830	2.9%	Specialty Capitation FQHC	21,603,417	22,289,520	686,103	3.1%
752,520	709,785	(42,735)	(6.0%)	Laboratory Capitation	2,998,285	2,834,558	(163,727)	(5.8%)
339,396	342,019	2,624	0.8%	Vision Capitation	1,356,883	1,365,584	8,701	0.6%
112,391	110,982	(1,409)	(1.3%)	CFMG Capitation	438,444	442,659	4,214	1.0%
266,926	276,391	9,465	3.4%	ANC IPA Admin Capitation FQHC	1,065,530	1,103,951	38,421	3.5%
0	0	0	0.0%	Kaiser Capitation	(995)	0	995	0.0%
0	0	0	0.0%	Maternity Supplemental Expense	27,953	0	(27,953)	0.0%
1,015,252	946,182	(69,070)	(7.3%)	DME Capitation	4,050,796	3,782,925	(267,871)	(7.1%)
19,050,817	**19,868,598**	**817,781**	**4.1%**	**7. TOTAL CAPITATED EXPENSES**	**72,340,775**	**79,345,343**	**7,004,567**	**8.8%**
				FEE FOR SERVICE MEDICAL EXPENSES				
(8,716,801)	0	8,716,801	0.0%	IBNR Inpatient Services	(3,303,163)	0	3,303,163	0.0%
(261,503)	0	261,503	0.0%	IBNR Settlement (IP)	(99,094)	0	99,094	0.0%
(697,345)	0	697,345	0.0%	IBNR Claims Fluctuation (IP)	(264,254)	0	264,254	0.0%
59,455,387	46,259,484	(13,195,903)	(28.5%)	Inpatient Hospitalization FFS	200,878,083	181,495,417	(19,382,666)	(10.7%)
3,206,631	0	(3,206,631)	0.0%	IP OB - Mom & NB	12,540,164	0	(12,540,164)	0.0%
225,216	0	(225,216)	0.0%	IP Behavioral Health	1,070,307	0	(1,070,307)	0.0%
1,939,590	0	(1,939,590)	0.0%	Inpatient Facility Rehab FFS	5,770,736	0	(5,770,736)	0.0%
55,151,176	**46,259,484**	**(8,891,692)**	**(19.2%)**	**8. Inpatient Hospital Expense**	**216,592,779**	**181,495,417**	**(35,097,362)**	**(19.3%)**
(593,845)	0	593,845	0.0%	IBNR PCP	(293,439)	0	293,439	0.0%
(17,815)	0	17,815	0.0%	IBNR Settlement (PCP)	(8,801)	0	8,801	0.0%
(47,509)	0	47,509	0.0%	IBNR Claims Fluctuation (PCP)	44,791	0	(44,791)	0.0%
4,680,311	3,752,312	(927,999)	(24.7%)	PCP FFS	15,067,759	14,840,007	(227,752)	(1.5%)
452,575	1,443,421	990,846	68.6%	PCP FQHC FFS	1,638,422	5,712,971	4,074,549	71.3%
0	0	0	0.0%	Physician Extended Hrs. Incent	12,000	0	(12,000)	0.0%
(4,621,564)	955,882	5,577,446	583.5%	Prop 56 Physician Pmt	(4,620,603)	3,816,754	8,437,357	221.1%
16,264	0	(16,264)	0.0%	Prop 56 Hyde	64,923	0	(64,923)	0.0%
(107,221)	0	107,221	0.0%	Prop 56 Trauma Screening	110,133	0	(110,133)	0.0%
(152,739)	0	152,739	0.0%	Prop 56 Developmentl Screening	96,040	0	(96,040)	0.0%
(3,060,393)	0	3,060,393	0.0%	Prop 56 Family Planning	(767,666)	0	767,666	0.0%
(2,718,741)	0	2,718,741	0.0%	Prop 56 VBP	(2,718,741)	0	2,718,741	0.0%
(6,170,677)	**6,151,615**	**12,322,292**	**200.3%**	**9. Primary Care Physician Expense**	**8,624,817**	**24,369,731**	**15,744,914**	**64.6%**
(720,463)	0	720,463	0.0%	IBNR Specialist	(747,176)	0	747,176	0.0%
(21,613)	0	21,613	0.0%	IBNR Settlement (SCP)	(22,414)	0	22,414	0.0%
(57,637)	0	57,637	0.0%	IBNR Claims Fluctuation (SCP)	(59,775)	0	59,775	0.0%
507,690	0	(507,690)	0.0%	Psychiatrist FFS	1,559,071	0	(1,559,071)	0.0%
4,455,136	7,959,076	3,503,940	44.0%	Specialty Care FFS	15,254,426	31,486,298	16,231,872	51.6%
382,597	0	(382,597)	0.0%	Specialty Anesthesiology	1,061,004	0	(1,061,004)	0.0%
1,866,314	0	(1,866,314)	0.0%	Specialty Imaging FFS	6,843,037	0	(6,843,037)	0.0%
73,489	0	(73,489)	0.0%	Obstetrics FFS	181,208	0	(181,208)	0.0%
417,273	0	(417,273)	0.0%	Specialty IP Surgery FFS	1,679,499	0	(1,679,499)	0.0%
1,245,319	0	(1,245,319)	0.0%	Specialty OP Surgery FFS	4,353,452	0	(4,353,452)	0.0%
717,191	0	(717,191)	0.0%	Speciality IP Physician	2,543,833	0	(2,543,833)	0.0%
161,888	102,043	(59,845)	(58.6%)	Specialist FQHC FFS	530,883	403,573	(127,310)	(31.5%)
9,027,183	**8,061,119**	**(966,064)**	**(12.0%)**	**10. Specialty Care Physician Expense**	**33,177,048**	**31,889,871**	**(1,287,177)**	**(4.0%)**

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

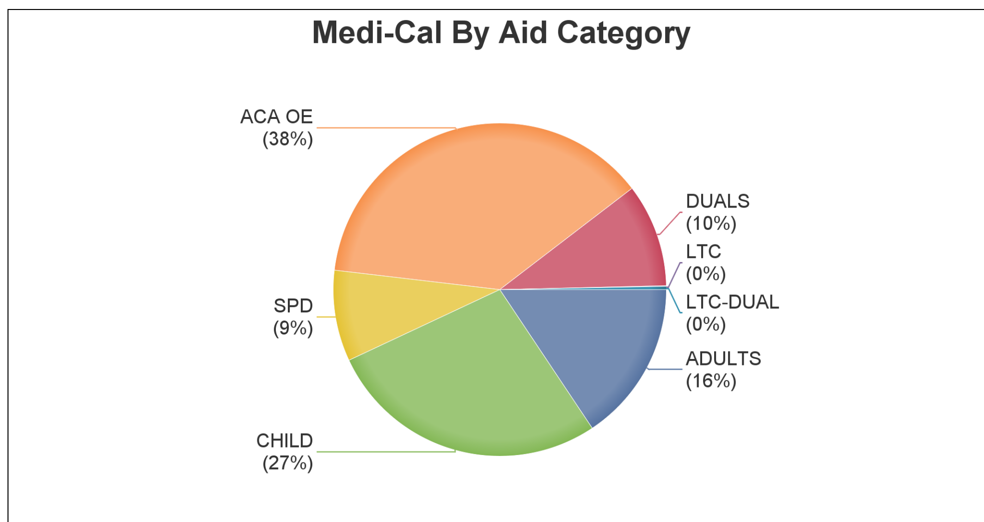
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(287,117)	0	287,117	0.0%	IBNR Ancillary (ANC)	904,191	0	(904,191)	0.0%
(8,616)	0	8,616	0.0%	IBNR Settlement (ANC)	114,188	0	(114,188)	0.0%
(22,969)	0	22,969	0.0%	IBNR Claims Fluctuation (ANC)	236,248	0	(236,248)	0.0%
46,127	0	(46,127)	0.0%	IBNR Transportation FFS	207,856	0	(207,856)	0.0%
2,446,565	0	(2,446,565)	0.0%	Behavioral Health Therapy FFS	8,190,565	0	(8,190,565)	0.0%
2,239,494	0	(2,239,494)	0.0%	Psychologist & Other MH Prof	7,234,250	0	(7,234,250)	0.0%
511,680	0	(511,680)	0.0%	Other Medical Professional	1,865,835	0	(1,865,835)	0.0%
192,427	0	(192,427)	0.0%	Hearing Devices	674,558	0	(674,558)	0.0%
28,830	0	(28,830)	0.0%	ANC Imaging	228,147	0	(228,147)	0.0%
70,405	0	(70,405)	0.0%	Vision FFS	280,298	0	(280,298)	0.0%
10	0	(10)	0.0%	Family Planning	10	0	(10)	0.0%
2,578,553	0	(2,578,553)	0.0%	Laboratory FFS	6,593,456	0	(6,593,456)	0.0%
218,641	0	(218,641)	0.0%	ANC Therapist	644,262	0	(644,262)	0.0%
1,144,011	0	(1,144,011)	0.0%	Transp/Ambulance FFS	5,962,027	0	(5,962,027)	0.0%
1,551,590	0	(1,551,590)	0.0%	Non-ER Transportation FFS	8,526,483	0	(8,526,483)	0.0%
2,438,259	0	(2,438,259)	0.0%	Hospice FFS	9,250,960	0	(9,250,960)	0.0%
2,124,118	0	(2,124,118)	0.0%	Home Health Services	7,088,754	0	(7,088,754)	0.0%
0	12,584,162	12,584,162	100.0%	Other Medical FFS	128	49,620,225	49,620,097	100.0%
40,357	0	(40,357)	0.0%	Medical Refunds through HMS	290,192	0	(290,192)	0.0%
44,899	0	(44,899)	0.0%	DME & Medical Supplies FFS	187,833	0	(187,833)	0.0%
1,816,004	1,782,192	(33,812)	(1.9%)	ECM Base/Outreach FFS ANC	3,198,634	7,121,332	3,922,698	55.1%
180,601	45,939	(134,662)	(293.1%)	CS Housing Deposits FFS ANC	491,192	181,045	(310,147)	(171.3%)
1,346,137	652,348	(693,789)	(106.4%)	CS Housing Tenancy FFS ANC	3,213,206	2,552,468	(660,738)	(25.9%)
832,019	473,600	(358,420)	(75.7%)	CS Housing Navi Servic FFS ANC	1,908,073	1,878,478	(29,595)	(1.6%)
658,204	550,061	(108,143)	(19.7%)	CS Medical Respite FFS ANC	2,523,657	2,179,810	(343,847)	(15.8%)
545,781	214,052	(331,729)	(155.0%)	CS Med. Tailored Meals FFS ANC	877,869	834,607	(43,262)	(5.2%)
12,383	38,407	26,025	67.8%	CS Asthma Remediation FFS ANC	27,459	139,864	112,405	80.4%
0	10,000	10,000	100.0%	MOT Wrap Around (Non Med MOT)	0	40,000	40,000	100.0%
0	15,000	15,000	100.0%	CS Home Modifications FFS ANC	24,053	60,000	35,947	59.9%
307,253	498,723	191,470	38.4%	CS P.Care & Hmker Svcs FFS ANC	1,500,318	1,973,002	472,684	24.0%
8,626	89,376	80,750	90.3%	CS Cgiver Respite Svcs FFS ANC	42,347	331,968	289,621	87.2%
0	137,176	137,176	100.0%	CS Sobering Center FFS ANC	0	544,279	544,279	100.0%
679,466	0	(679,466)	0.0%	CommunityBased Adult Svc(CBAS)	2,203,374	0	(2,203,374)	0.0%
34,214	22,840	(11,374)	(49.8%)	CS LTC Diversion FFS ANC	67,778	88,503	20,725	23.4%
0	14,375	14,375	100.0%	CS LTC Transition FFS ANC	0	53,750	53,750	100.0%
21,777,951	**17,128,250**	**(4,649,701)**	**(27.1%)**	**11. Ancillary Medical Expense**	**74,558,201**	**67,599,332**	**(6,958,869)**	**(10.3%)**
(1,214,265)	0	1,214,265	0.0%	IBNR Outpatient	231,629	0	(231,629)	0.0%
(36,427)	0	36,427	0.0%	IBNR Settlement (OP)	6,949	0	(6,949)	0.0%
(97,143)	0	97,143	0.0%	IBNR Claims Fluctuation (OP)	18,527	0	(18,527)	0.0%
2,993,296	11,588,104	8,594,808	74.2%	Outpatient FFS	10,488,110	45,656,575	35,168,465	77.0%
3,098,578	0	(3,098,578)	0.0%	OP Ambul Surgery FFS	11,593,959	0	(11,593,959)	0.0%
3,023,461	0	(3,023,461)	0.0%	Imaging Services FFS	10,130,403	0	(10,130,403)	0.0%
26,235	0	(26,235)	0.0%	Behavioral Health FFS	97,460	0	(97,460)	0.0%
837,834	0	(837,834)	0.0%	Outpatient Facility Lab FFS	2,863,424	0	(2,863,424)	0.0%
281,581	0	(281,581)	0.0%	Outpatient Facility Cardio FFS	844,453	0	(844,453)	0.0%
113,995	0	(113,995)	0.0%	OP Facility PT/OT/ST FFS	400,408	0	(400,408)	0.0%
3,462,184	0	(3,462,184)	0.0%	OP Facility Dialysis Ctr FFS	12,647,437	0	(12,647,437)	0.0%
12,489,328	**11,588,104**	**(901,224)**	**(7.8%)**	**12. Outpatient Medical Expense**	**49,322,759**	**45,656,575**	**(3,666,184)**	**(8.0%)**
(2,347,204)	0	2,347,204	0.0%	IBNR Emergency	(165,803)	0	165,803	0.0%
(70,416)	0	70,416	0.0%	IBNR Settlement (ER)	(4,974)	0	4,974	0.0%
(187,777)	0	187,777	0.0%	IBNR Claims Fluctuation (ER)	(13,266)	0	13,266	0.0%

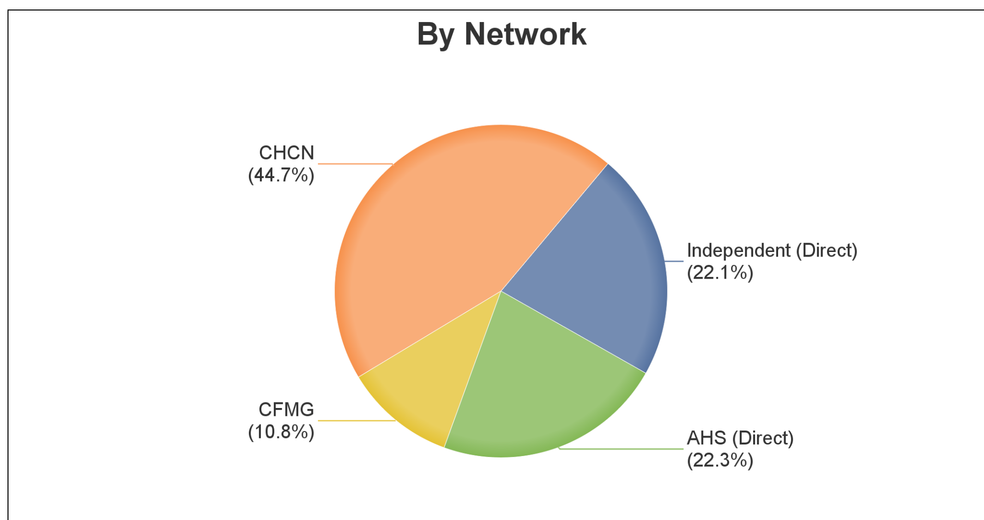
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED OCTOBER 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
11,343,315	8,867,764	(2,475,551)	(27.9%)	ER Facility	37,235,897	34,889,170	(2,346,728)	(6.7%)
1,372,005	0	(1,372,005)	0.0%	Specialty ER Physician FFS	4,880,392	0	(4,880,392)	0.0%
10,109,923	**8,867,764**	**(1,242,158)**	**(14.0%)**	**13. Emergency Expense**	**41,932,246**	**34,889,170**	**(7,043,076)**	**(20.2%)**
550,855	0	(550,855)	0.0%	IBNR Pharmacy (OP)	1,991,773	0	(1,991,773)	0.0%
16,525	0	(16,525)	0.0%	IBNR Settlement Rx (OP)	59,755	0	(59,755)	0.0%
44,068	0	(44,068)	0.0%	IBNR Claims Fluctuation Rx(OP)	159,342	0	(159,342)	0.0%
809,730	391,366	(418,364)	(106.9%)	Pharmacy FFS (OP)	3,039,935	1,551,278	(1,488,657)	(96.0%)
103,918	11,778,334	11,674,415	99.1%	Pharmacy Non PBM FFS Other-ANC	543,892	46,450,137	45,906,246	98.8%
10,607,868	0	(10,607,868)	0.0%	Pharmacy Non PBM FFS OP-FAC	39,326,556	0	(39,326,556)	0.0%
254,879	0	(254,879)	0.0%	Pharmacy Non PBM FFS PCP	985,563	0	(985,563)	0.0%
2,669,838	0	(2,669,838)	0.0%	Pharmacy Non PBM FFS SCP	10,617,727	0	(10,617,727)	0.0%
23,764	0	(23,764)	0.0%	Pharmacy Non PBM FFS FQHC	82,575	0	(82,575)	0.0%
17,314	0	(17,314)	0.0%	Pharmacy Non PBM FFS HH	91,629	0	(91,629)	0.0%
0	0	0	0.0%	RX Refunds HMS	(306)	0	306	0.0%
(54,000)	49,902	103,902	208.2%	Medical Expenses Pharm Rebate	(216,000)	197,471	413,471	209.4%
15,044,760	**12,219,602**	**(2,825,158)**	**(23.1%)**	**14. Pharmacy Expense**	**56,682,439**	**48,198,887**	**(8,483,552)**	**(17.6%)**
(2,083,592)	0	2,083,592	0.0%	IBNR LTC	(3,756,936)	0	3,756,936	0.0%
(62,508)	0	62,508	0.0%	IBNR Settlement (LTC)	(112,709)	0	112,709	0.0%
(166,687)	0	166,687	0.0%	IBNR Claims Fluctuation (LTC)	(300,555)	0	300,555	0.0%
1,635,904	0	(1,635,904)	0.0%	LTC - ICF/DD	6,755,726	0	(6,755,726)	0.0%
27,716,203	0	(27,716,203)	0.0%	LTC Custodial Care	99,683,289	0	(99,683,289)	0.0%
8,963,885	29,332,395	20,368,510	69.4%	LTC SNF	32,021,639	116,104,135	84,082,496	72.4%
36,003,205	**29,332,395**	**(6,670,810)**	**(22.7%)**	**15. Long Term Care Expense**	**134,290,453**	**116,104,135**	**(18,186,318)**	**(15.7%)**
153,432,849	**139,608,333**	**(13,824,516)**	**(9.9%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**615,180,741**	**550,203,117**	**(64,977,624)**	**(11.8%)**
531,200	0	(531,200)	0.0%	Medical Exp. OthClinicalGrants	(278,321)	0	278,321	0.0%
0	169,914	169,914	100.0%	Clinical Vacancy #102	0	533,334	533,334	100.0%
182,182	193,423	11,241	5.8%	Quality Analytics #123	589,367	748,947	159,580	21.3%
320,325	345,865	25,540	7.4%	LongTerm Services and Support #139	836,825	1,316,534	479,708	36.4%
978,815	869,697	(109,118)	(12.5%)	Utilization Management #140	4,066,469	3,380,330	(686,138)	(20.3%)
698,350	623,018	(75,333)	(12.1%)	Case & Disease Management #185	2,745,152	2,321,679	(423,473)	(18.2%)
558,566	429,099	(129,467)	(30.2%)	Medical Management #230	1,719,313	1,908,548	189,235	9.9%
1,266,474	1,095,769	(170,705)	(15.6%)	Quality Improvement #235	4,578,559	4,160,924	(417,635)	(10.0%)
324,169	377,725	53,556	14.2%	HCS Behavioral Health #238	1,298,841	1,437,523	138,682	9.6%
124,391	239,677	115,286	48.1%	Pharmacy Services #245	472,319	958,098	485,779	50.7%
36,229	59,072	22,843	38.7%	Regulatory Readiness #268	276,665	239,000	(37,666)	(15.8%)
5,020,702	**4,403,259**	**(617,443)**	**(14.0%)**	**17. Other Benefits & Services**	**16,305,188**	**17,004,915**	**699,727**	**4.1%**
(2,037,489)	(1,158,717)	878,773	(75.8%)	Reinsurance Recoveries	(6,711,986)	(4,630,434)	2,081,552	(45.0%)
1,755,506	1,544,956	(210,551)	(13.6%)	Reinsurance Premium	6,997,625	6,173,913	(823,712)	(13.3%)
(281,983)	**386,239**	**668,222**	**173.0%**	**18. Reinsurance Expense**	**285,638**	**1,543,478**	**1,257,840**	**81.5%**
177,222,385	**164,266,429**	**(12,955,957)**	**(7.9%)**	**20. TOTAL MEDICAL EXPENSES**	**704,112,343**	**648,096,853**	**(56,015,490)**	**(8.6%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend						
Category of Aid	**Oct 2024**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**
ADULTS	62,608	16%	12,945	14,279	7	35,377
CHILD	109,680	27%	9,208	13,554	40,986	45,932
SPD	35,389	9%	11,549	5,593	1,424	16,823
ACA OE	151,098	38%	26,103	53,525	1,490	69,980
DUALS	40,144	10%	26,290	2,883	6	10,965
LTC	249	0%	231	8	0	10
LTC-DUAL	1,265	0%	1,264	0	0	1
Medi-Cal	400,433		87,590	89,842	43,913	179,088
Group Care	5,769		2,166	920	0	2,683
Total	**406,202**	**100%**	**89,756**	**90,762**	**43,913**	**181,771**
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	**22.1%**	**22.3%**	**10.8%**	**44.7%**
			% Direct:	**44%**	**% Delegated:**	**56%**

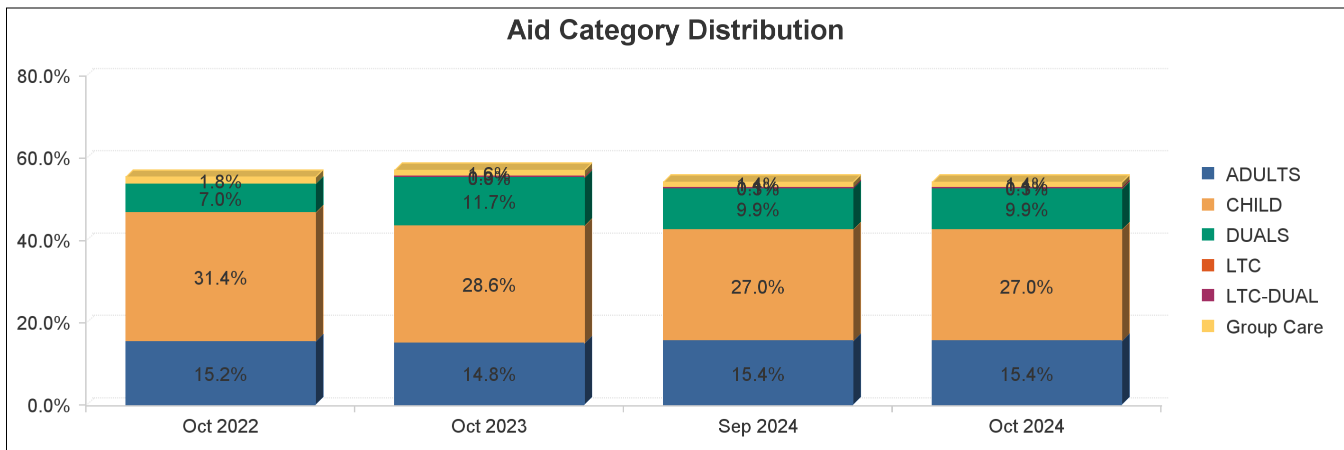




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

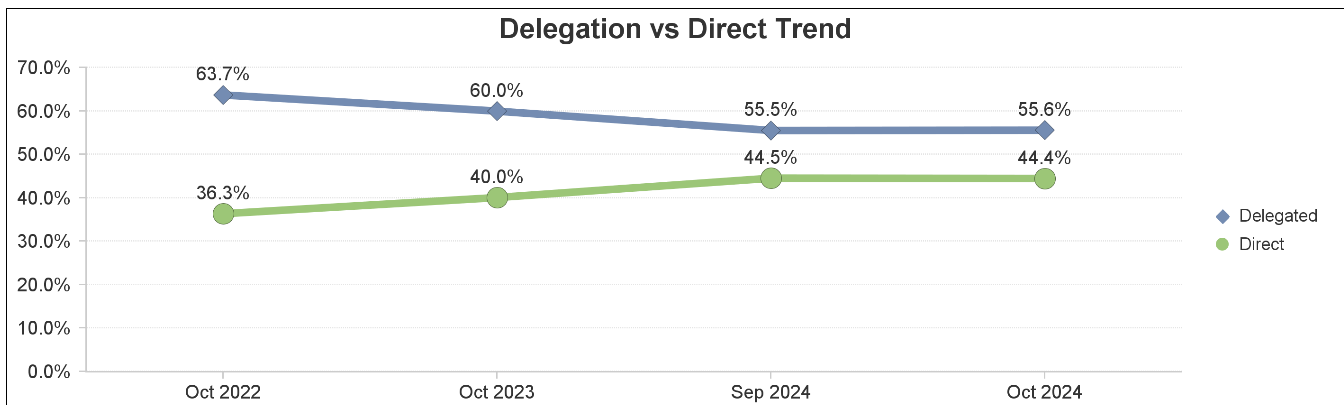
Category of Aid Trend

Category of Aid	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022 to Oct 2023	Oct 2023 to Oct 2024	Sep 2024 to Oct 2024
ADULTS	49,162	52,396	62,572	**62,608**	15.2%	14.8%	15.4%	15.4%	6.6%	19.5%	0.1%
CHILD	101,323	101,120	109,739	**109,680**	31.4%	28.6%	27.0%	27.0%	-0.2%	8.5%	-0.1%
SPD	28,237	30,888	35,322	**35,389**	8.7%	8.7%	8.7%	8.7%	9.4%	14.6%	0.2%
ACA OE	116,205	121,430	150,999	**151,098**	36.0%	34.3%	37.2%	37.2%	4.5%	24.4%	0.1%
DUALS	22,482	41,496	40,117	**40,144**	7.0%	11.7%	9.9%	9.9%	84.6%	-3.3%	0.1%
LTC	0	135	240	**249**	0.0%	0.0%	0.1%	0.1%	0.0%	84.4%	3.8%
LTC-DUAL	0	997	1,254	**1,265**	0.0%	0.3%	0.3%	0.3%	0.0%	26.9%	0.9%
Medi-Cal	317,409	348,462	400,243	**400,433**	98.2%	98.4%	98.6%	98.6%	9.8%	14.9%	0.0%
Group Care	5,789	5,605	5,710	**5,769**	1.8%	1.6%	1.4%	1.4%	-3.2%	2.9%	1.0%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.6%**	**14.7%**	**0.1%**



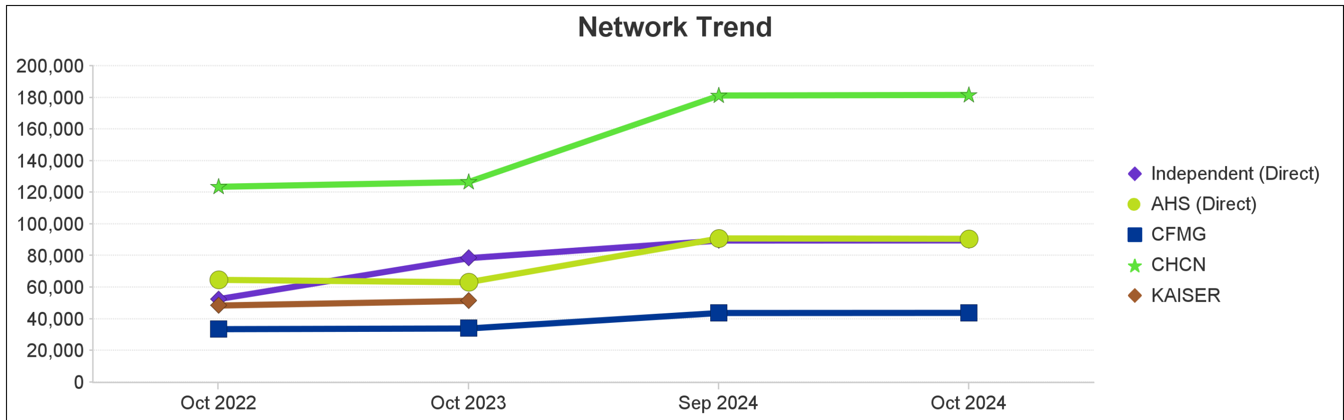
Delegation vs Direct Trend

Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022 to Oct 2023	Oct 2023 to Oct 2024	Sep 2024 to Oct 2024
Delegated	205,828	212,266	225,266	**225,684**	63.7%	60.0%	55.5%	55.6%	3.1%	6.3%	0.2%
Direct	117,370	141,801	180,687	**180,518**	36.3%	40.0%	44.5%	44.4%	20.8%	27.3%	-0.1%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.6%**	**14.7%**	**0.1%**



Network Trend

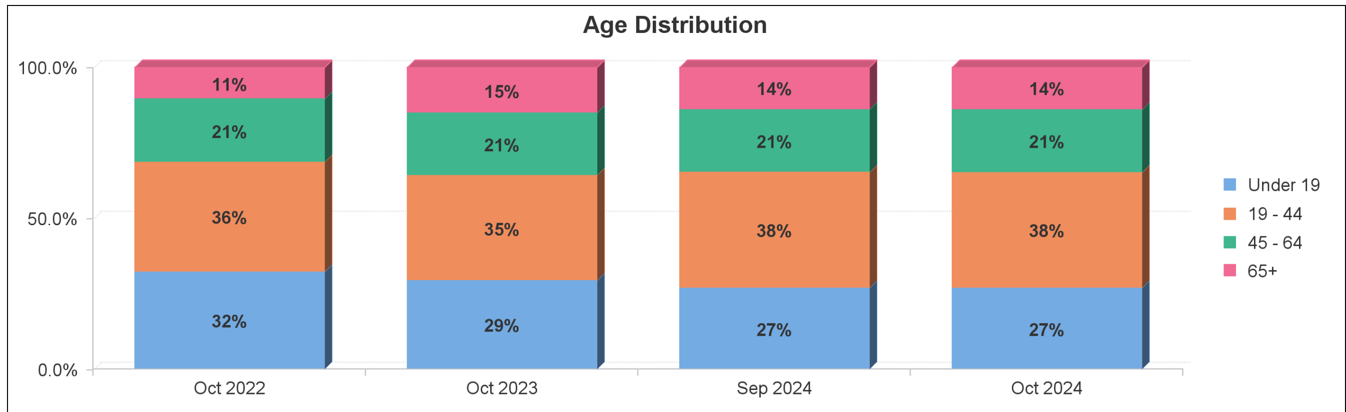
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022 to Oct 2023	Oct 2023 to Oct 2024	Sep 2024 to Oct 2024
Independent (Direct)	52,571	78,530	89,659	**89,756**	16.3%	22.2%	22.1%	22.1%	49.4%	14.3%	0.1%
AHS (Direct)	64,799	63,271	91,028	**90,762**	20.0%	17.9%	22.4%	22.3%	-2.4%	43.4%	-0.3%
CFMG	33,617	34,035	43,838	**43,913**	10.4%	9.6%	10.8%	10.8%	1.2%	29.0%	0.2%
CHCN	123,666	126,705	181,428	**181,771**	38.3%	35.8%	44.7%	44.7%	2.5%	43.5%	0.2%
KAISER	48,545	51,526	0	**0**	15.0%	14.6%	0.0%	0.0%	6.1%	-100.0%	0.0%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.6%**	**14.7%**	**0.1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

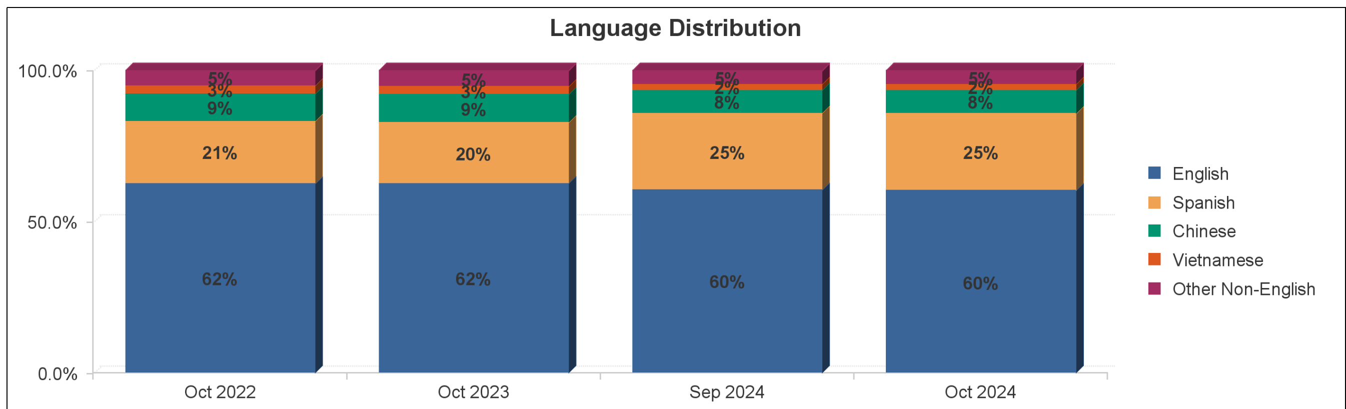
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022 to Oct 2023	Oct 2023 to Oct 2024	Sep 2024 to Oct 2024
Under 19	103,541	103,512	108,338	**108,379**	32%	29%	27%	27%	0%	5%	0%
19 - 44	117,664	123,390	155,780	**155,783**	36%	35%	38%	38%	5%	26%	0%
45 - 64	67,687	73,229	84,362	**84,315**	21%	21%	21%	21%	8%	15%	0%
65+	34,306	53,936	57,473	**57,725**	11%	15%	14%	14%	57%	7%	0%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100%**	**100%**	**100%**	**100%**	**10%**	**15%**	**0%**



Language Trend

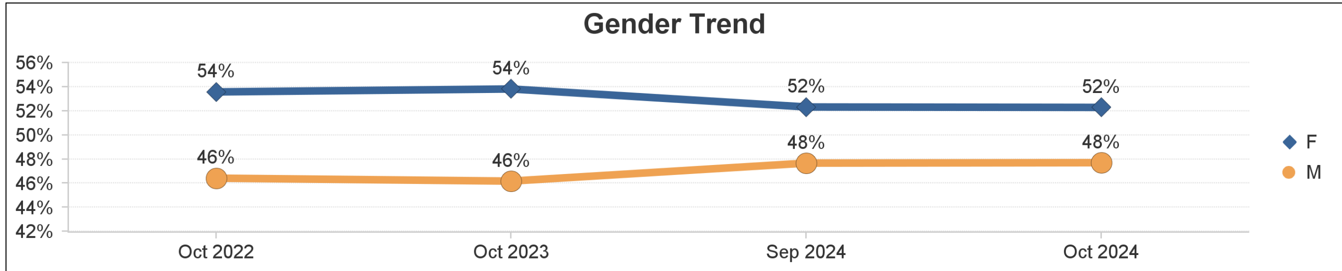
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022 to Oct 2023	Oct 2023 to Oct 2024	Sep 2024 to Oct 2024
English	201,780	221,283	245,070	**244,693**	62%	62%	60%	60%	10%	11%	0%
Spanish	66,629	71,409	102,701	**103,228**	21%	20%	25%	25%	7%	45%	1%
Chinese	29,052	32,770	30,727	**30,669**	9%	9%	8%	8%	13%	-6%	0%
Vietnamese	8,934	9,405	8,280	**8,243**	3%	3%	2%	2%	5%	-12%	0%
Other Non-English	16,803	19,200	19,175	**19,369**	5%	5%	5%	5%	14%	1%	1%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100%**	**100%**	**100%**	**100%**	**10%**	**15%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

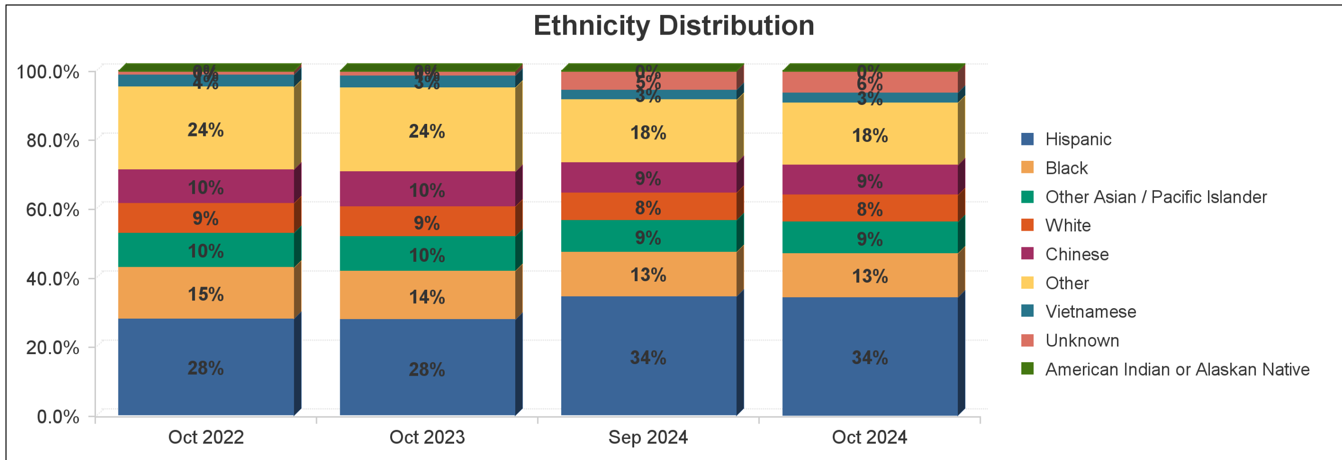
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	**Oct 2022**	**Oct 2023**	**Sep 2024**	**Oct 2024**	**Oct 2022**	**Oct 2023**	**Sep 2024**	**Oct 2024**	**Oct 2022 to Oct 2023**	**Oct 2023 to Oct 2024**	**Sep 2024 to Oct 2024**
F	173,160	190,566	212,422	**212,415**	54%	54%	52%	52%	10%	11%	0%
M	150,038	163,501	193,531	**193,787**	46%	46%	48%	48%	9%	19%	0%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100%**	**100%**	**100%**	**100%**	**10%**	**15%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	**Oct 2022**	**Oct 2023**	**Sep 2024**	**Oct 2024**	**Oct 2022**	**Oct 2023**	**Sep 2024**	**Oct 2024**	**Oct 2022 to Oct 2023**	**Oct 2023 to Oct 2024**	**Sep 2024 to Oct 2024**
Hispanic	90,312	98,158	139,641	**138,637**	28%	28%	34%	34%	9%	41%	-1%
Black	48,088	49,717	52,255	**51,748**	15%	14%	13%	13%	3%	4%	-1%
Other Asian / Pacific Islander	32,221	35,487	37,604	**37,202**	10%	10%	9%	9%	10%	5%	-1%
White	27,881	30,637	32,080	**31,678**	9%	9%	8%	8%	10%	3%	-1%
Chinese	31,624	35,807	35,544	**35,243**	10%	10%	9%	9%	13%	-2%	-1%
Other	77,437	86,487	74,071	**73,399**	24%	24%	18%	18%	12%	-15%	-1%
Vietnamese	11,427	12,050	11,649	**11,527**	4%	3%	3%	3%	5%	-4%	-1%
Unknown	3,514	4,980	22,311	**25,982**	1%	1%	5%	6%	42%	422%	16%
American Indian or Alaskan Native	694	744	798	**786**	0%	0%	0%	0%	7%	6%	-2%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100%**	**100%**	**100%**	**100%**	**10%**	**15%**	**0%**



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

Medi-Cal By City

City	Oct 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	160,318	40%	23,682	42,378	17,268	76,990
HAYWARD	64,357	16%	13,117	17,481	7,500	26,259
FREMONT	37,526	9%	15,440	6,662	2,200	13,224
SAN LEANDRO	33,098	8%	8,260	5,683	4,218	14,937
UNION CITY	14,665	4%	5,597	2,614	858	5,596
ALAMEDA	13,799	3%	3,267	2,501	2,067	5,964
BERKELEY	14,977	4%	4,036	2,275	1,765	6,901
LIVERMORE	13,016	3%	1,854	602	2,249	8,311
NEWARK	9,387	2%	2,718	4,110	527	2,032
CASTRO VALLEY	9,508	2%	2,600	1,617	1,417	3,874
SAN LORENZO	7,366	2%	1,464	1,667	858	3,377
PLEASANTON	7,596	2%	1,748	407	824	4,617
DUBLIN	7,541	2%	1,966	433	908	4,234
EMERYVILLE	2,836	1%	631	614	455	1,136
ALBANY	2,545	1%	688	298	568	991
PIEDMONT	463	0%	102	185	62	114
SUNOL	85	0%	27	14	6	38
ANTIOCH	27	0%	8	5	2	12
Other	1,323	0%	385	296	161	481
Total	400,433	100%	**87,590**	**89,842**	**43,913**	**179,088**

Group Care By City

City	Oct 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,818	32%	356	341	0	1,121
HAYWARD	655	11%	313	149	0	193
FREMONT	655	11%	432	75	0	148
SAN LEANDRO	610	11%	244	96	0	270
UNION CITY	304	5%	188	51	0	65
ALAMEDA	302	5%	91	25	0	186
BERKELEY	152	3%	50	12	0	90
LIVERMORE	100	2%	32	4	0	64
NEWARK	133	2%	77	31	0	25
CASTRO VALLEY	191	3%	83	30	0	78
SAN LORENZO	137	2%	46	24	0	67
PLEASANTON	72	1%	25	2	0	45
DUBLIN	116	2%	38	4	0	74
EMERYVILLE	31	1%	13	3	0	15
ALBANY	20	0%	10	1	0	9
PIEDMONT	9	0%	2	0	0	7
SUNOL	2	0%	2	0	0	0
ANTIOCH	26	0%	6	5	0	15
Other	436	8%	158	67	0	211
Total	**5,769**	**100%**	**2,166**	**920**	**0**	**2,683**

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

Total By City						
City	Oct 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,136	40%	24,038	42,719	17,268	78,111
HAYWARD	65,012	16%	13,430	17,630	7,500	26,452
FREMONT	38,181	9%	15,872	6,737	2,200	13,372
SAN LEANDRO	33,708	8%	8,504	5,779	4,218	15,207
UNION CITY	14,969	4%	5,785	2,665	858	5,661
ALAMEDA	14,101	3%	3,358	2,526	2,067	6,150
BERKELEY	15,129	4%	4,086	2,287	1,765	6,991
LIVERMORE	13,116	3%	1,886	606	2,249	8,375
NEWARK	9,520	2%	2,795	4,141	527	2,057
CASTRO VALLEY	9,699	2%	2,683	1,647	1,417	3,952
SAN LORENZO	7,503	2%	1,510	1,691	858	3,444
PLEASANTON	7,668	2%	1,773	409	824	4,662
DUBLIN	7,657	2%	2,004	437	908	4,308
EMERYVILLE	2,867	1%	644	617	455	1,151
ALBANY	2,565	1%	698	299	568	1,000
PIEDMONT	472	0%	104	185	62	121
SUNOL	87	0%	29	14	6	38
ANTIOCH	53	0%	14	10	2	27
Other	1,759	0%	543	363	161	692
Total	406,202	100%	**89,756**	**90,762**	**43,913**	**181,771**

Operations

Ruth Watson

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

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

Date: **December 13th, 2024**

Subject: **Operations Report**

<u>Member Services</u>

- 12-Month Trend Blended Summary:
    - The Member Services Department received a two percent (2%) decrease in calls in November 2024, totaling fourteen thousand eight hundred-six (14,806) compared to fifteen thousand and fifty (15,050) in November 2023.
    - The abandonment rate for November 2024 was four percent (4%), compared to four percent (4%) in November 2023.
    - The Department's service level was ninety-five percent (95%) in November 2024, compared to eighty-six percent (86%) in November 2023. The average speed to answer (ASA) was twelve seconds (00:12) compared to twenty-seven seconds (00:27) in November 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 thirteen seconds (07:13) for November 2024 compared to six minutes and forty-eight seconds (06:48) for November 2023.
    - One hundred percent (100%) of calls were answered within 10 minutes for November 2024 and one hundred percent (100%) of calls were answered within 10 minutes for November 2023.
    - Outbound calls totaled seventy-four hundred forty-three (7,443) in November 2024 compared to fifty-eight hundred thirty-six (5,836) in November 2023.
    - The top five call reasons for November 2024 were: 1). Eligibility/Enrollment, 2). Change of PCP, 3). Provider Network, 4). Grievances/Appeals, 5). Benefits. The top five call reasons for November 2023 were: 1). Eligibility/Enrollment, 2). Change of PCP 3). Benefits, 4). Grievance and Appeals, 5). Provider Network.
    - November utilization for the member automated eligibility IVR system totaled one thousand fifty-seven (1,057) in November 2024 compared to one thousand one hundred sixty-six (1,166) in November 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 and fifty-four (1,054) web-based requests in November 2024 compared to eight hundred thirty-three (833) in November 2023. The top three web reason requests for November 2024 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information. Forty-three (43)

members were assisted in-person in November 2024 compared to twenty-four (24) in 2023.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health Unit received a total of nine hundred and thirty-two (932) calls in November 2024 compared to nine hundred and nineteen (919) in November 2023.
    - The abandonment rate was eight percent (8%) in November 2024 compared to six percent (6%) in 2023.
    - The service level was seventy-eight percent (78%) in November 2024 and eighty-eight percent (88%) in November 2023.
    - The average speed to answer (ASA) in November 2024 was one minute and one second (01:01) compared to forty seconds (00:40) in November 2023.
    - Calls answered in 10 minutes were ninety-nine percent (99%) in November 2024 compared to ninety-nine percent (99%) in November 2023.
    - The Average Talk Time (ATT) was nine minutes and eight seconds (09:08) in November 2024 compared to nine minutes and thirty-nine seconds (09:39) in November 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 nineteen (119) screenings were completed in November 2024 compared to one hundred eighty-three (183) in November 2023.
    - Twenty-three (23) referrals were made to the County (ACCESS) in November 2024 compared to forty-one (41) in November 2023.
    - Six hundred and sixty-eight (668) outbound calls were completed in November 2024 compared to nine-hundred and ninety-one (991) in November 2023.
    - Forty-five (45) outreach campaigns were completed in November 2024 compared to two hundred and sixty-five (265) in November 2023.
    - Twenty-two (22) members were referred to Center Point for SUD services in November 2024 compared to thirteen (13) in November 2023.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 364,130 claims in November 2024 compared to 247,537 in November 2023.
    - The Auto Adjudication was 87.6% in November 2024 compared to 81.0% in November 2023.
    - Claims compliance for the 30-day turn-around time was 93.2% in November 2024 compared to 94.0% in November 2023. The 45-day turn-around time was 99.8% in November 2024 compared to 99.9% in November 2023.

- Monthly Analysis:
    - In the month of November, we received a total of 364,130 claims in the HEALTHsuite system. This represents a minimal decrease of 1% from October and is higher, by 116,593 claims, than the number of claims received in November 2023.
    - Drivers of the higher volume of received claims includes:
        - The increased membership since January 2024.
        - Members who delayed care during the pandemic are now catching up and utilizing services.
        - 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 90.7% of claims via EDI and 9.3% of claims via paper.
    - During the month of November, 99.8% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 87.6% for the month of November.

Provider Services

- 12-Month Trend Summary:
    - The Provider Services department's call volume in November 2024 was seven thousand twenty-two (7,022) calls compared to six thousand eight hundred seventy-seven (6,877) calls in November 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 fifty (350) calls/visits during November 2024.
    - The Provider Services department answered five thousand two hundred nineteen (5,219) calls for November 2024 and made seven hundred twenty-two (722) outbound calls.

Credentialing

- 12-Month Trend Summary:
    - At the Peer Review and Credentialing (PRCC) meeting held on November 19th, 2024, there were one hundred ninety (190) initial network providers approved; sixteen (16) primary care providers, twenty (20) specialists, twelve (12) ancillary providers, eleven (11) midlevel providers, and one hundred thirty-one (131) behavioral health providers. Additionally, forty-five (45) providers were re-credentialed at this meeting; twelve (12) primary care

providers, twenty-six (26) specialists, two (2) ancillary providers, and five (5) 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 November 2024, the Provider Dispute Resolution (PDR) team received 2,568 PDRs compared to 1,276 in November 2023.
  - The PDR team resolved 1,935 cases in November 2024 compared to 2,028 cases in November 2023.
  - In November 2024, the PDR team upheld 68% of cases versus 77% in November 2023.
  - The PDR team resolved 99.8% of cases within 45 working days in November 2024 compared to 100% in November 2023; the compliance standard is 95% within 45 working days.

- Monthly Analysis:
  - AAH received 2,568 PDRs in November 2024.
  - In the month of November, 1,935 PDRs were resolved. Out of the 1,935 PDRs, 1,323 were upheld and 612 were overturned.
  - 1,932 out of 1,935 cases were resolved within 45 working days resulting in a 99.8% compliance rate.
  - The average turnaround time for resolving PDRs in November was 42 days.
  - There were 4,368 PDRs pending resolution as of 11/30/2024, 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 primary reason which caused the Department to miss the goal of 25% or less are:
      - Member OHC corrections – 155 cases that were denied incorrectly.
  - The full breakdown of all 612 overturned PDRs is as follows:

Category	# of Cases	% of Cases	Comments
System Related Issues	**134**	**22%**	
General configuration issues	42	7%	Non-covered code, modifier, etc.
Retro eligibility changes	11	2%	Member not eligible at time claim was denied
Financial responsibility	65	10%	Mental Health denied to delegate
Claims Editing System (CES)	16	3%	
OHC Issues	**155**	**25%**	OHC Member TPL data, incorrect primary EOB not matching, incorrect manual entry
Authorization Issues	**149**	**23%**	
Processor error	57	8%	Claim denied in error; authorization was on file
UM/retro auth review	92	15%	Auth updated after claim was processed and sent for medical review
Additional Documentation	**50**	**9%**	
Duplicate claim	46	8%	Documentation received confirmed claim was not a duplicate
Timely filing	4	1%	Documentation received confirmed claim was submitted on time
Incorrect Rates	**52**	**9%**	
Contract	16	3%	Incorrect rates in system
Letter of Agreement (LOA)	4	1%	Underpaid; LOA on file
COB calculation	12	2%	Incorrectly calculated
Share of Cost (SOC)	20	3%	Underpaid; SOC already met Overpaid; SOC not billed
Processor Errors	**72**	**12%**	
Duplicate claim	13	2%	Claim was a duplicate; processor paid it in error
Incorrect rate	29	5%	Claim manually priced incorrectly
Incorrect Manual Denial	28	5%	
Misc errors	2	0%	
PDR Overturn Totals	**602**	**100%**	

Community Relations and Outreach

- 12-Month Trend Summary:
  - In November 2024, the Alliance completed 941 live member orientation outreach calls and 120 member orientations by phone.
  - The C&O Department reached 263 people (73% identified as Alliance members) during outreach activities, compared to 122 individuals (96% identified as Alliance members) in November 2023.

- The Alliance spent a total of $45 on donations, fees, and/or sponsorships, compared to $0 in November 2023.
- The C&O Department reached members in 16 cities/unincorporated areas throughout Alameda County, the Bay Area, and the U.S., compared to 15 cities in November 2023.

- Monthly Analysis:

  - In November 2024, the C&O Department completed 941 member orientation outreach calls and 120 member orientations by phone, 45 Alliance website inquiries, and three (3) member education events.
  - Among the 263 people reached, 73% identified as Alliance members.
  - In November 2024, the C&O Department reached members in 16 locations throughout Alameda County, the Bay Area, and the U.S.
  - Please see attached **Addendum A**.

Housing and Community Services Program Report – November Activities

Overview

The Housing and Community Services Program (HCSP) leads, develops, and implements a comprehensive housing and 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:

- ROI project for housing-related Community Supports (CS) – ongoing
- Development of Standard Operating Procedures (SOPs) for housing-related CS – ongoing
- Alameda County Health (AC Health) Initial Authorization Clean Up Report – in progress
- Developing Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis for the housing bundle – ongoing
- Housing CS automation planning for referrals – in progress

Interdepartmental Collaborations:

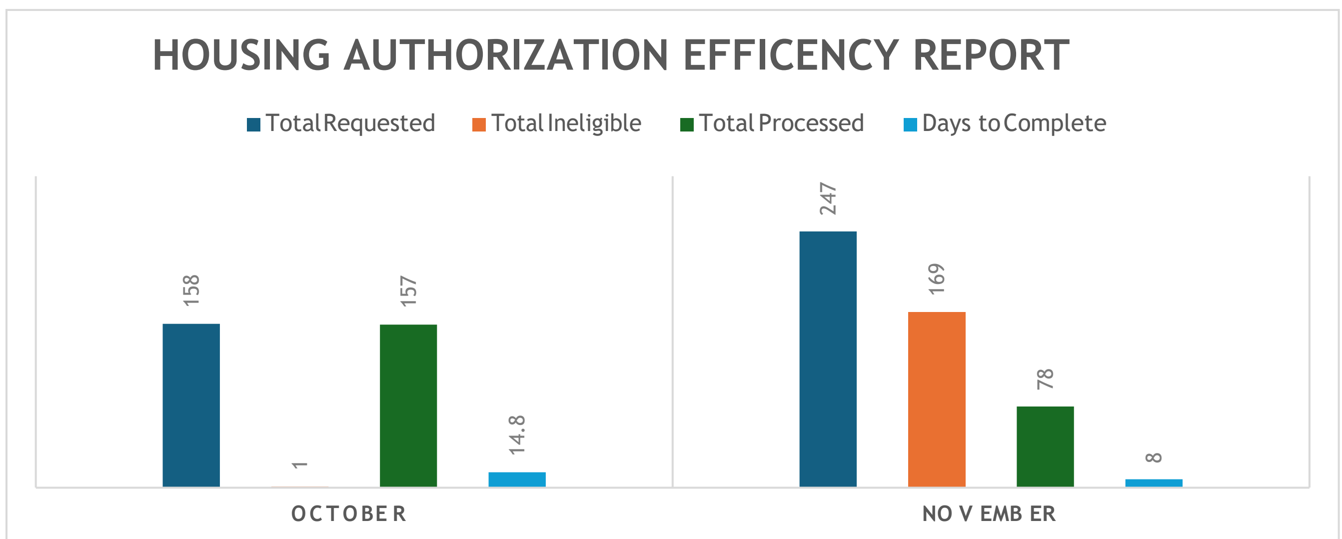
- Health Care Services and Housing Operations
  - Operational Efficiency Workgroup and Transition support – ongoing
  - TruCare Steering Committee workgroup – ongoing
  - SOPs UM guidance projects
  - PATH Collaborative Workgroup – HCSP is now participating in the monthly meetings

Community Networks and Partnership Development:

- Continued participation with various stakeholders throughout Alameda County, including the Continuum of Care (CoC), Racial Equity Committee, Outreach Access

and 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 and HMIS Committee – co-developed 2025 HMIS workplan infusing Racial Equity
- Corporation for Supportive Housing Advisory Council – CS standardization workflow feedback project
- National Association of Housing and Redevelopment Officials – AAH Housing Manager is the President of the Local Chapter and is in the planning phase for the regional conference, highlighting Housing CS
- DHCS Transitional Rent Workgroup

Housing Authorization Efficiency Project Report:



HCSD assumed responsibility for the housing bundle on October 1st, 2024. The following provides an overview of the initial authorization efficiency report:

- October 2024:
  - HCSD received five (5) batches of initial housing authorizations requests which included 158 individual requests
    - One (1) authorization request was determined to be ineligible due to member not meeting the criteria for the service
  - The team successfully processed 157 authorizations, achieving an average completion time of 14.8 days per batch
- November 2024:
  - HCSD received five (5) batches of initial housing authorizations requests which included 247 individual requests
    - 169 authorizations were determined to be ineligible due to members not meeting the criteria for the service
  - The team completed 78 authorizations, with an improved average completion time of 8 days per batch

HCSD aims to enhance operations and address current challenges and is focused on developing SOPs and providing training opportunities for contracted providers. These efforts aim to improve the quality, accuracy, and efficiency of submissions while also building team capacity, operational effectiveness, and timeliness in approving services for members.

Community Health Worker Program Overview

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.

Project Status Updates:

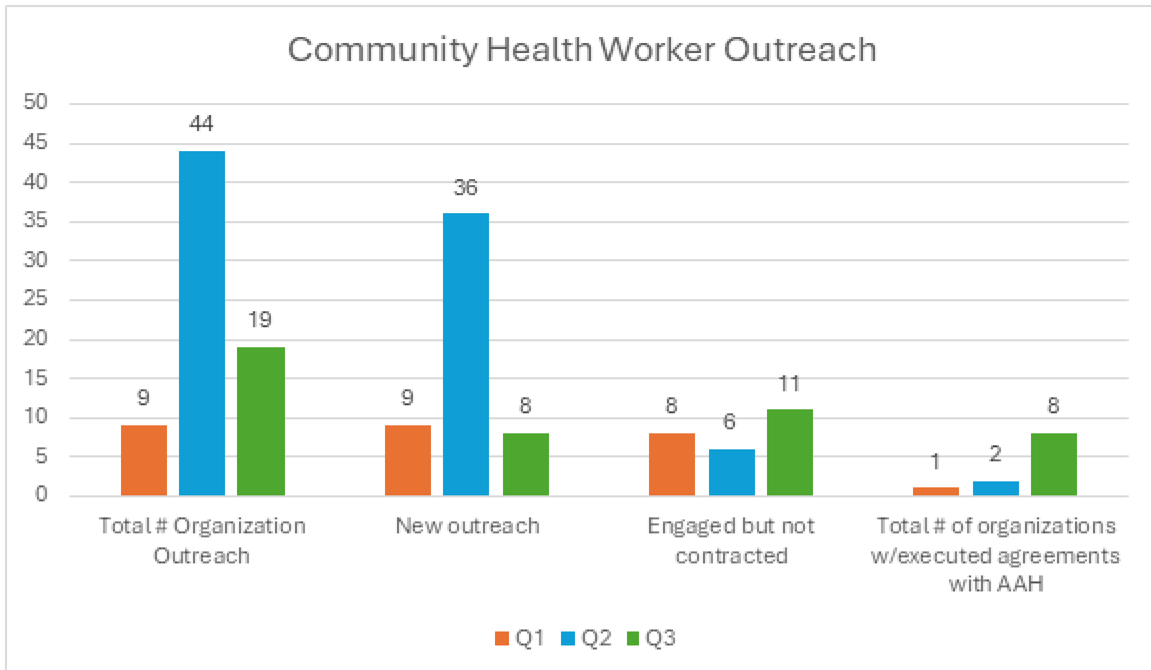
- CHW Training Cohort – designed to engage public health professionals, community-based organizations, hospital partners, and other local health jurisdictions in the CHW work; go-live targeted for March 2025

Interdepartmental Collaboration:

- Quality Team – CHW utilization projects
  - CHW utilization to support member follow-up for Mental Health (FUM) measures – active project
  - CHW integration to improve A1C for Alameda Alliance members; go–live targeted for January 2025
- Population Health Management – integration of CHW services for Perinatal Depression
  - New provider pending contracting; go-live January 2025

Community Networks & Partnership Development:

- The Alliance submitted the Q3 2024 monitoring report to DHCS on November 15th
  - AAH outreached to 19 organizations in Q3 2024
    - Eight (8) organizations were new to the Alliance CHW process
    - Eleven (11) organizations were engaged in Q2 but not contracted
  - Eight (8) provider organizations were fully contracted by the close of Q3



While the Alliance's efforts for outreach decreased from Q2, the Alliance's focus during this quarter was to move providers who were pending in Q2 across the finish line and become fully contracted in Q3. As the above data shows, this resulted in six (6) newly contracted providers in Q3. Provider organizations continue to struggle with becoming CHW providers due to infrastructure, operational, and financial barriers which translate into challenges to the sustainability of programming caused by lack of staffing. During Q3, two (2) organizations declined to contract with the Alliance due to staffing challenges. Here is a brief snapshot of partners Alameda Alliance welcomed to the CHW network in Q3:

- Dorothy Day House – specializing in working with unhoused populations to provide comprehensive wraparound services from medical linkage, housing assessments, meals, and shelter.
- Alameda Health Systems (Highland Hospital) – developing evidence-based bridged care services at Highland Hospital, supporting clients with resource connections.
- Roots Community Health Clinic – a respected staple and longtime contracted provider in Oakland, California, Roots joined the Alliance CHW program focused on preventative health and wellness through health education delivery for members with asthma.

Incentives & Reporting Board Report – November 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 12 (12) providers and organizations to support ECM and CS programs
    - Alameda Alliance earned 71.81% of the allocated points for the Submission 4 report, reflecting the lookback period of 7/1/2023 - 12/31/2023
- 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
    - Alameda Alliance earned 86.59% of the allocated points for the Submission 5 report, reflecting the lookback period of 1/1/2024 - 06/30/2024

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

- Partner meetings continued with the Local Education Agencies (LEAs) regarding project plan activities and to prepare for the last SBHIP submission, the Project Outcome Report, which is due to DHCS December 31st
- DHCS notified the Alliance on September 18th, 2024, that the Alliance earned 100% of eligible funds tied to the Bi-Quarterly Report (BQR) for the reporting period of January – June 2024
    - Funds were received from DHCS on October 28th, 2024, and the Alliance began distributing payments to the LEAs in November
- To date, $8.6M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $7.6M 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
    - $19.2M 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 continues
- In a separate HHIP-funded initiative, the Alliance awarded $11.2M in funding to ten (10) community partners through a program that supports the HHIP goals of reducing and preventing homelessness

- MOUs are in place or underway for projects related to capacity building, innovation, diversity and health equity, and housing stability

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

- Program launched on June 1st, 2024, and 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 applications totaling $6M in funding requests
- A multi-disciplinary team evaluated the applications and made funding recommendations to a group of senior leaders (CEO, COO, CFO, CMO); funding decisions were approved on October 25th, 2024, and partners were notified
- $2M in funding will be awarded to thirteen (13) provider partners, pending finalization of MOUs and related program deliverables for the following:
    - Eighteen (18) providers in total, nine (9) of which are bi-lingual
        - Six (6) Nurse Practitioners (NPs), including behavioral health NPs
        - Five (5) Primary Care Medical Doctors
        - Four (4) Licensed Clinical Social Workers (LCSW) and Licensed Marriage and Family Therapists (LMFT)
        - Three (3) Obstetrics and Gynecology Medical Doctors
        - Thirty-three (33) scholarships for Community Health Worker (CHW) certification training

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

- Of the fourteen (14) practices that submitted program applications, Alameda Health System was the only Alliance-associated applicant selected by DHCS to participate
- The original funding was $700 million over five (5) years; however, due to state budget constraints, the funding was reduced to $140 million over three (3) years

Recruiting and Staffing

Incentives & Reporting Open position(s): There are no open positions at this time.

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 was 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:

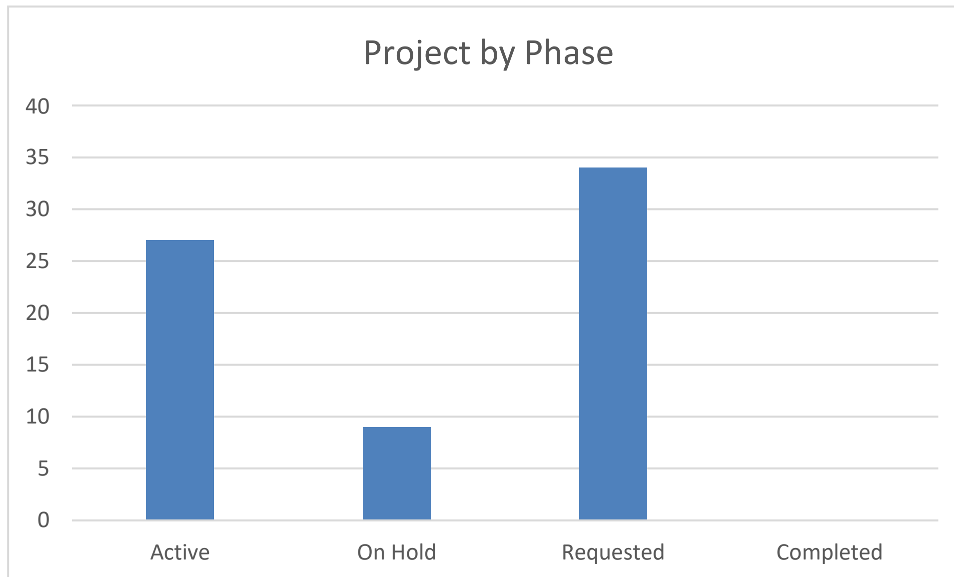
- Expanding the Alameda Alliance Provider network
- Improving member access to Primary Care Providers, Specialists, and Behavioral Health professionals
- Promoting diverse and culturally inclusive care reflective of Alliance members

Integrated Planning

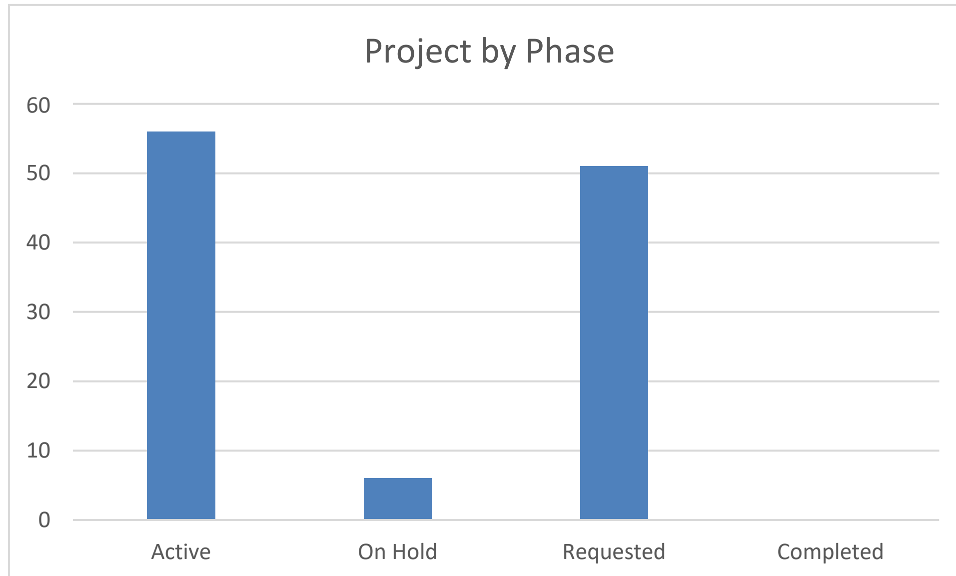
Ruth Watson

INTEGRATED PLANNING DIVISION BOARD REPORT – NOVEMBER 2024 ACTIVITIES

- Enterprise Portfolio
  - 70 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 27 Active projects (discovery, initiation, planning, execution, warranty)
    - 9 On Hold projects
    - 34 Requested and Approved Projects
    - 0 Completed Projects (Last month)



- D-SNP Portfolio
  - 113 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 56 Active projects (discovery, initiation, planning, execution, warranty)
    - 51 Requested Projects
    - 6 On Hold



- D-SNP Key Initiatives and Dates
  - DMHC Material Modification Submission – MA Service Area Expansion – March 2024
  - DMHC Material Modification Submission – D-SNP 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 – November 2024
  - Provider Services & Contracting
    - Provider contracting started July 22nd, 2024. Following the changes to the sequestration language in the Medicare amendment, 46 of the 146 previously signed amendments have been received. An outreach campaign is in place to manage follow up and provide immediate response to questions.
    - Completed the final of three D-SNP Consideration Campaign 2 theme "*Understanding what matters the most. Creating a vision for the future*" webinars on November 1st. Planning of Campaign 3 In Person Townhall is in process.
    - Continued development of business process future state workflows and requirements for the Provider Portal and Provider Repository

- Product
  - Continued D-SNP Branding Project and finalized three recommendations for D-SNP and refresh Alliance brands.
  - Continued the D-SNP Medicare Organizational Structure Exercise and 18 documents reviewed / approved out of 21 total number of departments.
  - Request sent for Business Requirement Document (BRD) for Enrollment, Disenrollment and Eligibility approval
  - Decision made to move forward with 3 months for the deeming period.
  - Engagement with the following vendors to support Supplemental Benefit Offering(s)
    - Dental –Initial benefit discussion in process
    - Vision – in Pre-Delegation / Contracting
    - Hearing – in Pre-Delegation/ Contracting
    - Flex Card – scoring in process
    - MTM – scoring in process
    - HRA – scoring in process

- Quality
  - 73 Narratives completed along with 3 additional narratives required by DHCS.
  - MOC 2 all narratives have been reviewed by the business and edits have been completed. Currently being reviewed by ED of Medicare Programs
  - MOC 3 all narratives have been reviewed by the business and edits have been completed. Next step is review by ED of Medicare Programs
  - MOC 4 narratives are currently being reviewed by the business.
  - MOC 1 all narratives are complete and currently being reviewed by the business.
  - Defining specific goals and objectives for QIP and CCIP initial stages.

MOC Element	Total Factors	# Draft Complete	# In Progress	# Not Started
MOC 1	8	8	0	0
MOC 2	32	32	0	0
MOC 3	12	12	0	0
MOC 4	21	21	0	0
Totals	**73**	**73**	**0**	**0**
		100%	**0%**	**0%**

- Health Care Services (HCS) and Behavioral Health (BH)
  - UM clinical guidelines demo completed with MCG on 10/15
  - Redlining UM and CM Program Descriptions for D-SNP elements
  - Developing Prior Authorization Form
  - Updating existing HRA with D-SNP Requirements
  - Future State (D-SNP) Inpatient and OP UM Business Requirement Document (BRD) – System Requirements Documentation started in collaboration with vendor
  - Future State D-SNP CM Global Workflow in draft – Outlining process flows for new D-SNP components to include Face-to-Face visit, Palliative Care Program, and Dementia Care Program
  - Completing inventory of existing CM and UM artifacts including assessments and notes to identify needs
  - BH UM Future State (D-SNP) Business Process Documentation in progress – Defining program model and IT needs as this will be a new process for D-SNP
  - BH CM – Continuing to document proposed D-SNP CM program structure

- Finance
  - Continued development of policies and business processes to support the approved requirements

- Compliance
  - Notice of Intent to Apply (NOIA) submitted on 11/8 with the HealthPlan contract received (H2035)
  - DMHC Material Modification – D-SNP Product (Filing #20244060)
    - Initial AAH responses submitted to DMHC on 9/9/24
    - DMHC Comment Table received 11/21/24; responses due 12/21

- Pharmacy
  - Pre-delegation audit is nearing completion. Additional documentation was requested from PerformRx and received week of 11/2. Final scoring in progress.
  - PBM contracting efforts have been initiated and are expected to complete by end of January 2025
  - Medication Therapy Management (MTM) vendor scoring and selection is underway. Additional demonstrations from the 3 potential vendors are in progress. Final scoring will be tallied once all 3 demos are completed: targeting mid-December
  - 17 P&Ps in development with Rebellis: 8 are in review, 9 are ready for committee review

- Operations (Claims / Member Services / Mailroom / IVR)
  - Continue development of Claims, Member Services, Mailroom, and IVR business process and requirements.

- IT
  - TruCare: Requirements documentation sessions in progress. BHP configuration was completed and will be tested before configuration in TruCare can start.
  - HEALTHsuite: Workstream Leads identified and working sessions are in progress. HEALTHsuite confirmed as source of letter triggers. Staging Region upgrade preparation in progress.
  - QualitySuite: Requirement development supporting G&A, PDR, PQI & Part D are in process. Grievances requirements completed

- P&Ps / SOPs / KPIs
  - Continued policy review within all workstreams
  - Initial development of KPI strategy and tracking documents for all workstreams

- Program Decisions Reviewed
  - Supplemental Benefits

  - Grievance & Appeals
    - QualitySuite will support a separate module for the D-SNP integrated appeals process
    - Appointment of Representative (AOR) form will be accessed and viewed in QualitySuite
    - G&A Member Portal Form will be updated the QIO disclaimer language (i.e. paper form, member portal form, and public-facing form, underneath the DMHC language)
    - G&A will create a program description in support of D-SNP

  - Enrollment and Eligibility
    - HEALTHsuite auto-letter functionality will be used to support D-SNP only member enrollment letters

  - Pharmacy
    - Pharmacy will proceed with a closed pharmacy network
    - Pharmacy will proceed with a standard formulary with some minor customizations

  - Product
    - D-SNP collateral will be branded by The Creative Department (TCD) and will include letterhead, envelopes, brochures, business cards, services promotional materials, post card mailers, email and fax coversheets, PowerPoint template

- Quality
  - Development of a D-SNP sub-committee for quality program
  - Mandatory Model of Care (MOC) training for AAH organization

- Utilization Management
  - One (1) integrated PA list will be used for Medi-Cal, Medicare, and Group Care.
  - Behavioral Health UM functions will be managed within the Behavioral Health department.

- **<u>CalAIM Initiatives:</u>**
  - Community Supports (CS):
    - Due to Budget Constraints, all CS enhancement and expansion are on hold.

  - Justice-Involved (JI) Initiative:

  - Community Supports (CS):
    - Due to Budget Constraints, all CS enhancement and expansion are on hold.

  - Justice-Involved (JI) Initiative:
    - CalAIM Re-entry
      - Correctional facilities go-live date for pre-release services 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.
        - 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; impacts to project scope and schedule will be assessed once this is released
    - DHCS JI Learning Collaboratives initiated in August and continues through January 2025. These collaborative sessions include correctional facilities, county behavioral health agencies, probation, managed care plans, and ECM providers.
    - On 10/28, AAH SLT approved to place CalAIM JI Re-Entry project on hold until July 2025 to await final policy guide from DHCS and give Alameda County partners time to develop their internal processes and readiness.

  - AAH/Roots JI Pilot Project:
    - Project closeout processes are in progress and expected to close the project on 12/6.

- 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
    - Project closeout processes are in progress and expected to close the project on 12/6

- 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 Health Plan Work Group (HPWG were to meet every week, Fridays between August and September 10 – 11 am, however, most meetings have been cancelled in the month of October
        - An email was to be shared each Monday with recaps and agendas for subsequent meetings, however, this has not been taking place
    - 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
            - MOU still pending finalization
        - 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 – Position started on Nov. 12th
    - Business Analyst – Integrated Planning – Position pending
    - Backfill Business Analyst – Integrated Planning – Position pending

Projects and Programs

Supporting Documents

Integrated Planning

Supporting Documents Project Descriptions

Key projects currently in-flight:

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

seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary.

- Community Health Worker Services Benefit – Community Health Worker (CHW) services became a billable Medi-Cal benefit effective July 1st, 2022. CHW services are covered as preventive services on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law for individuals who need such services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being.
- 2024 Single Plan Model
    - 2024 Managed Care Plan Contract Operational Readiness – new MCP contract developed as part of Procurement RFP; all MCPs must adhere to new contract effective January 1st, 2024
        - Business Continuity Plan required as part of Operational Readiness
        - MOUs with third parties required as part of Operational Readiness
    - MCP Member Transition
        - Anthem members will transition to AAH effective January 1st, 2024
        - Members currently delegated to Kaiser will transition to Kaiser as part of their direct contract with DHCS effective January 1st, 2024
- CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed 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	November 2024
Incoming Calls (R/V)	14,806
Abandoned Rate (R/V)	4%
Answered Calls (R/V)	14,240
Average Speed to Answer (ASA)	00:12
Calls Answered in 30 Seconds (R/V)	95%
Average Talk Time (ATT)	07:13
Calls Answered in 10 minutes	100%
Outbound Calls	7,443

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

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) November2024
Change PCP
ID Card Requests
Update Contact Info

MSBH	NOVEMBER 2024
Incoming Calls (R/V)	932
Abandoned Rate (R/V)	8%
Answered Calls (R/V)	862
Average Speed to Answer (ASA)	01:01
Calls Answered in 30 Seconds (R/V)	80%
Average Talk Time (ATT)	09:08
Calls Answered in 10 minutes	99%
Outbound Calls	668
Screenings Completed	119
ACBH Referrals	23
SUD referrals to Center Point	22

Claims Department
October 2024 Final and November 2024 Final

METRICS

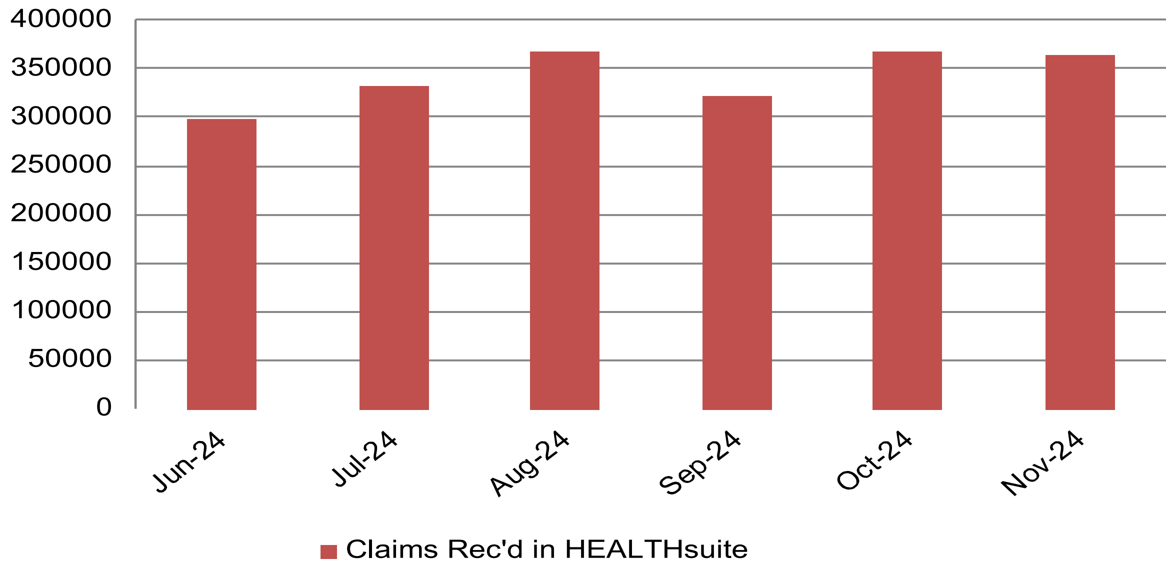
Claims Compliance	Oct-24	Nov-24
90% of clean claims processed within 30 calendar days	90.8%	93.2%
95% of all claims processed within 45 working days	99.8%	99.8%
Claims Volume (Received)	**Oct-24**	**Nov-24**
Paper claims	34,606	33,722
EDI claims	333,383	330,408
Claim Volume Total	**367,989**	**364,130**
Percentage of Claims Volume by Submission Method	**Oct-24**	**Nov-24**
% Paper	9.4%	9.3%
% EDI	90.6%	90.7%
Claims Processed	**Oct-24**	**Nov-24**
HEALTHsuite Paid (original claims)	304,352	232,293
HEALTHsuite Denied (original claims)	95,910	68,269
HEALTHsuite Original Claims Sub-Total	**400,262**	**300,562**
HEALTHsuite Adjustments	9,287	20,454
HEALTHsuite Total	**409,549**	**321,016**
Claims Expense	**Oct-24**	**Nov-24**
Medical Claims Paid	$174,220,848	$132,414,360
Interest Paid	$139,209	$112,351
Auto Adjudication	**Oct-24**	**Nov-24**
Claims Auto Adjudicated	335,624	263,359
% Auto Adjudicated	83.9%	87.6%
Average Days from Receipt to Payment	**Oct-24**	**Nov-24**
HEALTHsuite	14	13
Pended Claim Age	**Oct-24**	**Nov-24**
0-30 calendar days	44,707	44,280
HEALTHsuite		
31-61 calendar days	885	15,812
HEALTHsuite		
Over 62 calendar days	3	7
HEALTHsuite		
Overall Denial Rate	**Oct-24**	**Nov-24**
Claims denied in HEALTHsuite	95,910	68,269
% Denied	23.4%	21.3%

Claims Department
October 2024 Final and November 2024 Final

Nov-24	
Top 5 HEALTHsuite Denial Reasons	**% of all denials**
Responsibility of Provider	26%
No Benefits Found For Dates of Service	14%
Non-Covered Benefit For This Plan	12%
Duplicate Claims	8%
Must Submit Paper Claim With Copy of Primary Payor EOB	8%
% Total of all denials	**68%**

Claims Received By Month

Run Date	7/1/2024	8/1/2024	9/1/2024	10/1/2024	11/1/2024	12/1/2024
Claims Received Through	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**
aims Rec'd in HEALTHsuite	297,267	332,150	368,235	322,196	367,989	364,130



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing November 2024 to November 2023 as follows: 30 Days - 93.2% (2024) vs 94.0% (2023) 45 Days - 99.8% (2024) vs 99.9% (2023) 90 Days - 99.9% (2024) vs 99.9% (2023)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 364,130 claims in November 2024 vs 247,537 in November 2023	N/A	N/A
EDI - the volume of EDI submissions was 90.7% which exceeded our normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 300,562 in November 2024 (18 working days) vs 272,298 in November 2023 (20 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in November 2024 was $132,414,360 (4 check runs) vs $98,752,649 in November 2023 (5 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in November 2024 was $112,351 vs $44,980 in November 2023	N/A	< $496,000 per fiscal year or $30,000 per month
Auto Adjudication - the AAH rate in November 2024 was 87.6% vs 82.9% in November 2023	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in November 2024 was 13 days vs 14 days in November 2023	N/A	<= 25 days
Pended Claim Age - comparing November 2024 to November 2023 as follows: 0-30 calendar days - 44,280 (2024) vs 30,590 (2023) 31-61 calendar days - 15,812 (2024) vs 2,681 (2023) Over 62 calendar days - 7 (2024) vs 5 (2023)	N/A	N/A
Top 5 Denial Reasons - the claim denial reasons remain consistent from month to month so there is no significant changes to report from November 2024 to November 2023	N/A	N/A

Provider Relations Dashboard November 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	8456	7022	
Abandoned Calls	4806	4325	3272	2275	1519	1207	1787	1663	1529	1554	1803	
Answered Calls (PR)	5889	5034	5761	5789	5950	5618	6806	6570	6105	6902	5219	
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	1055	1392	
Abandoned Calls (R/V)												
Answered Calls (R/V)	413	2551	1970	1595	1093	896	1247	1211	985	1055	1392	
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	751	722	
N/A												
Outbound Calls	1140	1358	1298	831	1018	829	1066	893	889	751	722	
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	10262	9136	
Abandoned Calls	4806	4325	3272	2275	1519	1207	1787	1663	1529	1554	1803	
Total Answered Incoming, R/V, Outbound Calls	7442	8993	9029	8215	8061	7343	9119	8674	7979	8708	7333	

Provider Relations Dashboard November 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%	5.8%	6.0%	
Benefits	4.3%	3.6%	2.4%	3.0%	2.5%	2.8%	2.8%	2.9%	2.9%	2.9%	3.5%	
Claims Inquiry	38.5%	41.7%	45.4%	40.1%	43.3%	42.1%	43.8%	44.0%	44.9%	45.6%	43.0%	
Change of PCP	3.3%	3.9%	2.6%	3.6%	2.6%	2.9%	2.9%	2.9%	2.9%	3.1%	2.8%	
Check Tracer	1.1%	1.1%	1.2%	1.0%	1.3%	1.2%	0.9%	0.9%	1.0%	1.0%	0.9%	
Complaint/Grievance (includes PDR's)	4.4%	4.3%	6.1%	5.8%	7.9%	7.5%	7.6%	8.0%	7.5%	7.1%	6.1%	
Contracts/Credentialing	1.1%	1.0%	1.5%	1.4%	0.7%	0.7%	0.6%	0.9%	1.0%	0.7%	0.8%	
Demographic Change	0.0%	0.0%	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%	15.4%	18.1%	
Exempt Grievance/ G&A	0.6%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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%	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%	0.6%	0.8%	
Provider Portal Assistance	3.7%	3.8%	3.2%	3.2%	3.6%	3.6%	3.5%	3.2%	2.9%	4.5%	5.5%	
Pharmacy	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	
Prop 56	0.2%	0.4%	0.3%	0.3%	0.4%	0.4%	0.2%	0.2%	0.4%	0.5%	0.5%	
Provider Network Info	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	
Transportation Services	0.2%	0.2%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%	0.2%	0.1%	
Transferred Call	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	
All Other Calls	13.4%	13.1%	13.1%	13.1%	12.3%	13.5%	12.9%	12.4%	11.4%	12.2%	11.9%	
TOTAL	100.0%	100.0%	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	70	32	
Contracting/Credentialing	9	21	50	26	19	49	63	99	53	44	26	
Drop-ins	27	49	29	30	54	73	77	174	119	168	141	
JOM's	3	2	2	2	2	1	2	3	2	1	1	
New Provider Orientation	104	103	140	101	113	219	82	125	N/A	334	100	
Quarterly Visits	0	0	0	0	82	89	125	94	65	1	45	
UM Issues	0	0	0	0	0	1	7	7	4	2	5	
Total Field Visits	156	231	259	199	298	492	422	567	320	620	350	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS - NOVEMBER 2024						
Practitioners		BH/ABA 2,447	AHP 594	PCP 390	SPEC 755	PCP/SPEC 13
AAH/AHS/CHCN Breakdown			AAH 2,975	AHS 309	CHCN 576	COMBINATION OF GROUPS 340
Facilities	**427**					

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	65	4	Y	Y	Y
Recred Files in Process	194	0	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**259**				
		*** 25 business days = 35 calendar days**			

November 2024 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	16
SPEC	20
ANCILLARY	12
MIDLEVEL/AHP	11
BH/ABA	131
Sub-total	**190**
Recredentialing	
PCP	12
SPEC	26
ANCILLARY	2
MIDLEVEL/AHP	5
Sub-total	**45**
TOTAL	**235**

November 2024 Facility Approvals	
Initial Credentialing	**0**
Recredentialing	**9**
Sub-total	**9**
Facility Files in Process	**43**

November 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
Abdelrazek	Ahmed	BH	INITIAL	11/19/2024
Abel	Brittany	Primary Care Physician	INITIAL	11/19/2024
Aguirre	Jose	BH	INITIAL	11/19/2024
Ahmed	Palwasha	Specialist	INITIAL	11/19/2024
Ahn	Elaine	Allied Health	INITIAL	11/19/2024
Alcocer	Antonio	BH	INITIAL	11/19/2024
Alexander	Veronica	Primary Care Physician	INITIAL	11/19/2024
Anderson	Melissa	BH	INITIAL	11/19/2024
Aslam	Rabia	Primary Care Physician	INITIAL	11/19/2024
Au	Lee	Specialist	INITIAL	11/19/2024
Ballesteros	Judy Ann	ABA-Telehealth	INITIAL	11/19/2024
Beattie	Genna	Specialist	INITIAL	11/19/2024
Beaty	Craig	BH	INITIAL	11/19/2024
Bellingham	Julie	ABA-Telehealth	INITIAL	11/19/2024
Belloso	Tanya	BH-Telehealth	INITIAL	11/19/2024
Benn	Courtney	BH	INITIAL	11/19/2024
Berber	Roberto	ABA-Telehealth	INITIAL	11/19/2024
Berkowitz	Alan	BH-Telehealth	INITIAL	11/19/2024
Blandon	Pamela	ABA	INITIAL	11/19/2024
Blaustein	Samantha	BH	INITIAL	11/19/2024
Bolick	Alice	Allied Health	INITIAL	11/19/2024
Bosworth	Kelli	ABA	INITIAL	11/19/2024
Box	Elisabeth	BH-Telehealth	INITIAL	11/19/2024
Bray	Ashley	BH-Telehealth	INITIAL	11/19/2024
Brown	Krystal		INITIAL	11/19/2024
Bushee	Fallon	Specialist	INITIAL	11/19/2024
Buttner	Melissa	BH-Telehealth	INITIAL	11/19/2024
Cade	Mika	Doula	INITIAL	11/19/2024
Campos	Samantha	Ancillary	INITIAL	11/19/2024
Castillo	Mia	BH	INITIAL	11/19/2024
Chang	Raymond	Specialist	INITIAL	11/19/2024
Charbonneau	Denise	BH	INITIAL	11/19/2024
Chavez Moron	Florencia	ABA	INITIAL	11/19/2024
Chen	Jason	Primary Care Physician	INITIAL	11/19/2024
Chigbu	Victoria	BH	INITIAL	11/19/2024
Chiquete	Diana	BH	INITIAL	11/19/2024
Comstock	Curt	Specialist	INITIAL	11/19/2024
Conboy	Crista	ABA-Telehealth	INITIAL	11/19/2024
Crinion	Sophie	Primary Care Physician	INITIAL	11/19/2024
Delgado	Gabriela	BH	INITIAL	11/19/2024
Denny	Sue	BH	INITIAL	11/19/2024
Devany	Caroline	Allied Health	INITIAL	11/19/2024
Dongre	Shivani	BH	INITIAL	11/19/2024
Doughty	Frances	BH	INITIAL	11/19/2024
Durante	Lea	AHP SP_CHW	INITIAL	11/19/2024
Eggers	Hilary	Specialist	INITIAL	11/19/2024
Ehrig	Michael	BH	INITIAL	11/19/2024
Escalera-Serna	Fernando	ABA-Telehealth	INITIAL	11/19/2024
Estrada	Nataly	ABA-Telehealth	INITIAL	11/19/2024
Ezra	Joseph	BH-Telehealth	INITIAL	11/19/2024
Farfan	Cynthia	BH	INITIAL	11/19/2024
Farmer	Jessica	Primary Care Physician	INITIAL	11/19/2024
Flemings	Shemonica	ABA	INITIAL	11/19/2024
Flores-Lopez	Jose	BH-Telehealth	INITIAL	11/19/2024
Fraire	Luis	BH	INITIAL	11/19/2024
Franco	Mauricio	Primary Care Physician	INITIAL	11/19/2024

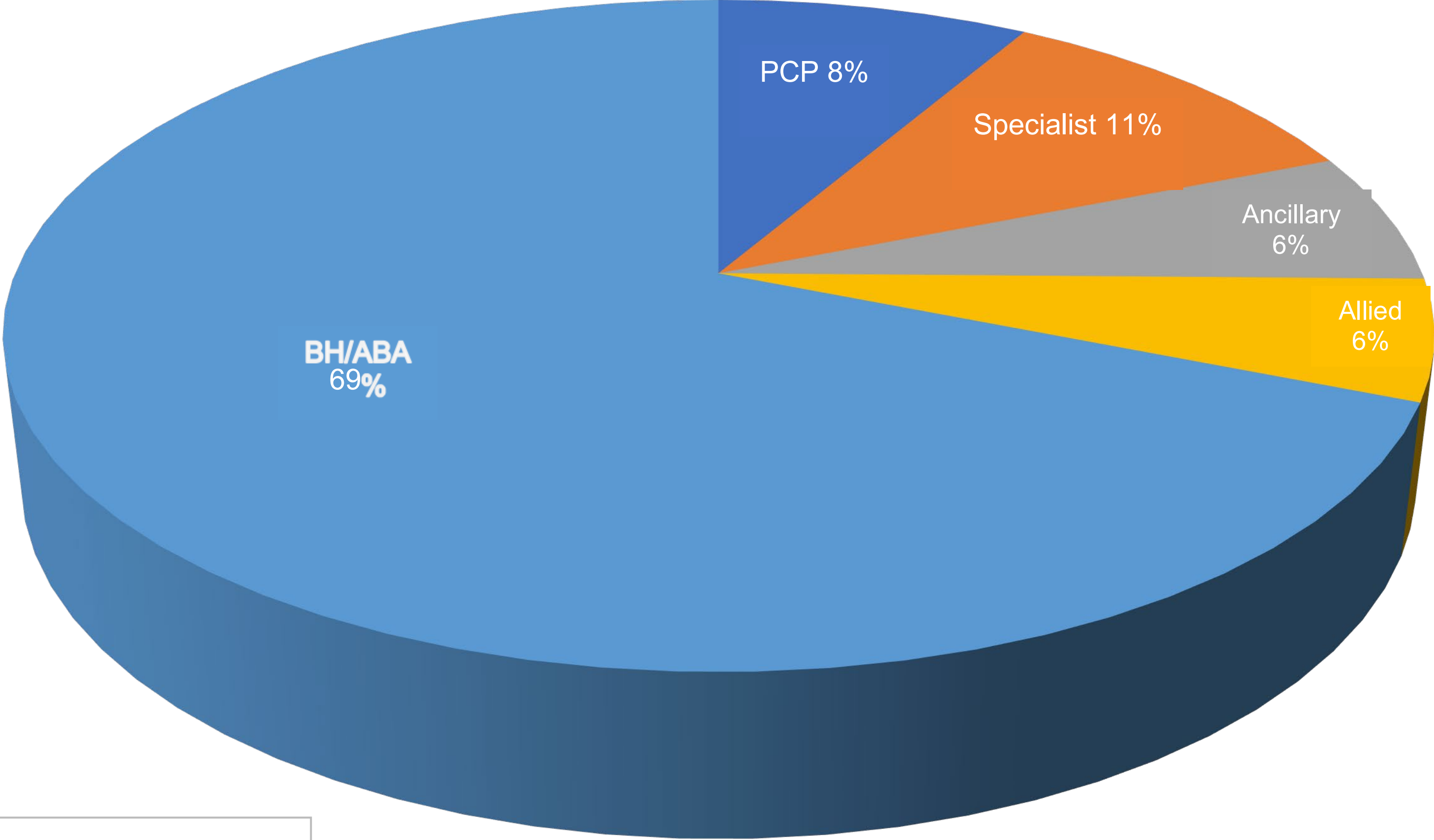
LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Garcia	Yingju	ABA	INITIAL	11/19/2024
Garg	Anuja	Primary Care Physician	INITIAL	11/19/2024
Geedipally	Hanisha	Primary Care Physician	INITIAL	11/19/2024
Gendelberg	David	Specialist	INITIAL	11/19/2024
Ghanem	Mariko	BH-Telehealth	INITIAL	11/19/2024
Gietzen	Megan	BH-Telehealth	INITIAL	11/19/2024
Gillis	Jessica	ABA-Telehealth	INITIAL	11/19/2024
Ginkens	Shing Chin	BH	INITIAL	11/19/2024
Gonzales	Marissa	BH	INITIAL	11/19/2024
Gordin	Roberta	BH-Telehealth	INITIAL	11/19/2024
Griggs	Courtney	ABA-Telehealth	INITIAL	11/19/2024
Gutierrez	Adam	Specialist	INITIAL	11/19/2024
Halici	Melissa	BH	INITIAL	11/19/2024
Hargis	Coletta	Specialist	INITIAL	11/19/2024
Harstad	Cody	ABA-Telehealth	INITIAL	11/19/2024
Hayes	Gurett	BH	INITIAL	11/19/2024
He	Ronald	ABA	INITIAL	11/19/2024
Helm	Brooke	ABA	INITIAL	11/19/2024
Hernandez	Stephanie	ABA-Telehealth	INITIAL	11/19/2024
Herrera	Margarita	BH	INITIAL	11/19/2024
Hodges	Heather	BH-Telehealth	INITIAL	11/19/2024
Houston Baker	Kamila	BH	INITIAL	11/19/2024
Irvine	T'Anna	BH	INITIAL	11/19/2024
Isidro	Theresa	BH	INITIAL	11/19/2024
Izekor	Abiola	BH-Telehealth	INITIAL	11/19/2024
Jackson	Raquel	BH	INITIAL	11/19/2024
Jasmin	Mylene Grace	BH	INITIAL	11/19/2024
Jeanty-Higgins	Naomi	BH-Telehealth	INITIAL	11/19/2024
Jones	Alissa	ABA	INITIAL	11/19/2024
Kajos Kingsby	Jacqueline	BH	INITIAL	11/19/2024
Kamath	Dipti	Primary Care Physician	INITIAL	11/19/2024
Kampas	Emily	BH-Telehealth	INITIAL	11/19/2024
Kaur	Rachhpal	Allied Health	INITIAL	11/19/2024
Kediyal	Jaya	Primary Care Physician	INITIAL	11/19/2024
Kircher	John	Specialist	INITIAL	11/19/2024
Kitlinski-Hong	Christina	ABA-Telehealth	INITIAL	11/19/2024
Kohn	Casey	BH-Telehealth	INITIAL	11/19/2024
Koozekanani	Roshan	BH-Telehealth	INITIAL	11/19/2024
Krutsch	Stephanie	BH	INITIAL	11/19/2024
Lau	Ricky	BH	INITIAL	11/19/2024
Leyda	Savannah	BH	INITIAL	11/19/2024
Lim	Angela	BH-Telehealth	INITIAL	11/19/2024
Lopez	Karissa	BH	INITIAL	11/19/2024
Ly	Wilson	Specialist	INITIAL	11/19/2024
Macdonald	Dustin	BH-Telehealth	INITIAL	11/19/2024
Magana	Alma	AHP SP_CHW	INITIAL	11/19/2024
Malin-Roodman	Sarah Ann	Allied Health	INITIAL	11/19/2024
Manago	Darian	BH	INITIAL	11/19/2024
Mann	Navneet	BH-Telehealth	INITIAL	11/19/2024
Martin	Tiffany	BH	INITIAL	11/19/2024
Martinez-Cabal	Emma	BH	INITIAL	11/19/2024
Melchner	Sarah	ABA-Telehealth	INITIAL	11/19/2024
Meliala	Anjelica	ABA	INITIAL	11/19/2024
Mendez-Pugh	Morgan	BH	INITIAL	11/19/2024
Mettu	Helen	BH-Telehealth	INITIAL	11/19/2024
Miller	Jennifer	Primary Care Physician	INITIAL	11/19/2024
Miller	Rachael	BH	INITIAL	11/19/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Mirza	Hiba	ABA	INITIAL	11/19/2024
Monterrosa	Pamela	BH	INITIAL	11/19/2024
Morris	Stephen	Specialist	INITIAL	11/19/2024
Morrison	Jeannie	ABA-Telehealth	INITIAL	11/19/2024
Morrow	Ashley	Ancillary	INITIAL	11/19/2024
Nabhan	David	ABA-Telehealth	INITIAL	11/19/2024
Nagao	Masato	Specialist	INITIAL	11/19/2024
Nagas	Atousa	Ancillary	INITIAL	11/19/2024
Newhouse	Emily	Allied Health	INITIAL	11/19/2024
Nikolla	Irisi	AHP SP_CHW	INITIAL	11/19/2024
Noghli	Natasha	BH	INITIAL	11/19/2024
Oiyemhonlan Halbert	Etuajie	BH	INITIAL	11/19/2024
Olmstead-Newman	Carla	BH	INITIAL	11/19/2024
Orr	Lynne	Allied Health	INITIAL	11/19/2024
Parashar	Pooja	BH-Telehealth	INITIAL	11/19/2024
Paulsen	Kellie	ABA-Telehealth	INITIAL	11/19/2024
Paulson	Kyle	ABA	INITIAL	11/19/2024
Paxton	Heather	BH	INITIAL	11/19/2024
Peterson	Mackenzie	ABA	INITIAL	11/19/2024
Pittman	Latarsha	BH-Telehealth	INITIAL	11/19/2024
Posadas	Charity	BH	INITIAL	11/19/2024
Price	Kellie	BH	INITIAL	11/19/2024
Purcell	Mark	BH	INITIAL	11/19/2024
Quiceno	Michael	BH-Telehealth	INITIAL	11/19/2024
Ramirez	Christina	ABA	INITIAL	11/19/2024
Ranjit	Anju	Specialist	INITIAL	11/19/2024
Reynoso	Bryana	ABA	INITIAL	11/19/2024
Ritchie	Robert	ABA-Telehealth	INITIAL	11/19/2024
Rivas-Rios	Naomi	ABA-Telehealth	INITIAL	11/19/2024
Rodriguez	Amanda	ABA	INITIAL	11/19/2024
Rosas Vera	Leticia	ABA	INITIAL	11/19/2024
Ruiz	Viridiana	ABA-Telehealth	INITIAL	11/19/2024
Rymland	Emily	Allied Health	INITIAL	11/19/2024
Sahar	Christoph	PCP SP_CHW	INITIAL	11/19/2024
Salas	Dimarrah	ABA-Telehealth	INITIAL	11/19/2024
Salas	Jeanette	AHP SP_CHW	INITIAL	11/19/2024
Salem	Rachel	Specialist	INITIAL	11/19/2024
Sanchez	Alyssa	ABA-Telehealth	INITIAL	11/19/2024
Schmidt	Joseph	BH	INITIAL	11/19/2024
Schoellkopf	Brittany	Specialist	INITIAL	11/19/2024
Scott	Catherine	BH	INITIAL	11/19/2024
Sears	Lorraine	BH-Telehealth	INITIAL	11/19/2024
Shaikh	Atef	BH-Telehealth	INITIAL	11/19/2024
Simental	Irene	BH	INITIAL	11/19/2024
Singh	Satinder	Primary Care Physician	INITIAL	11/19/2024
Soderman	Susan	BH-Telehealth	INITIAL	11/19/2024
Sridhar	Bama	BH-Telehealth	INITIAL	11/19/2024
Stano	Jacki	ABA-Telehealth	INITIAL	11/19/2024
Stanton	Allison	Doula	INITIAL	11/19/2024
Stecher	Ivy	ABA-Telehealth	INITIAL	11/19/2024
Stewart	Elaina	Ancillary	INITIAL	11/19/2024
Sweet	Monica	Allied Health	INITIAL	11/19/2024
Szczech	Lynda	Specialist	INITIAL	11/19/2024
Teitelbaum	Marc	BH	INITIAL	11/19/2024
Tham	Carmen	BH-Telehealth	INITIAL	11/19/2024
Tovar	Alexis	BH	INITIAL	11/19/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Trapp	Charlisa	BH	INITIAL	11/19/2024
Trujillo	Myrna	ABA-Telehealth	INITIAL	11/19/2024
Truong	Timothy	Specialist	INITIAL	11/19/2024
Tse	Yee Eyan	ABA-Telehealth	INITIAL	11/19/2024
Valdes	Melissa	AHP SP_CHW	INITIAL	11/19/2024
Vangala	Hemalatha	Primary Care Physician	INITIAL	11/19/2024
Villaume	Laila	BH	INITIAL	11/19/2024
Wallace	Brian	BH	INITIAL	11/19/2024
Wan	Xingxing	BH	INITIAL	11/19/2024
Wen	Mindy	Allied Health	INITIAL	11/19/2024
Wentworth	April	BH-Telehealth	INITIAL	11/19/2024
Wong	Clarisse	Primary Care Physician	INITIAL	11/19/2024
Wynglass	Randy	BH-Telehealth	INITIAL	11/19/2024
Yi	Rosanne	Allied Health	INITIAL	11/19/2024
Yonebayashi	Moemi	BH	INITIAL	11/19/2024
Yu	Ruben	BH-Telehealth	INITIAL	11/19/2024
Zadrozny	Erin	BH	INITIAL	11/19/2024
Zhang	Lily	Specialist	INITIAL	11/19/2024
Zhong	Xiaoyin	BH	INITIAL	11/19/2024
Zhu	Weiguo	BH-Telehealth	INITIAL	11/19/2024
Zieske	Lawrence	Primary Care Physician	INITIAL	11/19/2024
Agarwal	Carrie	Specialist	RE-CRED	11/19/2024
Akileswaran	Chitra	Specialist	RE-CRED	11/19/2024
Ayyala	Sreedevi	Primary Care Physician	RE-CRED	11/19/2024
Beckerman Johnson	Jessica	Specialist	RE-CRED	11/19/2024
Beharie	Danielle	Specialist	RE-CRED	11/19/2024
Chang	Kimberly	Primary Care Physician	RE-CRED	11/19/2024
Cowan	Beth	Specialist	RE-CRED	11/19/2024
Dao	Bao	Specialist	RE-CRED	11/19/2024
Edelman	Robert	Specialist	RE-CRED	11/19/2024
Essapoor	Shayan	Specialist	RE-CRED	11/19/2024
Fang	Susan	Primary Care Physician	RE-CRED	11/19/2024
Flattery	Davida	Primary Care Physician	RE-CRED	11/19/2024
Frey	Douglas	Allied Health	RE-CRED	11/19/2024
Gupta	Shelly	Specialist	RE-CRED	11/19/2024
Howell	Tiffany	Primary Care Physician	RE-CRED	11/19/2024
Imes	Richard	Specialist	RE-CRED	11/19/2024
Jain	Ashit	Primary Care Physician and Specialist	RE-CRED	11/19/2024
Jain	Sneha	Ancillary	RE-CRED	11/19/2024
James	Adrian	Primary Care Physician	RE-CRED	11/19/2024
Jumig	Elmer	Primary Care Physician	RE-CRED	11/19/2024
Kahlon	Ravinder	Specialist	RE-CRED	11/19/2024
Khong	Dorothy	Specialist	RE-CRED	11/19/2024
Lee	Kevin	Specialist	RE-CRED	11/19/2024
Leite	Lorena	Primary Care Physician	RE-CRED	11/19/2024
Leung	Suktak	Ancillary	RE-CRED	11/19/2024
Levine	Arnold	Specialist	RE-CRED	11/19/2024
Lugo	Ricardo	Specialist	RE-CRED	11/19/2024
Mallavaram	Navin	Specialist	RE-CRED	11/19/2024
Moyer	Janice	Specialist	RE-CRED	11/19/2024
Pagtalunan	Maria	Specialist	RE-CRED	11/19/2024
Pereira-Ambrose	Ivana	Allied Health	RE-CRED	11/19/2024
Phangureh	Varinder	Specialist	RE-CRED	11/19/2024
Postma	Sarah	Primary Care Physician	RE-CRED	11/19/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Prakash	Shraddha	Specialist	RE-CRED	11/19/2024
Reddy	Srikanth	Specialist	RE-CRED	11/19/2024
Reiter	Samuel	Specialist	RE-CRED	11/19/2024
Rodriguez	Maiti	Primary Care Physician	RE-CRED	11/19/2024
Schwarting	Elizabeth	Allied Health	RE-CRED	11/19/2024
Sunkavally	Bhuvaneshwar Rao	Specialist	RE-CRED	11/19/2024
Swinson	Jasmine	Allied Health	RE-CRED	11/19/2024
Ternus	Peter	Specialist	RE-CRED	11/19/2024
Thornblade	Lucas	Specialist	RE-CRED	11/19/2024
Tsai	Timothy	Allied Health	RE-CRED	11/19/2024
Wang	Jessica	Primary Care Physician	RE-CRED	11/19/2024
Zitter	Jessica	Specialist	RE-CRED	11/19/2024

NOVEMBER PEER REVIEW AND CREDENTIALING INITIAL APPROVALS BY SPECIALTY



PCP	16
SPECIALIST	20
ANCILLARY	12
ALLIED	11
BH/ABA	131
TOTAL	190

Provider Dispute Resolution
October 2024 and November 2024

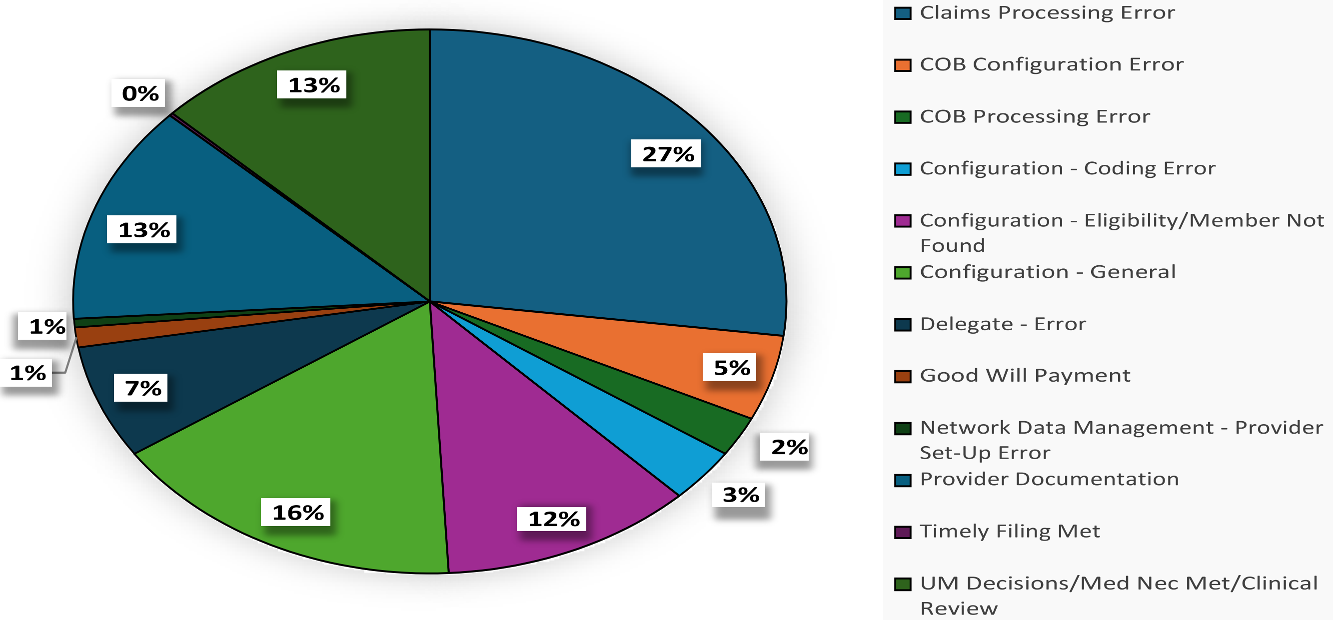
METRICS

PDR Compliance	Oct-24	Nov-24
# of PDRs Resolved	2,200	1,935
# Resolved Within 45 Working Days	2,181	1,932
% of PDRs Resolved Within 45 Working Days	99.1%	99.8%
PDRs Received	**Oct-24**	**Nov-24**
# of PDRs Received	2,708	2,568
PDR Volume Total	**2,708**	**2,568**
PDRs Resolved	**Oct-24**	**Nov-24**
# of PDRs Upheld	1,253	1,323
% of PDRs Upheld	57%	68%
# of PDRs Overturned	947	612
% of PDRs Overturned	43%	32%
Total # of PDRs Resolved	**1,897**	**1,935**
Average Turnaround Time	**Oct-24**	**Nov-24**
Average # of Days to Resolve PDRs	41	42
Oldest Resolved PDR in Days	139	118
Unresolved PDR Age	**Oct-24**	**Nov-24**
0-45 Working Days	4,609	4,368
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**4,609**	**4,368**

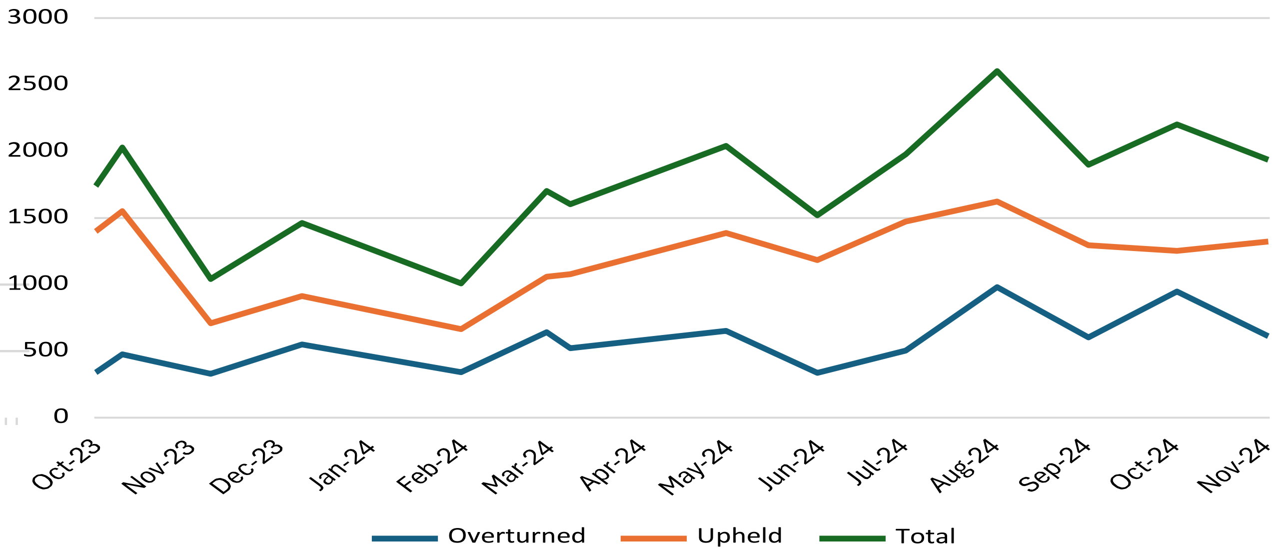
Provider Dispute Resolution
October 2024 and November 2024

Nov-24

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Provider Dispute Resolution Year Over Year Summary		
Monthly Results	**Regulatory Requirements**	**AAH Goal**
# of PDRs Resolved - 1,935 in November 2024 vs 2,028 in November 2023	N/A	N/A
# of PDRs Received - 2,568 in November 2024 vs 1,276 in November 2023	N/A	N/A
# of PDRs Resolved within 45 working days - 1,932 in November 2024 vs 2,027 in November 2023	N/A	N/A
% of PDRs Resolved within 45 working days - 99.8% in November 2024 vs 100% in November 2023	95%	95%
Average # of Days to Resolve PDRs - 42 days in November 2024 vs 36 days in November 2023	N/A	30
Oldest Resolved PDR in Days - 118 days in November 2024 vs 50 days November 2023	N/A	N/A
# of PDRs Upheld - 1,323 in November 2024 vs 1,552 in November 2023	N/A	N/A
% of PDRs Upheld - 68% in November 2024 vs 77% in November 2023	N/A	> 75%
# of PDRs Overturned - 612 in November 2024 vs 476 in November 2023	N/A	N/A
% of PDRs Overturned - 32% in November 2024 vs 23% in November 2023	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 26% (2024) vs 23% (2023) Configuration errors - 30% (2024) vs 45% (2023) COB - 7% (2024) vs 22% (2023) Clinical Review/UM Decisions/Medical Necessity Met -12% (2024) vs 7% (2023)	N/A	N/A

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2024-2025 | **NOVEMBER 2024 OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

FY 2024-2025 | NOVEMBER 2024 OUTREACH REPORT

In November 2024, the Alliance completed **941** member orientation outreach calls among net new and non-utilizer members and conducted **120** member orientations (**13%** member participation rate). In addition, in November 2024, the Outreach team completed **45** Alliance website inquiries, **6** service requests and **3** member education events. The Alliance reached a total of **143** people and spent a total of $45 on donations, fees, and/or sponsorships at the Alliance presentation question and answer (Q&A) at Harrison Street Senior Housing and South Lake Tower Senior Housing, MexiPino Fiesta events.*

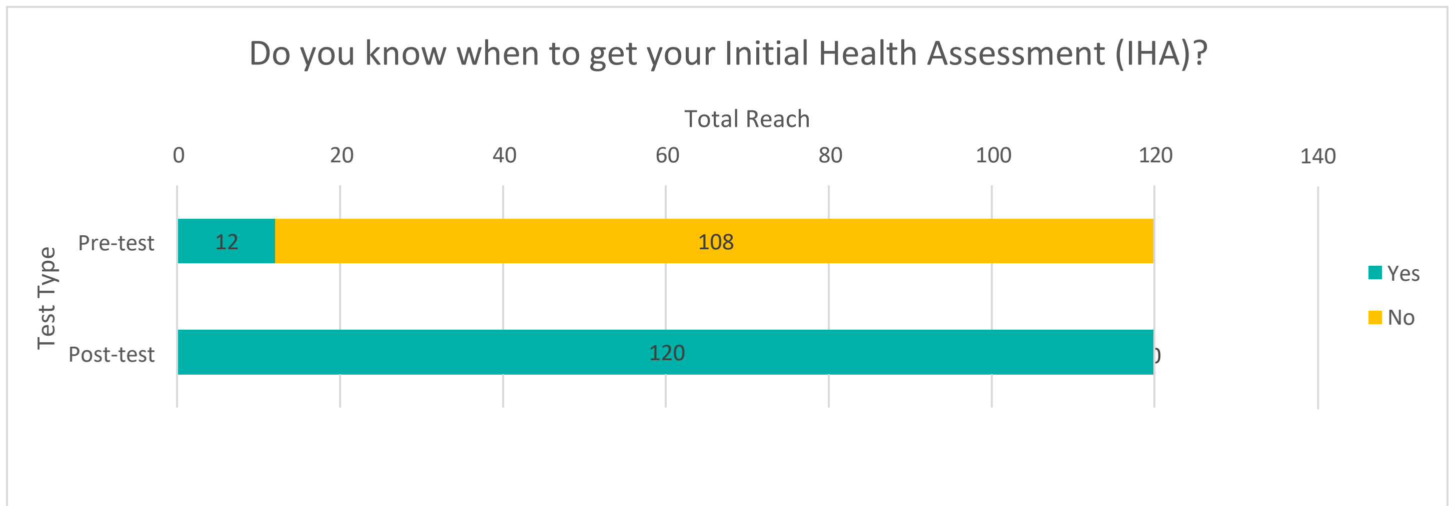
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **35,735** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of November 30, 2024, the Outreach Team completed **44,250** member orientation outreach calls and conducted **9,210** member orientations (**21%** member participation rate).

The Alliance Member Orientation (MO) program has existed since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment (IHA) by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between November 1, through November 30, 2024 (18 working days) – **120** members completed an MO by phone.

After completing the MO **100%** of members who completed the post-test survey in November 2024 reported knowing when to get their IHA, compared to only **10%** of members knowing when to get their IHA in the pre-test survey.

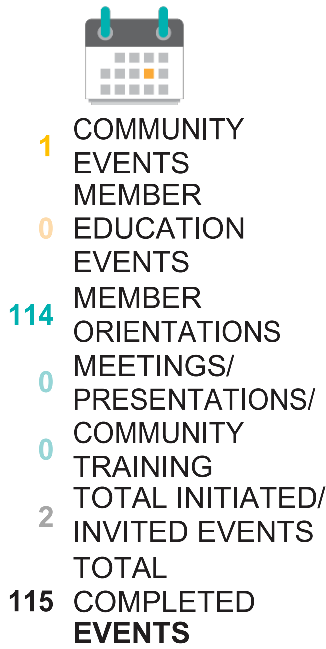


All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 24-25\Q2\2. November 2024**

ALLIANCE IN THE COMMUNITY

FY 2024-2025 | NOVEMBER 2024 OUTREACH REPORT

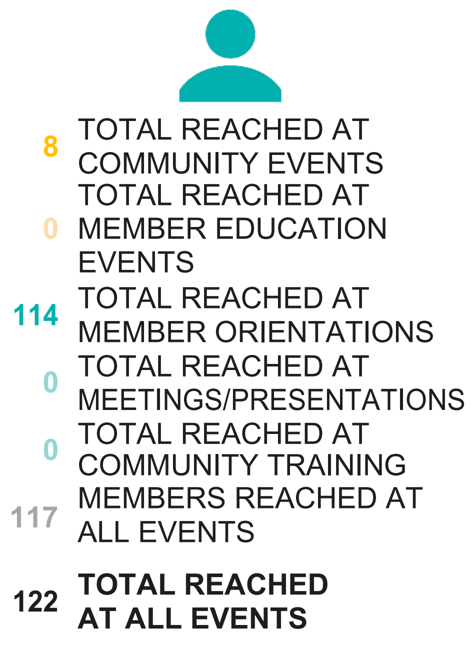
FY 2023-2024 NOVEMBER 2023 TOTALS



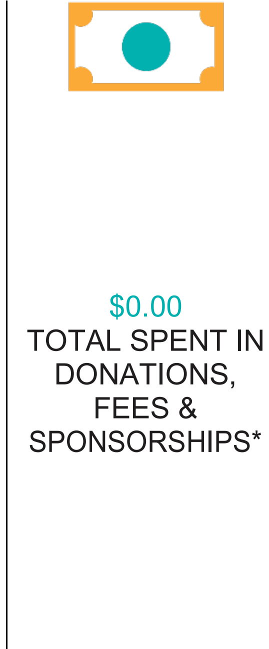
1	COMMUNITY EVENTS
0	MEMBER EDUCATION EVENTS
114	MEMBER ORIENTATIONS
0	MEETINGS/ PRESENTATIONS/
0	COMMUNITY TRAINING
2	TOTAL INITIATED/ INVITED EVENTS
115	TOTAL COMPLETED **EVENTS**

15 CITIES

Alameda
Albany
Berkeley
Castro Valley
Dublin
Fremont
Hayward
Livermore
Los Angles
Newark
Oakland
Piedmont
San Leandro
San Lorenzo
Union City

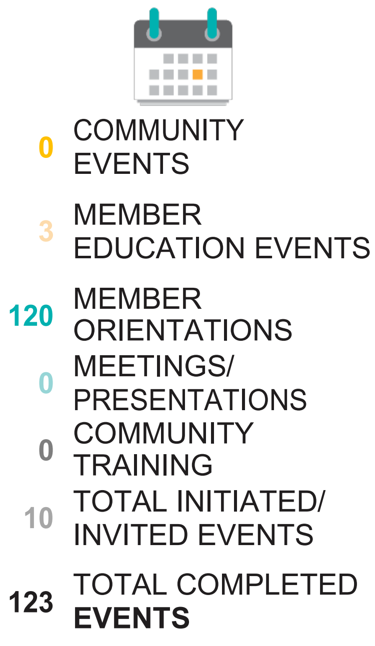


8	TOTAL REACHED AT COMMUNITY EVENTS
0	TOTAL REACHED AT MEMBER EDUCATION EVENTS
114	TOTAL REACHED AT MEMBER ORIENTATIONS
0	TOTAL REACHED AT MEETINGS/PRESENTATIONS
0	TOTAL REACHED AT COMMUNITY TRAINING
117	MEMBERS REACHED AT ALL EVENTS
122	**TOTAL REACHED AT ALL EVENTS**



$0.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

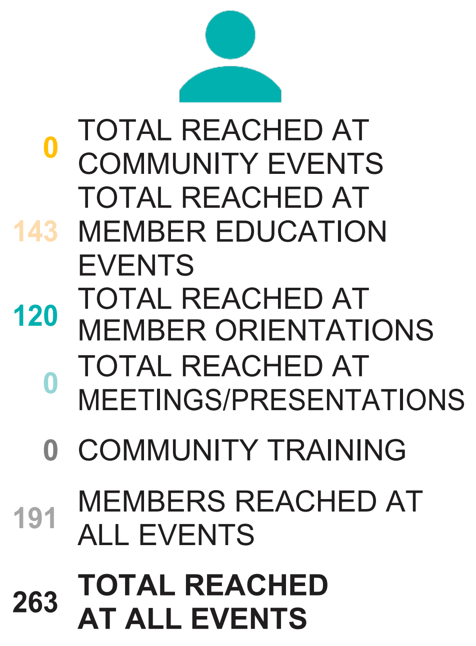
FY 2024-2025 NOVEMBER 2024 TOTALS



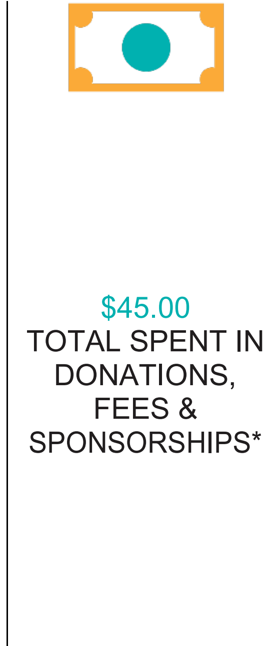
0	COMMUNITY EVENTS
3	MEMBER EDUCATION EVENTS
120	MEMBER ORIENTATIONS
0	MEETINGS/ PRESENTATIONS
0	COMMUNITY TRAINING
10	TOTAL INITIATED/ INVITED EVENTS
123	TOTAL COMPLETED **EVENTS**

16 CITIES**

Alameda
Albany
Berkeley
Castro Valley
Dublin
Fremont
Hayward
Livermore
Newark
North Chesterfield
Oakland
Pleasanton
San Francisco
San Leandro
San Lorenzo
Union City



0	TOTAL REACHED AT COMMUNITY EVENTS
143	TOTAL REACHED AT MEMBER EDUCATION EVENTS
120	TOTAL REACHED AT MEMBER ORIENTATIONS
0	TOTAL REACHED AT MEETINGS/PRESENTATIONS
0	COMMUNITY TRAINING
191	MEMBERS REACHED AT ALL EVENTS
263	**TOTAL REACHED AT ALL EVENTS**



$45.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

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

COMMUNICATIONS & OUTREACH DEPARTMENT

SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | **November 2024**

The Alliance Communications and Outreach (C&O) Department created the social media and website activity (SM&WA) Report to provide a high-level overview of stakeholder engagement through various digital media platforms. Between **November 1, 2024**, and **November 30, 2024**:

1. Alliance Website:
    - Received **23,000** unique visits
    - Received **19,000** new user visits
    - The top **10** website page visits were:
        i. Homepage
        ii. Provider Page
        iii. Find a Doctor
        iv. Medi-Cal Benefits and Services
        v. Members Medi-Cal
        vi. Check-in for Checkups
        vii. Contact Us
        viii. Careers
        ix. Members
        x. Get a New ID Card
2. Facebook Page:
    - Maintained Fans at **633**
    - Did not receive any reviews in **November 2024**
3. Glassdoor Page:
    - **3** out of a **5-star** overall rating
    - Received one (1) review in **November 2024**
4. Instagram Page:
    - Page debuted **June 10, 2021**
    - Increased in followers from **584** to **593**
5. X (previously Twitter) Page:
    - Maintained followers at **366**
6. LinkedIn Page:
    - Increased followers from **5.9k to 6k**
    - Received **176-**page clicks
7. Yelp Page:
    - Page visits **53**
    - Appeared in Yelp searches **93** times
    - Received one (1) review in **November 2024**
8. Google Page:
    - **2,205** website clicks made from the business profile
    - **1,301** calls made from the business profile
    - Received one (1) review in **November 2024**

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | **November 2024**

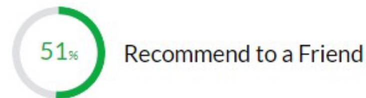
GLASSDOOR OVERVIEW

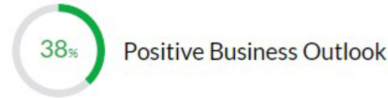
Alameda Alliance for Health Ratings and Trends

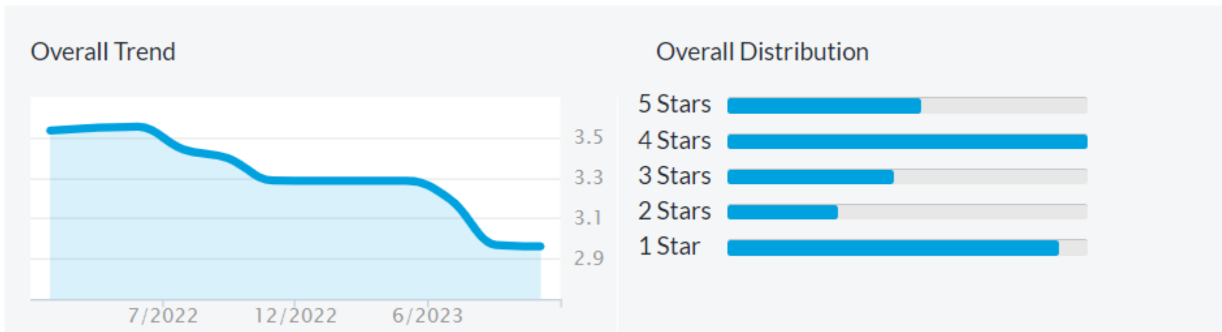
About Glassdoor ratings

Ratings may vary depending on what filters are applied, but ratings include reviews in all languages. Learn More

Category	Rating
Overall	3
Culture & Values	2.9
Diversity & Inclusion	3.5
Work/Life Balance	3.1
Senior Management	2.5
Compensation and Benefits	3.8
Career Opportunities	2.8





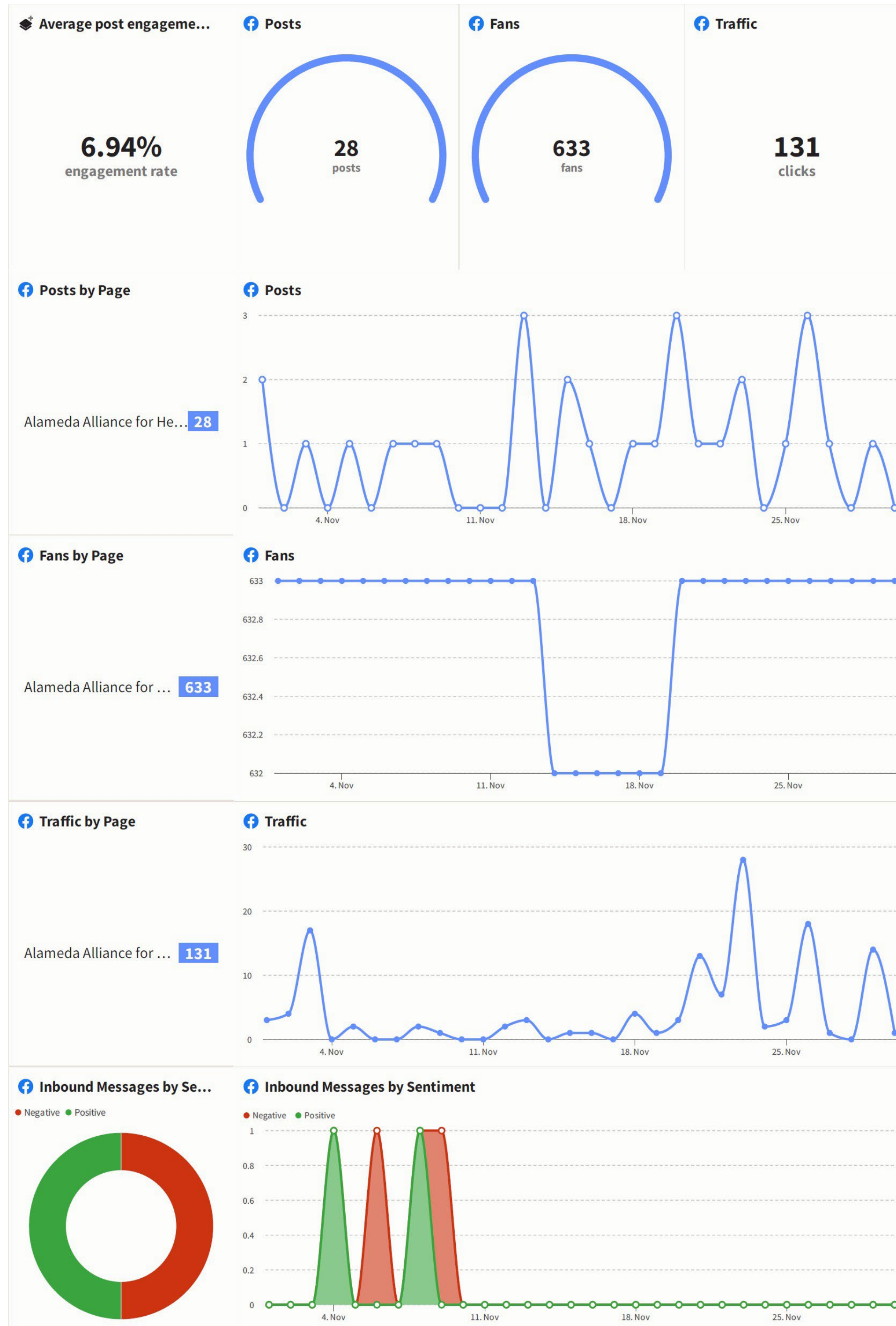


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\2. November 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | November 2024

FACEBOOK OVERVIEW

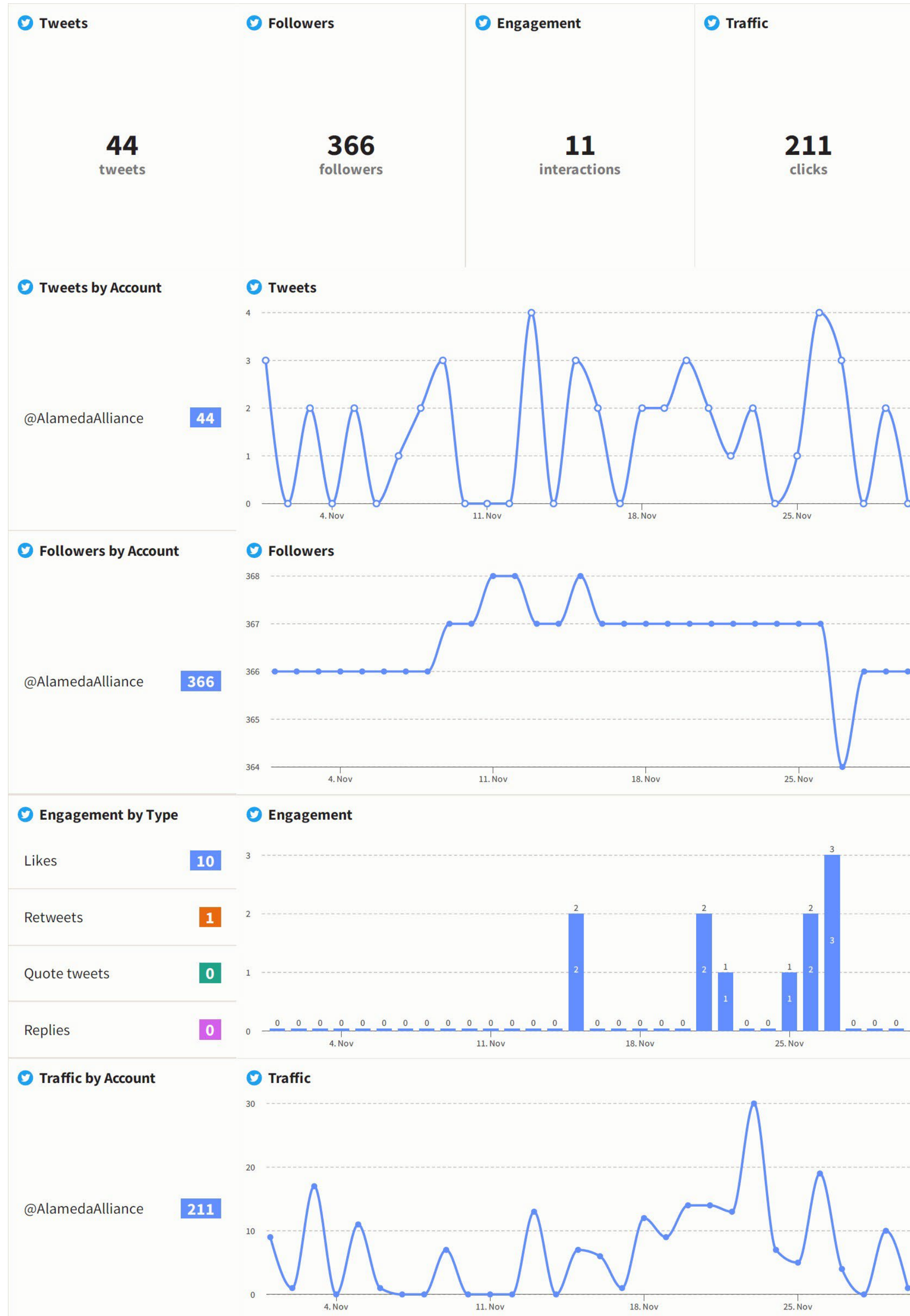


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\2. November 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | **November 2024**

X (previously TWITTER) OVERVIEW

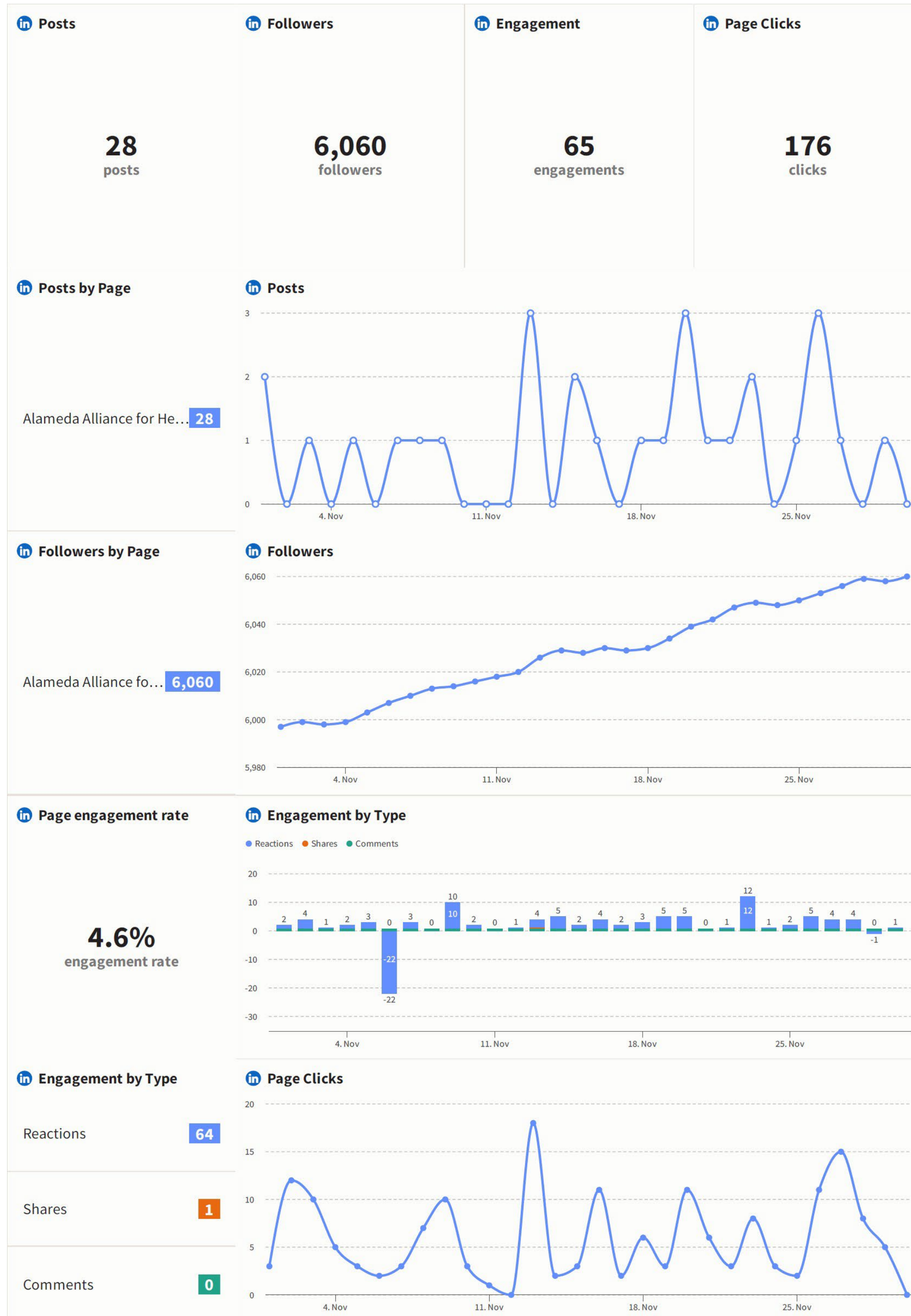


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\2. November 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | **November 2024**

LINKEDIN OVERVIEW

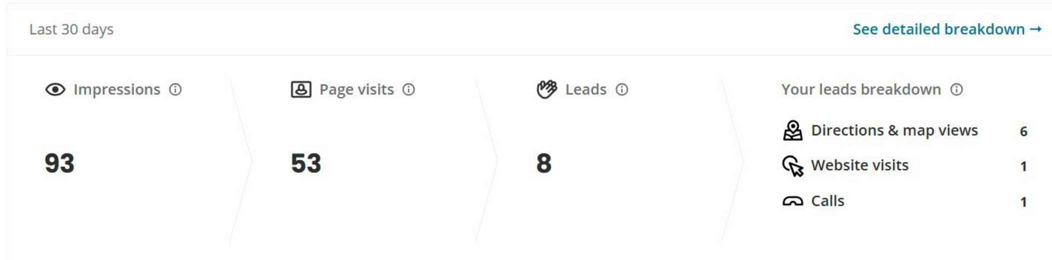


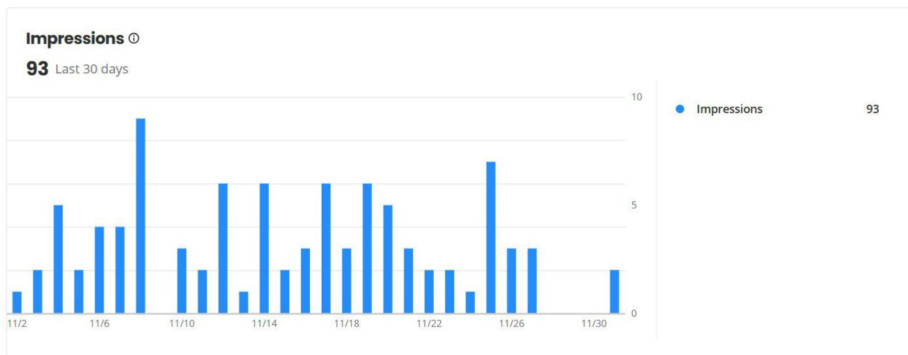
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\2. November 2024

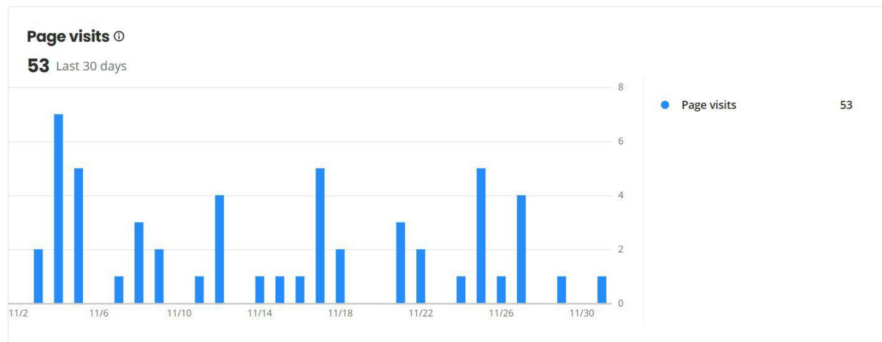
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

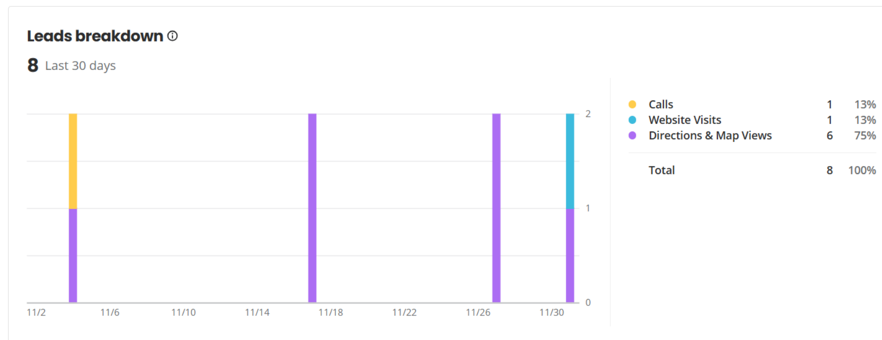
FY 2024-2025 | November 2024

YELP OVERVIEW







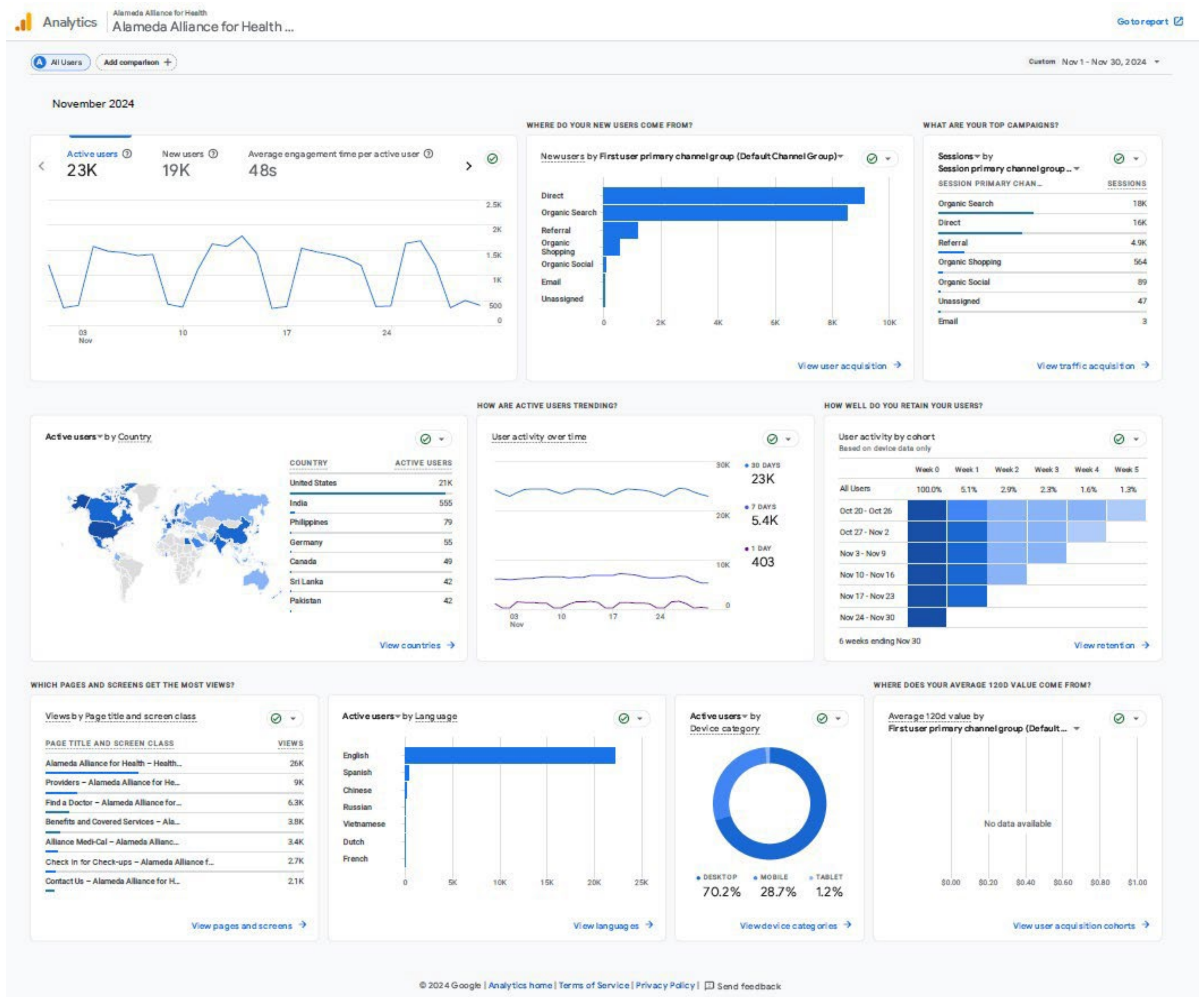


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\2. November 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | November 2024

ALLIANCE WEBSITE OVERVIEW:

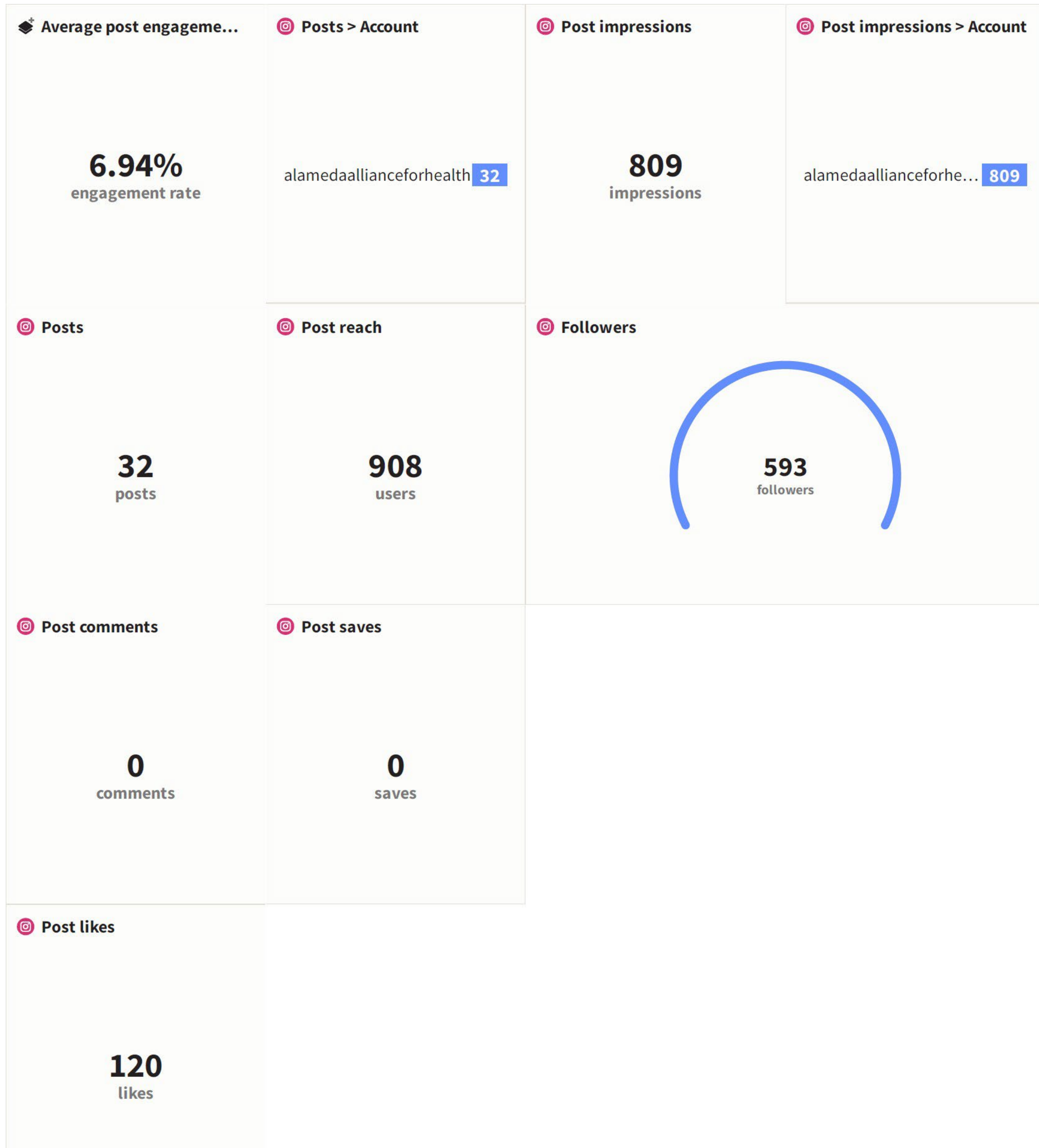


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\2. November 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | **November 2024**

Instagram OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\2. November 2024

Google OVERVIEW:

All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\2. November 2024

Compliance

Richard Golfin III

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

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

Date: **December 13th, 2024**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2025 Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) Routine Full Medical Survey (Joint Audit)
  - On October 3rd, 2024, the Plan received notification from DMHC stating it will conduct a joint routine survey with the Department of Health Care Services (DHCS) beginning March 3rd, 2025. The lookback period is from October 1st, 2022, through September 30th, 2024. The audit will include oversight of previously terminated delegates no longer included in our network, as well as active downstream entities. The Plan expects to receive a full set of DHCS pre-audit requests by December 20th, 2024.
- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey
  - DHCS conducted its 2024 Routine Full Medical Survey from June 17th, 2024 - June 28th, 2024. The DHCS held its Exit Conference with the Plan on October 16th, 2024. The DHCS issued the Preliminary Report on October 11th, 2024. The Plan submitted its response to DHCS on October 31st, 2024. DHCS issued the final report on November 18th, 2024, citing twenty (20) final findings. The Plan's CAP response is due to the DHCS on December 21st, 2024.
- 2023 Department of Health Care Services (DHCS) Focused Medical Survey
  - On September 4th, 2024, the DHCS issued the Medical Survey Audit Report and CAP Request for the 2023 DHCS Focused Medical Survey. The DHCS identified findings related to Behavioral Health Services and Transportation Services. On October 4th, 2024, the Plan submitted CAP responses to DHCS and has committed to monthly updates since October.

- 2024 Department of Health Care Services (DHCS) Facility Site Review (FSR) and Medical Record Review (MRR)
    - On September 17th, 2024, DHCS conducted its random full-scope FSR and MRR Review consistent with APL 22-017. As a part of the review, the DHCS selected ten (10) PCPs from the Plan's provider network. The Final Report required a CAP from all ten (10) providers. The Plan submitted its CAP response to DHCS on November 21st, 2024. The Plan's FSR Team is working with the PCPs to assist with CAP implementation and validation. The PCP's CAPs are due to DHCS' Site Review Unit by December 6th, 2024.

Compliance Activity Updates

- Centers for Medicare & Medicaid Services (CMS) Notice of Intent to Apply (NOIA)
    - On November 8th, 2024, the Plan submitted to NOIA that informed CMS of its intent to participate in Medicare Advantage by establishing an Exclusively Aligned Enrollment Dual-Eligible Special Needs Plan (EAE D-SNP) product for Calendar Year 2026. In response, the CMS assigned the Plan a unique identifier also known as an H-Contract. This enabled Plan staff to access CMS' Health Plan Management System (HPMS). HPMS is a web enabled information system that facilitates data collection and reporting and provides ongoing operational support for Medicare Advantage and Part D programs.
- Department of Managed Health Care (DMHC) Medicare Filings – CY26 Medicare, 2024 EAE D-SNP Material Modification Filing (E-Filing *No. 20244060*):
    - The Plan received comments from the DMHC on November 21st, 2024. The comments are due to DMHC by December 21st, 2024. Compliance is working with internal SMEs to provide adequate responses by December 6th, 2024. The Plan expects DMHC to close by mid-January 2025.
- 2024 Corporate Compliance Annual Training
    - The Plan launched its Annual Corporate Compliance Trainings on Monday, September 9th, 2024. The training courses cover HIPAA, FWA, and Cultural Sensitivity. Staff must complete assigned courses by December 9th, 2024. More than ninety percent (90%) of staff have completed their assigned training.

- 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 (TL) that it applies to medical/ surgical (Med/Surg) benefits in the same classification.	The Plan received five comments on November 27th. Internal SMEs have met to develop a strategy for addressing the DMHC comments and anticipates submitting its responses by December 15th. The team still expects that DMHC will be able to close this filing by the end of 2024.

Compliance

Supporting Documents

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	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-001 to provide guidance to plans on the Amendment to section 1300.71.31 of title 28 of the California Code of Regulations (Rule 1300.71.31).
3	DMHC	24-002	1/22/2024	Large Group Renewal Notice Requirements	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-002 to provide guidance to plans on the timing and content requirements for renewal notices to large group contract holders under HSC section 1374.21 and HSC section 1385.046.
4	DMHC	24-003	1/29/2024	Plan Year 2025 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-003 to assist in the preparation of Plan Year 2025 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules).
5	DHCS	24-002	2/8/2024	Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members	MEDI-CAL	The purpose of this All Plan Letter (APL) is to summarize and clarify existing federal and state protections and alternative health coverage options for American Indian Members enrolled in Medi-Cal managed care plans (MCPs). Additionally, this APL consolidates various MCP requirements pertaining to protections for Indian Health Care Providers (IHCPs), including requirements related to contracting with IHCPs and reimbursing claims from IHCPs in a timely and expeditious manner. This APL also provides guidance regarding MCP tribal liaison requirements and expectations in relation to their role and responsibilities.
6	DMHC	24-004	2/22/2024	Coverage of Over-the Counter FDA Approved Contraceptives	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-004 to remind health plans, effective January 1, 2024, the rules changed regarding health plan coverage of over-the-counter (OTC) contraceptive drugs, devices, and products approved by the federal Food and Drug Administration (FDA).
7	DMHC	24-005	3/11/2024	Change Healthcare Cyberattack	GROUP CARE & MEDI-CAL	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	GROUP CARE & MEDI-CAL	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	GROUP CARE & MEDI-CAL	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	GROUP CARE & MEDI-CAL	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	GROUP CARE & MEDI-CAL	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	GROUP CARE & MEDI-CAL	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	GROUP CARE & MEDI-CAL	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	GROUP CARE & MEDI-CAL	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	GROUP CARE & MEDI-CAL	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.
35	DMHC	24-019	10/30/2024	Amendments to Rule 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2025	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to inform health care service plans (health plans) of new amendments to 28 CCR § 1300.67.2.2 and the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for the reporting year (RY) 2025 Annual Network Report submission.
36	DHCS	18-022	10/31/2024	Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services (TECHNICAL CHANGE)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify the requirements for Medi-Cal managed care health plans (MCPs) regarding their responsibilities to provide members with access to freestanding birth centers (FBCs) as well as to services provided by Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs).
37	DHCS	23-024	11/3/2024	Doula Services (TECHNICAL CHANGE)	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 providing doula services, effective for dates of service on or after January 1, 2023.
38	DMHC	24-020	11/13/2024	RY 2026/MY 2025 Provider Availability Survey Manual and Report Form Amendments	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide notice to health care service plans (health plans) of amendments to Rule 1300.67.2.2 and the following reporting year (RY) 2026/measurement year (MY) 2025 Timely Access Compliance Report documents: Provider Appointment Availability Survey (PAAS) Manual, PAAS Report Forms and the Timely Access Submission Instruction Manual (TA Instruction Manual).
39	DHCS	24-016	12/5/2024	Diversity, Equity, and Inclusion Training Program Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the Diversity, Equity, and Inclusion (DEI) training program requirements.
40	DHCS	24-017	12/5/2024	Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the transgender, gender diverse, intersex (TGI) cultural competency training program and Provider Directory changes required by Senate Bill (SB) 923 (Chapter 822, Statutes of 2022) for the purpose of providing trans-inclusive health care to MCP Members.

COMPLIANCE DASHBOARD SUMMARY

	Resource	Type	2018	2019	2020	2021	2022	2023	2024	TOTAL	% Completed
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	27	27	148	
		Total Self-Identified Issues	12	0	0	2	0	5	7	26	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**32**	**23**	**190**	
		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**	**221**	

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

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

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

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

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

	Total Findings	2	

2022 DMHC RBO Audit: Delegate

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

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

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

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

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

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

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

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

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
Yellow = Plan Observations (Included in the final report)
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R = Repeat Findings

2024 DHCS Audit - *Audit Review Period 6/1/2023 - 5/31/2024*
Audit Onsite Dates - June 17, 2024 - June 28, 2024

#	Category	Deficiency	Department Responsible
1	UM	(1.2.1) Referral to Transplant Program Within 72 Hours The Plan did not directly refer an adult member to a transplant program for evaluation within 72 hours of the member's specialist identifying the member as a potential candidate for MOT.	UM
2	UM	(1.2.2) Centers of Excellence (COE) for Major Organ Transplants The Plan did not ensure that all MOT procedures were performed in a Medi-Cal approved COE transplant program. The Plan did not confirm that its COEs were unable to perform a MOT surgery before arranging the MOT at a transplant program that is not a Medi-Cal approved COE.	UM
3	UM	(1.3.1) Written Member Consent The Plan did not obtain members' written consent when providers requested appeals on behalf of members.	G&A
4	UM	(1.3.2) Appeals Letters: Nondiscrimination Notice (NDN) and Language Assistance Taglines (LAT) The Plan did not send NDN and LAT information that met the minimum requirements in APL 21-004 with member notifications for appeals.	G&A
5	UM	(1.5.1) Overutilization of Subacute Level of Facility Care The Plan did not ensure that its delegate, Community Health Center Network (CHCN), had mechanisms to detect overutilization of subacute level of facility care; the delegate inappropriately approved higher levels of subacute care for members who required lower levels of regular skilled nursing facility care.	UM
6	UM	(1.5.2) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services The Plan did not ensure that its delegate, CHCN, provided medically necessary EPSDT services, care coordination, and appointment scheduling assistance to members under the age of 21.	Behavioral Health

ALAMEDA ALLIANCE FOR HEALTH
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2024 DHCS Audit - *Audit Review Period 6/1/2023 - 5/31/2024*
Audit Onsite Dates - June 17, 2024 - June 28, 2024

#	Category	Deficiency	Department Responsible
7	CM and CoC	(2.1.1) Provision of Blood Lead Screening The Plan did not ensure that blood lead screening tests were conducted for members up to six years of age.	QI
8	CM and CoC	(2.3.2) Timely Access to Behavioral Health Therapy (BHT) Services The Plan did not arrange and coordinate BHT services for members under the age of 21 within 60 calendar days.	Behavioral Health
9	CM and CoC	(2.3.1) Provision of Behavioral Health Therapy (BHT) Services The Plan did not ensure the provision of BHT services in accordance with approved BHT treatment plans for members under the age of 21.	Behavioral Health
10	CM and CoC	(2.4.1) Notice of Action (NOA) Letters for Continuity of Care (COC) Requests The Plan did not ensure that NOAs for COC requests that were sent to members contained a clear explanation of the reason for the denial decision.	UM
11	Access and Availability	(3.1.1) Appointment Waitlist Timeliness The Plan did not ensure members were able to obtain medically necessary appointments within established timely access standards. One of the Plan's medical groups placed members on an appointment waitlist and had members waiting up to six months to make an appointment.	QI
12	Access and Availability	(3.1.2) Monitoring In-Office Wait Times for Specialty and Behavioral Health Services The Plan did not monitor in-office wait time for specialists and behavioral health providers.	QI
13	Access and Availability	(3.1.3) Monitoring Telephone Calls for Specialty and Behavioral Health Services The Plan did not monitor wait times for specialty and behavioral health providers to answer and return telephone calls.	Behavioral Health

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2024 DHCS Audit ***- Audit Review Period 6/1/2023 - 5/31/2024***
Audit Onsite Dates - June 17, 2024 - June 28, 2024

#	Category	Deficiency	Department Responsible
14	Member Rights	(4.1.1) Grievances Involving Clinical Issues The Plan did not ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues.	G&A
15	Member Rights	(4.1.2) Resolution of Grievances The Plan did not completely resolve the members' grievances.	G&A
16	Member Rights	(4.1.3) Clear and Concise Resolution Letters The Plan's written resolution did not contain a clear and concise explanation of the Plan's decision.	G&A
17	Member Rights	(4.1.4) Grievance Letters: Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT) The Plan did not include updated NDN and LAT information with grievance acknowledgement and resolution letters.	G&A
18	Member Rights	(4.2.1) Monitoring of Linguistic Performance The Plan did not assess the performance of its vendors' staff that provided linguistic services such as interpreter services.	Cultural and Linguistic Services
19	Member Rights	(4.3.1) Notification to DHCS The Plan did not notify DHCS within 24 hours upon discovery of any suspected breach or security incident, unauthorized access, use or disclosure of PHI or PI.	Compliance
20	Quality Management	(5.3.1) Notification of Provider Terminations The Plan did not meet DHCS reporting and member notification requirements for provider terminations.	Operations

ALAMEDA ALLIANCE FOR HEALTH
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2024 DHCS Audit - *Audit Review Period* 6/1/2023 - 5/31/2024 *Audit Onsite Dates - June 17, 2024 - June 28, 2024*			
#	**Category**	**Deficiency**	**Department Responsible**
21	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
22	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
23	CM and CoC	(2.1) California Children's Services (CCS) The Plan did not monitor CCS referral program pathways to identify members who may be eligible for CCS	Case Management
24	CM and CoC	(2.1) Initial Health Assessment (IHA) The Plan did not ensure reasonable member outreach attempts for the IHA document	QI
25	CM and CoC	(2.1) Initial Health Assessment (IHA) The Plan did not ensure the provision of Initial Health Assessments for members	QI
26	CM and CoC	(2.1) Member Outreach Attempts for Initial Health Assessment (IHA) The Plan did not ensure that reasonable member outreach attempts for IHAs were conducted and documented for newly enrolled members.	QI
27	CM and CoC	(2.3) Behavioral Health Therapy (BHT) The Plan did not ensure care coordination for members needing BHT services	Behavioral Health

ALAMEDA ALLIANCE FOR HEALTH
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2023 DMHC Follow-Up Review : *Audit Review Period 11/1/2022 - 05/31/2023* Audit Onsite Dates - 10/23/2023 - 10/27/2023			
#	**Category**	**Deficiency**	**Department Responsible**
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.	G&A
2	Grievances & Appeals	The Plan does not correctly display the statement required by Section 1368.02(b) in all required enrollee communications.	G&A Member Services UM Rx
3	Prescription (Rx) Drug Coverage	The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.	Rx

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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
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.
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.
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.

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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**
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.
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.
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.

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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**
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.
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.
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.

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**
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
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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
COMPLIANCE DASHBOARD

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

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

ALAMEDA ALLIANCE FOR HEALTH
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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
4	QI	(2.1.1) The Plan did not document attempts to contact members and schedule the IHA.	1. The plan will continue to inform members of the IHA through the EOC, welcome letters to all new members, and videos. - In addition, all members are eligible for a new member orientation (including a financial incentive). - Information regarding the IHA will be included in the member newsletter. The Alliance will initiate a new phone campaign where all new members will receive a phone call encouraging the member to receive an IHA. This phone log will be appropriately documented. The Alliance will create a call script for new member phone calls. 2. The plan will create a report to identify new plan membersUpdate 5/12/2023: Fulfillment Report created to track mailing of member Orientation reports that contain reminder to schedule IHA to new members. Member Orientation Service Request tracking report tracks outreach attempts to members to complete new member orientation, which includes communication about scheduling IHAs 3. The plan will create workflows for informing members of the IHA.Update 5/12/2023: Clinical QI Program Coordinator will review IVR reports to determine all new members have received an outreach call. 4. The plan will update the IHA P&P to reflect the updated workflowsUpdate 3/10/2023: Draft policy QI-124 completed, IVR outreach is pending DHCS approval of script. Upon DHCS approval we will continue to develop the process for IVR outreach and develop desktop procedures. Update 4/15/2023: The updated P&P was approved at Compliance Committee 3/21/2023 5. The plan will create a phone call campaign, create a script, and work with the state for approvalUpdate 3/10/2023: Awaiting DHCS approval of script. Update 6/9/2023: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreach attempts via providers, by reviewing documentation as part of FSRs.	9/8/2023	Completed	QI		State	DHCS	2022
5	CM	**R** (2.5.1) The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.	1. The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with the MHP to review redline changes to the MOU. The MHP is currently under review of the redline changes and will notify the Alliance when they can move forward 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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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
7	Claims	(3.6.1) The Plan improperly denied emergency services claims.	1. Case #7 – The claim was paid on 8/11/2021. The vendor was notified of the finding on 5/19/2022 and asked to review their internal process to ensure that codes on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. 2. Case #20 –The vender was notified of the issue on 5/19/2022 and asked to review their internal process to ensure that dates on clams are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. In addition, an edit was enhanced to ensure that the date range order is correct. 3. The claim was paid on 1/5/2022 correctly. The Claims Processor was shown the claim finding for review along with the correct workflow document that shows the correct process to help ensure moving forward this does not occur again. This workflow was also reviewed by the Claim Processor team and training occurred.	10/11/2022	Completed	Claims		State	DHCS	2022
8	Access and Availability	**R** (3.8.1) The Plan did not use PCS forms for NEMT services.	1. The Plan will educate providers on PCS requirements. Update 3/10/2023: Provider Alert PCS Form Reminder and Form was sent out to Providers in a fax blast on Tuesday, 12/27/22. 2. Refine PCS workflows to meet all regulatory requirements. Update 3/10/2023: Workflow updated. 3. The Plan will conduct staff trainings on process workflow changes.Update 4/15/2023: Training completed 1/31/2023. 4. The Plan will ensure that the transportation subcontractor trains their staff on the PCS process workflow changes. The transportation subcontractor will provide training materials and sign in sheets.Update 4/15/2023: Training completed 1/31/2023. 5. The Plan will develop reports on PCS form outcomes using both transportation subcontractor information and the Plan's process to obtain PCS forms.Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 6. The Plan will monitor process workflows from the transportation subcontractor and the Plan to obtain missing PCS forms Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 7. The Plan will analyze trends in provider practices and provide feedback to providers regarding PCS form requirements. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022, where trends analyzed. 8. The plan will evaluate whether to continue having the transportation subcontractor manage the PCS forms or take the direct management of PCS forms back into the Plan.Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. Will continue to analyze quarterly. 9. The Plan will provide a quarterly report to UM 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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#	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 **<u>12/30/2022</u>**: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.**<u>12/30/2022:</u>**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.**<u>12/30/2022:T</u>**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. **<u>12/30/2022:</u>** 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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#	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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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
9	Case Management	(2.1.2) The Plan did not ensure coordination of care in certain cases where EPSDT services were medically necessary.	1.The Plan will develop training on EPSDT PA requests to identify and refer members who need coordination of their care. Update 11/12/2021: Training developed 2.The Plan will provide training to UM and CM staff. Update 11/12/2021: Training completed for UM and CM staff 3.The Plan will create a reporting system to capture referrals to CM and the provision of care coordination. Update 11/12/2021: Reporting system to capture referrals has been created, change in reporting will be reflected mid-December 4.The Plan will report outcomes at UMC on a quarterly basis. Update 5/13/2022: Outcomes reported at January and March 2022 UMC Meetings.	Medium	5/13/2022	Completed	Case Management		State	DHCS	2021
10	Case Management	(2.2.1) The Plan did not ensure the completion of Individualized Care Plans for members enrolled in Complex Case Management.	1. The Plan revised its CCM ICP workflow and added the requirement that all staff complete ICPs for all members in CCM. 2. The Plan re-trained staff to complete ICPs for all members in CCM. 3. The Plan will revise its CM Aging Report to capture completion of ICPs for daily management and reporting outcomes. Update 10/8/2021: Aging report has been updated to capture completion of ICPs 4. The Plan will develop a monitoring workflow. Update 10/8/2021: The monitoring workflow has been completed 5. The Plan will routinely monitor completion of the ICPs. Update 10/8/2021: The log has been created and is being monitored weekly 6. The Plan will report outcomes at UMC quarterly. Update 09/09/2022: Monitoring of the ICPs is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
11	Case Management	(2.2.2) The Plan did not ensure development of care plans in collaboration with the PCP.	1. The Plan re-trained staff on policy regarding developing care plans in collaboration with PCP. 2. The Plan will revise its CM Aging Report to capture the date the letter regarding Care Plans was sent to the PCP.10/8/2021: The CM Aging Report has been updated to capture the date the letter regarding Care Plans was sent to the PCP 3. The Plan will monitor, on an ongoing basis, the CM Aging Report to ensure CP letters are being sent to PCPs. Update 10/8/2021: Monitoring has begun, automation of this report is in progress 4. The Plan will report outcomes to UMC quarterly. Update 09/09/2022: Monitoring of the development of care plans with the PCP is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
12	Case Management	(2.2.3) The Plan did not conduct periodic evaluations to ensure the provision of complex case management based on the member's medical needs. The Plan did not implement procedures for monitoring time frame standards or maintaining monthly contact with members.	1. The Plan developed a workflow to maintain regular contact with members and ensure that the continuation of CCM is based on medical needs by using the Complex Criteria Checklist. 2. The Plan conducted staff training. 3. The Plan will revise its CM Aging Report to capture provision of CCM and maintaining monthly contact with member. 10/8/2021: The CM Aging Report has been revised to capture the provision of CCM and maintaining monthly contact with member 4. The Plan will monitor, on an ongoing basis, the CM Aging Report. 10/8/2021: Monitoring has begun, automation of this report is in progress 5. The Plan will report outcomes quarterly to UMC. Update 09/09/2022: Monitoring of the CM Aging Report is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021

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R = Repeat Findings

2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
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13	Case Management	(2.2.4) The Plan did not ensure that interdisciplinary team assessments were included in the updating of members' care plans. The Plan did not ensure timely documentation of the interdisciplinary team meeting notes.	1. The Plan created an additional column in the Complex Case Log to monitor timely entry of IDT Round note into system of record. 2. The Plan will develop a workflow for staff to include the IDT note in the updated care plans. Update 10/8/2021: The workflow has been updated to include the IDT note in the updated care plans. 3. The Plan will develop a monitoring workflow. Monitoring will be done on a bi-weekly basis. Update 9/9/2022: Monitoring is now being completed on a bi-weekly basis 4. The Plan conducted a staff training on the process. 5. The Plan will use Complex Case Log to monitor adherence to procedure. Update 11/12/2021: The Plan is now using the Complex Case Log to monitor adherence 6. The Plan will report outcomes quarterly to UMC. Update 09/09/2022: Monitoring of the IDT assessments is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	UM		State	DHCS	2021
14	Case Management	(2.5.1) The Plan's MOU with the County MHP did not meet all the requirements specified in APL 18-015.	1. The Plan will conduct annual meetings with the County to ensure that the MOU is being updated (when appropriate). Update 1/14/2022: Due to staffing availability, the meeting with the County to review the MOU was not able to take place in December, and will be scheduled for early 2022. Update 2/11/2022: The first meeting with the county took place on 1/31/2022. 1.a. The Plan will develop meeting minutes to demonstrate topic of discussions. The Plan will submit meeting minutes to DHCS. Update 2/11/2022: Meeting minutes completed for first meeting on 1/31/2022. 2. The Plan's internal departments will work together to ensure clinical and quality components that are not present be updated in the MOU to reflect the requirements in APL-018. Update 2/11/2022: MOU has been updated to ensure clinical and quality components reflected.	Low	1/31/2022	Completed	Case Management Provider Network		State	DHCS	2021
15	Case Management	(2.5.2) The Plan's MOU with the County MHP did not specify policies, procedures, and reports to address quality improvements requirements specified in APL 18-015. The Plan did not conduct semi-annual calendar year reviews of referral and care coordination processes, generate semi-annual reports, or develop performance measures and quality improvement initiatives during the audit period.	1. The Plan will establish a cross-functional workgroup to develop specific P&Ps and QI performance metrics, in addition to referral and care coordination reports. Update 12/10/2021: The cross-functional workgroup was established and held it's first meeting on 10/20/2021. County JOMs will begin January 2022.	High	12/10/2021	Completed	Case Management Provider Network		State	DHCS	2021
16	Access	(3.1.1) The Plan did not enforce and monitor providers' compliance with the requirement to document when timeframes for appointments were extended.	1. The Plan revised P&P QI-107 to include appointment extension language and will be submitted to committee for approval. Update 11/12/2021: The P&P has been revised and is awaiting approval at committee on 11/23/2021. Update 12/10/2021: The policy was approved at Compliance Committee on 11/23/2021. 2. The Plan revised Timely Access Standards Provider Communication Sheet and will be submitted to committee for approval. Update 11/12/2021: The Timely Access Standards Provider Communication Sheet has been revised and is awaiting approval at committee on 11/18/2021. Update 12/10/2021: The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021.	Low	11/23/2021	Completed	QI		State	DHCS	2021
17	Access	(3.1.2) The Plan did not continuously review, evaluate and improve access to and availability of the first prenatal appointment.	1.The Plan revised P&P QI-107 to indicate current Access Standards for First Prenatal Appointment from 2 weeks from date of request to 10 days for PCP OB/GYN and 15 days from request for OB/GYN Specialty Care. P&P will be submitted to committee for approval. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: QI-107 was approved at the Compliance Committee on 11/23/2021. 2.The Plan revised Timely Access Standards Provider Communications Sheet. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021. 3.The Plan will be implementing a tracking and trending report of First Prenatal PQIs. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: The Tracking and Trending report of First Prenatal PQIs has been implemented	Medium	11/23/2021	Completed	QI		State	DHCS	2021

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

2020 DHCS STATE AUDIT FINDINGS - *Audit Review Period: 10/01/2018 - 9/30/2020*								INTERNAL AUDITS			
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
1	Claims	The Plan denied payment to a contracted hospital for continued treatment of Plan members with chronic medical conditions. The Plan did not provide for all medically necessary covered services for members	1. The Plan and the hospital renegotiated its hospital agreement with an effective date of February 1, 2021. The Alliance and the hospital agreed to a step down approach where The Alliance will authorize care at the appropriate level and work in conjunction with the hospital toward an appropriate discharge. The rate paid by Plan will be equal to the medical surgical rate. Please see Section 3.6 Utilization Management of The Alliance and hospital Contract Amendment. 2. The Plan and the hospital have a meeting set up for 4/6/2021 at 3:30 PM. The goal of this meeting is to finalize the cases in arbitration and any other outstanding claims. Update 5/14/21 The legal team is continuing to review which claims to pay. Update 6/11/21 The Alliance is working with the provider on evaluating and assessing the claims from the audit. Senior level discussions are in process between the hospital and the Alliance. Update 10/8/2021 The Plan paid the hospital for all claims in Arbitration on the 7/22/2021 check run. The hospital had some additional claims they wanted reviewed and we met on 7/27/2021 to review them. The Plan agreed to pay these claims, as well, and they were paid out on the 8/25/2021 and 9/1/2021 check runs. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	9/1/2021	Completed	UM / Claims		State	DHCS	2020	Completed
2	UM	The Plan did not apply written criteria for each concurrent review of continued long term acute care (LTAC) services throughout members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021: Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
3	UM	The Plan did not document that qualified physicians reviewed all denials of continued long term acute care (LTAC) services throughout members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021: Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The results of the next quarterly audit will be reported at the December UM Committee. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress

ALAMEDA ALLIANCE FOR HEALTH
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4	UM	The Plan did not notify members and the hospital of continued denial of long term acute care (LTAC) services through NOA letters and "Your Rights" attachments for each concurrent review throughout the members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021 Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
5	UM	The Plan provided unclear information about the Plan's decision for denial of long term acute care (LTAC) services in the only NOA letters that were issued to members and the Hospital. Letters contained inaccurate information about denied dates and requesting providers.	1. The automated section of the NOA letter generated by the Plan's system of record, TruCare, was incorrectly configured and displayed inaccurate information about the requesting LTAC provider and the dates of denial. The Plan's system of record, TruCare, was re-configured to display the correct dates and correct requesting provider in the automated portion of the NOA letters. 2. The Plan's In-Patient Utilization Management Leadership will continue to audit the NOA letters to ensure that they contain accurate information and meet the regulatory requirements. Update 5/15/2021: Identified deficiencies have been added to the audit tool and audits of inpatient NOA letters are currently taking place. 3. The Plan will report the results of NOA letter audit at Utilization Management Committee on a quarterly basis, starting Q3 2021. Update 7/9/2021: Manual tracking continues, report will be provided starting in Q3 2021 Update 10/8/2021: Manual tracking continues, awaiting completion of automated report. First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress

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

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

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

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

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

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2019 DHCS AUDIT FINDINGS - *Audit Review Period: 6/1/2018-5/31/2019*							INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Repeat Finding (Yes/No)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**	
1	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required PA for an initial visit with a mental health provider to determine if the member had mild-to-moderate mental health issues, which the contract does not allow.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and agree with the changes for member self-referral process. Discussing with DHCS prior to final CAP submission.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed	
2	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required a two-step prior authorization (PA) process for BHT services, which is allowed, but did not send written notification when it denied services at the first step. The delegate did not consistently apply criteria for approving BHT.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and still have open items not documented. Plan will be meeting with the delegate to discuss criteria and procedures for further documentation needed. Update as of 2/7/2020: Met with the delegate to review their criteria and approval process. Requested policy language changes to meet the regulatory requirements. Policy was approved by Committee on 1/27/20. Updated CAP response submitted to DHCS on 2/7/2020.	No	2/7/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed	
3	UM Delegation	(1.1.3) The Plan did not review ownership and control disclosure information for their Utilization Management (UM) delegates	The Plan will ensure that its delegated providers complete the Ownership and Control disclosure forms. The Plan will create a tracking log and document any follow up attempts made with the delegate to ensure accuracy. Update as of 12/2/2019: PR has created a tracking log and is working on a desktop procedure.	Yes	1/1/2020	Completed	Provider Services	✓	State	DHCS	2019	Completed	
4	UM Delegation	The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan will conduct staff retraining of delegation reporting procedures to ensure all are tracked and monitored for receipt and review. Update as of 12/5/2019: Staff training was conducted on 12/3/2019.	Yes	12/1/2019	Completed	Compliance	✓	State	DHCS	2019	Completed	
5	UM Delegation	The Plan's oversight of its delegate did not identify unclear NOA letters, and incorrect appeal and SFH information	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has developed on a new process regarding NOA letters, appeal rights and SFH Information. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and agreed with changes of procedure checklist and training materials.	No	1/15/2020	Completed	Utilization Management		State	DHCS	2019	Completed	
6	Referral Tracking process	The Plan did not track all approved PAs; the specialty referral tracking process did not include modified PAs and in-network approved services.	The UM Department is working with analytics to expand the routine referral tracking report to include all approved authorizations. Update as of 12/5/19: Clarity is being sought from DHCS on the scope of specialty referral tracking. Update as of 1/8/20: An updated referral tracking report is being developed to include all decision types and specialty services that require authorization. Update as of 2/7/20. Updated report sample generated and submitted to DHCS. Working with Analytics to create routine report that captures all needed data elements. Update as of 3/5/2020 UM met with Analytics to create the routine report capturing all needed elements. Report is in development. Update as of 5/8/20 Specialty Tracking Report has been created by Analytics, including all required elements, and will now be routinely reported quarterly through UMC and HCQC. Reported at HCQC on 5/21/20. Update as of 6/12/20: Report sent to HCQC on 5/21/20 and reviewed at UMC at 5/29/20.	Yes	5/21/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed	
7	Prior Authorizations	A review of PA data showed non-qualified Plan staff denied retrospective cases for administrative reasons other than non-eligibility for membership. The Plan denied retrospective service requests without review by a medical director if the provider submitted the request more than 30 days after the service delivery date, or if requests did not meet Plan-imposed conditions. The Plan's contract did not specify submission timeframes or other conditions that, if not met, allowed eliminating medical necessity review of retrospective requests for covered services.	Policy and procedure UM-001 Utilization Management will be updated to comply with the contractual requirements. Workflows will be updated to have all retrospective requests reviewed by a medical director. Workflows have been updated to have all retrospective requests reviewed by a medical director. Update as of 12/5/2019: Clarity is being sought from DHCS on allowing a time limit of 30 days. Update as of 1/8/2020: Plan received clarity from DHCS and is updating internal procedures. Update as of 2/7/2020: P&Ps updated to reflect that only an MD can deny retro PA requests. P&Ps approved at HCQC on 1/16/2020.	Yes	1/16/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed	
8	Prior Authorizations	(1.2.2) The Plan did not ensure it used appropriate processes to review and approve medically necessary covered services when it did not ensure that qualified medical personnel rendered medical decisions. Dependent practitioners reviewed, assessed and approved requests for continued hospital stays	The process for ensuring LVNs perform only within their scope of practice was updated and implemented on 10/2/2019. Additional changes to the UM systems to better track the change in process are being developed. Update as of 12/5/2019: Changes to the UM systems to better track the RN oversight role with the LVNs completed. Other Managed Medi-Cal plans have LVNs performing UM. Clarity is being sought from DHCS on the use of LVNs in UM. Policies and procedures and job descriptions are being reviewed to be aligned with the updated oversight process. Update as of 1/8/2020: Plan received clarity from DHCS and updated procedures for RN oversight.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed	
9	Prior Authorizations (UM and Rx)	The Plan's notice of action (NOA) letters did not follow specifications in Health and Safety Code Section 1367.01. Provider letters in medical cases did not include the decision makers' direct phone number or contained the incorrect number. Letters did not explain the reasons for the denial. Pharmacy NOAs were not concise.	Accurate phone numbers for the decision makers are on the NOA, monitoring will be conducted through internal audits. UM NOA template letters were updated and implemented on 11/4/2019, internal auditing will be conducted monthly to ensure that the letters are clear and concise and explain the reasons for denial. Pharmacy NOA template letters were updated and implemented in April 2019, internal auditing will be conducted at least monthly to ensure that the letters are clear and concise and explain the reasons for denial. The pharmacy team also meets with the PBM on a weekly basis to optimize PA review process, NOA letter language and reasons for denial.	Yes	11/4/2019	Completed	Utilization Management /Pharmacy		State	DHCS	2019	Completed	

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#	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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2019 DHCS AUDIT FINDINGS - *Audit Review Period: 6/1/2018-5/31/2019*						INTERNAL AUDITS							
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
23	Quality Program	The QIPD did not list the individuals' qualifications, which was inconsistent with Plan policy.	The 2019 Annual Quality Improvement Program Description (QIPD) was revised to include the leadership positions and their qualifications (Licensure, Education, Work Exp) The program description was presented and approved in the July 18, 2019 Health Care Service oversight committee.	No	7/18/2019	Completed	Quality	✓	State	DHCS	2019	Completed
24	Provider Training	The Plan did not ensure provider training was conducted within 10 working days	During the last review period of June 2017 through May 2018, the Plan acknowledged deficiencies in the NPO process to be corrected by the end of December 2018. Since January 2019, the plan is meeting its goal of conducting training with the 10 day working timeframe 100% of the time.	Yes	1/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
25	Fraud, Waste, and Abuse (FWA)	The Plan did not conduct preliminary investigations of all suspected cases of fraud and abuse.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. Staff training of the revised procedure will be completed by 12/01/2019. Update as of 12/5/2019: Staff training will be conducted on 12/11/2019 to review the updated procedure. Update as of 1/8/2020: Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
26	Fraud, Waste, and Abuse (FWA)	The Plan did not investigate all suspected fraud and abuse incidents promptly. The Plan did not conduct a preliminary or follow-up investigation of 4 of 12 suspected fraud and abuse cases until two to six months after it became aware of the incidents.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. All cases will be resolved and closed within 90 days of receipt. Staff training of the revised procedure will be completed by 12/01/2019. Update as of 12/5/2019: Staff training will be conducted on 12/11/2019 to review the updated procedure. Update as of 1/8/2020: Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
27	Fraud, Waste, and Abuse (FWA)	The Plan's compliance officer did not develop and implement fraud, waste, and abuse policies and procedures	The Plan's designated compliance officer will develop and attest to all new and updated policies and procedures prior to committee review.	No	12/13/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
28	State Supportive Services Claims	The Plan did not forward all misdirected claims within 10 working days.	The post-adjudication script that adds the forwarding action was corrected and deployed.	No	7/11/2019	Completed	IT/ Claims	✓	State	DHCS	2019	Completed

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2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Utilization Management (UM) Program	1.1.1 The Plan did not continuously update and improve its UM program during the audit period.	The Plan's policy and procedure UM-001 includes the annual review process of the UM program. The 2018 UM program was approved by Committee timely this year on 3/20/2018. The Plan will continue to update its UM program annually and track for a timely approval by Committee.	3/31/2018	Completed	Utilization Management	✓	State	DHCS	2018	Completed
2	Prior Authorizations	1.2.1 The Plan did not conduct IRR testing to evaluate the consistency of UM criteria application during the audit period.	The Plan has implemented an IRR testing policy and procedure to ensure clinical staff is evaluated on an annual basis to ensure consistency in decision making and criteria application. - UM/Appeals IRR conducted on 5/25/2018 - Pharmacy IRR conducted on 12/17/2018 Update as of 1/31/2019: IRR testing for Health Care Services (Pharmacy & UM) has been completed as of 1/31/2019.	12/17/2018	Completed	Utilization Management/ Pharmacy	✓	State	DHCS	2018	Completed
3	Prior Authorizations	1.2.2 The Plan did not use appropriate processes to determine medical necessity for PA requests. The Plan's UM staff used outdated criteria and criteria that did not meet the case details.	The Plan has updated its policy and procedure to ensure the Plan's criteria is reviewed at least annually. IRR testing of clinical staff is completed annually to ensure consistency in decision making and criteria application. - UM/Appeals IRR conducted on 5/25/2018 - Pharmacy IRR conducted on 12/17/2018 Update as of 1/31/2019: IRR testing for Health Care Services (Pharmacy & UM) has been completed as of 1/31/2019.	12/17/2018	Completed	Utilization Management	✓	State	DHCS	2018	Completed
4	Prior Authorizations	1.2.3 The Plan denied retrospective service requests for medical services without documentation of a qualified health care professional's review for medical necessity.	The Plan updated its policy and procedure for the retrospective authorization request process to include details of the review process. The P&P and workflow will be reviewed and approved on 1/17/2019. Staff training will then be conducted on 1/22/2019. Update as of 1/31/2019: Updated P&P and workflow retro authorization request processes were approved at HCQC on 1/17/2019. Staff training was conducted on 1/29/2019.	1/22/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
5	Prior Authorizations	1.2.4 The Plan did not respond to pharmacy requests within 24 hours or one business day.	The Plan monitors pharmacy authorization request timeframes by a daily aging report. Staff training of the turnaround timeframe requirements was provided on 10/02/2018. Update as of 1/07/2019: The Plan has determined that timeframe requirements were not consistently met due to a lack of coverage on weekends and holidays. The Plan has updated its Pharmacy Benefit Management contract to include coverage for weekends and holidays as of 12/1/2018. Staff training of the updated procedures will be completed by 1/22/2019. Update as of 1/31/2019: Staff training was completed on 1/23/2019.	1/22/2019	Completed	Pharmacy	✓	State	DHCS	2018	Completed
6	Prior Authorizations	1.2.5 The Plan's NOA letters were not clear and concise, or at sixth grade reading level.	Update as of 3/5/2019: Continuing internal audits revealed issues with how TruCare generates letters, leading to potentially confusing language for members. A team is working on a plan to mitigate the issues. Once the TruCare issues are resolved, staff will be retrained on the mitigation procedures. In the meantime, audits continue to ensure that the language is clear and concise and a process for final review before sending out is being developed. The updated timeline for completion is 4/30/2019. Update as of 4/10/2019: Denial rationale language has been updated. Staff training was completed on 3/29/2019.	4/30/2019	Completed	Utilization Management/ Pharmacy		State	DHCS	2018	Completed
7	Prior Authorizations	1.2.6 The Plan provided incorrect appeal, grievance, and state fair hearing information in translated pharmacy member notifications. The translated "Your Rights" attachments did not follow the required format.	The Plan will update its pharmacy member notifications to ensure the translated versions are in the required format with updated member rights information by 1/25/2019. Update as of 2/4/2019: Updated translated versions of the "Your Rights" attachments have been provided to the Pharmacy Benefits Manager. Update as of 2/19/2019: Updated translated versions of the "Your Rights" attachments have been placed into production by the Pharmacy Benefits Manager.	1/25/2019	Completed	Pharmacy	✓	State	DHCS	2018	Completed
8	Prior Authorizations	1.2.7 The Plan provided conflicting information to providers about podiatry benefits, which required PA; it therefore did not communicate to providers the services that required PA.	The Plan will be updating its Prior Authorization Grid and Provider Training Presentation to include clear communication of the prior authorization process including clarification of the podiatry benefit. Update as of 1/07/2019: The Plan will be updating its prior authorization grid and provider training materials by 1/25/2019. Update as of 1/31/2019: The PA Grid and Provider Training Presentation have been updated. The PA Grid and updated Provider Manual have been posted to the Plan website.	1/25/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
9	Referral Tracking process	1.3.1 The Plan did not track authorized PAs to completion and inform providers of the referral tracking process.	The Plan has updated its referral tracking policy and procedure. Routine reporting has been developed to track authorization PAs to completion. The Plan's provider manual has been updated to include information on the Plan's referral tracking process for providers. Update as of 1/07/2019: The Plan will be uploading the provider manual to the website by 1/25/19. Update as of 1/31/2019: The updated Provider Manual has been posted to the Plan website.	1/25/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
10	Appeal	1.4.1 The Plan did not ensure health care professionals with appropriate clinical expertise in treating the member's condition resolved pharmacy appeals. The Plan allowed the Pharmacy Director to resolve appeals for medication requests instead of requiring a clinical professional with expertise in treating the member's condition.	The Plan updated its appeal procedures to reflect MD review for final decision for pharmacy appeals on 09/26/2018 and conducted staff training on 10/30/2018.	10/30/2018	Completed	Health Care Services	✓	State	DHCS	2018	Completed

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
11	Appeal	1.4.2 The Plan did not translate acknowledgement and resolution appeal letters into the required threshold languages.	The Plan's appeal policies and procedures in place are compliant with the translation requirements. Staff training refresher of translation of letters was conducted on 10/30/2018.	10/30/2018	Completed	Grievance & Appeals	✓	State	DHCS	2018	Completed
12	Appeal	1.4.3 The Plan did not update its provider manual to include the new timeframes for filing a state fair hearing that became effective July 1, 2017.	The Plan updated its provider manual on 12/25/2018 to include the correct new SFH filing timeframes. Update as of 1/07/2019: The Manual is scheduled to be uploaded on our website on 1/25/2019. Update as of 1/31/2019: The updated Provider Manual has been posted to the Plan website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
13	Delegation Oversight	1.5.1 The Plan did not collect and review ownership and control disclosure information for their UM delegates.	The Plan's subcontractor policy & procedure addresses the ownership and control disclosure information requirements. Update as of 1/07/2019: The Plan has requested ownership and control disclosure information of its UM delegates as of 1/4/2019. Update as of 1/30/2019: All forms from the Plan's UM delegates have been received as of 1/31/2019 with the exception of the Plan Pharmacy Benefits Manager (PBM). Update as of 3/6/2019: All forms from the Plan's UM delegates have been received.	3/15/2019	Completed	Provider Relations	✓	State	DHCS	2018	Completed
14	Delegation Oversight	1.5.2 The Plan did not require corrective action for all identified deficiencies as a part of their annual oversight audits.	The Plan updated its corrective action plan policy and procedure on 11/8/2018 to ensure all identified deficiencies are a part of annual audits such as policy and procedure deficiencies. UM annual delegation audits conducted for 2018 reflect the policy and procedure deficiencies in the corrective action.	11/8/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
15	Delegation Oversight	1.5.3 The Plan did not continuously monitor and evaluate the functions of its UM delegates. The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan has updated its monitoring of UM delegates to ensure all contractual and regulatory reports are being tracked for review. The Plan's delegation reporting tracking log has been updated to document all UM delegation reporting.Update as of 1/7/2019: The Plan will update the desktop procedure and conduct staff training on the monitoring process by 1/22/2019. Update as of 1/31/2019: The Plan completed staff training on 12/20/2018.	1/22/2019	Completed	Compliance	✓	State	DHCS	2018	Completed
16	Initial Health Assessment (IHA)	2.4.1 The Plan did not ensure that new members receive an IHA within 120 days from enrollment. The Plan's IHA completion records were inaccurate.	The Plan updated its procedures to monitor IHA completion and validate the procedure codes. Medical record auditing procedures will be conducted to monitor IHA completion and conduct validity testing.Update as of 1/07/2019: The Plan completed the audit and is completing the summary report for Committee by 1/17/2019.	1/17/2019	Completed	Quality Management	✓	State	DHCS	2018	Completed
17	Complex Case Management (CCM)	2.5.1 The Plan did not implement its policy and did not consistently monitor its CCM program.	The Plan monitors its daily aging report to ensure compliance with its CCM program.	12/1/2018	Completed	Health Services	✓	State	DHCS	2018	Completed
18	Complex Case Management (CCM)	2.5.2 The Plan did not ensure PCP participation in the provision of CCM services to each eligible member.	The Plan's updated CCM policy and procedure includes a process for PCP participation. The PCP Input Form was implemented for use on 5/31/2018.	5/31/2018	Completed	Health Services	✓	State	DHCS	2018	Completed
19	Access & Availability	3.1.1 The Plan did not initiate and implement steps to monitor wait times for providers to answer members' telephone calls.	The Plan will be updating its policy and procedure to include the telephone wait times standards for answering and returning calls. The Plan will monitor wait times for providers and answering member telephone calls through a quarterly survey. Update as of 1/31/2019: The Plan has updated its P&P to include all wait time standards. The Plan conducted a survey in January 2019 to assess and monitor wait times as required.	1/31/2019	Completed	Quality Management	✓	State	DHCS	2018	Completed
20	Access & Availability	3.1.2 The Plan did not maintain an accurate and complete provider directory.	The Plan implemented an audit process of the provider directory. The Plan expanded its annual audit for its Pharmacy Benefit Manager (PBM) to include monitoring its provider data included in the directory.Update as of 1/30/2019: Provider Directory Data P&P and desktop procedure for internal auditing have been updated.	2/28/2019	Completed	Provider Services/ Pharmacy	✓	State	DHCS	2018	Completed
21	Emergency & Family Planning Claims	3.5.1 The Plan denied emergency room (ER) service and family planning (FP) claims containing procedures that normally require prior authorization outside of an ER or FP setting.	The Plan updated its system configuration to ensure ER and FP claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
22	Emergency & Family Planning Claims	3.5.2 The Plan did not pay the greater of $15 or 15 percent interest annually for emergency service claims not reimbursed within 45 working days of receipt.	The Plan updated its system to ensure interest is paid based on the greater of the $15 or 15 percent interest annually for emergency services not reimbursed timely. Update as of 1/07/2019: The Plan will run a pre-payment monitoring report prior to each check run to ensure interest is paid based on the greater of the $15 or 15% per annum for emergency services claims not adjudicated timely. Update as of 1/31/2019: The Plan's pre-payment monitoring report process is now in place prior to each check run to ensure interest is paid accurately for emergency services claims when interest is required. All claims identified on the weekly report are manually adjusted as needed prior to payment to providers.	1/25/2019	Completed	Claims	✓	State	DHCS	2018	Completed

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

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2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*						**INTERNAL AUDITS**					
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
35	Fraud, Waste, and Abuse (FWA)	6.3.1 The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10-working days.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to ensure timely reporting of incidents to DHCS. Staff training on updated procedures was conducted on 7/17/2018. The Plan updated its monitoring tracking log to monitor the reporting timeframe requirement.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
36	Fraud, Waste, and Abuse (FWA)	6.3.2 The Plan did not conduct prompt and complete investigations of all suspected fraud and abuse incidents.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to investigate all suspected incidents and update DHCS until the case closure. Standardized investigation form for documentation was implemented as of 7/17/2018. Staff training on updated procedures was conducted on 7/17/2018.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
37	State Supportive Services	SSS.1 The Plan denied state supported services (SSS) claims containing procedures that normally require prior authorization outside of a SSS setting. These claims were denied based on edits in the Plan's claims system and review by claims analysts; the Plan's process did not include exceptions for FP or ER services.	The Plan updated its system configuration to ensure SSS claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
38	State Supportive Services	SSS.2 The Plan did not disclose the specific rationale used in determining why claims are rejected.	The Plan's Remittance Advice (RA) includes the specific rationale for claims denials. Denial codes can be applied at the Header level, line level or both. The Plan's claims processing system edits each claims and assigns all denial or informational codes that are applicable to the claim. <u>Update as of 1/31/2019:</u> The Plan will provide training to providers to ensure comprehension concerning the remittance advice set-up. <u>Update as of 3/6/19:</u> 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. <u>Update 4/8/2019:</u> 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.	<u>Update 9/27/2019:</u> MOUs have transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including CCS. <u>Update as of 12/2/2019:</u> 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.	<u>Update 9/27/2019:</u> MOUs have been transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including EI/DD services. <u>Update as of 12/2/2019</u>: The Plan is currently working on developing a full county MOU to include services for early intervention and development disabilities services <u>Update 7/10/2020:</u> The MOU was sent to the County for review on6/16/2020. <u>Update 10/9/2020</u>: The County has accepted the Alliance's edits and the MOU is currently under review for final approval with the County.<u>Update 11/10/2020</u>: The County has cancelled the November 3rd meeting. This agenda item will be carried over to the December 15th docket.**<u>Update 5/14/2021</u>**: 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. <u>Update 11/6/2018:</u> Codes were validated and updated by QM department.	11/1/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
7	Initial Health Assessment (IHA)	The Plan does not have a system in place for monitoring member's missed appointments.	Missed appointments are identified during the Medical Record Review that is part of a FSR. The criteria for missed primary care appointments and outreach efforts, which is part of DHCS's tool. The FSR review nurse evaluates this information and if a deficiency is identified the provider is educated on the importance of outreaching to the member and that documentation of the outreach attempts is required.	11/26/2019	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
8	Access & Availability	The Plan did not monitor appointment wait times.	Policy and procedure is in place for monitoring appointment wait time standards. Standardized process for monitoring and corrective action plan in place as of 9/20/2018.	9/20/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
9	Grievances	Some exempt grievance cases were not resolved within the next business day timeframe (applied to 1 3 cases).	Policies and procedures in place are compliant with the exempt grievance resolution timeframe requirements. Staff training refresher of resolving all exempt grievances by close of next business day was conducted on 10/12/2018.	10/12/2018	Completed	Member Services	✓	Self Identified	AAH	2018	Completed

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
10	Quality Improvement	Reporting of the HCQC was not consistently reported to the Board.	The Chief Medical Officer will provide HCQC summary updates to the Board starting in November. The meeting minutes will be included in the Board materials.	11/9/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
11	Utilization Management	The Plan did not routinely review overturned UM denials for trends & to develop plans for intervention where needed.	The Plan will pull reporting of UM denial trends that will be presented at the UM committee. The first UM committee for presenting the overturn UM denial trends at UM committee will be on 9/28/2018. These findings will be presented to the HCQC and subsequently to the Board of Governors.	9/28/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
12	Utilization Management	The Plan did not have a clear process for peer-to-peer clinician discussions concerning denied services.	Steps Plan took or will take to correct deficiency: 1.Plan develop a desktop procedure on peer to peer discussion by 9/14/2018. 2. Plan to train physicians and pharmacists of desktop procedure and when and how to document peer-to-peer clinician discussions by 9/26/2018. 3.Plan has started a weekly meeting with physicians and pharmacist for peer to peer discussions as of 7/17/2018.	9/26/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed

Health Care Services

Donna Carey, MD

To: Alameda Alliance for Health Board of Governors

From: Dr. Donna Carey, Chief Medical Officer

Date: December 13th, 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 into the 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 97%, above 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

<u>Overall Authorization Volumes *(inpatient, outpatient, and long-term care):*</u>

- There was a month-over-month decrease in total authorization volume from October to November 2024.

Total Authorization Volume (Medical Services)			
Authorization Type	**September 2024**	**October 2024**	**November 2024**
Inpatient	2,779	3,130	2,808
Outpatient	4,466	5,304	4,062
Long-Term Care	808	775	745
Total	**8,053**	**9,209**	**7,615**

***Source**: #02569_AuthTAT_Summary*

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

<u>Utilization Management: Outpatient</u>

- Anthem CoC volume has reduced to 5-7% of all incoming authorizations at any given time. Adult expansion CoC represents 4%.

- We have successfully transitioned 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.

- The team is also preparing for the transition of the Foster Youth Population to ensure CoC. Open DHCS treatment authorizations have been identified for case creation 1/1/25. For OON providers identified as having foster youths in active treatment, contracting is making initial contact with the providers for ongoing services. Those providers who agree to continue care will have authorizations generated in January when our eligibility files are received. For members where their previous providers won't be continuing services, CM will work with the members to secure network providers for their ongoing care needs.

- We continue to partner with our Medical Directors to review current prior authorization rules and evaluate which services should continue to require prior authorization, and which services should have prior authorization requirements removed (so as to decrease provider administrative burden).

- OP processed a total of 4,062 authorizations in the month of November.

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

Total Outpatient Authorization Volume			
Authorization Status	**September 2024**	**October 2024**	**November 2024**
Approvals	4,304	5,088	3,856
Partial Approvals	13	25	28
Denials	149	191	178
Total	**4,466**	**5,304**	**4,062**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**September 2024**	**October 2024**	**November 2024**
Overall Denial Rate	**3.1%**	**3.1%**	**3.1%**
Denial Rate Excluding Partial Denials	**2.9%**	**2.8%**	**2.8%**
Partial Denial Rate	**0.2%**	**0.3%**	**0.3%**

***Source**: #03690_Executive_Dashboard*

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

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- As of November 1st, IP UM implemented TAT change from 24 hours to 72 hours for concurrent review determination and notification, in alignment with regulatory guidance, applying to all lines of business. Provider notification was sent, with a reminder that TAT for notification of acute admission and prior authorization requirements have not changed. The change was operationalized internally. Staff training, monitoring and oversight for adherence to TAT change are ongoing.

- Also in November, TruCare EMR system of record underwent successful upgrade with associated testing, and implementation collaboration with IT department and configuration teams.

- Total inpatient auth volume decreased from 3,130 in October to 2808 authorizations processed in November.

- Inpatient overall average LOS continues to decrease from 5.2 in October to 5.1 in November. Conversely, an upward trend in admits per thousand from 50.5 in September to 53.5 in October, and days per thousand, from 264.3 in September to 274.4 in October. The trend is consistent among Child, Adult, ACA and SPD categories.

- IP overall denial rate was 2.2% in Sept, 2.6% in% October, and 1.8% in November.

- IP Auth TAT compliance continues to surpass benchmark, with overall TAT of 99% in October, and 97% in November.

- IP UM team identifies members eligible for care management services including ECM, and those enrolled in LTC, who are currently admitted to a hospital. Team 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.

- We have initiated discussions with Kaiser to start interdisciplinary rounds, with the goal of supporting AAH members at Kaiser facilities who have complex discharge needs and high ER utilization.

Total Inpatient Authorization Volume			
Authorization Status	**September 2024**	**October 2024**	**November 2024**
Approvals	2,740	3,082	2,770
Partial Approvals	0	0	0
Denials	39	48	38
Total	**2,779**	**3,130**	**2,808**

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**August 2024**	**September 2024**	**October 2024***
Authorized LOS	**5.3**	**5.2**	**5.1**
Admits/1,000	**48.9**	**50.5**	**53.5**
Days/1,000	**259.4**	**264.3**	**274.7**

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

Inpatient Authorization Denial Rates			
Denial Rate Type	**September 2024**	**October 2024**	**November 2024**
Full Denials Rate	**0.7%**	**0.7%**	**1.0%**
Partial Denials	**1.5%**	**1.9%**	**0.8%**
All Types of Denials Rate	**2.2%**	**2.6%**	**1.8%**

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance			
Line of Business	**September 2024**	**October 2024**	**November 2024**
Overall	**98%**	**99%**	**97%**
Medi-Cal	**98%**	**99%**	**97%**
IHSS	**100%**	**100%**	**96%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during November 2024 was 2,446 members. This is a decrease of 2.51% from October 2024.

- Month to Month, the admissions, days and readmissions are decreasing. From August to October the admissions decreased by 35.14%, the days decreased by 50.59% and the readmissions also decreased by 18.52%. Some of this could be due to a lag in claims data being available, but we are seeing a decrease overall.

Totals	August 2024	September 2024	October 2024*
Admissions	111	108	72
Days	767	659	379
Readmissions	27	31	22

Source: #14236_LTC_Dashboard - *data only available through September 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

- Continued 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 support to members preparing to discharge from an LTC custodial facility.

- LTSS Liaison is visiting and meeting with facilities to discuss any claims issues and educating on processes.

- Health Navigator continues to assist with TCS for members coming back from an acute stay or transitioning from acute into long-term care.

- 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 a decrease in November of 3.87%, compared to October 2024.

- Authorization processing turn-around time (TAT) did not meet benchmark for the month of November at 92%. This is related to staffing gaps; mitigation strategies are underway, including recruiting temporary staff.

Total LTC Authorization Volume			
Authorization Status	**September 2024**	**October 2024**	**November 2024**
Approvals	760	733	699
Partial Approvals	0	0	0
Denials	48	42	46
Total	**808**	**775**	**745**

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	**September 2024**	**October 2024**	**November 2024**
Medi-Cal	**97%**	**97%**	**92%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Behavioral Health

In November, Behavioral Health processed 475 authorizations, 402 Care Coordination referrals, and 187 Medi-Cal Mental Health Screenings.

Total BH Authorization Volume			
	24-Sep	**24-Oct**	**24-Nov**
Approvals	561	589	474
Partial Approval	0	0	0
Denials	2	2	1
Total	563	591	475

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
**Goal ≥95%*	**24-Sep**	**24-Oct**	**24-Nov**
Determination TAT%	96%	99%	95%
Notification TAT%	98%	94%	97%

Source: 14939_BH_AuthTAT

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
**Goal ≥95%*	**24-Sep**	**24-Oct**	**24-Nov**
Determination TAT%	99%	97%	98%
Notification TAT%	100%	99%	100%

Source: 14939_BH_AuthTAT

Behavioral Health Denial Rates

**Goal ≤ 5%* BH Denial Rates		
24-Sep	**24-Oct**	**24-Nov**
0.01%	0.01%	0.01%

Source: 14939_BH_AuthTAT

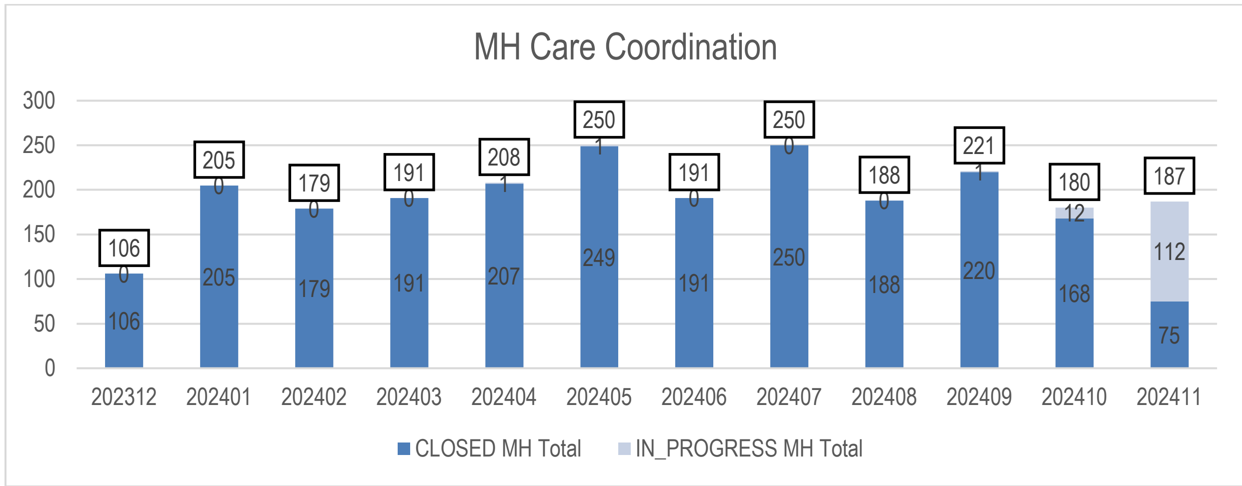
Mental Health Care Coordination

- 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-Aug	24-Sep	24-Oct
Youth Screenings	59	78	60
Adults Screenings	141	123	127

Source: PBI_14460 – MLS BH TruCare Assessments

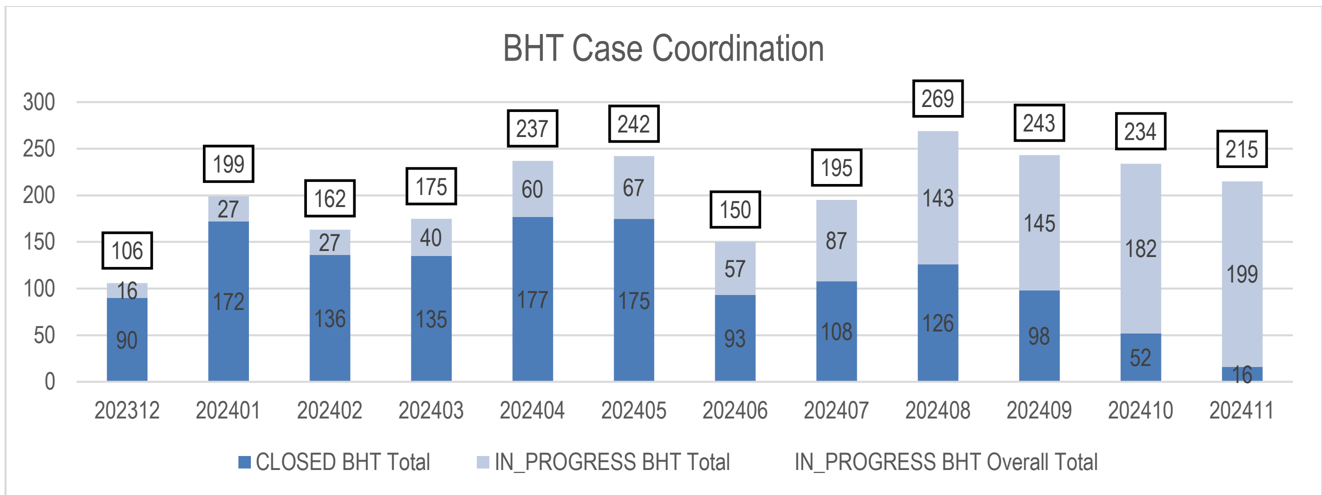
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



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.

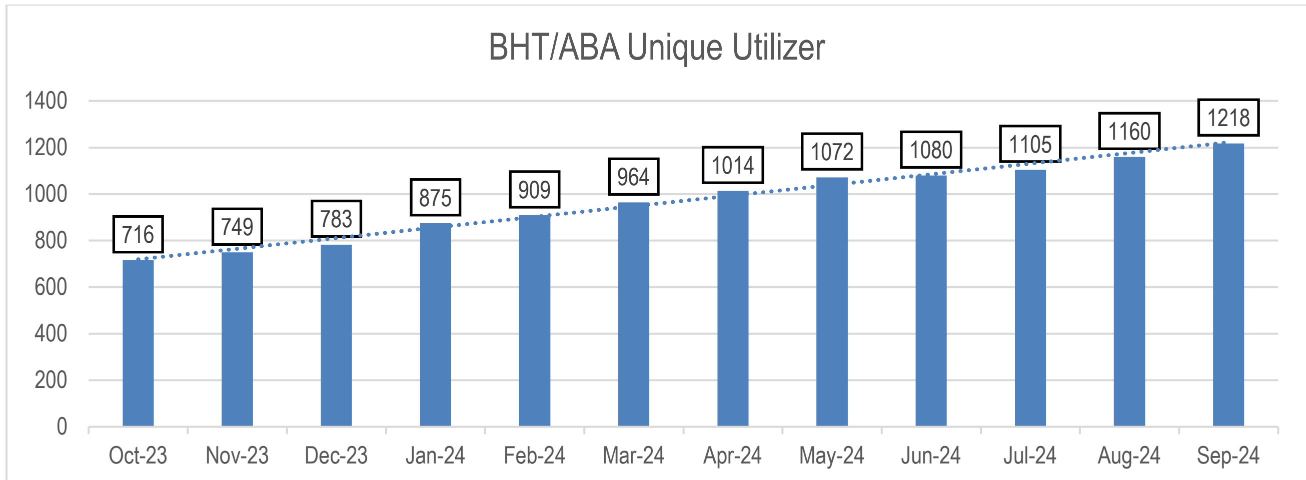


Source: 14665_BH_Cases

Behavioral Health Unique Utilizers

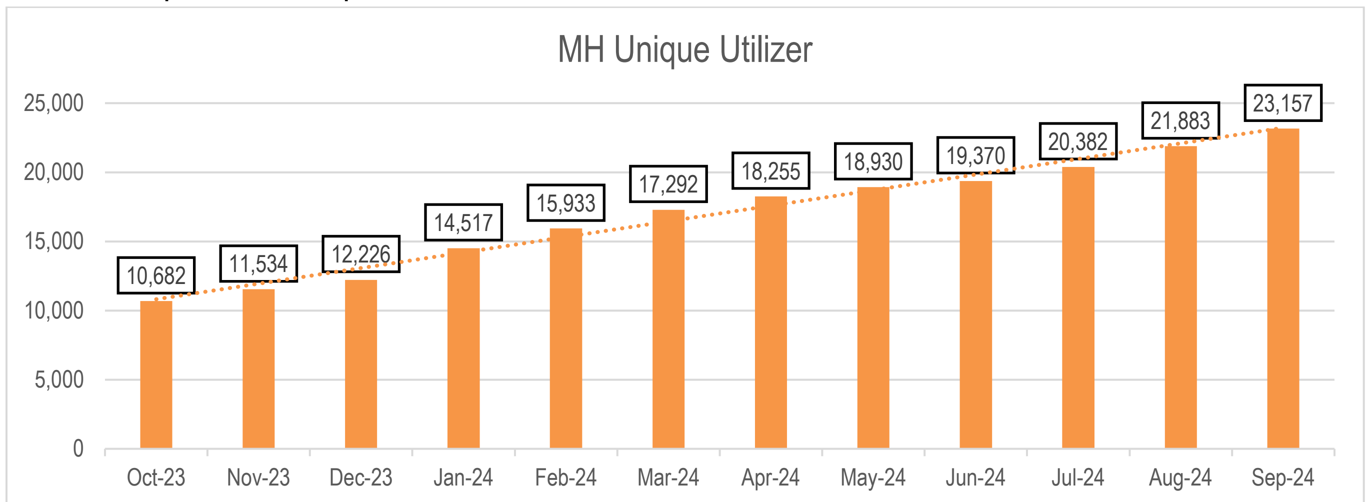
Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.

- We observed a continuing rise in unique utilizers of BHT/ABA services, reflecting a 5% increase compared to the previous month.



Source: PBI 14621 BHT Utilization Report

- The number of unique utilizers of mental health services has increased by 6% compared to the previous month.



Source: PBI 14637 BH12M Report

Pharmacy

- Pharmacy is leading initiatives on PAD (physician administered drugs) focused internal and external partnership and reviewed PAD related UM authorizations as follows

Top 10 Requested Drugs Submitted for Authorizations

HCPCS Code	Drug Name	Authorizations
J2919	INJ METHYLPRED SOD SUCC 5MG	233
J9035	INJECTION BEVACIZUMAB 10 MG	152
J7030	INFUS NORMAL SALINE SOL 1000 CC	82
J0897	INJECTION DENOSUMAB 1 MG	68
J0585	BOTULINUM TOXIN TYPE A PER UNIT	65
J1100	INJ DEXMETHOSON SODIM PHOSHATE 1 MG	57
J0178	INJECTION AFLIBERCEPT 1 MG	49
J1453	INJECTION FOSAPREPITANT 1 MG	47
J2405	INJECTION ONDANSETRON HCL PER 1 MG	46
J2997	INJ ALTEPLASE RECOMBINANT 1 MG	45

Authorization Overview[1]

Line of Business	July 2024	August 2024	September 2024
IHSS	14	11	7
Medi-Cal	461	437	452

Turnaround Time and Determinations By Line of Business[2]

LOB	Determination	July 2024	August 2024	September 2024
Medi-Cal	Approved	344	347	364
	Denied/Partials	5	4	8
	TAT	99.71%	100.00%	99.46%
IHSS	Approved	13	7	5
	Denied/Partials	0	1	0
	TAT	100.0%	100.0%	100.0%

- Pharmacy has been collaborating with UM, C&O and Provider Services team to remind AAH provider network serving Medi-Cal members to bill the following carveout drugs to FFS Medi-Cal.
  - •Antivirals (HIV/AIDS/Hepatitis B) Drugs
  - •Alcohol and Heroin Detoxification and Dependency Treatment Drugs
  - •Blood Factor: Clotting Factor Disorder Treatment Drugs
  - •Psychiatric/Antipsychotic Drugs

[1] Includes closed authorizations

[2] Only includes authorizations that have been determined excluding closed authorizations.

Case and Disease Management

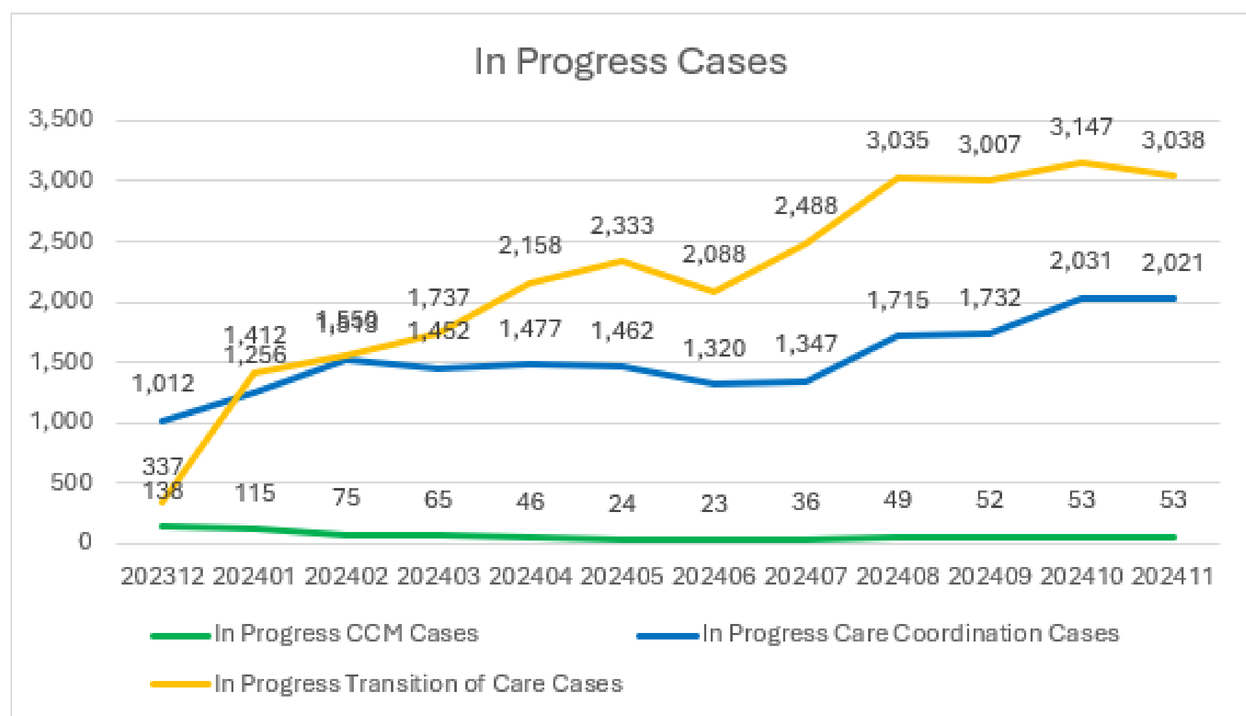
- The CM Team is assisting with coordination of continuity of care for the incoming foster youth population.

- The CM team continues to assist the high volume of all members needing Transitional Care Services (TCS) as they transition from one level of care to another. This includes member transitions where the Alliance is not the primary payor (such as members with Medicare primary insurance).

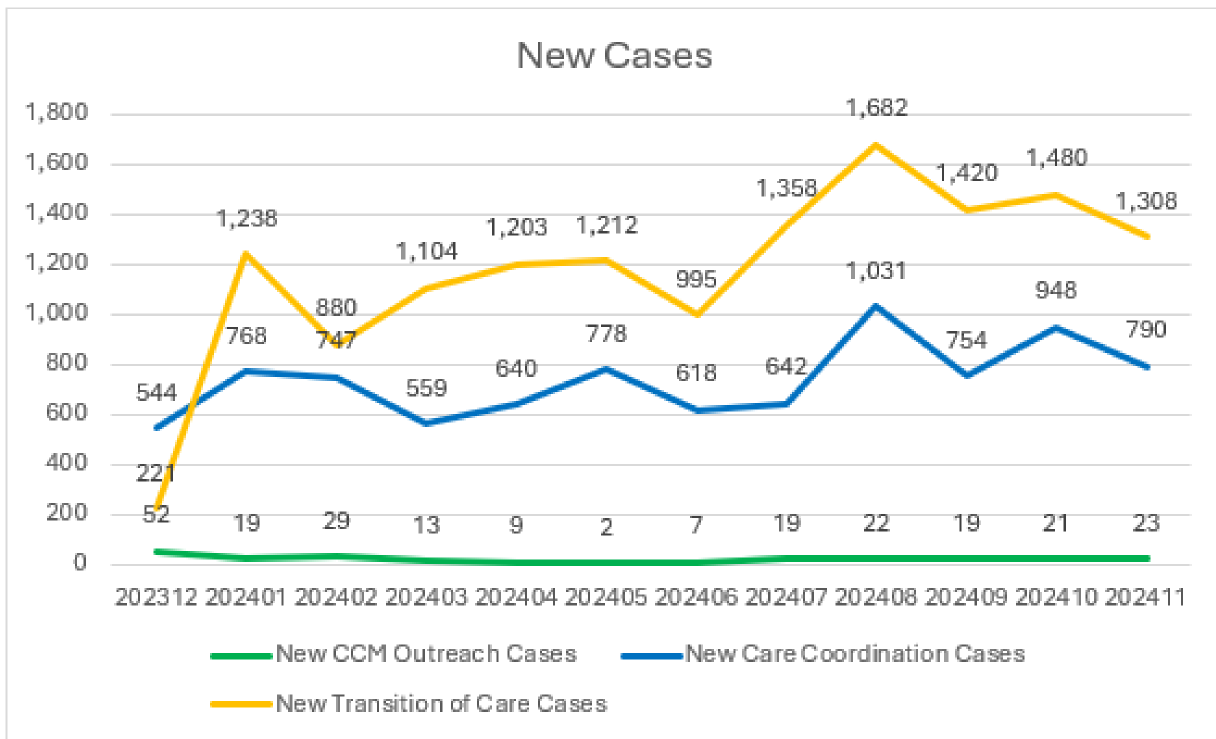
- The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including but not limited to scheduling and ensuring follow-up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners, members, caregivers, support teams, etc.).

- CM is collaborating with UM and LTC to support members at hospitals with long-length stays and complex discharge barriers, including facilitating referrals to Community Supports, ECM and other community resources, as needed.

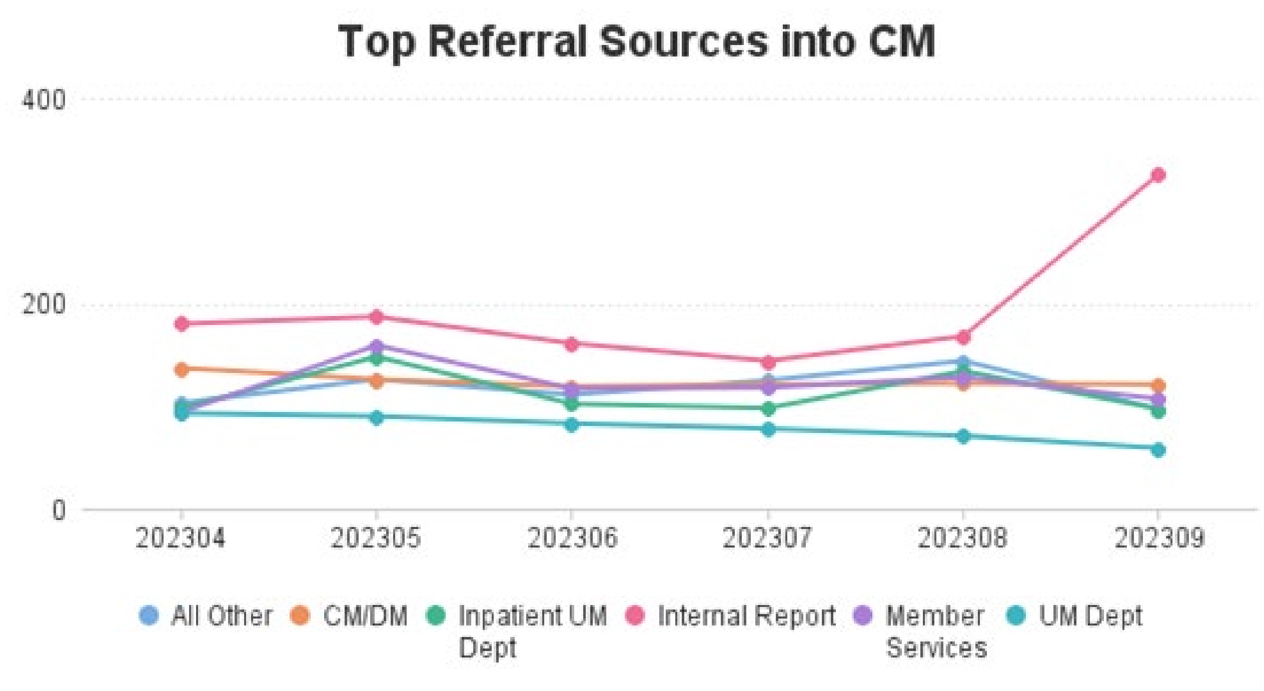
- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues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



Source: *#03342 TruCare Caseload*



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



***Source**: #03881 Case and Disease Management Dashboard*

CalAIM

Enhanced Case Management

- All Populations of Focus have been live since January 1, 2024.

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

- Behavioral Health linkages went live 10/1/24. In partnership with other county entities (Probation, JCC, Santa Rita, ACBH), the Alliance worked closely with the internal Behavioral Health (BH) team to prepare for members transitioning out of incarceration. The Alliance is continuing to collaborate with county entities in preparation of go-live for pre-release services in 2026.

- The ECM team continues to build rapport with the ECM providers, meeting at a minimum twice a month: once to discuss specific cases and once to discuss operational issues. This is leading to more collaboration and community referrals to additional resources. The ECM team works weekly with providers for follow-up to internal and external stakeholders to identify stages of outreach and engagement.

- The ECM team improved the ECM provider audit process to further understand key areas of member engagement for improvement. Examples of improvements are systematic audit measures to focus on transitional care services, person-centered care plan development, change in condition triggers and overlapping populations of focus (Justice-involved).

- AAH continues to collaborate with Alameda County (AC) Health to discuss Street Medicine alignment. The ECM team works closely with the Street Team providers to make sure encounters are submitted and billed appropriately.

- ECM staff are participating in DHCS Foster Care Youth Transition Stakeholder meetings, to prepare for the mandatory transition of Foster Care Youth on 1/1/2025. In addition to collaborating with county entities and external child welfare partners, the ECM team is working with DHCS data to determine courses of action related to coordination of care for new members from the child welfare/foster care youth transition.

- Further ECM network expansion is currently paused, and potential providers have been notified.

- The team is preparing for the new ECM referral standards and ECM presumptive authorization process, which DHCS requires to go-live on 1/1/2025. Provider communications are underway, including training on the new ECM referral form and presumptive authorization process.

	August 2024		September 2024		October 2024	
ECM Providers	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**
ACBH	0	14	-	14	-	14
Alameda Health System (AHS)	17	225	13	214	16	189
Bay Area Community Services (BACS)	-	106	-	107	-	118
California Cardiovascular Consultants	-	172	-	176	-	170
California Children's Services (CCS)	13	23	16	22	16	21
CHCN	-	832	-	826	-	858
East Bay Innovations (EBI)	2	103	-	109	2	109
Full Circle	87	234	115	217	67	206
Institute on Aging	8	184	8	183	333	200
La Familia	34	38	57	39	36	33
MedZed	23	563	27	540	41	536
Roots Community Health Center	29	141	-	147	7	159
Seneca Family Services	54	44	47	42	54	44
Pair Team	323	464	94	478	374	541
Titanium Health Care	1195	497	116	494	420	491
Tiburcio Vasquez Health Center (Street Medicine)	-	79	-	78	-	79
BACH (Street Medicine)	-	54	-	55	-	63
Lifelong (Street Medicine)	-	179	-	179	-	184
Roots Community Health Center (Street Medicine)	Combined with Roots 'traditional' ECM program					

Source*: #13360 ECM Dashboard*

Community Supports (CS)

- The team implemented new authorization criteria and Utilization Management processes effective 12/1/2024. The changes were needed to ensure full compliance with regulatory and contractual expectations. We continue to meet with CS providers to address questions about the new processes and support this change.
- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance offers the following community supports:
  - Housing Navigation
  - Housing Deposits
  - Tenancy Sustaining Services
  - Medical Respite
  - Medically Tailored/Supportive Meals
  - Asthma Remediation
  - (Caregiver) Respite Services
  - Personal Care & Homemaker Services
  - Environmental Accessibility Adaptations (Home Modifications)

- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home

- Further CS service & network expansion is paused; potential providers have been notified.

- AAH CS staff continue to meet with CS providers to work through logistical issues as they arise, including referral management, claims payment and member throughput.

- DHCS outlined new closed loop referral requirements and moved the closed loop referral target date to 07/01/25. AAH is working on requirements to comply with the new DHCS requirements.

- Housing-related community supports have transitioned to the Operations team effective 10/01/24. The Health Care Services and Operations teams coordinate to ensure communication and process alignment, where possible.

Community Supports	Services Authorized in August 2024	Services Authorized in September 2024	Services Authorized in October 2024
Housing Navigation	1,120	1,078	985
Housing Deposits	306	280	258
Housing Tenancy	1,245	1,141	1,038
Asthma Remediation	85	82	93
Meals	1,479	1,591	1,539
Medical Respite	129	137	128
Transition to Home	19	21	22
Nursing Facility Diversion	31	28	28
Home Modifications	6	3	1
Homemaker Services	139	113	113
Caregiver Respite	11	7	8
Total	**4,570**	**4,481**	**4,213**

Source: *#13581 Community Support Auths Dashboard*

Grievances & Appeals

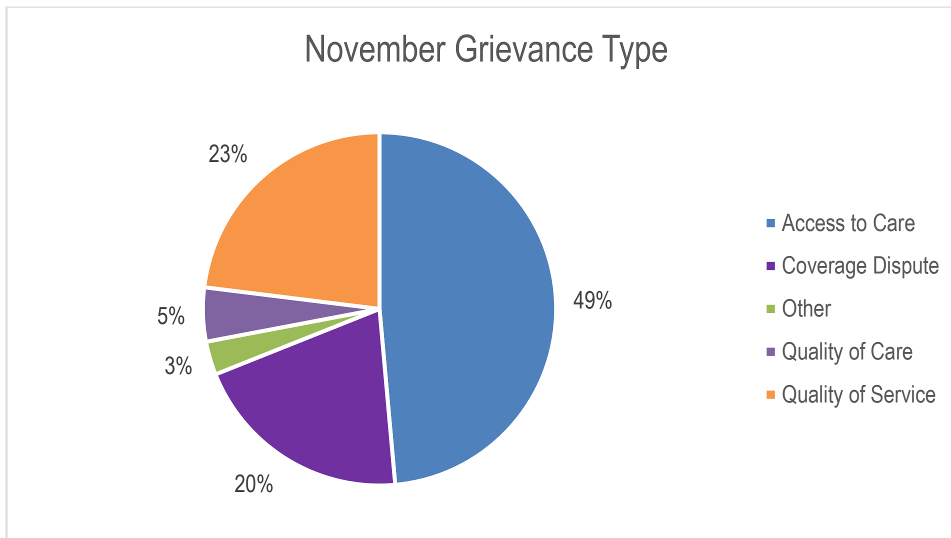
- All cases were resolved within the goal of 95% of regulatory timeframes.
- Total Unique grievances resolved in November were 7.08 complaints per 1,000 members.

November 2024 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,755	30 Calendar Days	95% compliance within standard	1,750	99.71%	3.62
Expedited Grievance	7	72 Hours	95% compliance within standard	7	100.00%	0.02
Exempt Grievance	1,555	Next Business Day	95% compliance within standard	1,552	99.81%	3.28
Standard Appeal	63	30 Calendar Days	95% compliance within standard	61	96.83%	0.15
Expedited Appeal	1	72 Hours	95% compliance within standard	1	100.00%	0.002
Total Cases:	3,381		95% compliance within standard	3,371	99.65%	7.08

*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:

There were 1,483 unique grievance cases resolved during the reporting period, with a total of 1,762 grievances including all 279 shadow cases.



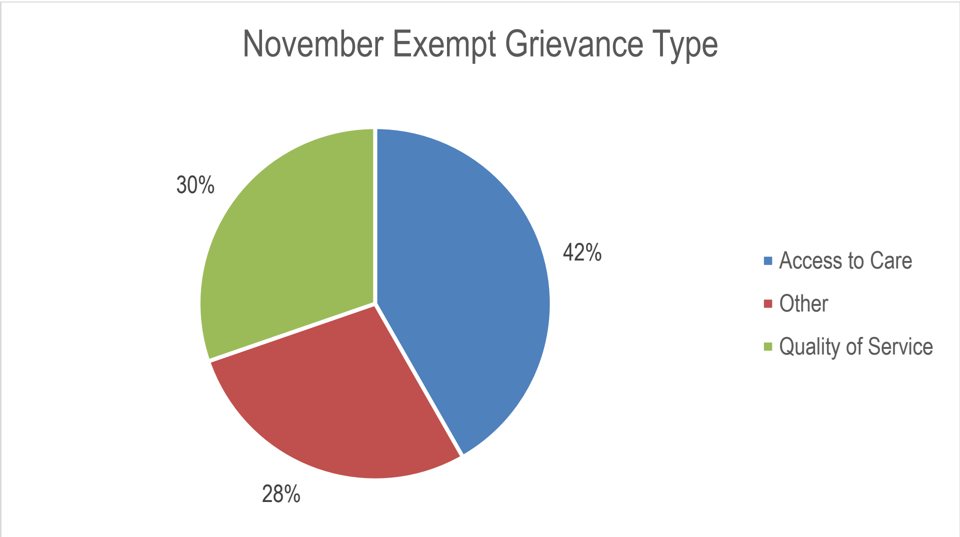
- **856** of 1,762 (49%) cases were related to Access to Care, the top 4 grievance categories are:
  - (374) Timely Access
  - (156) Technology/Telephone
  - (134) Authorization
  - (110) Provider Availability

- **406** of 1,762 (23%) cases were related to Quality of Service, the top 3 categories are:
  - (98) Plan Customer Service
  - (90) Transportation
  - (59) Provider/Staff Attitude

- **359** of 1,762 (20%) cases were related to Coverage Dispute, the top 3 grievance categories are:
  - (230) Provider Direct Member Billing
  - (70) Provider Balance Billing
  - (40) Reimbursement

Exempt Grievances:

There were 1,335 unique exempt grievance cases resolved during the reporting period, with a total of 1,555 grievances including all 220 shadow cases.



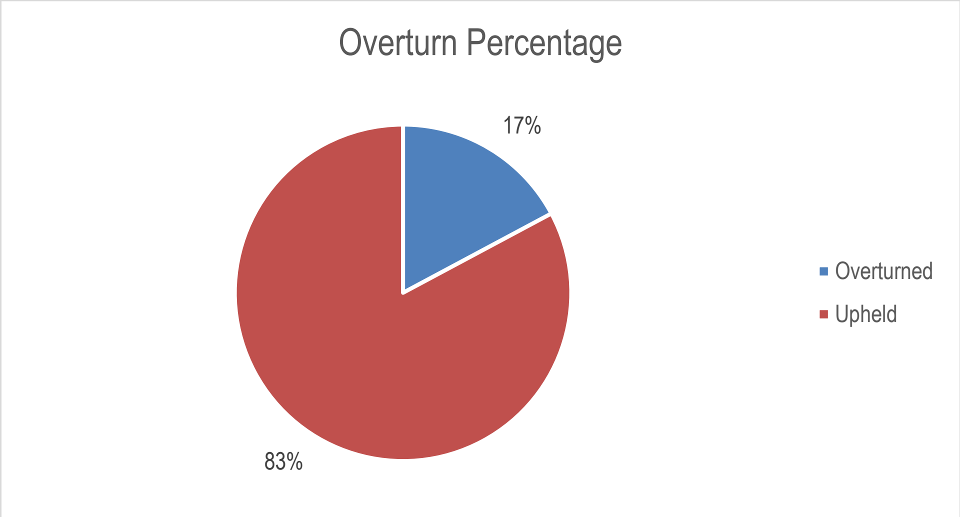
- 649 of 1,555 (42%) cases were related to Access to Care, the top 3 categories were:
  - (321) Telephone/Technology
  - (173) Provider Availability
  - (85) Geographic Access

- 435 of 1,555 (30%) cases were related to Quality of Service, the top 2 categories were:
  - (244) Plan Customer Service
  - (196) Provider/Staff Attitude

- 471 of 1,555 (28%) cases were related to Other, the 2 categories were:
  - (411) Enrollment
  - (24) Eligibility

<u>Appeals:</u>

The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of November 2024, we met our goal with a 17% overturn rate.



- **11** out of 64 (17%) cases were overturned or partially overturned for the month of November 2024:
    - (7) Out of Network (TOC, no INN, COC)
    - (4) Disputes Involving Medical Necessity

Quality

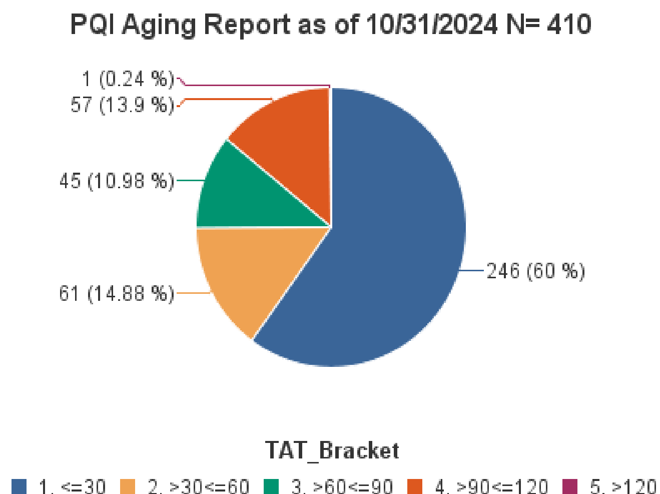
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQI cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

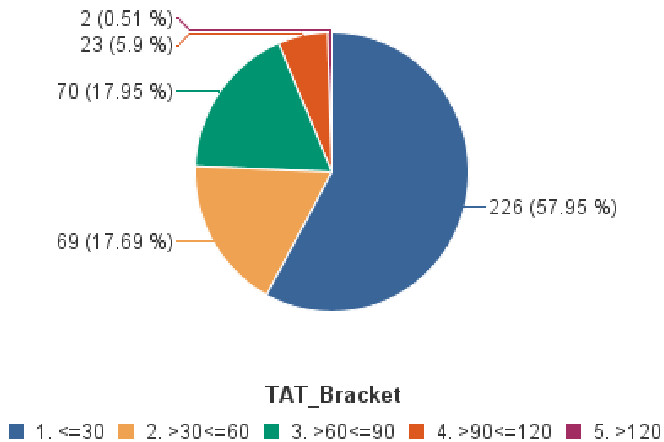
- Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics Services team after they are triaged by the QI Clinical team. The QI RN Reviewers review quality of Care and Service issues. Final leveling for Quality-of-Care cases 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.

- 0.51% cases in September and 0.24% in October 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 increased by 20 referrals from September to October. TATs are closely monitored on a weekly basis to ensure timely closure of cases within the standard 95%.

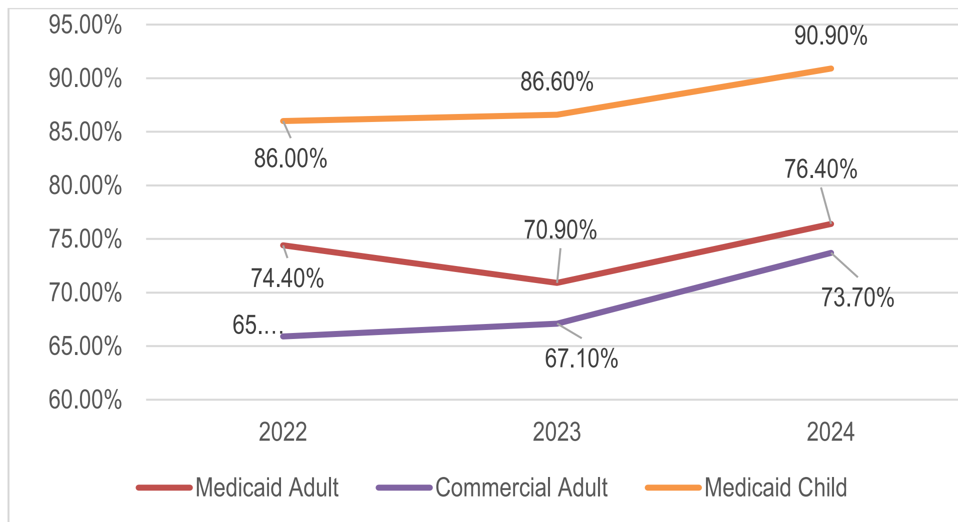




CAHPS 5.1H Survey

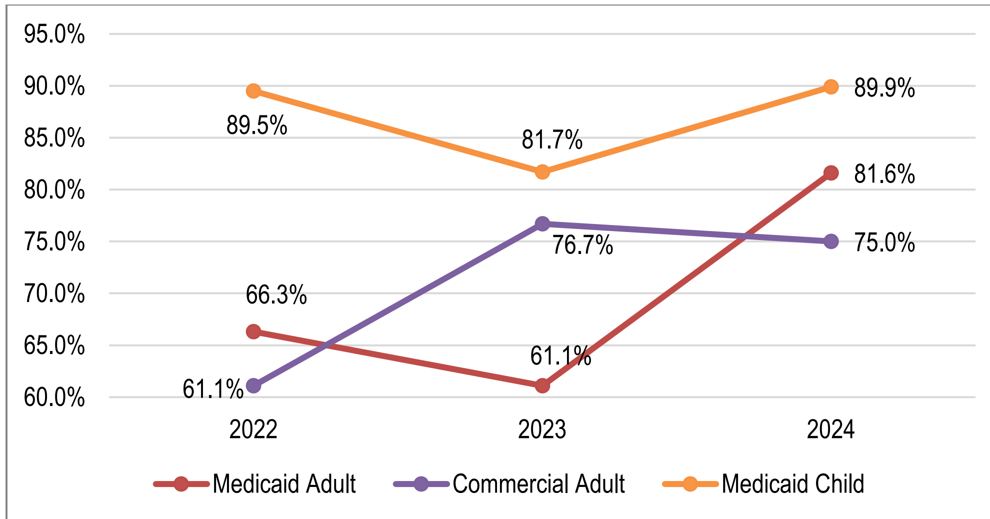
- Survey Objective: The overall objective of the CAHPS study is to capture accurate and complete information about consumer reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of services have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of provided care. AAH vendor PG analytics collected valid surveys from each eligible member population from February to May of each year.

Rating of Health Plan 8, 9 or 10



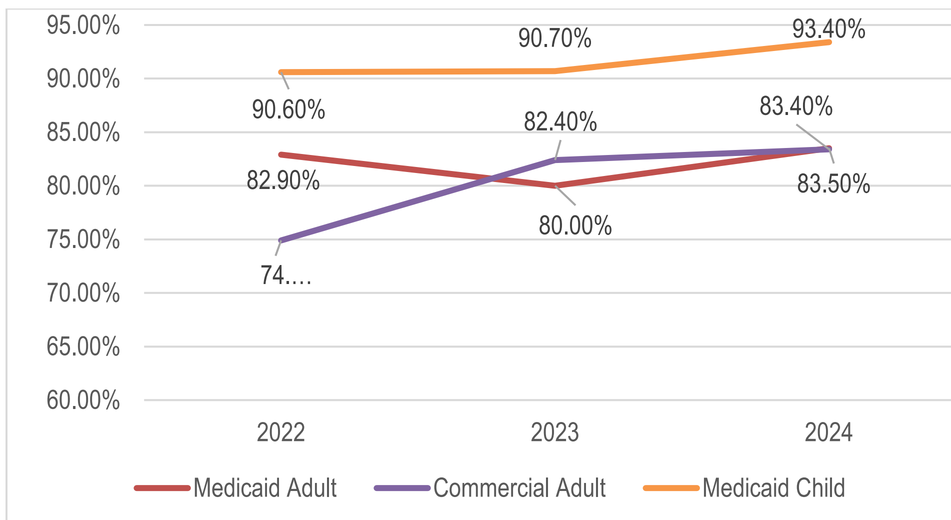
- Rates change from 2023 to 2024:
  - Medicaid Adult rate in 2024 increased from 2023 by 5.5%.
  - Medicaid Child rate in 2024 increased from 2023 by 4.3%.
  - Commercial Adult rate in 2024 increased from 2023 by 6.6%.

Rating of Health Care 8, 9 or 10



- Rates change from 2023 to 2024:
    - Medicaid Adult rate in 2024 increased from 2023 by 20.5%.
    - Medicaid Child rate in 2024 increased from 2023 by 8.2%.
    - Commercial Adult rate in 2024 decreased from 2023 by 1.7%.

Rating of Personal Doctor 8, 9 or 10



- Rates change from 2023 to 2024:
    - Medicaid Adult rate in 2024 increased from 2023 by 3.5%.
    - Medicaid Child rate in 2024 increased from 2023 by 2.7%.
    - Commercial Adult rate in 2024 increased from 2023 by 1.0%.

- Next Step: In the next two quarters, Access and Availability will continue to collaborate interdepartmentally to identify best practices and opportunities for improvement and develop improvement action plan for implementation, including provider education, joint meetings, and office visits.

Provider Satisfaction Survey

- Survey Objective: The Provider Satisfaction Survey targets providers to measure their satisfaction with Alameda Alliance for Health. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Provider Satisfaction Survey typically fielding from September to November of each year.

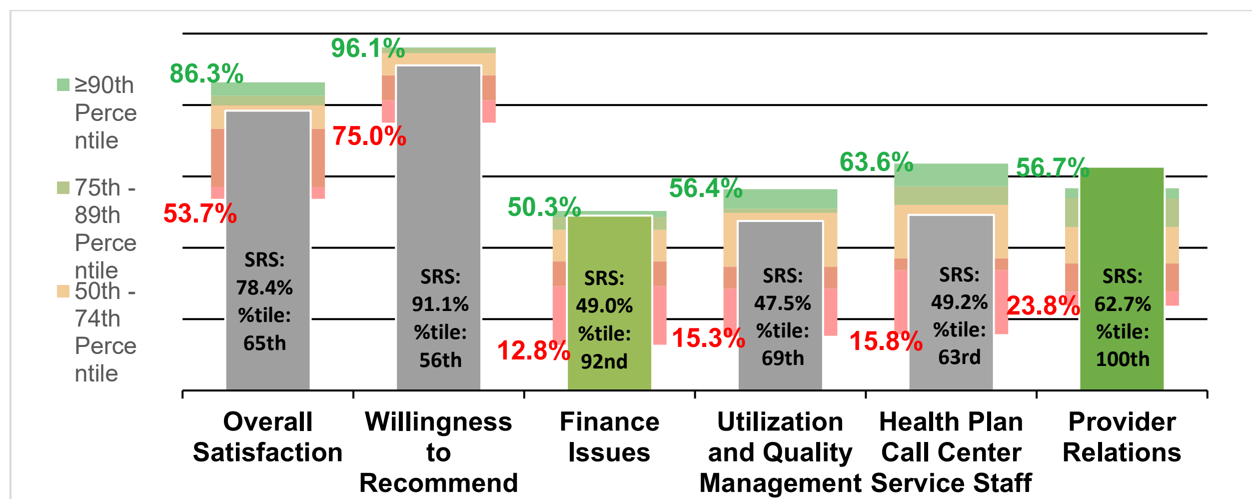
Provider Satisfaction Composite Scores

Composite	MY 2023 Result	Variance Compared to Previous Year	Variance Compared to SPH Commercial Benchmark BoB	MY 2022 Result	MY 2021 Result
Overall Satisfaction	**78.4%**	Lower	Significantly Higher	86.3%	77.3%
All Other Plans (Comparative Rating)	**55.3%**	Higher	Significantly Higher	53.5%	50.0%
Finance Issues (Claims)	**49.0%**	Higher	Significantly Higher	44.3%	44.5%
Utilization and Quality Management	**47.5%**	Lower	Significantly Higher	50.6%	45.3%
Network/Coordination of Care	**41.7%**	Higher	N/A	31.2%	37.6%
Pharmacy	**38.1%**	Higher	N/A	31.6%	35.1%
Health Plan Call Center Service Staff	**49.2%**	Lower	Significantly Higher	51.3%	54.0%
Provider Relations	**62.7%**	Higher	Significantly Higher	56.7%	63.5%

- The Alliance identified higher composite scores in 5 of 8 measures compared to MY 2022 scores.

- Six (6) of the 8 composites scores are significantly higher than the vendor commercial BoB scores.

Comparison Relative to SPH Book of Business



Green bar = AA performing at or above the 75th percentile
Red bar = AA performing below the 25th percentile

- Survey results indicate that the Alliance is performing above the 75th percentile for Finance Issues and Provider Relation compared to the distribution of scores in the 2022 PG Commercial Book of Business. On the remaining measure, the plan is performing above the median.

Key Drivers of the Overall Rating of Health Plan

- Power: Promote and leverage Strengths (Top 5 Listed)
    - Timeliness of plan decisions on routine prior authorization requests
    - Procedures for obtaining pre-certification/referral/authorization information
    - Timeliness of obtaining pre-certification/referral/authorization information
    - Timeliness of plan decisions on urgent prior authorization requests
    - The health plan's facilitation/support of appropriate clinical care for patients

- Opportunities: Focus resources on improving processes that underline these items
    - Ability to speak with plan medical director about prior authorization decisions, including Did You Know campaign outlining AAH activities focusing on improving providers' expectations and needs.

QUALITY IMPROVEMENT

Health Education

- Health Education continues to offer educational handouts and programs to members covering a wide variety of prevention, healthy lifestyle, and condition self-management topics.

- Distribution of health education materials and community referrals through member mailings from
    - Health Education
        - 385 Mailings
        - 381 Unique Members
    - Case Management
        - 2,300 mailings
        - 2,243 Unique Members

  This totaled 2,685 mailings YTD 2024 and included topics such as nutrition and exercise, heart health, diabetes and falls prevention and health care tools like advanced directives, medication lists, and health care visit checklist.

- Core health education programs in 2024 included:
    - Asthma Start pediatric case management
    - Alta Bates Summit Medical Center lactation services
    - Doula services to perinatal members
    - Family Paths parenting classes
    - Diabetes Prevention Program (DPP)

- Diabetes Self-Management Education and Supports (DSMES)
- La Clinica nutrition counseling

- Health Education conducted targeted outreach and referrals for members living with asthma and diabetes and our birthing members in 2024.
  - Asthma: There were 799 Asthma Start pediatric asthma post emergency department visit referrals and member outreach. Asthma Start provided asthma education and remediation services to 62 members.
  - Diabetes: Alliance providers offered DSMES to 769 unique members at hospital and clinic locations.
  - Pregnancy, Baby Care, and Lactation: Continued prenatal (5,227) and postpartum (3,395) mailing campaigns and referrals to Alameda County and Black Infant Health (637) for culturally responsive care.

- Health Education success in 2024 include:
  - Increased enrollment to both Diabetes Prevention Programs (HabitNu and Yumlish).
  - Completed evaluations of three health education programs including La Clinica nutrition counseling, WIC referrals, and CPR classes.
  - Increased Asthma Start pediatric case management referrals.
  - Developed resources and training to support doula providers and educate members about doula services.
  - Increased referrals to health coaching for asthma, diabetes, and hypertension.
  - Developed member newsletter articles about secondhand smoke, preventing diabetes, and cancer screening.

- Health Education areas for Improvement in 2024 include:
  - Continued development of education for members and providers about availability and benefits of doula services.
  - Low utilization of the doula benefits for eligible members.
  - Low web-referral rate to Kick It CA (a program for tobacco cessation).
  - Process for tracking Health Education requests, including readability and requests for new materials.

- Health education will address these areas through the following activities in 2025:
  - Create training videos and job aids for doulas.
  - Update prenatal and postnatal mailing of resources to promote doula benefits to members.
  - Implement a Secured File Transfer Protocol (SFTP) site with Kick It CA to streamline tobacco cessation counseling referrals from different departments across the organization.

Introduce an internal tracking and reporting mechanism for Health Education Requests.

Health Equity

Lao Paul Vang

To: Alameda Alliance for Health Board of Governors

From: Lao Paul Vang, Chief Health Equity Officer

Date: December 13th, 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.

- **Faith-Based Community Engagement Update**

  - As part of our Health Equity Roadmap strategy, a new committee called "Faith-Based Community Engagement Workgroup" was formed and had its first convening on November 22nd, 2024.
  - The work group consists of representatives from Medical Services, QI, PHM, C&O, HR, Housing and Community Services. The composition reflects a cross-functional collaboration based on the shared mission of advancing health equity through faith-based organizations.
  - Several high-stake faith-based organizations have been identified, and discussion about collaboration is in the works.
    a) San Lorenzo Samoan Free Methodist Church
    b) AC Care Alliance—Faith and Healing for the Community
    c) Fremont Sikh Temple
  - The FBCE will continue to build out the community engagement list and develop priorities based on a) members' relationships with the faith-based organization, b) the health disparity gap, and c) available funding and resources.

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.

- **Alameda County Community (ACC) Food Bank**
  - Initiated discussion with the community director of ACC Food Bank to explore potential partnership opportunities to reach out to our members with diet-related chronic diseases and /or food insecurity who do not receive ECM or CS.

- **Native American Health Center**
  - As part of the mission to reach out to the under-represented Indigenous community, we visited the Native American Health Center on December 11th. Discussion of culturally appropriate health equity partnership projects were explored.

Advancing Health Equity Initiative (AHEI) Update –

- **DEI Training APL 23-025 Update**
  - Timeline:
    - ✓ November 2024: complete training curriculum submitted to DHCS
    - ✓ Jan 2025: DEI Provider's Pilot launched. California Cardiovascular Consultants are selected to receive the pilot training.
    - ✓ April – June 2025: pilot training completed
    - ✓ July to Dec 2025: training given to downstream network providers and vendors.

- **APL 24-018:TGI-SB 923 Update**
  - The APL 24-018, in compliance with SB 923 requires all MCP staff to receive the Trans-Gender-Intersex Culturally sensitive training no later than February 14th, 2025, and every two years thereafter. If a complaint is made against a member of a plan's staff for failure to provide trans-inclusive care, and a decision has been made in favor of the complainant, the applicable plan staff member must retake the training.
  - IPD with HED convened a multifunctional workgroup to address the development and implementation of the training since October 2024.
  - Timeline:
    - ✓ Dec 2024: confirmation of vendor
    - ✓ Jan-Feb 2025: implementation of training for all staff
    - ✓ Feb 14, 2025: submission of all documents to state, which include Evidence-based TGI training curriculum, updated online Providers Directory for gender-confirming services, G&A, and P&P.

- **Alliance Health Equity Strategic Roadmap –**

    - The final meeting of the multi-stakeholder Health Equity Strategic Committee will occur in December, concluding the consultancy provided by Elevated Diversity.
    - The Health Equity Division will continue to validate and adjust the recommendations based on prevailing health equity best practices and subject matter expertise of the Health Equity Division.
    - A total of six milestones have been identified:

        1) Organization
        2) Data-Driven
        3) Education
        4) Communication
        5) Community Engagement and
        6) SDOH Mitigation Measures

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

- **DEIB Committee Update –**

    - The DEIB Committee met on November 1st and discussed bilingual requirements on new requisitions and expression guidelines. The Committee decided to ask Anastacia Swift to the next meeting to discuss these topics.
    - A Health Equity activities update was also given.

- **VIA Committee Update** –

    - At the November 18th VIA meeting, the Committee was updated on the gift drive for Building Futures.
    - The Committee also approved the PowerPoint presentation for the Holiday Cultural Celebrations to be shared at the All Staff Meeting.

BOG Presentation Dec 13, 2024

- Agenda
    1. Health Equity Division's Vision and Mission
    2. 4 Quadrants of Priority
        - Internal Stakeholders, Members, Providers, CBOs and downstream networks
        - Intersectoral Collaboration and Partnerships
    3. Short, Mid, and Long-term Action Plans
        - DHCS-APL 23-025 (DEI Training)
        - Health Equity Data (Alameda Alliance for Health & Alameda

County Data)
  - Health Equity & DEIB Roadmap
4. Health Equality vs Health Equity
5. Our MOTTO

Information Technology

Sasikumar Karaiyan

To: Alameda Alliance for Health Board of Governors

From: Sasi Karaiyan, Chief Information & Security Officer

Date: December 13th, 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. The Alliance is aiming to extend the system to include Spanish and contract execution has been finalized.
- Project work is now in progress to enable the Spanish language pack for Calabrio this includes installation scripts and phrase tuning will follow shortly after through our weekly working sessions.

Encounter Data

- In the month of November 2024, the Alliance submitted 177 encounter files to the Department of Health Care Services (DHCS) with a total of 388,266 encounters.

Enrollment

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

HEALTHsuite

- The Alliance received 364,130 claims in the month of November 2024.
- A total of 300,562 claims were finalized during the month out of which 263,359 claims auto adjudicated. This sets the auto-adjudication rate for this period to 87.6%.
- The HEALTHsuite application encountered a partial outage on November 14th, 2024, which lasted 30mins. This sets the up time to 99.93% for the application.

TruCare

- A total of 16,885 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.7%.

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.

- As part of the IT Security 3.0 initiative, InfoSec will be adopting the National Institute of Standards and Technology's Cyber Security Framework (NIST CSF) along with supplementals (CIS + 800-53) as guidance in managing digital risk across the business.

- 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.

- 318 migrations have been successfully completed, this includes 7 departments, which put the project completion to 49% and will continue to ramp up in the coming weeks.

- The newly formed Information Security team will be responsible for securing the organization's data, managing cyber risk, incident response, and ensuring governance and compliance.

- Hardened endpoint security by eliminating one of the most significant vulnerabilities discovered during the 2024 penetration test – the removal of a legacy local administration accounts that existed on all workstations.

- The 2024 Annual Security Awareness Trainings currently has a ninety-eight percent (98%) staff completion rate. The Security Office will follow the guidelines in CMP-026 to achieve 100% Staff completion.

Data Retention Project (Phase 1)

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

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

- The scan of the Windows file share (SFTP) is completed with 8.79 million files. Data retention policies are defined, and the maximum file type is .txt, which contributes approximately 80% of the overall findings.

- The data warehouse scanning focused on master and transactional data, excluding reference data. Over 11.9 million records, older than 10 years, were flagged.

- The data warehouse is divided into eight domains. Major findings are in two: the Medical Encounter Domain with twelve key tables having many over-retained records, and the Member Domain with four key tables, one staging table accounting for 98% of the findings. The Provider and Claims Domains have minimal findings.

- As part of Phase 1, DWH table scans and Data Retention configuration are complete.

Information Technology
Supporting Documents

Enrollment

- See Table 1-1 "Summary of Medi-Cal and Group Care member enrolment in the month of November 2024".
- See Table 1-2 "Summary of Primary Care Physician (PCP) Auto-assignment in the month of November 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 November 2024

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
November	406,926	7,739	7,579	5,771	126	123

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 November 2024

Auto-Assignments	Member Count
Auto-assignments MC	2,284
Auto-assignments Expansion	1,764
Auto-assignments GC	62
PCP Changes (PCP Change Tool) Total	4,110

TruCare Application

- See Table 2-1 "Summary of TruCare Authorizations for the month of November 2024".
- There were 16,885 authorizations processed within the TruCare application.
- TruCare Application Uptime – 99.7%.
- 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 November 2024*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,040
Provider Portal Requests (Zipari)	4910
EDI (CHCN)	5,845
Provider Portal to AAH Online (Long Term Care)	13
ADT	982
Behavioral Health COC Update - Online	46
Behavioral initial evaluation - Online	37
Manual Entry (all other not automated or faxed vs portal use)	3,012
Total	16885

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 are always one month behind current month)

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

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	7,928	5,834	452,273	803
MCAL	118,771	3.531	8.175	1,044
IHSS	3,854	81	292	23
Total	130,553	9,446	460,740	1,870

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

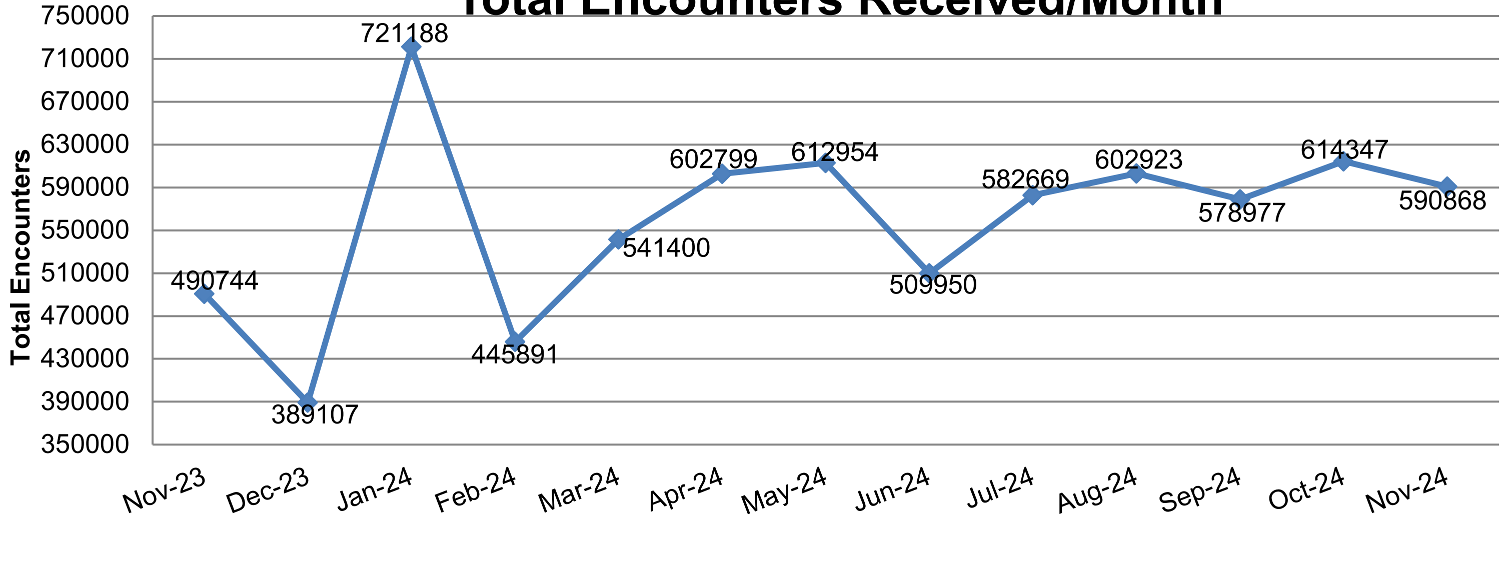
Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1,612,277
Provider - Claims	Claim Status	283,972
Provider - eligibility/claim	Claim Status	32,095
Provider - authorizations	Auth Submit	20,287
Provider - authorizations	Auth Search	8,386
Member Config	Provider Directory	5,372
Provider - Claims	Submit professional claims	4,537
Member My Care	Member Eligibility	4,288
Member Help Resources	Find a Doctor or Hospital	2,782
Provider - eligibility	Member Eligibility	2,662
Member Help Resources	ID Card	2,264
Provider - eligibility/claim	Member Roster	2,201
Member Help Resources	Select or Change Your PCP	1,643
Member Home	MC ID Card	1,339
Member My Care	My Claims Services	1,131
Provider - reports	Reports	1,088
Provider - Provider Directory	Provider Directory 2019	1,046
Member My Care	Authorization	793
Provider - Home	Behavior Health Forms SSO	562
Provider - Home	Forms	474
Member My Care	My Pharmacy Medication Benefits	423
Provider - Provider Directory	Instruction Guide	346
Member Help Resources	FAQs	318
Member My Care	Member Benefits Materials	296
Provider - Provider Directory	Manual	293
Member Help Resources	Forms Resources	259
Member Help Resources	Authorizations Referrals	251
Member Help Resources	Contact Us	227

Encounter Data From Trading Partners 2024

- **AHS**: November weekly files (10,535 records) were received on time.
- **BACH**: November monthly files (795 records) were received on time.
- **BACS**: November monthly files (98 records) were received on time.
- **CHCN**: November weekly files (127,223 records) were received on time.
- **CHME**: November monthly files (7,589 records) were received on time.
- **CFMG**: November monthly files (21,352 records) were received on time.
- **Docustream**: November monthly files (678 records) were received on time.
- **EBI**: November monthly files (1,724 records) were received on time.
- **FULLCIR**: November monthly files (2,038 records) were received on time.
- **HCSA**: November monthly files (3,423 records) were received on time.
- **IOA**: November monthly files (1,064 records) were received on time.
- **Kaiser**: November bi-weekly files (0 records) were received on time.
- **LAFAM**: November monthly files (76 records) were received on time.
- **LIFE**: November monthly files (335 records) were received on time
- **LogistiCare**: November weekly files (16,183 records) were received on time.
- **March Vision**: November monthly files (6,016 records) were received on time.
- **MED**: November monthly files (656 records) were received on time.
- **OMATOCHI**: November monthly files (0 records) were received on time.
- **PAIRTEAM**: November monthly files (2,204 records) were received on time.
- **Quest Diagnostics**: November weekly files (22,501 records) were received on time.
- **SENECA**: November monthly files (117 records) were received on time.
- **TITANIUM**: November monthly files (1,537 records) were received on time.
- **TVHC**: November monthly files (593 records) were received on time.
- **Magellan**: November monthly files (430,892 records) were received on time.

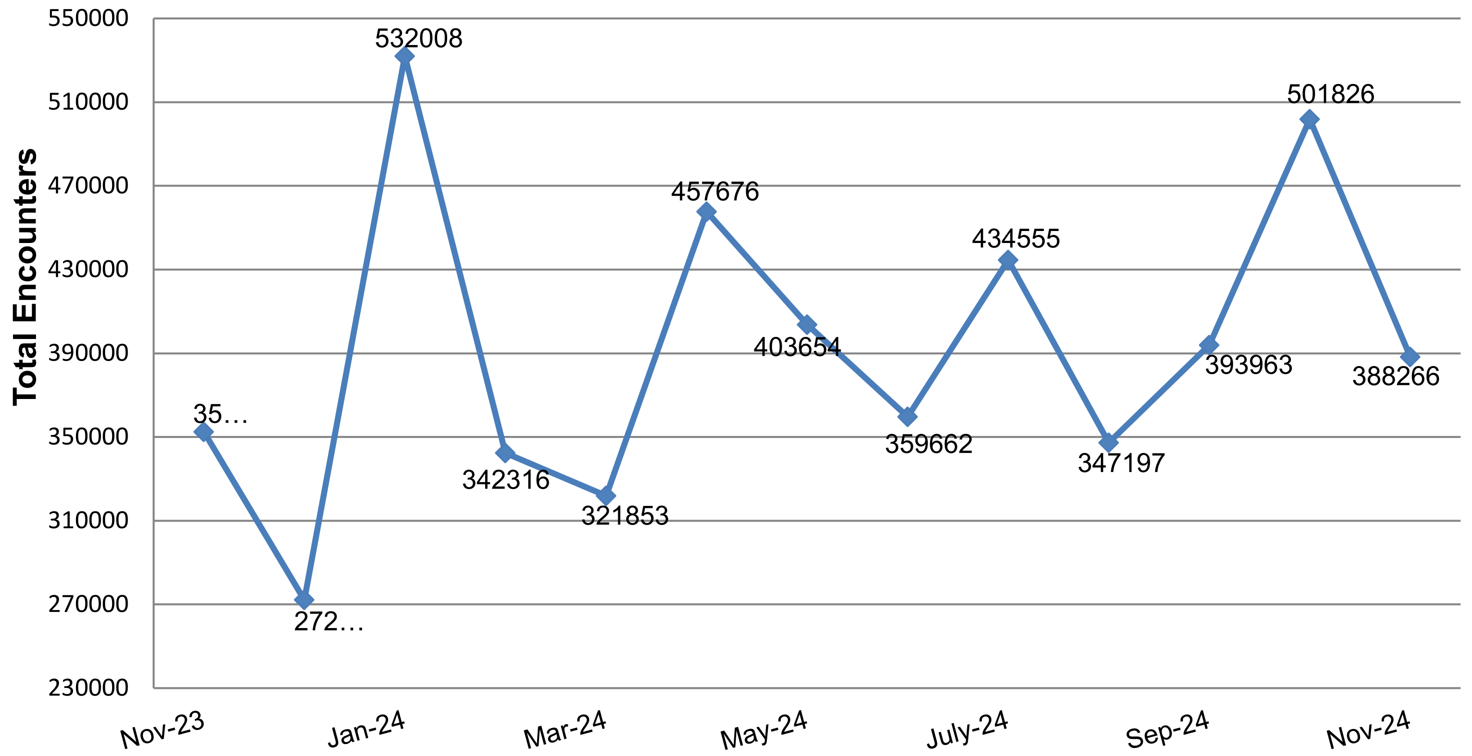
Trading Partner Encounter Inbound Submission History

Trading Partners	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Health Suite	247537	215246	298465	266339	308453	322786	375454	297267	332150	368235	322196	367989	364130
AHS	5243	6284	4570	7736	7005	6573	8412	13316	7296	8859	7498	8309	10535
BACH													795
BACS	73	55	59	57	55	64	70	77	88	86	85	76	98
CHCN	87839	58566	96124	103674	122217	170653	122445	110650	135444	122293	155825	125042	127223
CHME	6445	5694	5843	5560	6022	7969	7107	7449	7242	6902	7680	7102	7589
Claimsnet	11670	18995	12043	10557	12651	16394	15934	21143	10776	22335	16421	16045	21352
Docustream	705	476	930	814	698	302	1589	749	934	1102	1067	704	678
EBI	823	811	1047	2903	1625	1700	184	2043	1623	1825	3394	1640	1725
FULLCIR	598	177	828	1586	213	2261	8478	2842	1362	1798	3809	2523	2038
HCSA	2403	2087	2223	2097	2822	7118	5535	3663	6841	3256	3386	2389	3423
IOA	1073	1250	1453	1233	1054	1925	1163	1280	847	752	4227	588	1064
Kaiser	87005	26208	77407	3725	9966	2286	886	1079	2052	172	236	159	
LAFAM				60	39	105	116	86	70	88	63	89	76
LIFE								1694		614	168	119	335
LogistiCare	20781	32181	182822	20774	35600	32632	27531	16205	43038	29732	16139	49941	16183
March Vision	4428	4562	9693		6183	3633	8546	7092	6404	7719	5769	5143	6016
MED	523	532	535	742	683	633	722	744	615	608	610	645	656
OMATOCHI						29				2			
PAIRTEAM						5344	7582		5763		9359	1108	2204
Quest	13077	15834	27022	17658	22306	18000	18001	22500	18000	22502	18004	18002	22501
SENECA	56	52	124	222	112	159	113	71	109	129	101	105	117
TITANIUM	465	97		154	3696	2233	3086		2015	3914	2815	6192	1537
TVHC											125	437	593
Total	490744	389107	721188	445891	541400	602799	612954	509950	582669	602923	578977	614347	590868



Outbound Encounter Submission

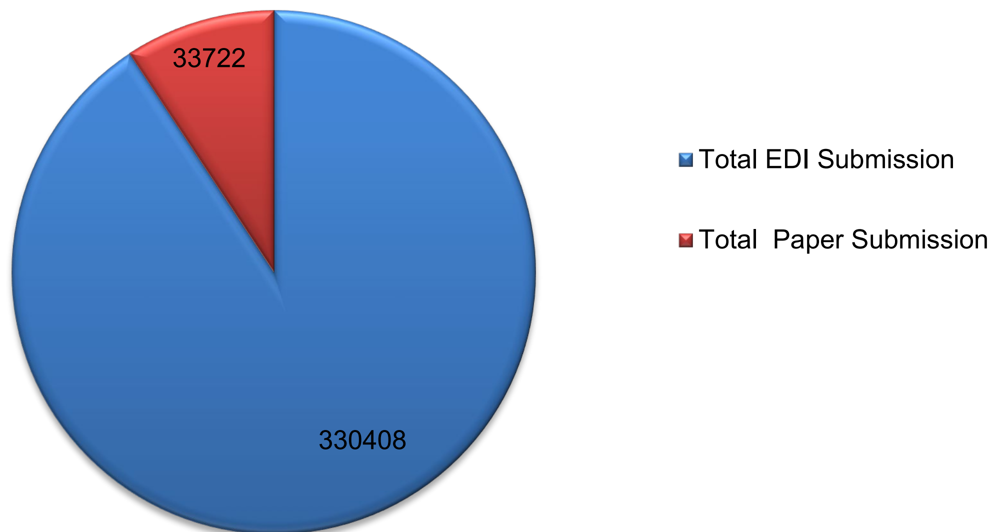
Trading Partners	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Health Suite	134823	136233	172386	177658	147776	250835	198595	204068	230706	183371	210971	276473	218194
AHS	5147	4936	5667	7497	6968	6524	7002	10684	6703	7101	8727	8201	10403
BACH													739
BACS	67	53	55	55	47	59	66	72	80	80	78	74	79
CHCN	73866	39846	67063	74336	80498	104625	107577	77200	94476	87485	87806	108806	88573
CHME	6321	5588	5703	5470	5889	7558	6749	7310	7095	6762	6994	6974	7474
Claimsnet	8031	11581	10145	7730	6757	13467	11561	11506	9994	4	24076	13152	13882
Docustream	573	404	387	600	377	267	839	570	725	806	715	545	482
EBI	794	802	987	1347	1002	1589	60	1835	1443	1727	3242	1559	1641
FULLCIR	516	124	653	540	116	1636	5401	2410	1084	674	1515	1767	1470
HCSA	2342	1991	2142	2013	2769	4710	5363	3493	6757	3171	3310	2376	3394
IOA	934	1228	1378	1156	1000	1868	1029	1221	749	680	1374	549	949
Kaiser	85807	26113	76335	3542	9650	1905	1292	812	1404	113	216	62	
LAFAM					16	92	103	58	66	81	58	86	62
LIFE								28		598	159	91	76
LogistiCare	25951	31546	157548	40529	34931	32247	27487	16221	43019	30006	16046	49705	15235
March Vision	2661	2752	2700	2616	3736	2407	5719	4553	3766	3482	4066	3543	3980
MED	438	428	446	624	528	518	579	654	552	540	514	579	568
OMATOCHI						56							
PAIRTEAM						4279	4422		3246		4617	782	1960
Quest	3655	8394	28299	16589	16333	20983	16912	16898	20898	16854	16937	21144	16909
SENECA	52	48	114	14	199	140	109	69	108	127	94	91	100
TITANIUM	438	75			3261	1911	2789		1684	3535	2332	5267	1278
TVHC											116		818
Total	352416	272142	532008	342316	321853	457676	403654	359662	434555	347197	393963	501826	388266


Total Outbound Encounter/Month
Total Encounters
550000
510000
470000
430000
390000
350000
310000
270000
230000
35…
272…
532008
342316
321853
457676
403654
359662
434555
347197
393963
501826
388266
Nov-23
Jan-24
Mar-24
May-24
July-24
Sep-24
Nov-24

HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
24-Nov	330408	33722	364130

Key: EDI – Electronic Data Interchange

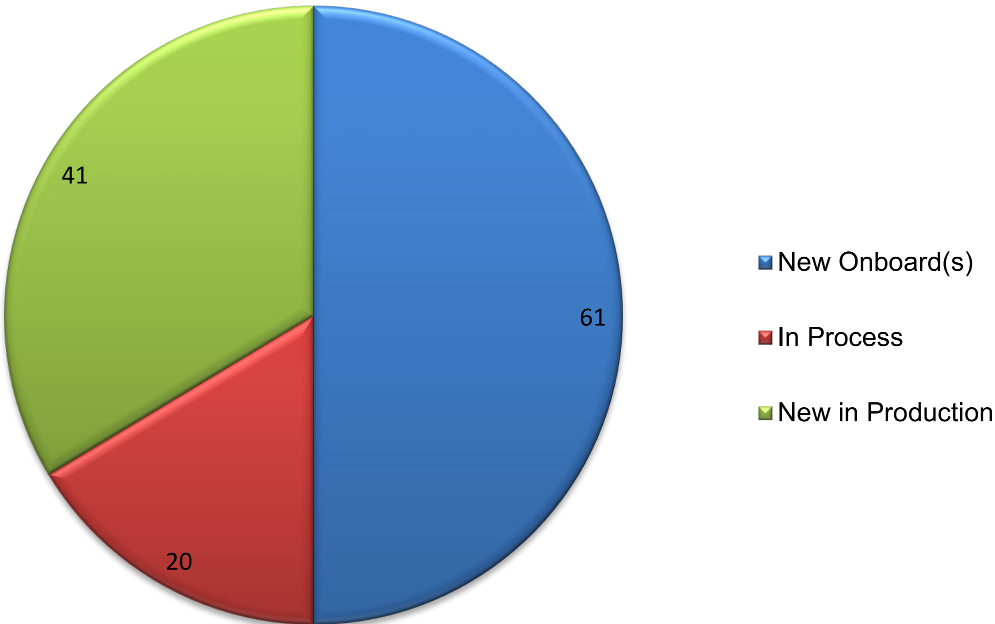


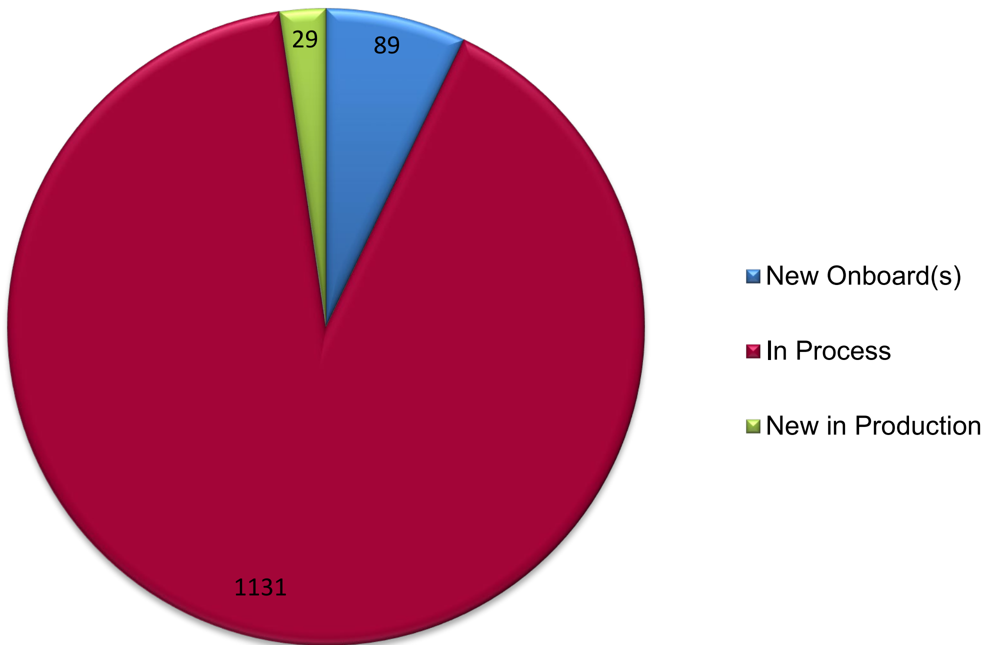
Onboarding EDI Providers – Updates

- Nov 2024 EDI Claims:
    - A total of 2780 new EDI submitters have been added since October 2015, with 41 added in November 2024.
    - The total number of EDI submitters is 3520 providers.

- Nov 2024 EDI Remittances (ERA):
    - A total of 1216 new ERA receivers have been added since October 2015, with 29 added in November 2024.
    - The total number of ERA receivers is 1203 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
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
Oct-24	60	4	56	3479	80	1071	36	1174
Nov-24	61	20	41	3520	89	1131	29	1203


837 EDI Submitters - NOV 2024
41
61
20
New Onboard(s)
In Process
New in Production


835 EDI Receivers - NOV 2024
29
89
1131
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 **November** 2024.

File Type	Nov-24
837 I Files	35
837 P Files	142
Total Files	177

Lag-time Metrics/Key Performance Indicators (KPI)

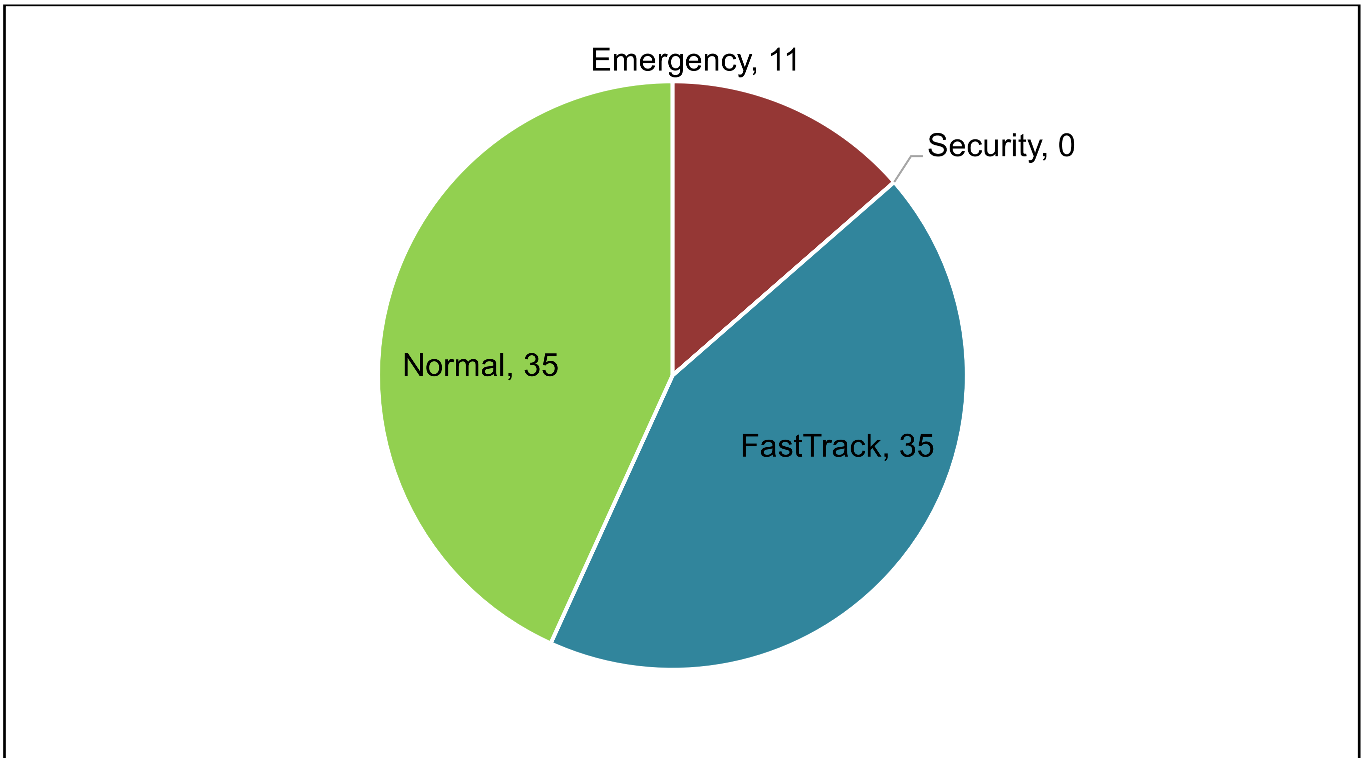
AAH Encounters: Outbound 837	Nov-24	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	93%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	97%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	91%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	95%	80%

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

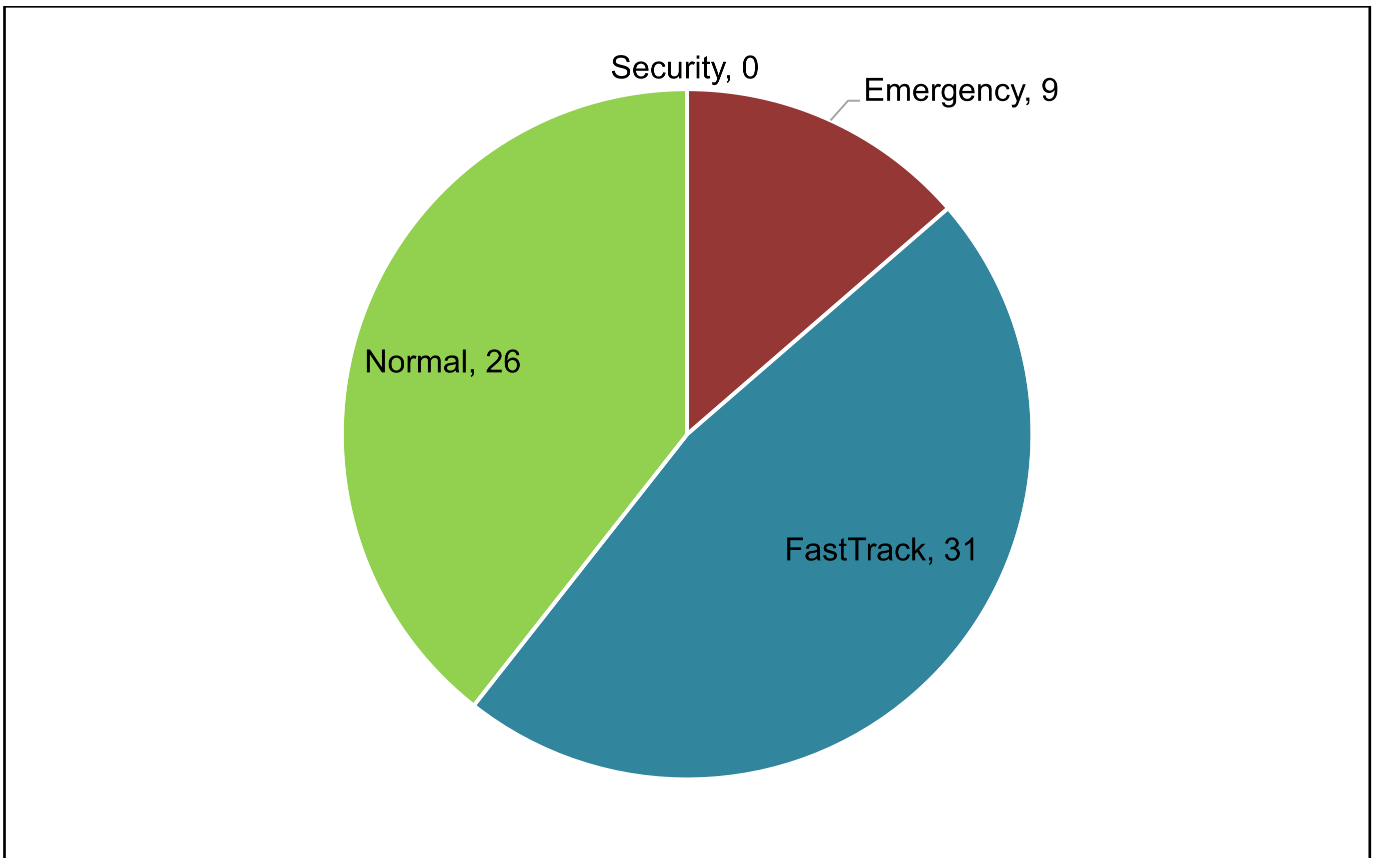
Change Management Key Performance Indicator (KPI)

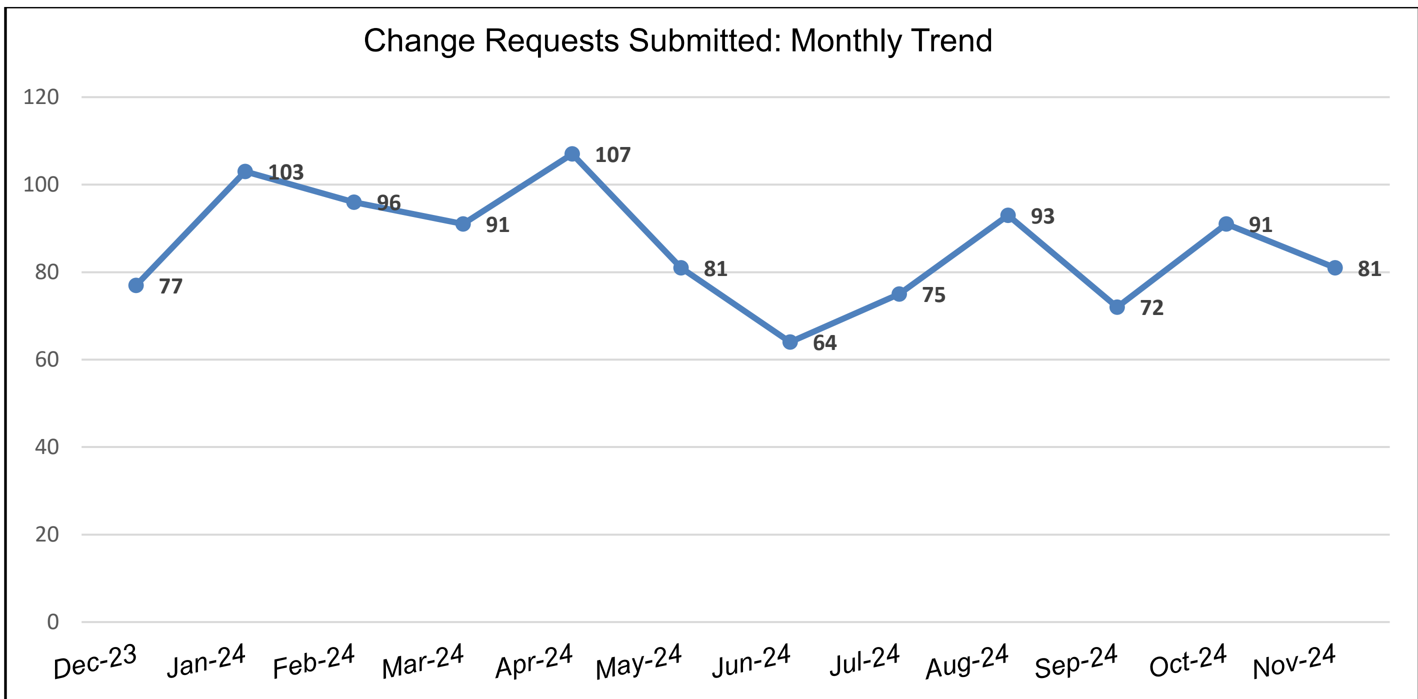
- Change Request Overall Summary in the month of November 2024 KPI:
  - 81 Changes Submitted.
  - 66 Changes Completed and Closed.
  - 117 Active Change Requests in pipeline.
  - 11 Change Requests Cancelled or Rejected.

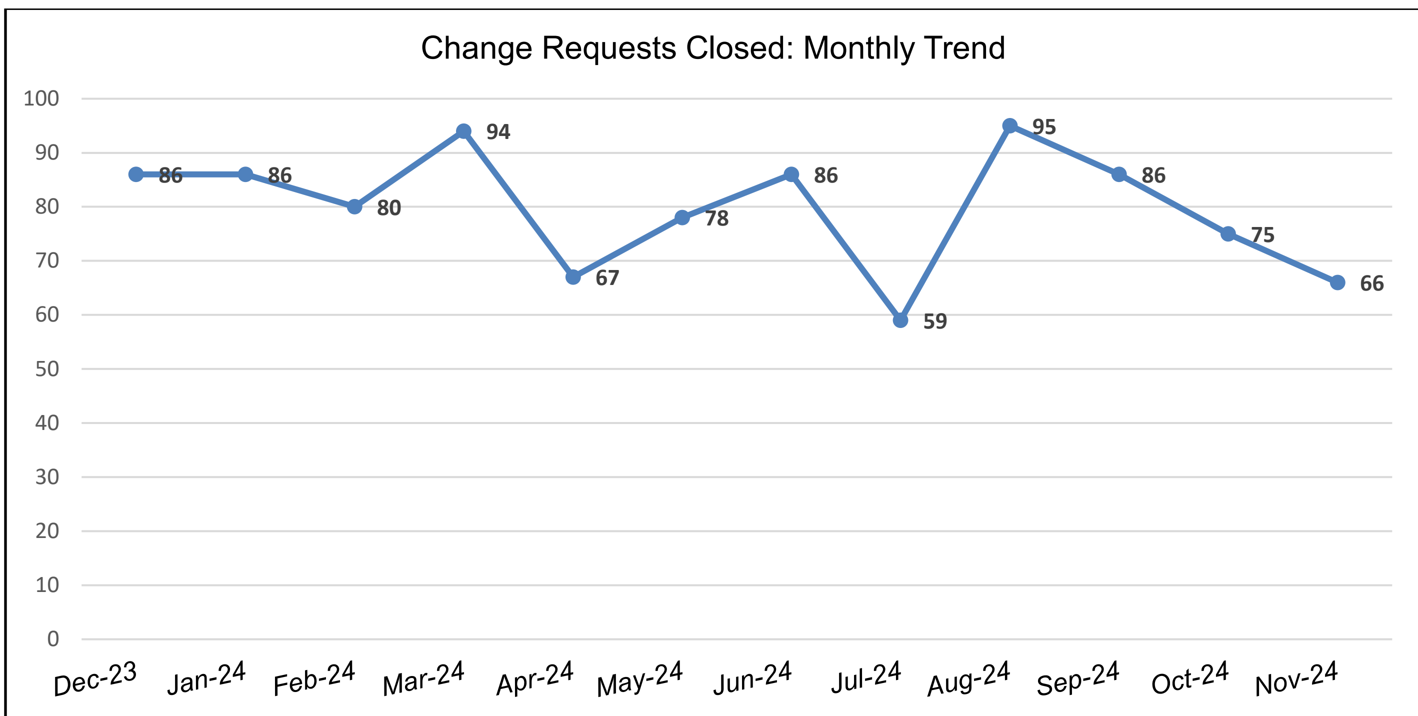
- 81 Change Requests Submitted/Logged in the month of November 2024



- 66 Change Requests Closed in the month of November 2024




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
77
103
96
91
107
81
64
75
93
72
91
81
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24


Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
86
86
80
94
67
78
86
59
95
86
75
66
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24

IT Stats: Infrastructure

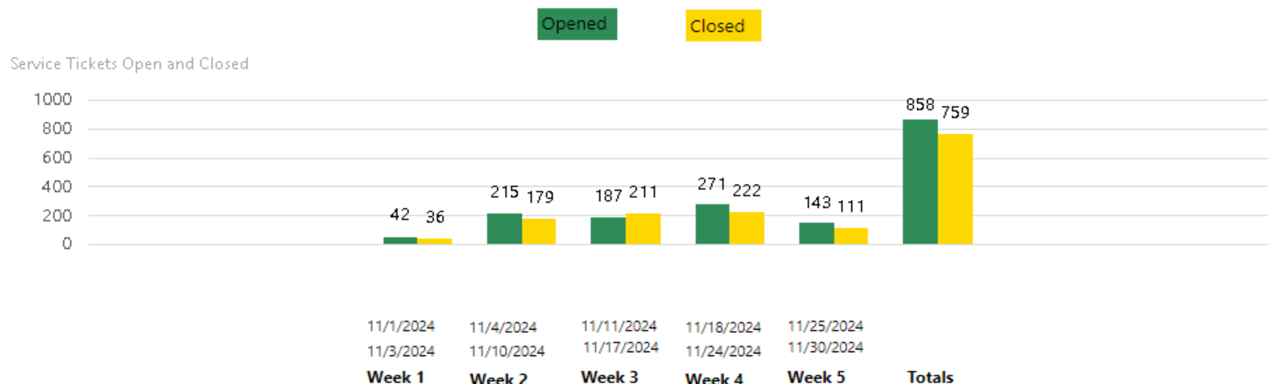
Application Server Uptimes - November 2024

	Call Center	DynamicsSL (Finance)	HealthSuite	OTG (Claims)	o365 (Email)	TruCare	FTP
Week 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 2	100.00%	100.00%	99.18%	100.00%	100.00%	100.00%	100.00%
Week 3	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 4	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- All mission critical applications are monitored and managed thoroughly.
- On Thursday, November 14, 2024, HEALTHsuite application experienced a partial outage that lasted for 20 mins.

IT Stats: Service Desk

IT Service Tickets Open and Closed



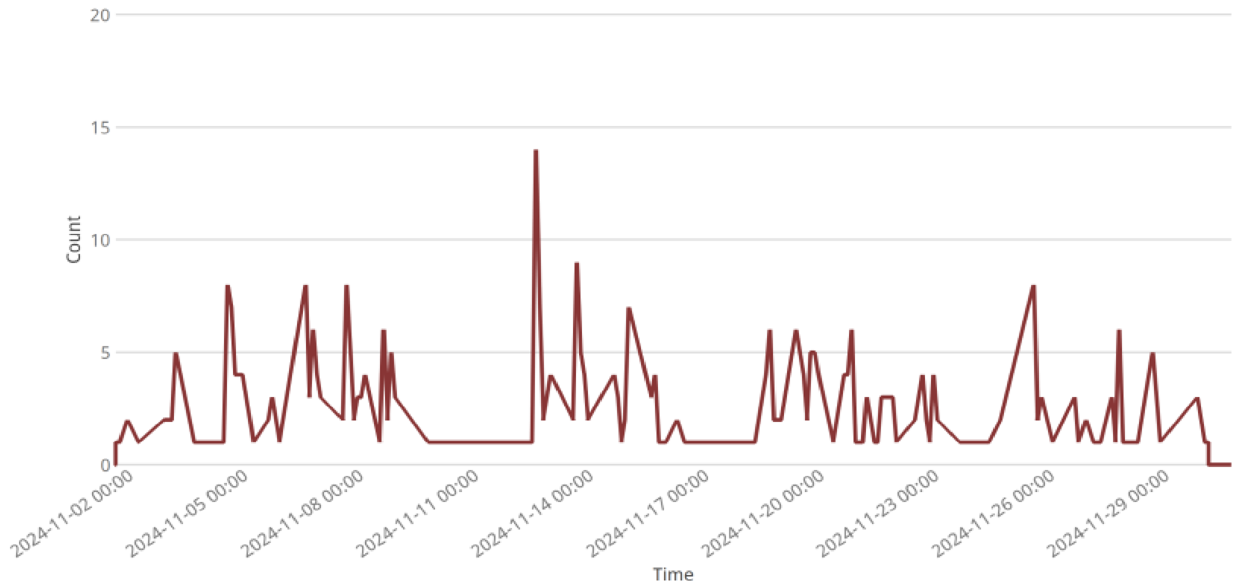
- 858 Service Desk tickets were opened in the month of November 2024, which is 15.22% lower than the previous month (1012) and 17.18% lower than the previous 3-month average of 1,036.

- 759 Service Desk tickets were closed in the month of November 2024, which is 29.26% lower than the previous month (1073) and 26.31% lower than the previous 3-month average of 1,030.

IT Stats: Network

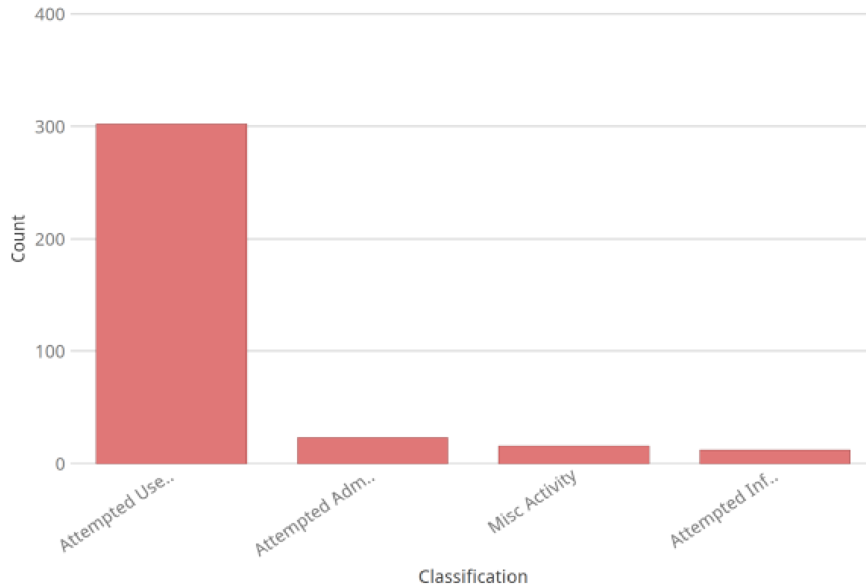
All Intrusion Events

Time Window: *2024-11-01 09:29:00 - 2024-11-30 09:29:00*



Dropped Intrusion Events

Time Window: *2024-11-01 09:30:00 - 2024-11-30 09:30:00*
Constraints: *Inline Result = !Alert,!Would **



Classification	Count
Attempted User Privilege Gain	302
Attempted Administrator Privilege Gain	23
Misc Activity	16
Attempted Information Leak	12

Item / Date	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	*May-24*	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	*Nov*
Attempted Admin Privilege Gain	0	1	7	4	48	3	1	4	1	3	250	5	*2*
Attempted User Privilege Gain	48	48	69	330	526	569	554	474	17	8	329	337	*3(*
Attempted Information Leak	51	50	65	51	72	57	46	66	0	46	118	11	*1*
Potential Corp Policy Violation	0	0	0	3	4	0	0	0	0	0	0	0	*(*
Network Scans Detected	0	0	0	0	0	0	0	0	0	0	0	0	*(*
Web Application Attack	4	4	1	0	0	5	3	4	0	0	15	0	*(*
Attempted Denial of Service	0	0	0	0	0	0	1	0	1	0	4	0	*(*
Misc. Attack	347	2,146	1	424	332	795	145	64	29	124	72	28	*1*

- 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.
- Attempted information leaks detected and blocked at the firewall is at 12 for the month of November 2024.
- Network scans returned a value of 0, which is in line with previous month's data.
- Attempted User Privilege Gain is at 337 from a previous six-month average of 244.5.

Analytics

Tiffany Cheang

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

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

Date: **December 13th, 2024**

Subject: **Performance & Analytics Report**

Member Cost Analysis

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

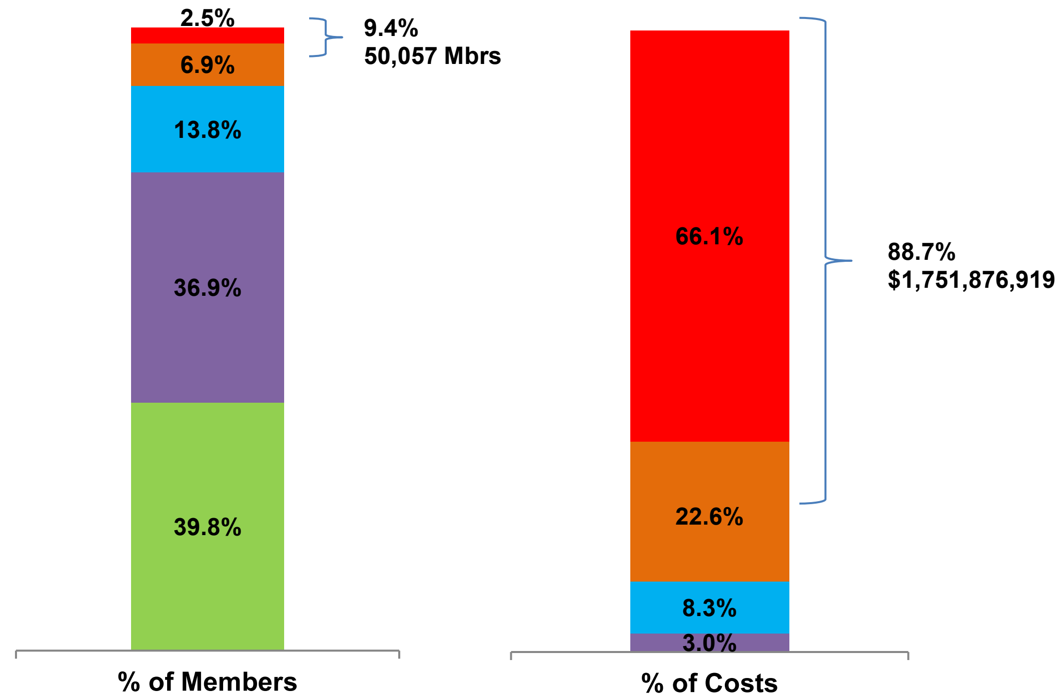
Current reporting period: Sep 2023 – Aug 2024 dates of service
Prior reporting period: Sep 2022 – Aug 2023 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 9.4% of members account for 88.7% 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 54.9% of the members, with SPDs accounting for 21.1% and ACA OE's at 33.8%.
    - The percent of members with costs >= $30K slightly decreased from 2.7% to 2.5%.
    - 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 9.4% is more concentrated in the 45-66 year old category (36.6%) 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: Sep 2023 - Aug 2024
Note: Data incomplete due to claims lag
Run Date: 11/26/2024



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	13,290	2.5%	$ 1,305,870,841	66.1%
$5K - $30K	36,767	6.9%	$ 446,006,077	22.6%
$1K - $5K	73,240	13.8%	$ 164,017,212	8.3%
< $1K	195,714	36.9%	$ 59,210,756	3.0%
$0	211,263	39.8%	$ -	0.0%
Totals	**530,274**	**100.0%**	**$ 1,975,104,886**	**100.0%**

Top 9.4% of Members = 88.7% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	3,809	0.7%	$ 784,260,649	39.7%
$75K to $100K	1,921	0.4%	$ 165,693,114	8.4%
$50K to $75K	2,752	0.5%	$ 169,213,886	8.6%
$40K to $50K	1,999	0.4%	$ 89,242,677	4.5%
$30K to $40K	2,809	0.5%	$ 97,460,514	4.9%
SubTotal	***13,290***	***2.5%***	***$ 1,305,870,841***	***66.1%***
$20K to $30K	5,135	1.0%	$ 125,259,799	6.3%
$10K to $20K	13,852	2.6%	$ 194,087,054	9.8%
$5K to $10K	17,780	3.4%	$ 126,659,225	6.4%
SubTotal	***36,767***	***6.9%***	***$ 446,006,077***	***22.6%***
Total	**50,057**	***9.4%***	**$ 1,751,876,919**	***88.7%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Aug 2024	405,455	$ 1,787,709,402
Dis-Enrolled During Year	124,819	$ 187,395,484
Totals	**530,274**	**$ 1,975,104,886**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
9.4% of Members = 88.7% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Sep 2023 - Aug 2024
Note: Data incomplete due to claims lag
Run Date: 11/26/2024

9.4% of Members = 88.7% of Costs
21.1% of members are SPDs and account for 27.5% of costs.
33.8% of members are ACA OE and account for 32.6% of costs.
9.0% of members disenrolled as of Aug 2024 and account for 9.5% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	172	842	1,014	2.0%
MCAL	MCAL - ADULT	1,132	6,685	7,817	15.6%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	553	3,400	3,953	7.9%
	MCAL - ACA OE	4,083	12,858	16,941	33.8%
	MCAL - SPD	3,644	6,909	10,553	21.1%
	MCAL - DUALS	1,005	2,947	3,952	7.9%
	MCAL - LTC	191	6	197	0.4%
	MCAL - LTC-DUAL	1,033	78	1,111	2.2%
Not Eligible	Not Eligible	1,477	3,042	4,519	9.0%
Total		**13,290**	**36,767**	**50,057**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 14,257,548	$ 9,817,695	$ 24,075,242	1.4%
MCAL	MCAL - ADULT	$ 104,845,543	$ 79,010,691	$ 183,856,233	10.5%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 41,507,487	$ 37,696,148	$ 79,203,635	4.5%
	MCAL - ACA OE	$ 416,128,062	$ 155,462,023	$ 571,590,085	32.6%
	MCAL - SPD	$ 392,456,451	$ 89,854,925	$ 482,311,377	27.5%
	MCAL - DUALS	$ 84,568,739	$ 34,924,816	$ 119,493,555	6.8%
	MCAL - LTC	$ 26,323,340	$ 104,689	$ 26,428,029	1.5%
	MCAL - LTC-DUAL	$ 97,895,797	$ 1,167,285	$ 99,063,082	5.7%
Not Eligible	Not Eligible	$ 127,887,874	$ 37,967,807	$ 165,855,681	9.5%
Total		**$ 1,305,870,841**	**$ 446,006,077**	**$ 1,751,876,919**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
31.7% of members are SPDs and account for 33.1% of costs.
28.6% of members are ACA OE and account for 33.2% of costs.
8.4% of members disenrolled as of Aug 2024 and account for 8.5% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	43	1.1%
MCAL	MCAL - ADULT	239	6.3%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	79	2.1%
	MCAL - ACA OE	1,090	28.6%
	MCAL - SPD	1,208	31.7%
	MCAL - DUALS	316	8.3%
	MCAL - LTC	126	3.3%
	MCAL - LTC-DUAL	388	10.2%
Not Eligible	Not Eligible	320	8.4%
Total		**3,809**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 7,556,803	1.0%
MCAL	MCAL - ADULT	$ 58,522,650	7.5%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 18,764,778	2.4%
	MCAL - ACA OE	$ 260,708,560	33.2%
	MCAL - SPD	$ 259,401,567	33.1%
	MCAL - DUALS	$ 42,028,539	5.4%
	MCAL - LTC	$ 21,667,782	2.8%
	MCAL - LTC-DUAL	$ 48,958,787	6.2%
Not Eligible	Not Eligible	$ 66,651,183	8.5%
Total		**$ 784,260,649**	**100.0%**

% of Total Costs By Service Type

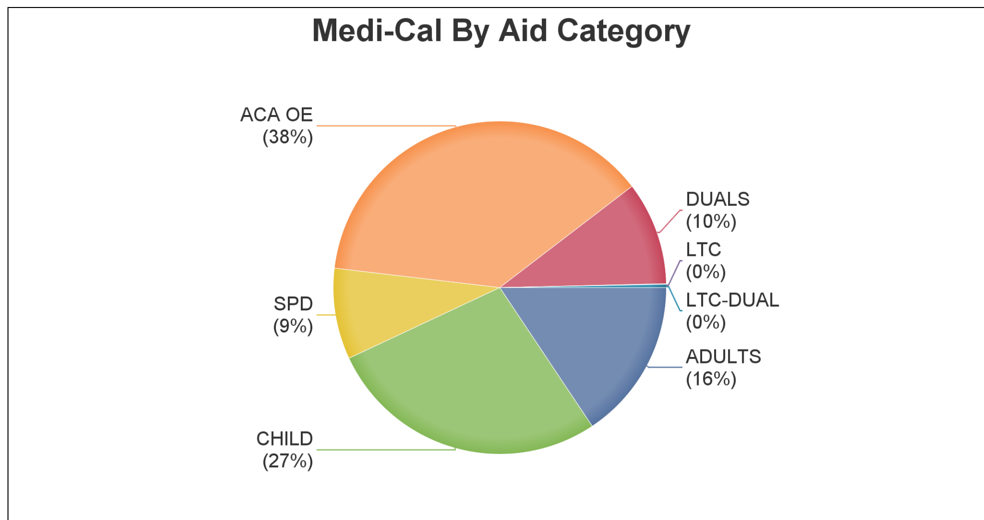
				Breakout by Service Type/Location						
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	6%	0%	1%	14%	40%	1%	11%	3%	2%	28%
$75K to $100K	4%	0%	1%	16%	23%	2%	4%	3%	4%	48%
$50K to $75K	4%	0%	1%	23%	27%	4%	6%	5%	4%	32%
$40K to $50K	6%	0%	2%	31%	28%	7%	5%	6%	2%	21%
$30K to $40K	10%	0%	3%	32%	22%	13%	5%	6%	1%	21%
$20K to $30K	3%	1%	5%	37%	23%	7%	7%	7%	1%	18%
$10K to $20K	0%	0%	11%	35%	25%	6%	9%	9%	2%	15%
$5K to $10K	0%	0%	6%	32%	13%	10%	12%	13%	1%	18%
Total	**5%**	**0%**	**3%**	**22%**	**31%**	**4%**	**9%**	**5%**	**2%**	**27%**

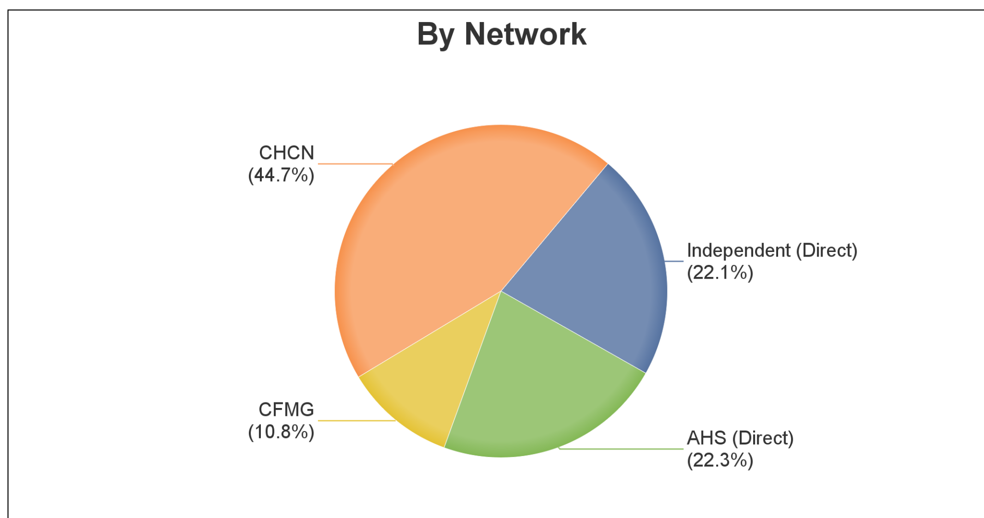
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Oct 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,608	16%	12,945	14,279	7	35,377
CHILD	109,680	27%	9,208	13,554	40,986	45,932
SPD	35,389	9%	11,549	5,593	1,424	16,823
ACA OE	151,098	38%	26,103	53,525	1,490	69,980
DUALS	40,144	10%	26,290	2,883	6	10,965
LTC	249	0%	231	8	0	10
LTC-DUAL	1,265	0%	1,264	0	0	1
Medi-Cal	400,433		87,590	89,842	43,913	179,088
Group Care	5,769		2,166	920	0	2,683
Total	**406,202**	**100%**	**89,756**	**90,762**	**43,913**	**181,771**
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	**22.1%**	**22.3%**	**10.8%**	**44.7%**
			% Direct:	**44%**	**% Delegated:**	**56%**

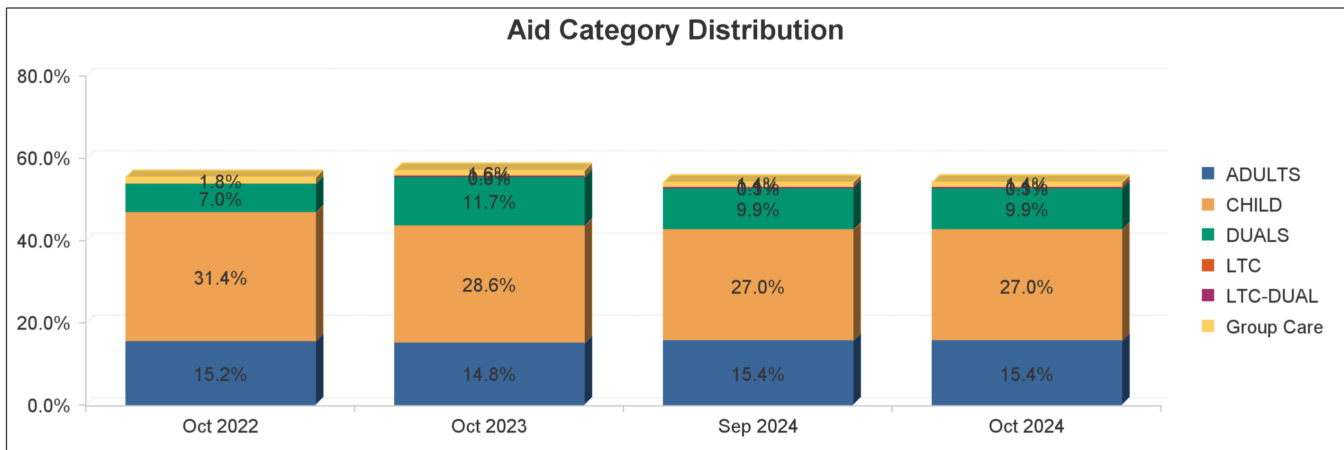




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

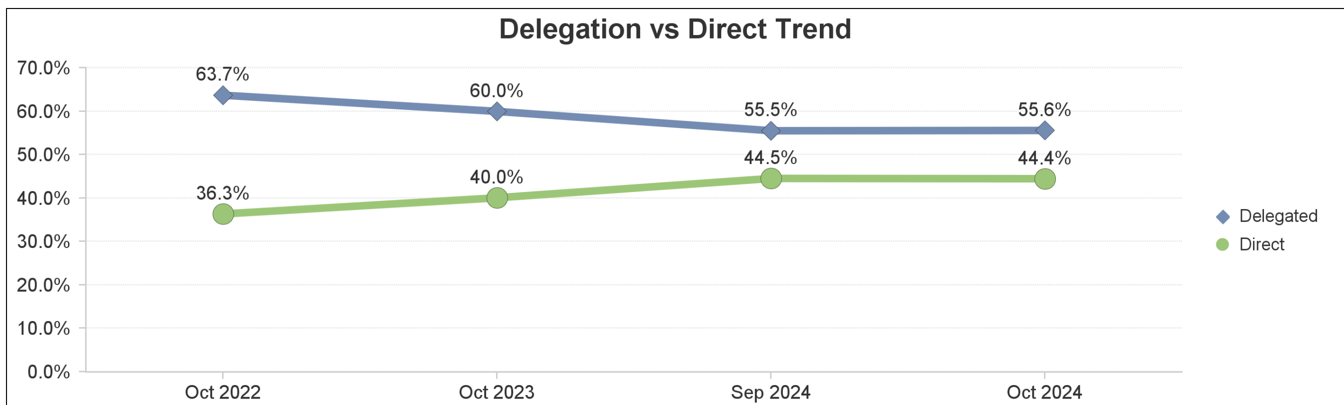
Category of Aid Trend

Category of Aid	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022 to Oct 2023	Oct 2023 to Oct 2024	Sep 2024 to Oct 2024
ADULTS	49,162	52,396	62,572	**62,608**	15.2%	14.8%	15.4%	15.4%	6.6%	19.5%	0.1%
CHILD	101,323	101,120	109,739	**109,680**	31.4%	28.6%	27.0%	27.0%	-0.2%	8.5%	-0.1%
SPD	28,237	30,888	35,322	**35,389**	8.7%	8.7%	8.7%	8.7%	9.4%	14.6%	0.2%
ACA OE	116,205	121,430	150,999	**151,098**	36.0%	34.3%	37.2%	37.2%	4.5%	24.4%	0.1%
DUALS	22,482	41,496	40,117	**40,144**	7.0%	11.7%	9.9%	9.9%	84.6%	-3.3%	0.1%
LTC	0	135	240	**249**	0.0%	0.0%	0.1%	0.1%	0.0%	84.4%	3.8%
LTC-DUAL	0	997	1,254	**1,265**	0.0%	0.3%	0.3%	0.3%	0.0%	26.9%	0.9%
Medi-Cal	317,409	348,462	400,243	**400,433**	98.2%	98.4%	98.6%	98.6%	9.8%	14.9%	0.0%
Group Care	5,789	5,605	5,710	**5,769**	1.8%	1.6%	1.4%	1.4%	-3.2%	2.9%	1.0%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.6%**	**14.7%**	**0.1%**



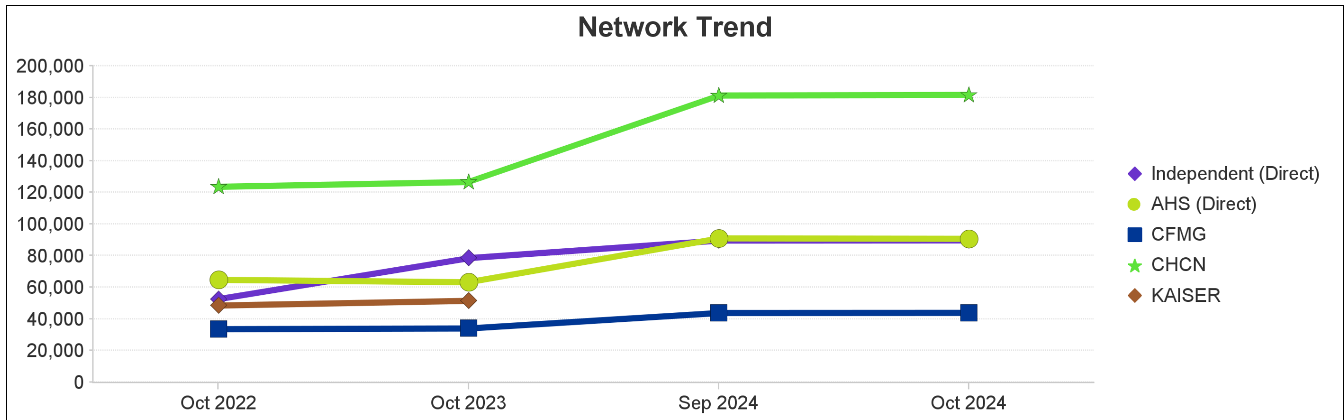
Delegation vs Direct Trend

Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022 to Oct 2023	Oct 2023 to Oct 2024	Sep 2024 to Oct 2024
Delegated	205,828	212,266	225,266	**225,684**	63.7%	60.0%	55.5%	55.6%	3.1%	6.3%	0.2%
Direct	117,370	141,801	180,687	**180,518**	36.3%	40.0%	44.5%	44.4%	20.8%	27.3%	-0.1%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.6%**	**14.7%**	**0.1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

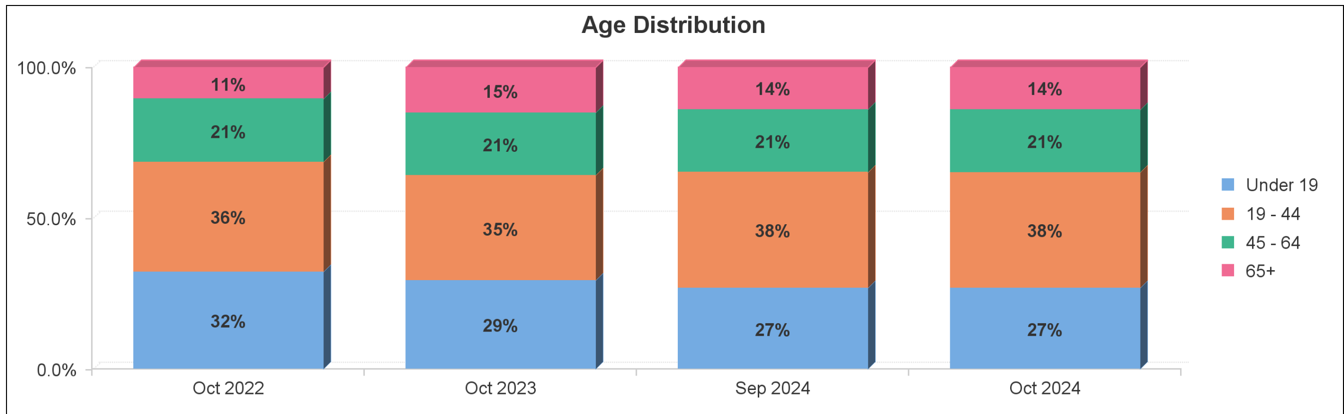
Network Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022 to Oct 2023	Oct 2023 to Oct 2024	Sep 2024 to Oct 2024
Independent (Direct)	52,571	78,530	89,659	**89,756**	16.3%	22.2%	22.1%	22.1%	49.4%	14.3%	0.1%
AHS (Direct)	64,799	63,271	91,028	**90,762**	20.0%	17.9%	22.4%	22.3%	-2.4%	43.4%	-0.3%
CFMG	33,617	34,035	43,838	**43,913**	10.4%	9.6%	10.8%	10.8%	1.2%	29.0%	0.2%
CHCN	123,666	126,705	181,428	**181,771**	38.3%	35.8%	44.7%	44.7%	2.5%	43.5%	0.2%
KAISER	48,545	51,526	0	**0**	15.0%	14.6%	0.0%	0.0%	6.1%	-100.0%	0.0%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.6%**	**14.7%**	**0.1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

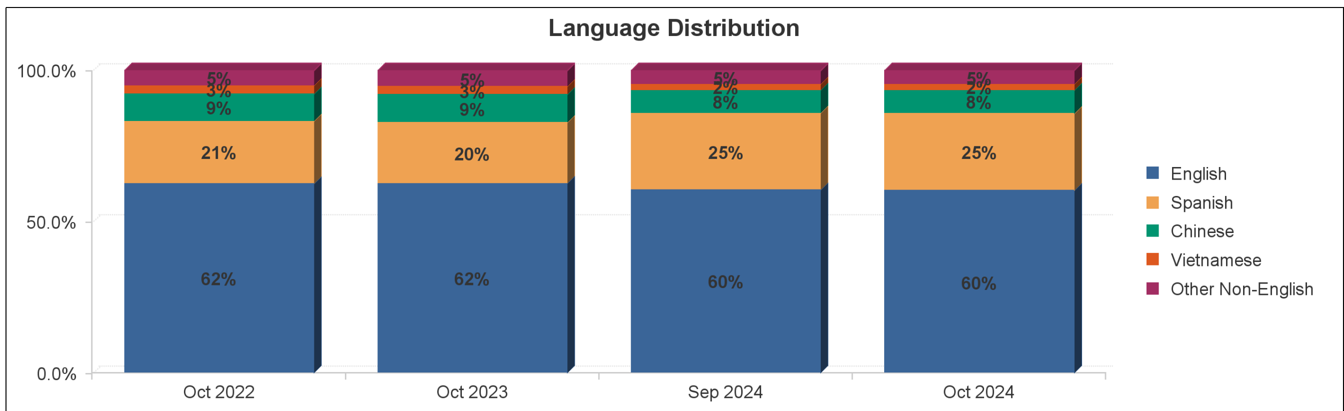
Age Category Trend

Age Category	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022 to Oct 2023	Oct 2023 to Oct 2024	Sep 2024 to Oct 2024
Under 19	103,541	103,512	108,338	**108,379**	32%	29%	27%	27%	0%	5%	0%
19 - 44	117,664	123,390	155,780	**155,783**	36%	35%	38%	38%	5%	26%	0%
45 - 64	67,687	73,229	84,362	**84,315**	21%	21%	21%	21%	8%	15%	0%
65+	34,306	53,936	57,473	**57,725**	11%	15%	14%	14%	57%	7%	0%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100%**	**100%**	**100%**	**100%**	**10%**	**15%**	**0%**



Language Trend

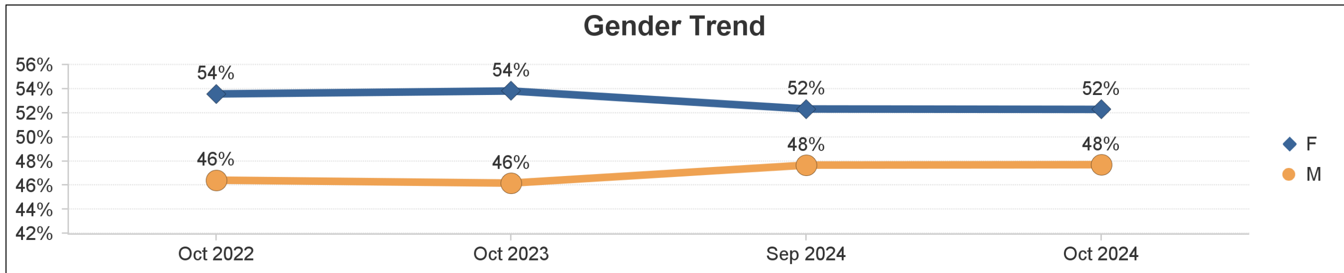
Language	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022	Oct 2023	Sep 2024	Oct 2024	Oct 2022 to Oct 2023	Oct 2023 to Oct 2024	Sep 2024 to Oct 2024
English	201,780	221,283	245,070	**244,693**	62%	62%	60%	60%	10%	11%	0%
Spanish	66,629	71,409	102,701	**103,228**	21%	20%	25%	25%	7%	45%	1%
Chinese	29,052	32,770	30,727	**30,669**	9%	9%	8%	8%	13%	-6%	0%
Vietnamese	8,934	9,405	8,280	**8,243**	3%	3%	2%	2%	5%	-12%	0%
Other Non-English	16,803	19,200	19,175	**19,369**	5%	5%	5%	5%	14%	1%	1%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100%**	**100%**	**100%**	**100%**	**10%**	**15%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

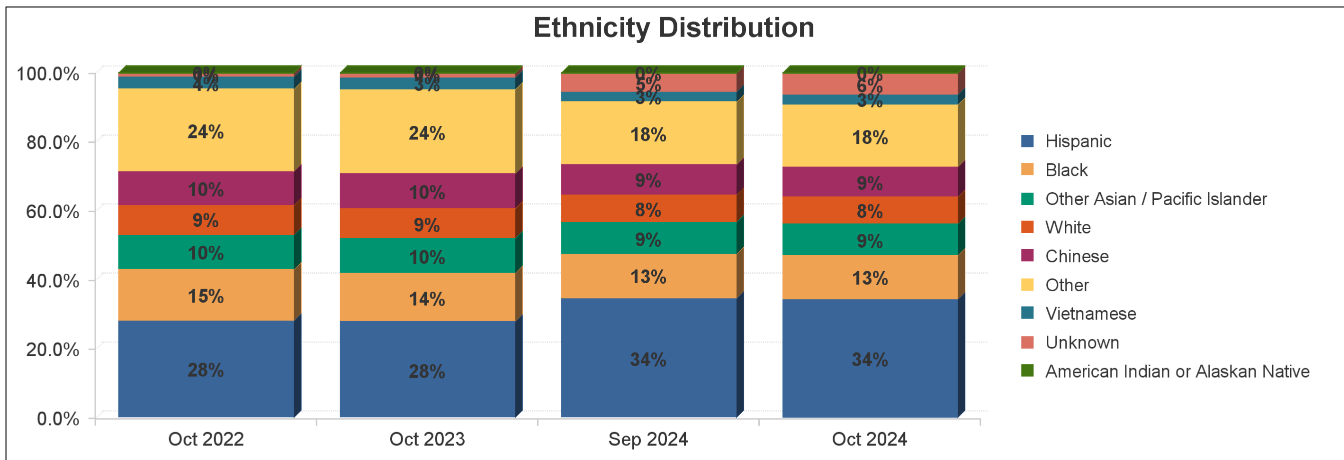
Gender Trend

Gender	Members: Oct 2022	Members: Oct 2023	Members: Sep 2024	Members: Oct 2024	% of Total (ie.Distribution): Oct 2022	% of Total: Oct 2023	% of Total: Sep 2024	% of Total: Oct 2024	% Growth (Loss): Oct 2022 to Oct 2023	% Growth (Loss): Oct 2023 to Oct 2024	% Growth (Loss): Sep 2024 to Oct 2024
F	173,160	190,566	212,422	**212,415**	54%	54%	52%	52%	10%	11%	0%
M	150,038	163,501	193,531	**193,787**	46%	46%	48%	48%	9%	19%	0%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100%**	**100%**	**100%**	**100%**	**10%**	**15%**	**0%**



Ethnicity Trend

Ethnicity	Members: Oct 2022	Members: Oct 2023	Members: Sep 2024	Members: Oct 2024	% of Total (ie.Distribution): Oct 2022	% of Total: Oct 2023	% of Total: Sep 2024	% of Total: Oct 2024	% Growth (Loss): Oct 2022 to Oct 2023	% Growth (Loss): Oct 2023 to Oct 2024	% Growth (Loss): Sep 2024 to Oct 2024
Hispanic	90,312	98,158	139,641	**138,637**	28%	28%	34%	34%	9%	41%	-1%
Black	48,088	49,717	52,255	**51,748**	15%	14%	13%	13%	3%	4%	-1%
Other Asian / Pacific Islander	32,221	35,487	37,604	**37,202**	10%	10%	9%	9%	10%	5%	-1%
White	27,881	30,637	32,080	**31,678**	9%	9%	8%	8%	10%	3%	-1%
Chinese	31,624	35,807	35,544	**35,243**	10%	10%	9%	9%	13%	-2%	-1%
Other	77,437	86,487	74,071	**73,399**	24%	24%	18%	18%	12%	-15%	-1%
Vietnamese	11,427	12,050	11,649	**11,527**	4%	3%	3%	3%	5%	-4%	-1%
Unknown	3,514	4,980	22,311	**25,982**	1%	1%	5%	6%	42%	422%	16%
American Indian or Alaskan Native	694	744	798	**786**	0%	0%	0%	0%	7%	6%	-2%
Total	**323,198**	**354,067**	**405,953**	**406,202**	**100%**	**100%**	**100%**	**100%**	**10%**	**15%**	**0%**



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

Medi-Cal By City

City	Oct 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	160,318	40%	23,682	42,378	17,268	76,990
HAYWARD	64,357	16%	13,117	17,481	7,500	26,259
FREMONT	37,526	9%	15,440	6,662	2,200	13,224
SAN LEANDRO	33,098	8%	8,260	5,683	4,218	14,937
UNION CITY	14,665	4%	5,597	2,614	858	5,596
ALAMEDA	13,799	3%	3,267	2,501	2,067	5,964
BERKELEY	14,977	4%	4,036	2,275	1,765	6,901
LIVERMORE	13,016	3%	1,854	602	2,249	8,311
NEWARK	9,387	2%	2,718	4,110	527	2,032
CASTRO VALLEY	9,508	2%	2,600	1,617	1,417	3,874
SAN LORENZO	7,366	2%	1,464	1,667	858	3,377
PLEASANTON	7,596	2%	1,748	407	824	4,617
DUBLIN	7,541	2%	1,966	433	908	4,234
EMERYVILLE	2,836	1%	631	614	455	1,136
ALBANY	2,545	1%	688	298	568	991
PIEDMONT	463	0%	102	185	62	114
SUNOL	85	0%	27	14	6	38
ANTIOCH	27	0%	8	5	2	12
Other	1,323	0%	385	296	161	481
Total	400,433	100%	**87,590**	**89,842**	**43,913**	**179,088**

Group Care By City

City	Oct 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,818	32%	356	341	0	1,121
HAYWARD	655	11%	313	149	0	193
FREMONT	655	11%	432	75	0	148
SAN LEANDRO	610	11%	244	96	0	270
UNION CITY	304	5%	188	51	0	65
ALAMEDA	302	5%	91	25	0	186
BERKELEY	152	3%	50	12	0	90
LIVERMORE	100	2%	32	4	0	64
NEWARK	133	2%	77	31	0	25
CASTRO VALLEY	191	3%	83	30	0	78
SAN LORENZO	137	2%	46	24	0	67
PLEASANTON	72	1%	25	2	0	45
DUBLIN	116	2%	38	4	0	74
EMERYVILLE	31	1%	13	3	0	15
ALBANY	20	0%	10	1	0	9
PIEDMONT	9	0%	2	0	0	7
SUNOL	2	0%	2	0	0	0
ANTIOCH	26	0%	6	5	0	15
Other	436	8%	158	67	0	211
Total	**5,769**	**100%**	**2,166**	**920**	**0**	**2,683**

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

Total By City						
City	Oct 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,136	40%	24,038	42,719	17,268	78,111
HAYWARD	65,012	16%	13,430	17,630	7,500	26,452
FREMONT	38,181	9%	15,872	6,737	2,200	13,372
SAN LEANDRO	33,708	8%	8,504	5,779	4,218	15,207
UNION CITY	14,969	4%	5,785	2,665	858	5,661
ALAMEDA	14,101	3%	3,358	2,526	2,067	6,150
BERKELEY	15,129	4%	4,086	2,287	1,765	6,991
LIVERMORE	13,116	3%	1,886	606	2,249	8,375
NEWARK	9,520	2%	2,795	4,141	527	2,057
CASTRO VALLEY	9,699	2%	2,683	1,647	1,417	3,952
SAN LORENZO	7,503	2%	1,510	1,691	858	3,444
PLEASANTON	7,668	2%	1,773	409	824	4,662
DUBLIN	7,657	2%	2,004	437	908	4,308
EMERYVILLE	2,867	1%	644	617	455	1,151
ALBANY	2,565	1%	698	299	568	1,000
PIEDMONT	472	0%	104	185	62	121
SUNOL	87	0%	29	14	6	38
ANTIOCH	53	0%	14	10	2	27
Other	1,759	0%	543	363	161	692
Total	406,202	100%	**89,756**	**90,762**	**43,913**	**181,771**

Human Resources

Anastacia Swift

To: Alameda Alliance for Health Board of Governors

From: Anastacia Swift, Chief Human Resources Officer

Date: December 13th, 2024

Subject: Human Resources Report

Staffing

- As of December 1st, 2024, the Alliance had 647 full time employees and 0-part time employee.

- On December 1st, 2024, the Alliance had 39 open positions in which 6 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 33 positions open to date. The Alliance is actively recruiting for the remaining 33 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by division:

Division	Open Position December 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	3	0	3
Operations	21	3	18
Healthcare Analytics	0	0	0
Information Technology	6	0	6
Finance	3	1	2
Compliance	4	2	2
Human Resources	2	0	2
Health Equity	0	0	0
Executive	0	0	0
Total	39	6	33

- Our current recruitment rate is 5%.

Employee Recognition

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

  5 years:
  - Derrick Harlan (Grievance & Appeals)
  - Rachel Munoz (Utilization Management)
  - Jeff Li (IT – Development)
  - Carlissa Knox (Pharmacy Services)

  6 years:
  - Monica Valle (Member Services)

  7 years:
  - Yemaya Teague (Health Equity)

  8 years:
  - Ginnie Rivera (Credentialing)
  - Donnie Viloria (Facilities)
  - Gurpreet Singh (IT - Apps Management, IT Quality & Process Improvement)

  10 years:
  - Rita Wisocky (Claims)
  - John Armstrong (Facilities)

  11 years:
  - Nancy Pun (Healthcare Analytics)

  14 years:
  - Fanita Bryant (Utilization Management)

  18 years:
  - Rex Ngov (Utilization Management)

  26 years:
  - Li Tran (Finance)