Board of Governors

Regular Meeting

Friday, June 12th, 2026
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 South Loop Road, Alameda, CA 94502

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, June 12th, 2026
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

PUBLIC COMMENTS: Public Comments can be submitted for any agendized item or for any item not listed on the agenda, by mailing your comment to: "Attn: Clerk of the Board," 1240 S. Loop Road, Alameda, CA 94502 or by emailing the Clerk of the Board at bgonzalez@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 88758315#. 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 two (2) 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 June 12th, 2026, at 12:00 p.m. in Alameda County, California, by Andrea Schwab-Galindo, 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) MAY 8th, 2026, BOARD OF GOVERNORS MEETING MINUTES

b) MAY 8th, 2026, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

c) **MAY 5th, 2026, FINANCE COMMITTEE MEETING MINUTES**

6. **BOARD MEMBER REPORTS**

   a) **COMPLIANCE ADVISORY COMMITTEE**

   b) **FINANCE COMMITTEE**

   c) **COMMUNITY ADVISORY SELECTION COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

   a) **LEGISLATIVE UPDATE**

   b) **FY26 GRANT UPDATES**

   c) **MEMBER ACUITY ANALYSIS**

   d) **REVIEW AND APPROVE APRIL 2026 MONTHLY FINANCIAL STATEMENTS**

   e) **REVIEW AND APPROVE FISCAL YEAR 2027 BUDGET**

9. **STAFF UPDATES**

10. **UNFINISHED BUSINESS**

11. **STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS**

12. **PUBLIC COMMENT (NON-AGENDA ITEMS)**

13. **ADJOURNMENT**

NOTICE TO THE PUBLIC

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

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

Additions and Deletions to the Agenda: Additions to the agenda are limited by California Government Code Section 54954.2 and confined to items that arise after the posting of the agenda and must be acted upon prior

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

Supplemental Material Received After the Posting of the Agenda: Any supplemental materials or documents distributed to a majority of the Board regarding any item on this agenda after the posting of the agenda will be available for public review. To obtain a document, please call the Clerk of the Board at (510) 995-1207.

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 Board 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 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 Gonzalez, at (510) 995-1207 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 June 9th, 2026, by 12:00 p.m.

Brenda Gonzalez, Clerk of the Board

EXECUTIVE SUMMARY APPENDIX

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

PRESENTATIONS APPENDIX

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

SUPPORTING MATERIALS APPENDIX

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

ALAMEDA Alliance FOR HEALTH

Consent Calendar

Board of Governors Meeting Minutes

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, May 8th, 2026
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: Andrea Schwab-Galindo (Chair), Dr. Noha Aboelata (Vice Chair), Aaron Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, Rebecca Gebhart, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam

Board of Governors Remote: None

Board of Governors Excused: Andie Martinez-Patterson, Jody Moore, Natalie Williams

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

Chair Andrea Schwab-Galindo called the regular Board of Governors meeting to order at 12:01 p.m.

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL

There were no modifications to the agenda.

4. INTRODUCTIONS

Mr. Marcus Watkins was introduced as the new board member, replacing Mr. Tosan Boyo. Mr. Stephen Smythe was announced as the Interim Compliance and Privacy Officer. The Board also acknowledged Ms. Ruth Watson's final day and thanked her for her service.

5. CONSENT CALENDAR

a) MARCH 13th, 2026, BOARD OF GOVERNORS MEETING MINUTES

b) MARCH 13th, 2026, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

c) APPROVE RESOLUTION FOR EXECUTIVE COMMITTEE MEMBERSHIP UPDATES

Motion: A motion was made by James Jackson and seconded by Dr. Marty Lynch to approve the Consent Calendar.

Vote: The motion was passed unanimously.

Ayes: Aaron Basrai, Dr. Rollington Ferguson, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Vice Chair Dr. Noha Aboelata, Chair Andrea Schwab-Galindo.

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

Dr. Kelley Meade reported that the 2023 audits are nearing completion, with remaining items being addressed collaboratively with the County, including matters related to data exchange and mental health. Updates were also provided regarding the 2025 DMHC full medical audit and the 2026 DHCS routine survey process. Upcoming CMS and network validation audits were discussed, with additional updates to be provided at future meetings.

Dr. Meade also highlighted ongoing privacy and compliance efforts, noting that all privacy incidents and breaches were resolved internally within required timeframes with no external escalations. The privacy team was commended for its diligence in addressing potential vulnerabilities and maintaining strong compliance practices.

b) FINANCE COMMITTEE

Dr. Rollington Ferguson presented the Finance Committee report and provided an overview of the Alliance's financial performance for January through March. Total expenses and net income trends remained positive during the reporting period, while the medical loss ratio and administrative loss ratio remained within expected ranges.

Dr. Ferguson also discussed ongoing enrollment declines, including impacts within the homeless population, noting that the trend will require further analysis and additional discussion at a future meeting. The Committee further reviewed ESG investment performance and discussed the potential reallocation of long-term investments, which would be presented to the Board for consideration at a later date. Overall, financial metrics were reported as stable and trending positively despite ongoing enrollment concerns.

7. CEO UPDATE

Mr. Woodruff presented the CEO report, highlighting organizational updates, program developments, and policy matters. He acknowledged the success of the Alliance's 30th anniversary event and provided updates on the Hospital to Home program at UCSF and the opening of Arnold's Place medical respite center in Alameda.

Mr. Woodruff also discussed ongoing Medi-Cal contracting challenges, state budget impacts affecting benefits for undocumented members, pending legislative proposals related to managed care, and a summary of member grievances and related compliance findings. Preliminary 2025 HEDIS results were reviewed, reflecting strong performance measures and successful medical record review validation. The report concluded with recognition of staff efforts in outreach, legislative advocacy, and privacy compliance, as well as continued concern regarding declining membership and its impact on access to care and the safety net system.

Question: Dr. Lynch asked Mr. Woodruff to clarify comments regarding the controlling blood pressure measure, including how the measure was missed and whether performance was being tracked across racial and ethnic groups. Mr. Woodruff explained that the measure was missed by nine records and emphasized the importance of blood pressure management. Ms. Cheang stated that the measure is sample-based and that additional evaluation across demographic groups would be conducted, with findings to be shared with providers and the Board at a future meeting.

8. BOARD BUSINESS

a) BROWN ACT CHANGE AND BOARD VOTE

Mr. Woodruff and Ms. Serri provided an overview of recent Brown Act legislative updates, including SB 707, which allows greater flexibility for teleconferenced public meetings and eliminates certain prior quorum and location posting requirements. The Board discussed proposed meeting format changes, designating the June, December, and January meetings as in-person meetings, with all remaining meetings to be held virtually. Discussion included the importance of in-person meetings for strategic discussions, Board engagement, and onboarding, while recognizing the flexibility provided through virtual participation. Clarification was provided that remote participation and voting would continue to count toward quorum requirements for all meetings.

Motion: A motion was made by Dr. Kathleen Clanon and seconded by James Jackson to approve the proposed meeting structure, designating the June, December, and January meetings as in-person meetings, with all remaining meetings to be held virtually.

Vote: The motion passed.

Ayes: Aaron Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Andrea Schwab-Galindo

Noes: Rebecca Gebhart, Wendy Peterson, Dr. Evan Seevak

Abstentions: Yeon Park

b) MEDICARE UPDATE

Ms. Watson and Mr. Meyers reported 276 successful enrollments, strategic pacing for CMS star ratings, aggressive growth targets, and operational highlights (call metrics, claims, HRAs). Provider engagement and pay-for-performance pilot were discussed, with challenges around pharmacy benefit manager transition and network adequacy.

Question: Ms. Gebhart asked for an example of a transaction that counts as risk adjustment and what it means. Mr. Meyers explained that risk adjustment is a Medicare and marketplace financial reimbursement method based on ICD-10 codes. When a member is diagnosed with a condition like diabetes, it is coded and sent to CMS, which adjusts payments based on the risk level. More complex or multiple diagnoses increase the risk score and reimbursement. Ms. Cheang and Mr. Woodruff added that accurate and annual coding is essential, and providers must document all relevant conditions each year for proper risk adjustment.

Question: Dr. Lynch asked if annual wellness visits (AWVs) would be covered in the presentation, noting their importance and the challenges in getting them done. Ms. Cheang responded that AWVs are included in the pay-for-performance pilot and acknowledged the workflow challenges. She said the team is collaborating with providers to improve processes and is exploring options like group visits, which CMS recently confirmed are allowed.

Question: Ms. Schwab-Galindo asked how learnings from the pilot are being shared with other providers? Ms. Cheang said best practices and lessons from the pilot are being carried forward; gap reports and outreach are expanding to more providers, though some have very few members.

Question: Ms. Peterson asked if there have been any learnings from the forty-four disenrollments. Mr. Meyers explained that seven members passed away; the workgroup is analyzing grievances, appeals, and benefit issues (e.g., unexpected prescription copays) to improve policies and communication.

Informational Item only.

c) REVIEW AND APPROVE FEBRUARY AND MARCH 2026 MONTHLY FINANCIAL STATEMENTS

FEBRUARY 2026 Financial Statement Summary

Enrollment:

Enrollment decreased by 3,787 members since January 2026. Total enrollment decreased by 19,950 members since June 2025.

Net Income:

For the month ended February 28th, 2026, the Alliance reported a Net Income of $21.8 million (versus budgeted Net Income of $8.3 million). For the year-to-date, the Alliance recorded a Net Income of $53.5 million versus a budgeted Net Income of $22.1 million.

Premium Revenue:

For the month ended February 28th, 2026, actual Revenue was $191.1 million vs. our budgeted amount of $186.3 million.

Medical Expense:

Actual Medical Expenses for the month were $160.3 million, vs. budgeted amount of $169.8 million. For the year-to-date, actual Medical Expenses were $1.4 billion vs. budgeted Medical Expense of $1.4 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 83.9%. The year-to-date MLR was 92.3%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending February 28th, 2026, were $10.7 million vs. our budgeted amount of $11.0 million. Our Administrative Loss Ratio (ALR) is 5.6% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Other Income / (Expense):

As of February 28th, 2026, our YTD interest income from investments shows a gain of $18.3 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending February 28th, 2026, we reported $65.0 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $61.9 million. Our MCO Tax Expense was $65.0 million vs. budgeted MCO Tax Expense of $61.9 million.

Tangible Net Equity (TNE):

For February, the DMHC requires that we have $78.4 million in TNE, and we reported $222.8 million, leaving an excess of $144.4 million. As a percentage, we are at 284%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $644.5 million in cash; $268.9 million is uncommitted. Our current ratio is above the minimum required at 1.16 compared to the regulatory minimum of 1.0.

Capital Investments:

We have acquired $36,000 in Capital Assets year-to-date. Our annual capital budget is $1.4 million.

MARCH 2026 Financial Statement Summary

Enrollment:

Enrollment decreased by 5,505 members since February 2026. Total enrollment decreased by 25,455 members since June 2025.

Net Income:

For the month ended March 31st, 2026, the Alliance reported a Net Income of $13.1 million (versus budgeted Net Loss of $2.9 million). For the year-to-date, the Alliance recorded a Net Income of $66.6 million versus a budgeted Net Income of $19.2 million.

Premium Revenue:

For the month ended March 31st, 2026, actual Revenue was $188.3 million vs. our budgeted amount of $184.1 million.

Medical Expense:

Actual Medical Expenses for the month were $167.2 million, vs. budgeted amount of $178.2 million. For the year-to-date, actual Medical Expenses were $1.6 billion vs. budgeted Medical Expense of $1.6 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 88.8%. The year-to-date MLR was 91.9%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending March 31st, 2026, were $11.2 million vs. our budgeted amount of $11.8 million. Our Administrative Loss Ratio (ALR) is 6.0% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Other Income / (Expense):

As of March 31st, 2026, our YTD interest income from investments shows a gain of $21.7 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending March 31st, 2026, we reported $63.8 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $61.1 million. Our MCO Tax Expense was $63.8 million vs. budgeted MCO Tax Expense of $61.1 million.

Tangible Net Equity (TNE):

For March, the DMHC requires that we have $79.4 million in TNE, and we reported $235.9 million, leaving an excess of $156.4 million. As a percentage, we are at 297%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $928.4 million in cash; $564.1 million is uncommitted. Our current ratio is above the minimum required at 1.17 compared to the regulatory minimum of 1.0.

Capital Investments:

We have acquired $51,000 in Capital Assets year-to-date. Our annual capital budget is $1.4 million.

Motion: A motion was made by Dr. Evan Seevak and seconded by Dr. Kelley Meade to approve the February and March 2026 monthly financial statements.

Vote: The motion was passed unanimously.

Ayes: Aaron Basrai, Dr. Kathleen Clanon, Andrea Ford, Rebecca Gebhart, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Andrea Schwab-Galindo.

No opposition or abstentions.

d) REVIEW AND APPROVE RESOLUTION FOR CALIFORNIA LOCAL AGENCY INVESTEMENT FUND (LAIF)

Motion: A motion was made by Dr. Evan Seevak and seconded by Aaron Basrai to approve the resolution for the California Local Agency Investment Fund (LAIF).

Vote: The motion was passed unanimously.

Ayes: Aaron Basrai, Dr. Kathleen Clanon, Rebecca Gebhart, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Vice Chair Dr. Noha Aboelata, Chair Andrea Schwab-Galindo.

No opposition or abstentions.

e) REVIEW AND APPROVE RESOLUTION: PROVIDER GRANTS

Motion: A motion was made by Dr. Marty Lynch and seconded by James Jackson to approve the Provider Grants Resolution.

Vote: The motion was passed unanimously.

Ayes: Aaron Basrai, Dr. Kathleen Clanon, Andrea Ford, Rebecca Gebhart, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Andrea Schwab-Galindo.

No opposition or abstentions.

9. STAFF UPDATES

There were no staff updates.

10. UNFINISHED BUSINESS

None.

11. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

12. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

13. ADJOURNMENT

The meeting was adjourned at 1:30 p.m.

Compliance Advisory Committee Meeting Minutes

COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes

Friday, May 8th, 2026
10:30 a.m. – 11:30 a.m.

Video Conference Call or
1240 South Loop Road
Alameda, CA 94502

***Committee Members Attendance**:* Dr. Kelley Meade (Chair), Rebecca Gephardt, Byron Lopez, Stephen Smythe

Remote: None

Committee Members Excused: None

1. CALL TO ORDER

The regular meeting of the Compliance Advisory Committee was officially called to order by Dr. Kelley Meade at 10:33 a.m.
It was noted for the record that Stephen Smythe serves as Interim Chief Compliance Officer and Chief Privacy Officer.

2. ROLL CALL

A roll call was conducted by the Clerk, and quorum was confirmed.

3. AGENDA APPROVAL OR MODIFICATIONS

No modifications were requested; the agenda was approved as presented.

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

No public comments were received.

5. CONSENT CALENDAR

a) March 13, 2026 Compliance Advisory Committee Meeting Minutes.

Motion: A motion to approve the minutes was made by Byron Lopez.

Second: Stephen Smythe.

Vote: All voting members present approved the motion.

6. **COMPLIANCE MEMBER REPORTS**

a) Compliance Activity Report:

i. Plan Audits and Regulatory Oversight:

1. 2023 DHCS Focused Medical Survey
    - The work on developing the data exchange with the County continues with a goal of completion by the end of summer.
    - A consent form for substance abuse data exchange was developed with the County
    - The Alliance has partnered with the State for feedback and partnership with the County.
    - The Alliance IT team will provide more information on the platform that is being used.
2. 2025 DMHC Financial Examination
    - The two (2) deficiencies have been remediated.
    - Pending closure from DMHC.
3. 2025 DMHC Routine Full Medical Survey
    - Final findings are pending from DMHC.
    - There were sixteen (16) preliminary findings.
    - The Plan requested reconsideration for four (4) pf the findings, and provided additional information and clarification. The four (4) findings involve Pharmacy and Behavioral Health remediations that had already been completed within the three (3) year look back period.
4. 2026 DHCS Annual Routine Medical Survey
    - The initial exit conference was held March 23rd, 2026, and twelve (12) preliminary findings were presented.
    - Due to the Medicare launch, the DHCS allowed an extended submission time for audit materials, which has continued since the exit conference, with additional requests for materials from DHCS.
    - DHCS has advised a final exit conference will be held the week of June 2nd.

        - There is a potential for additional findings, including additional findings in claims.
    5. 2026 CMS NAV Audit
        - Upcoming CMS Network Validation Audit will be our first.
        - This audit is straightforward, the Plan sends CMS our network, and we receive a pass or fail.
    6. 2026 HSAG NAV Audit
        - This is an annual audit coordinated by the Health Services Advisory Group (HSAG), which is the third party the state uses for this network validation audit.
        - We have the same auditor annually and have developed a partnership.
        - The audit consists of a walkthrough of how the Plan handles network adequacy.
- Compliance Dashboard
    1. 2023 DMHC Follow-Up Review
        - Three (3) findings completed.
        - Ongoing internal audit efforts to ensure that the remediation plans that were implemented are effective.
    2. 2026 DHCS Audit
        - Two (2) self-identified findings added for population health management and coordination of care.
            - Finding one (1) is related to oversight of the Comprehensive Perinatal Services Program.
            - Finding two (2) is related gaps found in the provider directory for enhanced care management (ECM) providers.
        - Once the final exit conference is held any additional findings will be added to the dashboard to be tracked to closure and remediation.
    3. 2025 DMHC Joint Audit
        - The Plan continues to await the receipt of the final report.

- The Health Plan Audits team is conducting follow-up reviews to ensure any corrective action plans that were submitted as part of the initial response are underway.
- There were two corrective actions related to access and availability of the network, change monitoring, and provider notifications, which are being mitigated.
    - Part of the mitigation included an update to policy PRV-003 for provider network capacity standards, which was approved at the Administrative Oversight Committee in February and is now final.
    - The update to the policy includes a process to monitor network changes and revises the provider demographic attestation form.
- The grievance and appeals finding is related to documentation of review of grievance records. This is scheduled for implementation at the May Board of Governors (BOG) meeting.
- The finding related to quality assurance and documentation of potential quality issues reviewed at the committee level is also set to be fully implemented at the May BOG meeting.

4. 2024 DHCS Audit
    - 2024 DHCS Audit CAPs have been closed by DHCS, however internal audits are ongoing to validate corrective actions have been fully implemented and are effective.
    - There are six (6) internal audits that have been validated by the internal audit team.
        - Case Management and Coordination of Care internal audits were closed with zero (0) findings.
        - Member Rights internal audits were conducted, and corrective action plans were closed.

        - Quality Management internal audits are ongoing, and results will be reported out once complete.
    5. 2023 DHCS Focused Audit
        - Work on findings regarding data exchange initiatives with Alameda County is ongoing.
- Privacy Activity Report
    1. In Q1 2026 the Privacy Office processed 10 privacy incidents, which is down from 35 in Q1 2025.
        - These incidents were low in severity.
        - None of the incidents met criteria to trigger regulatory enforcement.
    2. The Member Services department assisted in helping meet turnaround time metrics due to training, coaching, and process improvements which helped to reduce verification and authorization errors by 60%.
    3. Misdirected fax incidents were completely eliminated in the last several quarters due to partnership with key departments including Behavioral Health and Case Management.
    4. Overall privacy risk is stable and continues to decline.
    5. All regulatory compliance and oversight obligations were fully met in Q1 2026.
    6. In Q1 2026 there were two (2) cases that needed to be reported to, and reviewed by DHCS, and were deemed to be non-breaches.
    7. The Chief Compliance Officer provided formal attestation to every Q1 2026 incident indicating that it was properly investigated and addressed.
    8. Physical and operational safeguards for PHI also remain effective.
        - Q1 2026 Privacy Rounds at the Alliance found no major PHI exposure or policy breeches.
        - The need for proper notice of privacy practices (NPP) signage was documented and is being addressed.
        - The Facilities team also executed a key security initiative and by the end of Q1 2026 90% remediation of previously missing workstation cabinet keys was achieved.

9. The first annual Privacy Summit is scheduled to occur at the Alliance in September.
    - Peer plans will be in attendance to share best practices.
    - The Alliance IT team will be in attendance as well since IT is a key component of Privacy.

b) Medi-Cal and Medicare Program Updates
- Annual Trainings
    1. Fraud, Waste, and Abuse (FWA), HIPAA, and Model of Care (D-SNP) trainings are required annually.
    2. Training courses must be completed annually in accordance with CMS requirements.
    3. The Plan continues to improve training delivery for Board members, which may include self-paced modules, instruction-led sessions, and multi-session formats.
    4. Employee trainings are shifting from September to August 2026.
    5. Cultural Sensitivity Training has been updated and will be integrated into the learning management system (LMS).

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a) Compliance Advisory Committee Charter Update
- The Compliance Team has completed a review of the Compliance Advisory Committee (CoAC) charter and is in the process of making updates, including standardizing roles, clarifying reporting expectations, and strengthening governance alignment.
- Commentary will be added to ensure reporting of the Compliance Committee rolls up to the CoAC, and the BOG.
- The draft charter will be reviewed by the Senior Leadership Team and brought back to the Compliance Advisory Committee for review and feedback.

8. STAFF UPDATES

a) With the departure of Richard Golfin III, Stephen Smythe will be the Interim Chief Compliance Officer and Chief Privacy Officer.
b) Ruth Watson, Chief Operating Officer, is retiring as of May 8, 2026.

9. UNFINISHED BUSINESS

a) None

10. **STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS**
    a) None
11. **ADJOURNMENT**
    a) With no further business, the meeting was adjourned by Dr. Kelley Meade at 11:06 a.m.

Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

May 5th, 2026
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, Gil Riojas
Committee Members by Teleconference: James Jackson
Committee Members Excused: Yeon Park
Board of Governors members in-person and on Conference Call:

Alliance Staff in-person and on Conference Call: Matt Woodruff, Dr. Donna Carey, Tiffany Cheang, Lao Paul Vang, Pritika Dutt, Linda Ly, Brenda Gonzalez, Tome Meyers, Felix Rodriguez, Danube Serri, Anastasia Swift, Brett Kish, Elizabeth Olsen

CALL TO ORDER

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

ROLL CALL

Roll call was conducted and confirmed.

INTRODUCTIONS

There were no introductions.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

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

COMMITTEE BUSINESS

a) CEO UPDATE

The CEO update highlighted ongoing uncertainty regarding the upcoming May budget revise, which is expected to significantly affect future programs but currently remains speculative, with no concrete information available. Financially, the Alliance performed well in March, reporting net income above expectations despite a continued decline in enrollment. A notable concern was the loss of 4,000 homeless members since January, prompting plans to engage street and community teams to investigate whether these members remain eligible but missed sign-up opportunities. Mr. Woodruff indicated that further outreach and analysis are planned, and the board will receive an email update by the end of the month as more information becomes available.

b) REVIEW AND APPROVE THE FEBRUARY AND MARCH 2026 MONTHLY FINANCIAL STATEMENTS

FEBRUARY 2026 Financial Statement Summary

Enrollment:

Enrollment decreased by 3,787 members since January 2026. Total enrollment decreased by 19,950 members since June 2025.

Net Income:

For the month ended February 28th, 2026, the Alliance reported a Net Income of $21.8 million (versus budgeted Net Income of $8.3 million). For the year-to-date, the Alliance recorded a Net Income of $53.5 million versus a budgeted Net Income of $22.1 million.

Premium Revenue:

For the month ended February 28th, 2026, actual Revenue was $191.1 million vs. our budgeted amount of $186.3 million.

Medical Expense:

Actual Medical Expenses for the month were $160.3 million, vs. budgeted amount of $169.8 million. For the year-to-date, actual Medical Expenses were $1.4 billion vs. budgeted Medical Expense of $1.4 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 83.9%. The year-to-date MLR was 92.3%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending February 28th, 2026, were $10.7 million vs. our budgeted amount of $11.0 million. Our Administrative Loss Ratio (ALR) is 5.6% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Other Income / (Expense):

As of February 28th, 2026, our YTD interest income from investments show a gain of $18.3 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending February 28th, 2026, we reported $65.0 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $61.9 million. Our MCO Tax Expense was $65.0 million vs. budgeted MCO Tax Expense of $61.9 million.

Tangible Net Equity (TNE):

For February, the DMHC requires that we have $78.4 million in TNE, and we reported $222.8 million, leaving an excess of $144.4 million. As a percentage we are at 284%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $644.5 million in cash; $268.9 million is uncommitted. Our current ratio is above the minimum required at 1.16 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired $36,000 in Capital Assets year-to-date. Our annual capital budget is $1.4 million.

MARCH 2026 Financial Statement Summary

Enrollment:

Enrollment decreased by 5,505 members since February 2026. Total enrollment decreased by 25,455 members since June 2025.

Net Income:

For the month ended March 31st, 2026, the Alliance reported a Net Income of $13.1 million (versus budgeted Net Loss of $2.9 million). For the year-to-date, the Alliance recorded a Net Income of $66.6 million versus a budgeted Net Income of $19.2 million.

Premium Revenue:

For the month ended March 31st, 2026, actual Revenue was $188.3 million vs. our budgeted amount of $184.1 million.

Medical Expense:

Actual Medical Expenses for the month were $167.2 million, vs. budgeted amount of $178.2 million. For the year-to-date, actual Medical Expenses were $1.6 billion vs. budgeted Medical Expense of $1.6 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 88.8%. The year-to-date MLR was 91.9%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending March 31st, 2026, were $11.2 million vs. our budgeted amount of $11.8 million. Our Administrative Loss Ratio (ALR) is 6.0% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Other Income / (Expense):

As of March 31st, 2026, our YTD interest income from investments show a gain of $21.7 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending March 31st, 2026, we reported $63.8 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $61.1 million. Our MCO Tax Expense was $63.8 million vs. budgeted MCO Tax Expense of $61.1 million.

Tangible Net Equity (TNE):

For March, the DMHC requires that we have $79.4 million in TNE, and we reported $235.9 million, leaving an excess of $156.4 million. As a percentage we are at 297%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $928.4 million in cash; $564.1 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 $51,000 in Capital Assets year-to-date. Our annual capital budget is $1.4 million.

Question: Ms. Gebhart asked about the Part A changes – specifically, whether the changes not implemented in 2026 are scheduled for later or off the table, and requested clarification.

Response: Mr. Riojas explained that the Part A buy-in happened in 2025, was expected to continue in 2026, but was delayed due to state alignment with federal programs.

Motion: A motion was made by Rebecca Gebhart, and seconded by James Jackson, to accept and approve the February and March 2026 Financial Statements.

Motion Passed

No opposition or abstentions.

c) INVESTMENT PORTFOLIO UPDATE

Current Investment Portfolio

- **$930M** total invested as of end of March.
- **78%** of investments maturing within 0–90 days; **22%** maturing after 90 days.
- Average Yield: 3.79%, in 2025 average yield was 4.30%.
- Estimated FY26 annual return: **~$33M** (FY25: ~$34M).
- Continued focus on quality and liquidity of investments.
- All investments comply with California Government Code 53600.

ESG Investment Update

- Continuing to avoid investments that conflict with ESG principles.
- Actively pursuing long-term ESG investment opportunities.
- $15M in green investments financing renewable energy, energy efficiency, sustainable water, and pollution prevention. This aligns with our goal for FY26.
- ESG yields slightly underperformed regular long-term portfolio: 4.23% vs. 4.29%.
- ESG market tightening; future investments may carry a small premium.

Market Update and Portfolio Changes

- Market factors have negatively changed—war, U.S. economic outlook, consumer sentiment are key headwinds.
- Feds now expected to pause or make only 1 rate cut this year, down from a previously expected 1–2.
- Fewer cuts allow us to benefit from elevated short-term rates for longer.
- Strategy: Maintain focus on short-term investments (<90 days) to capitalize on high interest rates.
- Short-term/long-term investment mix expected to remain stable while the market steadies.

Portfolio Changes

- Consistent with board retreat message, we are evaluating alternate investment platforms.
- Reallocating funds to test cost and performance measures with the Local Agency Investment Fund (LAIF) and J.P. Morgan investment options.
- $10M will be shifted to LAIF and J.P. Morgan respectively to measure annual investment performance and net cost and returns.

- Will measure funds for 12 months to determine additional funds should be shifted to alternative funding options.
- Safety and liquidity remain the priority when investing.

Question: Dr. Ferguson asked how the Local Agency Investment Fund (LAIF) has been performed over the last 12 months?

Response: Mr. Riojas stated that JP Morgan's expenses may be lower than City National, with similar returns. LAIF's returns have been consistent with City National. Types of funds differ, and performance has been close across all three.

Question: Dr. Ferguson inquired about how LAIF and JP Morgan align with our business model and principles (e.g., avoiding investments in war, guns, tobacco)?

Response: Mr. Riojas stated that LAIF, being state-run, avoids such investments. JP Morgan offers ESG options, and the plan has ultimate control over investment choices to ensure alignment with principles.

Informational Item only.

d) REVIEW AND APPROVE RESOLUTION: CALIFORNIA LOCAL AGENCY INVESTMENT FUND (LAIF)

Motion: A motion was made by Rebecca Gebhart, and seconded by James Jackson, to accept and approve the California Local Agency Investment (LAIF) Resolution.

Motion Passed

No opposition or abstentions.

e) UPDATE ON PHARMACY BENEFIT MANAGER TRANSITION

The committee was informed that the Alliance's current PBM, Perform RFax, is ceasing operations. A rapid RFP process led to the selection of Med Impact as the new PBM, with transition targeted for January 2027. The committee was informed of potential risks due to the condensed timeline and will receive ongoing updates.

Informational Item only.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 8:50 a.m.

CEO Update

Matthew Woodruff

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

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

Date: **June 12th, 2026**

Subject: **CEO Report**

- **Financials:**
  - **April 2026:** Net Operating Performance by Line of Business for the month of April and Year-To-Date (YTD):

	April	YTD
Medi-Cal	$1.46M	$79.1M
Group Care	($77K)	($2.9M)
Medicare	($997K)	($9.3M)
Total	$388K	$67.0M

  - **Revenue was $188.1 million in April and $1.9 billion Year-to-Date (YTD)**.
    - Medical expenses were $179.5 million in April and $1.8 billion for the fiscal year-to-date; the medical loss ratio is 95.5% for the month and 92.3% for the fiscal year-to-date.
    - Administrative expenses were $11.4 million in April and $104.6 million for the fiscal year-to-date; the administrative loss ratio is 6.1% of net revenue for the month and 5.5% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 296% of the required DMHC minimum, representing $156.5 million in excess TNE.
  - **Total enrollment in April was 380,353**, decreased by 5,645 Medi-Cal members compared to March 2026.

- **Alliance Updates**
  - See legislative updates
- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - Member grievances scored 85% processing time for expedited grievances, which is below the 95% compliance mark. The department also scored 75% processing time for standard grievances, which is below the 95% compliance

standard. Currently the department is down 8 positions that they are looking to backfill.

- The Alliance's encounter data reporting fell below the 65% and 80% standards as the Alliance allowed providers to file claims outside of timely filing due to their providers new systems implementations.

- **Non-Regulatory Metrics:**
  - All non-regulatory metrics were met for January.

- **Legislative Updates:**
  - State And Federal Updates

- **IT Workflow Automation - Quarterly Updates**
  - Alliance completed the AI-powered compliance platform to automate regulatory adherence by linking internal documents with requirements. Phase 1 of the work is complete which includes:
    - Access to Readily platform has been provided to all business resources in Compliance, Regulatory affairs, audit Teams
    - Single Sign On (SSO) integration is complete. Users can access the platform with one click from the Alliance Internal portal.
    - Training completed for all modules.

    Our next 3 months plan is complete automation of PolicyTech documents workflow from AAH to Readily platform
  - The AI Governance Framework Policies and Procedures (PnP) have been presented in our Administrative Oversight Committee (AOC) and approved.
  - Alliance has kicked off AI-driven automation to transform software development by enhancing developer productivity, improving code quality, and accelerating delivery across the full software development lifecycle (SDLC) from design and development to deployment, quality assurance, and maintenance. This initiative includes capabilities such as automated code generation, DevOps and Continuous Integration/Delivery (CI/CD) automation, as well as code reviews and testing. The AI transformation is planned as a 12-month level of effort.
  - Alliance developed a high-accuracy (Optical Character Recognition) OCR using OpenAI, automating image interpretation and text extraction from faxes and user prompts, now integrated into key workflows.
    - Automated Phase 2 of Prior Authorization, Health Home, and Pre-Service Authorization in April 2026.
    - ECM end-to-end process redesign is underway.

        - Completed Community Support Referral Forms for DSNP & MediCal in the month of April 2026.
        - 10+ Health Care Services workflow processes are in the pipeline for automation in CY2026 which includes Health Ed Wellness, Behavioral Health care - Autism evaluation form etc.
    - The enterprise-wide implementation of Speech to Text capabilities has been initiated. Following a comprehensive product assessment, Alliance has selected Nuance Dragon as the preferred solution. The procurement of the product took additional timeline due to vendor licensing error. As of now, the procurement is complete and have started implementation to the pilot users.
    - To enhance Claim TAT, our IT Configuration team has pinpointed three main areas for process improvement that could potentially increase our claims auto-adjudication rate from 85% to 92%. As part of the implementation, we have engaged Optum AI to do a pilot program to automate some of the claims manual processing. At the same time, team is design solutioning to automate COB claim workflows.

- **Alliance in the Community – Quarterly Updates**

- **Community Relations Reinvestment Sponsorships - Quarterly Updates**

- **Medicare Overview**
    - Successfully launched the Medicare D-SNP product, **Alameda Alliance Wellness**, on January 1, 2026—marking a significant milestone that coincides with the Alliance's 30th anniversary and reinforces our strategic growth trajectory in Medicare.
    - The **CY2027 Medicare Bid** remains on track for June 1, 2026, submission deadline:
        - Plan Benefit Package (PBP) successfully submitted via CMS HPMS with Compliance validation completed.
        - Milliman has confirmed successful submission of the Benefit Pricing Tool (BPT), substantiation, and cost-sharing justification.
        - MedImpact, our selected pharmacy benefit manager (PBM) for CY2027, has completed submission of all required pharmacy files.
    - Strengthened Medicare sales capacity and structure:
        - Approved updated **Medicare Field Sales & Community Agent** role (non-bilingual) to enhance market reach.
        - Authorized hiring of four (4) additional licensed Medicare Field Sales and Community Agents to support growth objectives.

- Advanced key Medicare operational initiatives:
    - Initiated implementation of MedImpact as our new PBM, including execution of the Letter of Agreement (LOA) and formal project kickoff on May 5th, 2026.
    - Commenced CHCN delegation activities on May 21, 2026, positioning the organization for expanded delegated capabilities.
- Progressed **Medicare marketing vendor selection**:
    - Finalists narrowed to two (2) qualified vendors currently developing comprehensive go-to-market proposals.
- On track to select a preferred vendor during the week of June 1st, with onboarding targeted to ensure readiness for July implementation.

- **Member Advisory Committee**
    - Budgeting for Behavioral Health - how does the plan allocate money for these services? – There currently are no limits on the use of MH services. All services are based on whether they are medically necessary, not on receiving a maximum number of services or appointments.
    - Care giver support - what options are available for members? We have a community support specifically for caregivers – Caregiver Respite. This CS helps to provide short term, temporary, intermittent relief for a caregiver. Limitations:, maximum time is 336 hours per calendar year. The respite care can be in-home or in-facility. Per policy guide (April 2025):
    - Respite Services can include any of the following:
        1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
        2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
        3. Services that attend to the Member's basic self-help needs and other activities of daily living (ADL), including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.
    - Additional support for caregivers: Personal Care and Homemaker Services. This service helps to fill the time gap between an IHSS application or re-assessment and approval for those services.

    - Lastly, I would point to our benefits that can relieve the caregiver of some of the heavy-lifting duties:

- Transportation – can provide rides to and from appointments, pharmacy
- CM (CCM, ECM) – provide support with care coordination, scheduling appointments, etc.
- Behavioral Health – provide emotional support via therapy for the caregiver

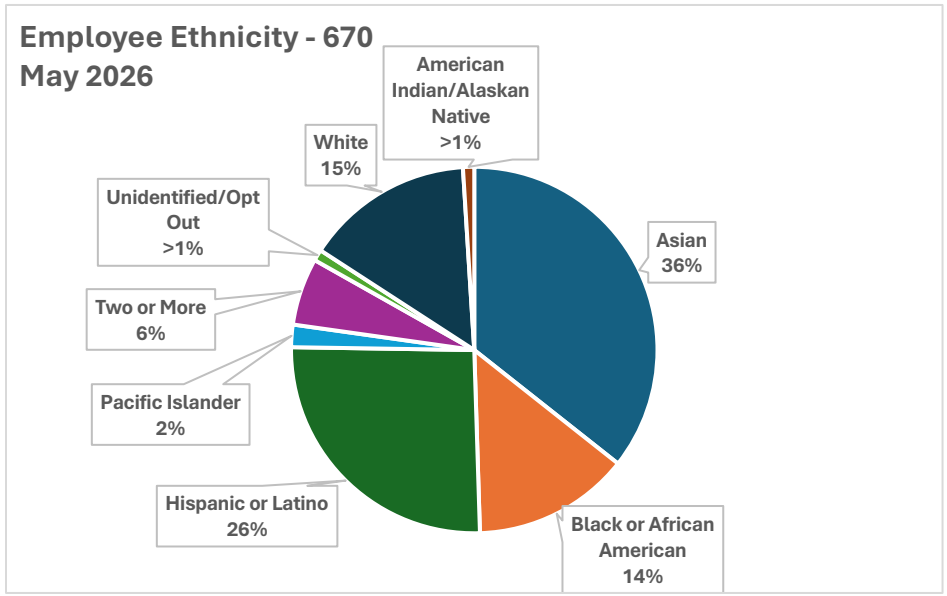
Demographics

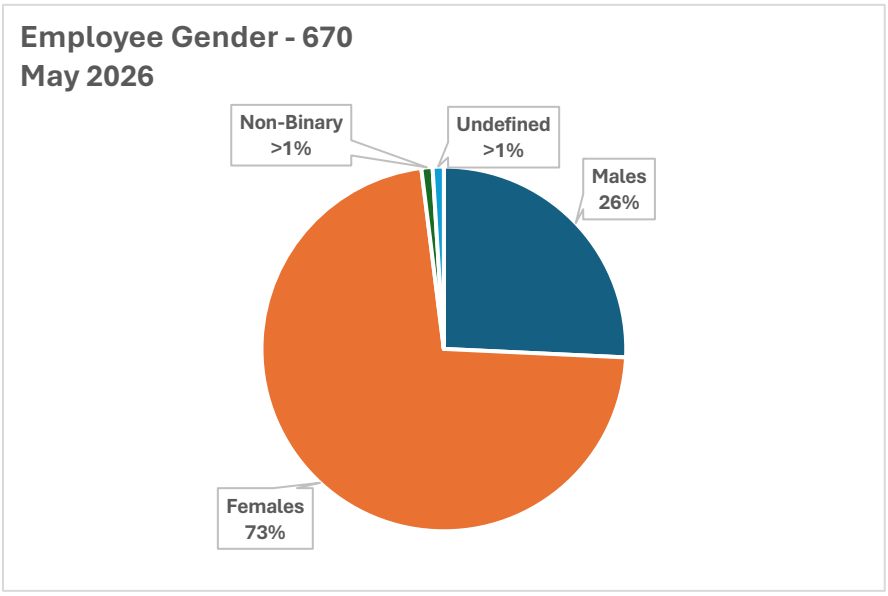
This report provides a comparative analysis of the demographic composition of Alameda Alliance for Health's workforce in relation to the population profile of Alameda County. The evaluation focuses on key demographic indicators, including race/ethnicity, gender, and age distribution. The objective is to assess the extent to which our workforce reflects the diversity of the community we serve and to identify strategic opportunities for strengthening and enhancing diversity, equity, and inclusion across the organization.

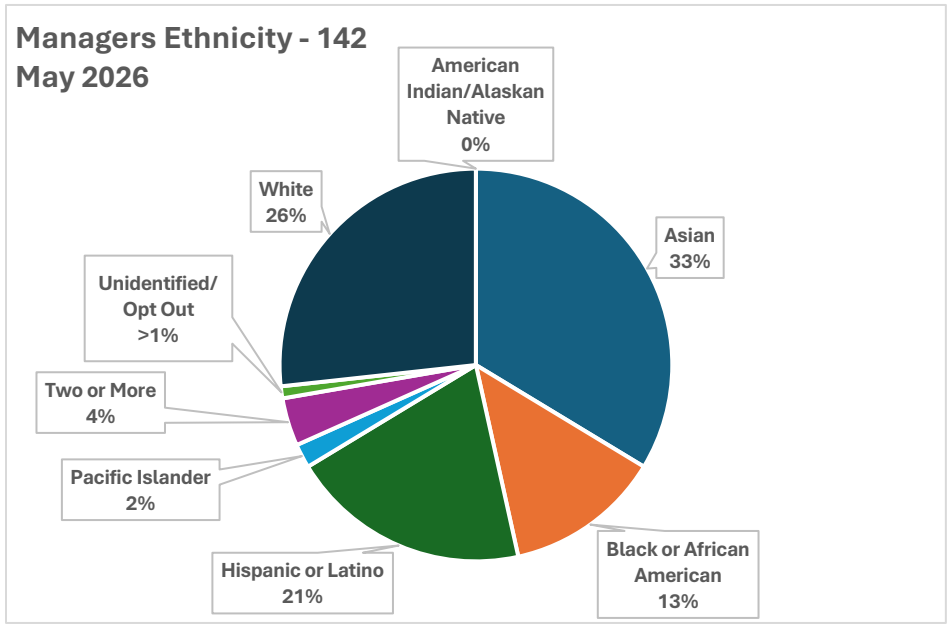
The demographic data for Alameda County, including total population figures and detailed demographic breakdowns, is sourced from Healthy Alameda County, a centralized data repository of information related to Alameda County, sponsored by the Alameda County Public Health Department. This platform provides the most current county-level information, encompassing over 250 indicators of community wellbeing (Healthy Alameda County :: Demographics :: County :: Alameda). The county data referenced in this report reflects updates as of May 2026. Additionally, demographic data for Alameda Alliance for Health was last updated May 2026 and is collected and maintained internally, monthly, by the Human Resources Department.

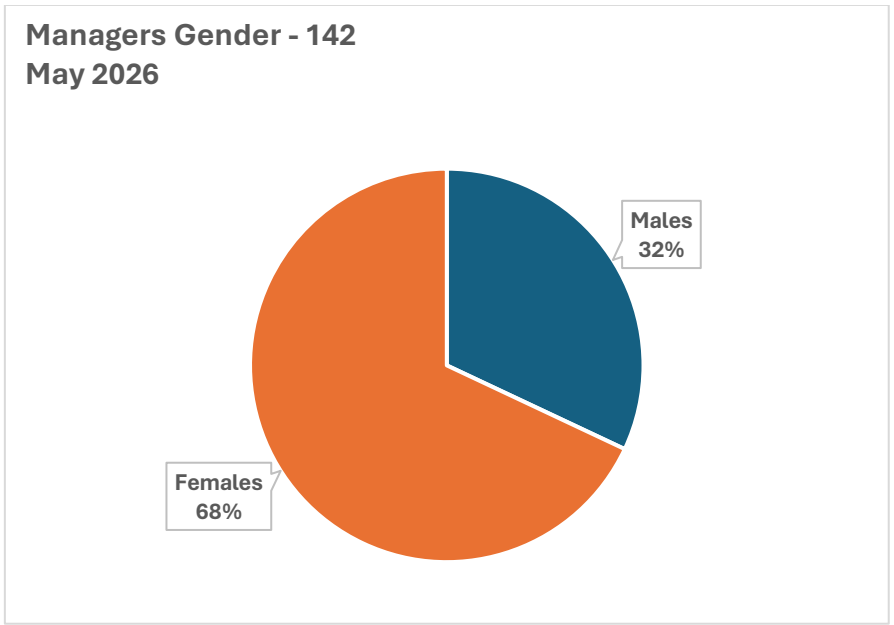
Category	**Alameda Alliance for Health** (Workforce information last updated May 2026)	**Alameda County** (Population information last updated in May 2026)
Population/Total Employees	670	1,647,132
Race & Ethnicity		
Asian	36%	35.62%
Hispanic	26%	23.53%
White	15%	24.90%
Black/African American	14%	8.82%
Native Hawaiian/Pacific Islander	2%	0.77%
American Indian/Alaskan Native	>1%	0.24%
Two or More Races	6%	5.51%
Unidentified/Opt Out	>1%	-
Gender		
Male	26%	49.57%
Female	73%	50.43%
Non-Binary	>1%	-
Undefined	>1%	-
Age Distribution		
Under 25	>1%	8.29%
25-34	18%	13.55%
35-44	37%	16.25%
45-54	27%	13.64%
55-Older	17%	29.35%

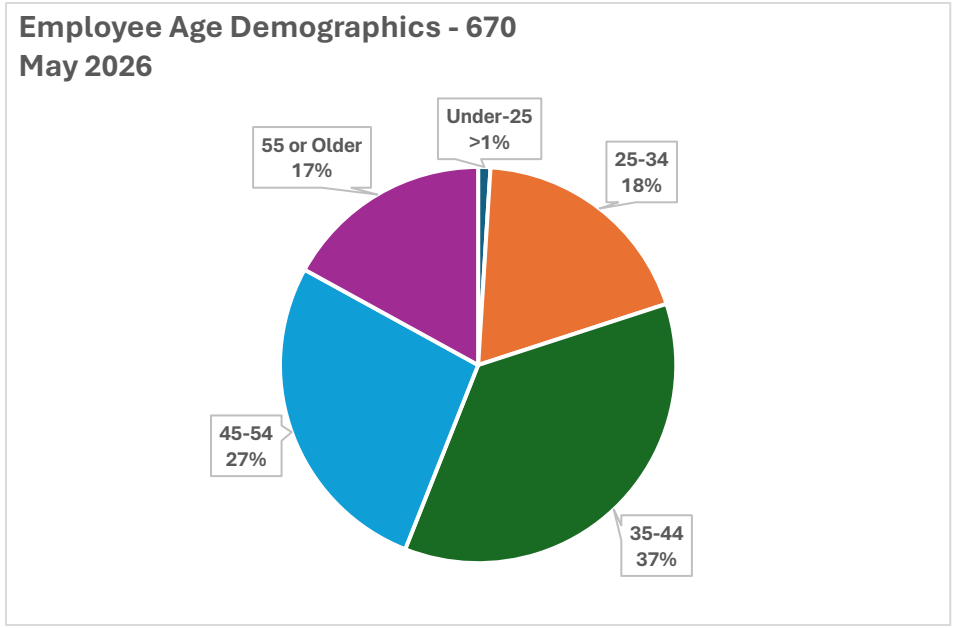
AAH Employee Demographics Data Report May 2026










Employee Age Demographics - 670
May 2026
Under-25
>1%
25-34
18%
35-44
37%
45-54
27%
55 or Older
17%

ALAMEDA Alliance FOR HEALTH

Legislative Tracking

June 2026 Legislative Update

Legislative Affairs and Media Relations Department

The purpose of this report is to provide an update on state and federal legislative actions that the Alliance's Legislative Affairs and Media Relations team is tracking and participating in.

Federal Policy Update

Last week, the GOP reconciliation bill to fund ICE and Border Patrol passed in the Senate on a party-line vote, 52-47, with one Republican voting against it. The House is now set to vote on the package this week. While some congressional Republicans have called for a third and final reconciliation bill to be enacted before the end of the year which could include health care cuts – it seems unlikely at this point given their work to get reconciliation 2.0 to the finish line, the reauthorization of FISA and other legislative priorities.

On June 1st, CMS released the "Medicaid Program: Community Engagement Requirement for Certain Individuals" interim final rule. Under H.R.1, states must begin implementing work requirements for certain adults ages 19 to 64, mainly the Medicaid expansion population, by January 1, 2027. The Interim Final Rule provides detailed definitions of the activities that count as meeting the requirements, specific exemptions to the work requirements, and defines medical frailty (which would exempt individuals from the requirements) as an "individual whose physical, mental, or other behavioral health condition significantly impairs the individual's ability to comply with the community engagement requirement." The Interim Final Rule also goes into further detail on short term hardship exceptions, verification requirements, how CMS will assess compliance, and whether good faith exemptions will be made available to states. Public comments are due July 31, 2026, which is the same day that the Interim Final Rule becomes effective.

The Alliance continues to participate in coordinated multi-agency efforts to address Medi-Cal changes due to H.R. 1 and the state budget. Our work is focused on preserving coverage for Medi-Cal beneficiaries. Since November 2025, the Alliance has sent out approximately 45,000 'Keep Your Coverage' postcards every month to Alliance members.

In an effort to continue this Alameda County specific coordinated work and in partnership with Alameda County Health, the Alliance responded to a Letter of Intent (LOI): Regional Medi-Cal Response & Learning Forums put out by the California Health Care Foundation.

The LOI focuses on supporting the Alliance and Alameda County health care partners with convening regular meetings to discuss strategies for keeping people enrolled in Medi-Cal; dedicating additional staff time to data sharing activities with the goal of forecasting and tracking

disenrollments; coordinating targeted outreach and enrollment supports across sectors; and conducting outreach for enrollment in indigent care.

State Legislative Update

On May 14, 2026, Governor Newsom released the updated 2026-27 state budget proposal or the "May Revise." The revised budget includes $334.2 billion ($90.4 billion GF) for health and human services programs in 2026-27 to maintain a balanced budget and protect California's safety net programs. The proposed Medi-Cal budget is $194.4 billion ($48.6 billion GF) in 2025-26 and $216.7 billion ($44.9 billion GF) in 2026-27. Medi-Cal is projected to cover approximately 14.4 million Californians in 2025-26 and 13.9 million in 2026-27, which is more than one-third of the state's population.

Notably, the May Revise proposes various Medi-Cal cuts including:

- *Unsatisfactory Immigration Status (UIS) Monthly Premiums*
  - Increases the monthly premium for adults with UIS, Aged 19-59, from $30 to $50
- *Medi-Cal Asset Test Limits*
  - Reinstates the Medi-Cal asset limit for seniors and disabled adults to $2,000 for an individual or $3,000 for a couple, effective no sooner than January 1, 2027
- *Enhanced Care Management (ECM) and Community Supports (CS)*
  - Improves eligibility criteria, service definitions, utilization management criteria, and payment adjustments for ECM and CS benefits, effective January 1, 2027
- *Adult Acupuncture Benefit*
  - Eliminates this Medi-Cal benefit to increase GF cost-savings
- *Managed Care Organization (MCO) Tax*
  - Proposes to renew the MCO tax effective January 1, 2027, to support the Medi-Cal program and maintain targeted rate increases for primary, maternal, and non-specialty mental health care
- *UIS Transition to FFS*
  - Proposes the transition of UIS Medi-Cal Members to FFS delivery system effective January 1, 2027
  - The Alliance, along with our trade associations, including the California Association of Health Plans (CAHP) and the Local Health Plans of California (LHPC), and other state and local partners have engaged in advocacy efforts with state legislators to oppose this proposal.

In early May, California State Senate Democrats released their 2026-27 budget plan with the focus of strengthening state reserves, maintaining full-scope Medi-Cal for asylees and other qualified non-citizens, and providing $100 million for CalFood to support local food banks. Senate Democrats also advocated to delay the elimination of dental benefits for UIS adults as well as Medi-Cal premiums until January 1, 2028.

On May 18, 2026, California Assembly Democrats released their "Road Map to a Responsible and Compassionate Budget" or 2026-27 budget priorities which are aligned with May Revise proposals. Assembly Democrats argued that cuts to safety net programs are unavoidable given declining federal funding from H.R. 1, but maintained that the state should continue investing in

the CalFood food bank program, help keep people enrolled in Medi-Cal, and expand the healthcare workforce.

Although Senate and Assembly Democrats have outlined ambitious aspirations for allocating state dollars around maintaining certain health and human services, the finalized budget is expected to primarily reflect the Administration's policy priorities. The Legislature has until June 15, 2026, to pass the budget.

The gubernatorial race to determine the successor to Governor Newsom occurred on June 2, 2026. Due to the influx of mail-in ballots, it may be weeks before the final vote tabulation is released. The three leading contenders in the primary are Xavier Becerra (D), Steve Hilton (R), and Tom Steyer (D). The top two candidates will advance to the general election on November 3, 2026.

Our team will continue to track the Governor's race, the 2026-27 finalized state budget, and attend relevant stakeholder meetings to ensure alignment with pending legislative and/or regulatory changes.

Priority Bill List

Below is a list of priority bills that our team is currently tracking, and which will be updated throughout the 2026-27 legislative cycle. These bills are of interest to and could have a direct impact on the Alliance and its membership.

Measure	*Author*	*Topic*	*Summary*
AB 1126	Patterson	Medi-Cal Managed Care Plans: Enrollees with Other Health Care Coverage	This bill would require the department, in the case of a Medi-Cal managed care plan enrollee who also has other health care coverage and for whom the Medi-Cal program is a payer of last resort, to ensure that a provider that is not contracted with the plan and that is billing the plan for Medi-Cal allowable costs not paid by the other health care coverage does not face administrative requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system. Under the bill, in the case of an enrollee who meets those coverage criteria, except as specified, a Medi-Cal fee-for-service provider would not be required to contract as an in-network provider with the Medi-Cal managed care plan in order to bill the plan for Medi-Cal allowable costs for covered health care services.

			The bill would authorize a Medi-Cal managed care plan to require a letter of agreement, or a similar agreement, under specified circumstances, including if a covered service requires prior authorization, or if a service is not covered by the other health care coverage but is a covered service under the plan, as specified. The bill would require the department to take the actions that it deems necessary to provide clarification regarding the conditions for billing plans to providers that render services to enrollees who also have other health care coverage. The bill would specify the intent of the Legislature that the department offer educational resources to an enrollee who needs assistance with understanding continuity of care and coordinating Medi-Cal and their other health care coverage when requested by the enrollee.
AB 1648	Rodriguez	Public Health: California Epilepsy Program	This bill would require the State Department of Public Health to establish the California Epilepsy Program for the purposes of epidemiological assessments of the incidence and prevalence of epilepsy and seizures. The bill would require the department to convene an advisory panel comprised of specified individuals to provide support and advice for the implementation of the program. AB 1648 would authorize the department to seek private or public funding and to spend those funds for the purposes of the program, and would authorize the department to contract with various entities for the purposes of collecting and collating data. The bill would require the department to analyze available data, to prepare and publish reports on its internet website as necessary, and to publish on its internet website a listing of agencies that offer services to individuals affected by epilepsy, as specified.

AB 1670	Arambula	Medi-Cal: Dental Care	This bill would make behavior management and desensitization services without an accompanying dental procedure covered benefits under the Medi-Cal program, subject to utilization controls, when a patient's physical, behavioral, developmental, or emotional condition requires significant extra time, attention, or personnel, or requires such services preceding a dental visit, respectively, in order to safely deliver dental care. The bill would condition implementation of these provisions on the availability of federal financial participation and any necessary federal approvals having been obtained. The bill would, notwithstanding any other law, authorize the department to implement, interpret, or make specific provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions without taking any further regulatory action.
AB 1682	Hart	Health care Coverage: Scalp Cooling	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires coverage by health care service plans and health insurers for various screening and treatment services with respect to cancer. This bill would require a health care service plan contract or health insurance policy, except as specified, that is issued, amended, delivered, or renewed on or after January 1, 2027, to provide coverage for scalp cooling, as defined, as prescribed by a health care provider in connection with chemotherapy for people with cancer. Because a violation of these provisions with respect to a health care service plan would be a crime, this bill would impose a state-mandated local program.

AB 1672	Solache	Medi-Cal: Program of All-Inclusive Care for the Elderly: Rates	The bill would require the department, as part of this negotiation before submission for federal approval, to notify the PACE organization of the proposed rates at least 60 days prior to submission and to respond in writing to questions or feedback on the proposed rates submitted by the PACE organization by no later than 30 days prior to submission. The bill would authorize the department to define a reasonable date by which the PACE organization must submit those questions or feedback. The bill would require the department to provide the rationale for any assumptions or calculations concerning the proposed rates upon request and to make a good faith effort to reach agreement with the contracting PACE organization on capitation rates.
AB 1561	Krell	Medi-Cal: Complex Rehabilitation Technology	This bill would prohibit the department from requiring prior authorization for the repair of a CRT-powered wheelchair if the cost of the repair does not exceed $1,250. Under the bill, a treatment authorization request for repair or replacement of a CRT-powered wheelchair would not require an individual prescription or documentation of medical necessity from the treating practitioner if the CRT-powered wheelchair has already been approved for use by the patient. For repair of a CRT-powered wheelchair, the bill would require the supplier to document and maintain records of the items being repaired, the reason for the repair, and the labor details, as specified, with the information being subject to a post-payment audit by the department. The bill would set forth other recording requirements for the supplier.
AB 1366	Flora	Reimbursement for Pharmacist Services	This bill would require the rate of reimbursement for advanced practice pharmacist services to be the same as the fee schedule for physician services, including MTM pharmacist services. The bill would

			require the department to implement an MTM reimbursement methodology relating to the use of drugs to ensure that Medi-Cal payments are only made to eligible advanced practice pharmacists or pharmacies for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories.
AB 1629	Haney	Dental Coverage	If a health care service plan or health insurer pays a contracting dental provider directly for covered services, this bill would require the plan or insurer to pay a noncontracting dental provider directly for covered services if the noncontracting provider submits to the plan or insurer a written assignment of benefits form signed by the enrollee or insured. The bill would require the plan or insurer to provide a predetermination or prior authorization to the dental provider and to reimburse the provider for not less than that amount, except as specified. The bill would require the plan or insurer to notify the enrollee or insured that the provider was paid and that the out-of-network cost may count towards their annual or lifetime maximum. The bill would require a noncontracting dental provider to make specified disclosures to an enrollee or insured before accepting an assignment of benefits.
AB 1649	Ahrens	Monthly Maintenance Amount: Personal and Incidental Needs	Existing law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $50, and would require that the amount be increased annually, as specified. The bill would

			make these changes subject to receipt of necessary federal approvals.
AB 1717	Castillo	Medi-Cal Dental Reimbursement: House/Extended Care Facility Call	Under the Medi-Cal Dental Provider Handbook, the maximum allowance for a house/extended care facility call under a specified billing code is $20. This bill would require the department to increase the Medi-Cal reimbursement base rate for a house/extended care facility call in order to reflect the reasonable travel costs for purposes of delivering dental services in the patient's private residence or applicable facility instead of the location of the dental provider.
AB 1773	Blanca Rubio	Pharmacy Benefit Managers	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a pharmacy benefit manager contracting with a health care service plan or health insurer to secure a license from the Department of Managed Health Care on or after January 1, 2027, or the date on which the department has established the licensure process, whichever is later. This bill would require the department to maintain a public internet website displaying specified information for each licensed pharmacy benefit manager, including, among other things, the legal name, license number, and license expiration date.
AB 1887	Zbur	Prescription Drug Coverage for Rare Diseases	This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, from imposing prior authorization, step therapy, or other utilization review for a drug approved for the treatment of a rare disease if the drug is prescribed by a specialist with expertise in the condition or

			disease being treated and the specialist has determined the drug is medically necessary, unless a biosimilar, interchangeable biologic, or generic version of the drug is available. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.
AB 1929	Ortega	Nonprofit Integrated Health Care Service Plans: Investments: Disclosure	This bill would require a health care plan annually to disclose its material investment holdings to the DMHC or Department of Insurance on or before July 1 of each year, unless otherwise specified by regulation, beginning on July 1, 2027. The bill would require departments to prominently display, and make accessible to the public, those disclosures on their internet websites. If a plan fails to comply with the disclosure requirements, the bill will require the applicable department to assess a civil penalty against the plan or insurer, as specified. The bill would require the applicable department and Covered California to prominently post the plan's noncompliance status on their internet websites until compliance is achieved.
AB 1949	Lee	Medi-Cal: Acupuncture Treatments	This bill would state the intent of the Legislature to enact legislation that allows more flexibility in Medi-Cal coverage for acupuncture treatments. require the Medi-Cal program to cover up to 24 acupuncture visits per beneficiary per calendar year and would state that additional visits per calendar year may be authorized based on medical necessity and the extent of federal funding.
AB 1970	Harabedian	Health Care Coverage: Mental Health or Substance Use Disorders	This bill would prohibit a health care service plan contract or a health insurance policy that is issued, amended, or renewed on or after January 1, 2027, from imposing step therapy as a prerequisite to authorizing coverage of any prescription drug used for the treatment of *a serious mental illness or substance use disorder, as those terms are defined*. The bill would specify that the prohibition on step

			therapy does not apply when the United States Food and Drug Administration-labeled indications and usage of a drug indicate that some prior medication must be taken.
AB 1979	Bonta	Health Care Services: Artificial Intelligence	This bill would require a health facility, clinic, physician's office, or office or a group practice to ensure that no clinical decision, as specified, is based solely on the output of a clinical decision support system, as defined, and that a licensed health care professional exercises independent professional judgment when reviewing and approving a clinical decision that is based on the output of a clinical decision support system. The bill would authorize the appropriate professional licensing board to pursue an injunction or restraining order to enforce these provisions to the extent that a violation constitutes the practice of a health care profession without a license. The bill would specify that these provisions do not prohibit the use of artificial intelligence for documentation and communication that does not involve the application of professional judgment, including automated messages to inform patients of updates to their health records. By placing new requirements on health facilities and clinics, this bill would expand the scope of a crime and would impose a state-mandated local program.
AB 2036	Patel	Medi-Cal: Federally Qualified Health Centers and Rural Health Clinics	Under existing law, to the extent that federal financial participation is available, federally qualified health center (FQHC) services and rural health clinic (RHC) services are covered Medi-Cal benefits. Under existing law, FQHCs and RHCs receive a per-visit prospective payment system (PPS) rate for each visit. Existing law provides different methods by which an FQHC or RHC may establish a PPS. This bill would authorize an FQHC or RHC that has multiple PPS rates to elect to consolidate those rates into a

			single PPS rate to be applied uniformly for all FQHC and RHC services.
AB 2077	Macedo	Protect the Promise Act	This bill, the Protect the Promise Act, would require the department, in coordination with counties, to verify Medi-Cal eligibility before enrollment approval whenever reliable data sources are available. The bill, subject to any exceptions under federal law, would prohibit self-attestation alone for Medi-Cal eligibility purposes from being accepted for the eligibility factors of income, residency, identity, household composition, or citizenship or immigration status. The bill would require the department and the county to fully utilize certain data sets and verification systems. The bill would require the department to cross-reference beneficiary data with certain databases, complete a one-time submission of enrollment data to the federal government, and review information from specified federal and state sources. The bill would require the department to maintain a continuous process to identify changes in residency. The bill would require the department to require regular and systematic eligibility redeterminations, as specified. The bill would require the department and the county to identify eligibility errors, correct errors, and recover improper payments. The bill would require the department to establish enforceable accountability mechanisms, including, among others, reports to the Legislature and designation of officials.
AB 2081	Stefani	Medi-Cal: Home and Community-Based Alternatives Waiver	This bill would recast the above-described waiver provisions to refer to the HCBA Waiver and would delete the provision relating to the 5,000 slots. The bill would require the department, beginning in 2027, and for the HCBA Waiver period, to increase the total number of waiver slots by 10,000, in addition to any planned expansion of waiver slots federally

			approved as of January 1, 2026, as specified. The bill would require the department, by March 1, 2027, to seek any necessary amendments to the HCBA Waiver to ensure that there is sufficient capacity to enroll all individuals who are eligible for, and express an interest in, participating in the HCBA Waiver who are currently on a waiting list. The bill would require the department to continue to monitor the capacity of the HCBA Waiver and to expand capacity, as specified.
AB 2160	Celeste Rodriguez	Medi-Cal: Lactation Services	This bill would require the department to, by July 1, 2027, issue updated Medi-Cal guidance that clarifies Medi-Cal coverage for lactation services. The bill would also require guidance to, among other things, clarify Medi-Cal coverage policies for a continuum of lactation services, including health education related to lactation, basic lactation support, and clinical lactation consultation. The bill would require the department to seek stakeholder input on draft guidance prior to issuing the guidance. The bill would make the implementation of these provisions contingent to the extent that federal financial participation is available and any necessary federal approvals are obtained.
AB 2161	Bonta	Medi-Cal: Work or Community Engagement	This bill would state the intent of the Legislature that the department implement work or community engagement requirements under the above-described federal law to ensure that all eligible Medi-Cal applicants and beneficiaries obtain and maintain coverage in ways that are least administratively burdensome to those individuals. The bill would set forth provisions to conform to the above-described federal provisions, including work or community engagement requirements, exemptions, and notices of noncompliance if applicable. The bill would require the department, before verifying an individual's compliance, to ensure and confirm that systems are programmed to maintain

			coverage with minimal data request requests to an applicant or beneficiary, as specified. For beneficiaries who cannot be deemed compliant following ex parte review, the bill would require the county to request a Medi-Cal managed care plan to provide any data that will verify that a beneficiary is exempted or meets the requirements before requesting information directly from the beneficiary.
AB 2123	Aguiar-Curry	Medical Debt Relief Act of 2026	This bill, the Medical Debt Relief Act of 2026, would establish the medical debt relief program, which would be administered by the authority. The bill would require the authority to enter into an interagency agreement with the Department of Health Care Access and Information to implement the program. The bill would require the authority and department to convene a stakeholder advisory group, as specified, no later than July 1, 2027, to advise on the development, implementation, and administration of the program. The bill would require the stakeholder advisory group, on or before January 1, 2028, to develop recommendations for the authority and department, including, among others, criteria for the ranking and priority of eligible recipients to receive discharge of their medical debt. This bill would authorize the authority, in consultation with the department, to, among other things, contract with a medical debt relief coordinator, as defined, for purposes of acquiring medical debt of eligible recipients either directly from a providing health institution or from a debt buyer, as specified. The bill would require the authority to, among other things, maintain books and records of all the medical debt acquired and canceled. The bill would require the authority to maintain a public internet website for information about the program.

			This bill would create the California Medical Debt Relief Program Account within the California Health Facilities Financing Authority Fund and would make all money in the account available, upon appropriation by the Legislature, to the authority for conducting the purposes of the Medical Debt Relief Act of 2026. The bill would require the authority, in consultation with the department, to provide a report to the Legislature and Governor by January 1 of each year, starting January 1, 2028.
AB 2138	Krell	Medi-Cal: Enhanced Care Management: Peer Support Specialists	This bill would require the department to require, as a condition of providing ECM, that any ECM provider, whose caseload of members meets certain criteria, maintain an interdisciplinary care team that includes at least one peer support specialist or trainee, as defined, who is integrated into ECM service delivery and available to support ECM members. The bill would set forth the functions of a peer support specialist or trainee for ECM purposes. The bill would require the department to allow an ECM provider to satisfy the requirement through any combination of staffing models, as specified. The bill would require the department to ensure that Medi-Cal managed care plan contracts, policies, and guidance reflect the requirement and to establish monitoring and compliance mechanisms to ensure that ECM providers implement the requirement. The bill would require the department to recognize virtual, telephonic, and technology-enabled peer support service delivery as meeting the integration requirement. Under the bill, an ECM provider subject to these provisions would have until January 1, 2028, to achieve full compliance, as specified. The bill would prohibit the department, a county, a Medi-Cal managed care plan, or a Medi-Cal provider, as applicable, from disqualifying a peer support specialist solely or primarily on the basis of a criminal background check, fingerprint-based background check, or similar screening that is a

			condition of employment, contracting, certification, credentialing, enrollment, or participation in providing peer support services. Under the bill, this restriction would be implemented to the extent not in conflict with federal law, and the restriction would not prohibit background checks under specified circumstances. The bill will also authorize consideration of an individual's criminal record as part of their overall fitness for the position of peer support specialist if the criminal record has a nexus to that position or its duties. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.
AB 2201	Boerner	Medi-Cal: Eligibility Redetermination	Existing state law generally requires a county to perform eligibility redeterminations for Medi-Cal beneficiaries every 12 months and to promptly redetermine eligibility whenever the county receives information about changes in a beneficiary's circumstances, as specified. This bill would amend those redetermination provisions to conform to the 6-month redetermination requirement under the above-described federal law for Medicaid expansion adults. The bill would make other conforming changes to related provisions. This bill would require the county, in the case of an annual or semiannual redetermination, to verify countable income and assets at renewal without requesting additional verification information or documentation if any of specified sets of conditions are met, relating to certain financial data sources. This bill would require that these provisions be implemented subject to an appropriation made by the Legislature.

AB 2208	Stefani	Medi-Cal: Cost Sharing, Retroactivity, and Accessibility	This bill would, no sooner than October 1, 2028, set a copayment of $0.01 for nonemergency services for the above-described population, as specified. The bill would authorize the provider to collect, retain, or waive the copayment amount. The bill would not apply the copayment requirements to emergency services, family planning services, or any services under certain categories. The bill would prohibit a service provider from denying care or services to an individual solely because of nonpayment of copayment. The bill would create an exemption from a copayment requirement for any visit, service, device, or item for which the Medi-Cal program's payment is $10 or less. The bill would prohibit the total aggregate amount of deductions, cost sharing, or similar charges imposed for all individuals in a family from exceeding 5% of the family income.
AB 2240	Stefani	Medi-Cal: Private Duty Nursing	Existing law, the Medi-Cal Act, establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Under existing law, early and periodic screening, diagnostic, and treatment (EPSDT) services, including private duty nursing services, are covered under Medi-Cal for an individual under 21 years of age in accordance with certain federal provisions. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. This bill would require the department to measure and assess whether private duty nursing services provided as part of the EPSDT benefit follow federal Medicaid requirements, as specified. The bill would require the assessment to include a comparison of the hours of EPSDT private duty nursing services authorized by the Medi-Cal program to the hours actually provided to eligible beneficiary children and a determination of whether the reimbursement rates for those services are

			sufficient to ensure that all authorized hours are able to be provided. The bill would require the department to prepare and submit a report to the Legislature on the findings of the assessment by no later than March 1, 2027.
AB 2268	Schiavo	In-Home Supportive Services Program	Existing law establishes the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, and disabled persons are provided with services to permit them to remain in their own homes. This bill would state the intent of the Legislature to enact legislation relating to the In-Home Supportive Services program.
AB 2278	Ávila Farías	In-home Supportive Services: Community First Choice Option Program: Noncompliance Penalties	Existing federal law, the Community First Choice Option (CFCO) program, authorizes states to provide home- and community-based attendant services and supports to eligible Medicaid enrollees, as specified. Existing federal law provides federal financial participation for a state that provides services under the CFCO program. Existing state law establishes the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, and disabled persons are provided with services in order to permit them to remain in their own homes. Existing law requires the state and counties to share the annual cost of providing IHSS pursuant to a specified cost ratio. Existing law requires all counties to have a rebased County IHSS Maintenance of Effort (MOE) and requires the rebased MOE to be adjusted for the annualized cost

			of increases in provider wages, health benefits, or other benefits, as prescribed. Existing law commencing July 1, 2026, requires a county to pay, separate from the rebased County IHSS MOE payment, a 100% share of the enhanced federal financial participation that would have been received if the state ceases to receive that funding for the provision of services due to noncompliance of timely case reassessment for the federal CFCO program. This bill would require the department to, on or before July 1, 2029, prepare and submit to the Legislature a report on the amount of the above-described payments made by counties due to noncompliance of timely case reassessment for the federal CFCO program.
AB 2327	Lowenthal	Medi-Cal: Subcontractors: Rates	This bill would authorize a subcontracting plan subject to the above-described agreement to request a review of the Medi-Cal managed care rates paid by the primary plan for a particular rating period, as specified. The bill would require the department to direct an independent, qualified actuarial consultant to review those rates upon a showing by the subcontracting plan that certain conditions have occurred or are likely to occur, including, among others, a medical loss ratio in excess of 93% for the preceding 12-month period. If the department determines that the rates paid by the primary plan to the subcontracting plan for a particular rating period are not actuarially sound, the bill will require the department to order a revision of those rates, as specified. The bill would make any failure by the department to comply with these provisions reviewable and subject to appeal at the request of the subcontracting plan through a notice of dispute pursuant to the terms of the Medi-Cal managed care contract. The bill would require these disputes to be concluded and resolved

			within 120 calendar days of the initial request. The bill would authorize the department to implement, interpret, or make specific provisions through the use of all-county letters, plan letters, plan bulletins, amendments to the state Medi-Cal managed care contract, or similar instructions without taking any further regulatory action.
AB 2348	Bonta	Medi-Cal: Community Supports	This bill would authorize a Medi-Cal managed care plan to continue to cover those community supports approved by the department as cost effective and medically appropriate, as specified. Under the bill, this continued coverage would commence on January 1, 2027, would be conditioned on the availability of federal financial participation, and would be set forth as part of a CalAIM successor program. The bill would require the department to continue to publish the above-described public report, but on a quarterly basis. The bill would require the department to provide ongoing technical assistance to Medi-Cal managed care plans and providers of community supports to enhance their ability to effectively provide these services.
AB 2352	Valencia	Medi-Cal Providers: Nonprofit Public Benefit Corporations	Existing law sets forth various procedures, including the submission of an application package, for provider enrollment, continuing enrollment, or enrollment at a new location or a change in location under the Medi-Cal program. Existing law requires an applicant or provider who is a natural person and is licensed or certificated under provisions relating to healing arts, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or is a professional corporation, to comply with the above-described procedures and to be enrolled in the Medi-Cal program as either an individual provider or as a rendering provider in a provider group for each application package that is submitted and approved.

			This bill would also apply the above-described provision to a nonprofit public benefit corporation that has been granted tax-exempt status and through which licensed providers enumerated in the Medicaid state plan provide non-specialty mental health services, as specified.
AB 2355	Gonzalez	Medi-Cal	In developing the comprehensive hospital value strategy described above, this bill would require the department to engage with relevant stakeholders with firsthand experience, including, but not limited to, hospitals, cities, counties, cities and counties, organizations representing these groups, and other affected stakeholders as the department deems necessary. The bill would require the department to ensure that the comprehensive hospital value strategy includes a focus on rural hospitals, critical access hospitals, and public hospitals.
AB 2359	Ta	Medi-Cal	Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Pursuant to existing law, health care granted under the Medi-Cal program is subject to laws amending, repealing, or supplementing provisions affecting the Medi-Cal program, and subject to the rules and regulations of the department. Existing law provides that an individual receiving health care from the Medi-Cal program does not have a claim for compensation or otherwise because their service is affected by those changes. This bill would make technical, non-substantive changes to that provision.
AB 2431	Patel	Downcoding Medical Claims	This bill would require a determination to downcode a claim, which is the unilateral alteration by a payer of the service or procedure code submitted on a claim resulting in a lower payment, to include a documented review of the clinical information supporting the billed service. The bill would set forth

			requirements for and limitations of downcoding decisions, and, if a claim is downcoded, would require a plan or insurer to provide a billing provider with specified information and a clear and accessible process for disputing downcoded claims. The bill would prohibit a plan or insurer from using downcoding practices in a targeted or discriminatory manner against physicians or other health care providers who routinely treat patients with high acuity, complex, or chronic conditions, and would authorize the departments to take action against a plan or insurer that engages in a pattern or practice of discriminatory downcoding or that otherwise violates these provisions. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would require the departments to collect data on coding and claims adjustment practices, evaluate the information, and submit a report with specified information to the Legislature.
AB 2448	Bauer-Kahan	Medical Information: Confidentiality	Existing law, the Confidentiality of Medical Information Act (CMIA), generally prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information regarding a patient, enrollee, or subscriber without first obtaining an authorization, unless a specified exception applies. Existing law makes a violation of the CMIA that results in economic loss or personal injury to a patient punishable as a misdemeanor. Existing law requires specified businesses that electronically store or maintain medical information on the provision of sensitive services on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer to develop capabilities, policies, and procedures, on or before July 1, 2024, to enable certain security features, including limiting user access privileges and segregating medical information related to

			gender affirming care, abortion and abortion-related services, and contraception, as specified. This bill would also require those specified businesses to enable the above-specified capabilities, policies, and procedures for those security features, as specified. Because the bill would expand the scope of an existing crime, it would impose a state-mandated local program
AB 2457	Connolly	Health Care Provider Credentialing	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires a full-service health care service plan, excluding a Medi-Cal managed care plan, or its delegate, to subscribe to and use the Council for Affordable Quality Healthcare credentialing form on and after January 1, 2028. On and after January 1, 2027, existing law requires a health care service plan, excluding a Medi-Cal managed care plan, or its delegate, that credentials health care providers for its networks to decide regarding the credentials of a provider within 90 days after receiving a completed provider credentialing application. This bill would extend the application of the above-described requirements to Medi-Cal managed care plans. Because a willful violation of these requirements by a Medi-Cal managed care plan would be a crime, the bill would impose a state-mandated local program.
AB 2511	Ahrens	Behavioral Health Provider Comparable Worth Study	This bill would require the department, in consultation with the Department of Managed Health Care, the Department of Insurance, the Department of Health Care Access and Information, and the Office of Health Care Affordability, to conduct a comparable worth study to examine and compare compensation and reimbursement for behavioral health providers with compensation and

			reimbursement for similarly situated medical-surgical providers. The bill would require a health care service plan or health insurer to report certain data to the department with respect to payments made directly to providers and payments made to intermediaries and health systems. The bill would also require specified intermediaries and health systems to report certain data to the department relating to payments received and payments made. The bill would make an entity that fails to comply with the reporting requirements subject to civil penalty, as prescribed.
AB 2551	Elhawary	Behavioral Health Care Coverage	This bill would require health care service plans and health insurers to conduct an annual survey to assess the number and prevalence of enrollees or insureds seeking or accessing behavioral health care services from out-of-network providers, the total expenditures paid out-of-pocket by enrollees and insureds for out-of-network and in-network behavioral health care services, as specified, and the reasons for seeking out-of-network behavioral health services. The bill would require the annual survey to be optional for enrollees or insureds. The bill would require health care service plans and health insurers to report survey findings to the departments on or before May 1, 2028, and annually thereafter. The bill would require the departments to adopt regulations establishing standard requirements and a survey tool, as specified. The bill would require the departments to develop annual reports based on the annual survey and other data, as specified. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program. Existing law requires specified boards, including the Board of Registered Nursing and the Respiratory

			Care Board of California, to collect certain workforce data from their respective licensees and registrants for future workforce planning at least biennially. Existing law requires other specified boards that regulate healing arts licensees or registrants to request workforce data from their respective licensees and registrants for future workforce planning at least biennially. Existing law requires the workforce data collected or requested to include specified information, including, among others, the type of employer or classification or primary practice site, as specified. Existing law prohibits a licensee or registrant from being required to provide the information as a condition for license or registration renewal, and prohibits licensees or registrants from being subject to discipline for not providing the information. This bill would require the information collected or requested by boards to include whether a licensee or registrant is a contracted provider and the types of health care coverage under which contracted services are provided.
AB 2565	Wallis	Medi-Cal: Pharmacist Services: Reporting	This bill would require the department to issue guidance clarifying Medi-Cal managed care plan obligations to cover pharmacist services, as specified. The bill would require the department to update its model evidence of coverage to explicitly include coverage of pharmacist services. The bill would also require the department to take appropriate corrective action for failure to comply with existing provisions of law relating to Medi-Cal coverage of pharmacist services or the issued guidance. The bill would authorize the department to implement, interpret, or make specific provisions by means of all-plan letters, plan letters, or other similar instructions, without taking any further regulatory action.

AB 2571	Flora	Reimbursement for Pharmacist Services	Under existing law, pharmacist services are a benefit under the Medi-Cal program, subject to federal approval, and the rate of reimbursement for pharmacist services is 85% of the fee schedule for physician services, except for medication therapy management (MTM) pharmacist services. This bill would require the rate of reimbursement for advanced practice pharmacist services to be the same as the fee schedule for physician services, including MTM pharmacist services. The bill would require the department to implement an MTM reimbursement methodology relating to the use of drugs to ensure that Medi-Cal payments are only made to eligible advanced practice pharmacists or pharmacies including those operating at federally qualified health centers or rural health clinics, for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories. This bill would require those health care service plans and disability insurers to pay or reimburse the cost of the service performed by a pharmacist enrolled as a provider with the plan or insurer. The bill would specify for these purposes that a pharmacist includes pharmacists who provide services at a federally qualified health center or a rural health clinic.

AB 2575	Ortega	Health Care Services: Artificial Intelligence	This bill would require a health facility, clinic, physician's office, or office of a group practice that uses or deploys a clinical decision support system, as defined, for patient care to provide written notice of required information to any licensed health care professional or other person using a clinical decision support system or viewing outputs from a clinical decision support system. The bill would require, among other things, the disclosure to include a notice that a worker providing direct patient care is authorized to override the output of a clinical decision support system if, in the judgment of the worker acting within their scope of practice, an override is necessary to meet the applicable standard of care or comply with applicable law. The bill would specify the required time and manner the disclosure is to be provided pursuant to these provisions. By placing new requirements on health facilities and clinics, this bill would expand the scope of a crime and would impose a state-mandated local program.
AB 2610	Addis	Patient Access to Health Records	Existing law generally governs a patient's access to the patient's own health records. Existing law establishes procedures for providing access to health care records or summaries of those records by patients and by those people who have responsibility for decisions regarding the health care of others, as described. Existing law sets forth the Legislature's findings and declarations regarding the right of access to that information, as specified. This bill would make technical, non-substantive changes to those findings and declarations.

AB 2613	Sharp-Collins	Health Care Service Plans: Notice	This bill would additionally require a health care service plan to notify an enrollee by email or text message, as specified, at least 60 days before the termination date of a contract between a health care service plan and a provider group or a general acute care hospital to which the enrollee is assigned. If the plan reaches an agreement with a terminated provider after sending the notice of termination, the bill will require the health care service plan to send written notice by United States mail and by email or text message, as specified, to affected enrollees within 60 days of reaching the agreement. Because a willful violation of these provisions would be a crime, this bill would impose a state-mandated local program.
AB 2614	Dixon	Public Health: Body Brokering and Patient Referral Integrity Act	This bill would prohibit any person from offering, paying, soliciting, or receiving a commission, benefit, bonus, or other form of remuneration or from engaging in a split-fee arrangement to induce a referral to a residential treatment facility or in return for acceptance of an individual into a residential treatment facility. The bill would make a violation of that provision a misdemeanor. The bill would define a “residential treatment facility” to include any sober living home, group home, recovery residence, residential care facility, or similar facility providing housing or residential services, in connection with alcohol or substance use disorder treatment or behavioral health recovery.

AB 2670	Castillo	Medi-Cal: Fraud Assessment Task Force	Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to qualified low-income people pursuant to a state plan. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would, upon appropriation by the Legislature, require the department to convene a task force of specified members by no later than January 1, 2027, to conduct a comprehensive assessment of fraud risks in the Medi-Cal program. The bill would require the task force, within 6 months of formation, to review current fraud prevention tools, analyze data-sharing gaps, and evaluate how best practices from the federal government and other states could be applied in California. The bill would require the task force to submit specified recommendations based on this assessment to the appropriate policy and fiscal committees of the Legislature by no later than January 1, 2028.
AB 2729	Bonta	Medi-Cal: Employer Responsibility for Medi-Cal Trust Fund	Existing federal law, Public Law 119-21, enacted on July 4, 2025, sets forth various changes to different health care programs, including certain requirements for Medicaid eligibility with regard to work or community engagement reporting, redeterminations, and cost sharing, among other factors, for certain Medicaid populations pursuant to a specified implementation timeline. Existing law, the federal Patient Protection and Affordable Care Act, imposes a certain assessment on an applicable large employer, as defined, that offers full-time employees and their dependents the opportunity to enroll in minimum essential coverage, and for whom one or more full-time employees have been certified as having enrolled in a qualified health plan for which a premium tax credit or cost-sharing reduction is allowed or paid.

			This bill would create the Employer Responsibility for Medi-Cal Trust Fund to consist of new taxes and deposits, including employer penalties specified in the Budget Act of 2026. The bill would continuously appropriate money in the funds to the department to fund the costs of administering the Medi-Cal program in a manner necessary to prevent loss of or to restore health care coverage, benefits, or access to care following the passage of Public Law 119-21 and subsequent state budget actions. The bill would state that these provisions would become operative only if the Medicaid provisions of Public Law 119-21 are not repealed prior to January 1, 2027. By creating a continuously appropriated fund, the bill would make an appropriation. This bill would declare that it is to take effect immediately as an urgency statute.
SB 490	Umberg	Alcohol and Drug Programs	This bill would require the department, if it determines whether it has jurisdiction over the allegation, to initiate that investigation within 10 days of receiving the allegation and, except as specified, complete the investigation within 60 days of initiating the investigation. The bill would require the department, if it receives a complaint that does not fall under its jurisdiction, to notify the complainant that it does not investigate that type of complaint. The bill would require the employee or agent to provide the notice described above within 10 days of the employee or agency submitting their findings to the department and to conduct a follow-up site visit to determine whether the facility has ceased providing services as required. The bill would authorize, in counties that elect to administer the Drug Medi-Cal organized delivery system and provide optional recovery housing services, the county behavioral health agency to request approval from the department to conduct a site visit of a recovery residence that is alleged to be operating without a license. The bill would permit the department to approve that request in certain

			circumstances, including that the department has sufficient evidence to substantiate the allegation. This bill would require the department, if it acts against a recovery residence pursuant to that provision, to conduct a site visit of a certified program or licensed facility that has disclosed the specified interest in the recovery residence. The bill would also require, no later than July 15, 2026, and by July 15 each year thereafter, that all programs certified or facilities licensed by the department submit to the department a report of all money transfers between the program or facility and a recovery residence during the previous fiscal year, in order to detect patient brokering, illicit kickbacks, or unethical inducements that harm patients. The bill would require the department to analyze that data and develop guidelines for permissible and impermissible transfers.
SB 874	Weber Pierson	Medi-Cal: Behavioral Health Treatment Workgroup	This bill would require the department, on or before July 1, 2027, to ensure that certain individuals providing BHT services under Medi-Cal undergo background checks. The bill would require the department to convene a stakeholder workgroup made up of BHT providers, managed care plans, and consumers with autism, among others, to review the implementation of BHT services in Medi-Cal and to advise the department on, among other topics, clinical guidelines for the provision of BHT services, treatment plan requirements, requirements for the provision of center-based services compared to services provided elsewhere, and supervision of unlicensed and uncertified professionals, as specified. The bill would require the department, on or before January 1, 2028, to release and maintain clear clinical guidance for the provision of the BHT benefit, as specified. The bill would require the department, on or before January 1, 2029, to report to the legislature on the utilization of the BHT benefit, a synopsis of changes made as a result of

			the stakeholder workgroup, and recommendations for actions necessary to ensure Medi-Cal reimbursement practices align with federal Medicaid program integrity requirements.
SB 912	Cervantes	Comprehensive Perinatal Services	This bill would require DHCS to oversee a statewide comprehensive community-based perinatal services program and enroll health care providers to deliver these services to Medi-Cal members and make conforming changes, but would maintain the State Department of Public Health's role with related contracts, grants, and agreements. The bill specify that any participation by the State Department of Public Health does not change the State Department of Health Care Services' authority to implement comprehensive community-based perinatal services for purposes of the Medi-Cal program. By January 1, 2028, the bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health, to clarify each department's roles and responsibilities regarding comprehensive perinatal services by regulation. The bill would, among other things, require the State Department of Health Care Services to develop informational and educational materials on comprehensive perinatal services by January 1, 2028, and require all Medi-Cal managed care plans to disseminate the materials, as specified. The bill would require the State Department of Health Care Services, no later than July 15, 2027, to submit to the Assembly Committee on Health and the Senate Committee on Health, and post on its internet website, a report that identifies the number of pregnant and postpartum individuals that received comprehensive perinatal services from January 1, 2022, to January 1, 2025, inclusive. The bill would also require the State Department of Health Care

			Services, commencing July 15, 2028, and every 3 years thereafter, to submit to those committees, and post on its internet website, a report that identify the number of pregnant and postpartum individuals that received and were offered comprehensive perinatal services during the previous 3 calendar years.
SB 944	Wiener	Medi-Cal: Acupuncture	Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Existing law sets forth a schedule of benefits covered under the Medi-Cal program, including acupuncture, but only to the extent federal matching funds are provided for acupuncture. This bill would remove the limitation requiring federal matching funds for acupuncture to be a covered benefit, thereby making acupuncture a covered benefit under Medi-Cal.

SB 950	Weber Pierson	Health Care Coverage: Dementia	This bill would require a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2027, to include coverage for all medically necessary treatments or medications, as determined by a health care provider, approved by the United States Food and Drug Administration (FDA) for the treatment of Alzheimer's disease or other related dementia. Under the bill, contracts and policies would not be required to cover drugs or treatments that are pharmaceutically equivalent drug products if the FDA approves more than one. On and after January 1, 2027, the bill would prohibit a health care service plan or health insurer from imposing step therapy protocols as a prerequisite to authorizing that coverage, except as provided.
SB 964	Smallwood-Cuevas	Prescription Drug Coverage: Dose Adjustments	This bill would authorize an enrollee's or insured's treating provider to request, and would require that they be granted, the authority to adjust the dose or frequency of a drug to meet the specific medical needs of the enrollee or insured without prior authorization if specified conditions are met.
SB 1023	Laird	Health Care Coverage: Antiretroviral Drugs, Drug Devices, and Drug Products	This bill would instead prohibit a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs, drug devices, or drug products that are medically necessary for the prevention of HIV/AIDS to prior authorization or step therapy. The bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, that covers non-self-administered antiretroviral drugs, drug devices, or drug products that are approved by the United States Food and Drug Administration (FDA) for the prevention of HIV/AIDS as a medical benefit to also include those non-self-administered antiretroviral drugs, drug devices, or drug products as an outpatient prescription drug benefit. Because a willful violation of these provisions by a health care

			service plan would be a crime, this bill would impose a state-mandated local program.
SB 1089	Richardson	Preventive Treatment Health Care Act	Existing law requires the California Health and Human Services Agency (CHHSA) to enter into partnerships resulting in the production of generic prescription drugs, including at least one form of insulin made available at production and dispensing costs, if one does not already exist in the market. Existing law additionally authorizes CHHSA to enter into partnerships to increase competition, lower prices, and address supply shortages for generic or brand name drugs to address emerging health concerns. This bill, the Preventive Treatment Health Care Act, would specify that the above-described authorized partnerships include those for at least one glucagon-like peptide-1 (GLP-1) approved by the United States Food and Drug Administration (FDA). Commencing January 1, 2028, until January 1, 2032, this bill would require a health benefit plan or contract offered to public employees and annuitants to offer coverage for chronic weight disease management or to treat obesity or overweight people, including nutritional information and at least one GLP-1 approved by the FDA.
SB 1037	Weber Pierson	Health Care Coverage: Rate Review	Existing law requires a health care service plan or health insurer to submit rates to their regulating entity for review and to demonstrate the impact of any changes in the rate of growth of health care costs resulting from health care cost targets. This bill would instead require a health care service plan or health insurer to demonstrate the impact of health care cost targets on rate development, including medical trends, medical inflation, and medical administrative costs. If a plan or insurer asserts that aging, high-cost drugs, or other cost drivers explain a rate increase, the bill would require the plan or insurer to explain how it reconciles this information with analysis published by the Office of Health Care Affordability. Because a willful violation of these

			provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. Existing law requires the director or the commissioner, as applicable, in determining whether a rate is unreasonable or not justified for purposes of the above-described review, to consider the impact on changes in health care costs as a result of the health care cost targets described above. This bill would require, in determining whether a rate increase is unreasonable, the director to consider whether the plan has sufficient or excessive tangible net equity and the commissioner to consider whether the insurer has sufficient or excessive risk-based capital. The bill would require the Department of Managed Health Care and the Department of Insurance, in collaboration with the Office of Health Care Affordability, as part of the existing rate review process, to each conduct an enhanced rate review to determine if health care premiums are affordable for individual and group purchasers. The bill would require the review to include the annual change in premiums and cost sharing for the prior 5 years, including deductibles, copayments, coinsurance, and any other cost sharing that impact actuarial value.
SB 1199	Weber Pierson	Prescription Drug Cost Sharing	This bill would require a health care service plan or health insurer, when calculating an enrollee's or insured's overall contribution to an out-of-pocket maximum or cost sharing requirement under the plan contract or insurance policy, to count any amount paid by the enrollee or insured or on behalf of the enrollee or insured toward the enrollee's or insured's cost sharing, including any form of direct support offered by drug manufacturers that is permitted, except as provided. The bill would prescribe an administrative penalty for each violation by a health insurer that is enforceable by the Insurance Commissioner after appropriate

			notice and opportunity for hearing. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.
SB 1202	Weber Pierson	Medi-Cal: Dashboard and Outreach	This bill would require the department to establish a data dashboard that provides data on applications, enrollment, redeterminations, disenrollments, and terminations, with certain objectives in consideration, related to the impact of the above-described federal law on Medi-Cal eligibility and enrollment, as specified. The bill would require the dashboard to track and report on the specific data for work or community engagement requirements and exemptions. The bill would require the department to undertake efforts to conduct outreach about work or community engagement requirements, more frequent redetermination, and changes to retroactive eligibility to impacted Medi-Cal beneficiaries, and to conduct listening sessions, as specified. Under the bill, beneficiary outreach and education would be coordinated across public social services programs to help minimize barriers to administrative disenrollments. The bill would require a Medi-Cal managed care plan to establish and conduct an outreach and education plan for its enrollees about the work or community engagement guidelines set forth in federal law based on guidance provided by the department. The bill would require the plan to address certain information on Medi-Cal eligibility, the right to appeal or reinstate Medi-Cal coverage, and resources, and to meet certain cultural and linguistic appropriateness standards. This bill would remove the requirement for the managed care plan to ask the beneficiary for approval for purposes of providing contact information to the county. The bill would remove the

			requirement for the county to make the verification attempt and would remove a related provision on the method of contact. The bill would require the sharing of beneficiary redetermination data with managed care plans to aid in managed care plans' efforts to assist beneficiaries with retaining Medi-Cal coverage, as specified.
SB 1242	Choi	Community Assistance, Recovery, and Empowerment (CARE) Court Program	The Community Assistance, Recovery, and Empowerment (CARE) Act, authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan and implement services to provide behavioral health care, including stabilization medication, housing, and other enumerated services, to adults who are currently experiencing a severe mental illness and/or psychotic disorders. This bill, if the original petitioner is a parent or specified family member, would require the court to allow the original petitioner to participate in the respondent's CARE program for the purpose of assisting in care coordination and providing relevant information to the CARE team, unless the court determines, on its own motion or on motion of the respondent, at any point in the proceedings, that it would likely be detrimental to the treatment or well-being of the respondent. The bill would authorize the court to limit or exclude participation by the original petitioner under these provisions upon a finding that participation by the original petitioner would likely be detrimental to the treatment or well-being of the respondent. The bill would prohibit disclosure to the original petitioner of information protected by specified confidentiality provisions unless the respondent consents.
SB 1244	Allen	Public Agency Benefits Intermediary	This bill, the Public Agency Benefits Intermediary Compensation Disclosure Act, would require a covered service provider, defined to mean a broker, agent, consultant, or advisor that meets specified

		Compensation Disclosure Act	criteria, to disclose to a public agency, defined to only include local entities, or its group health plan the direct and indirect compensation it expects to receive for providing brokerage or consulting services, among other information, before it enters into, extends, renews, or materially amends a contract or arrangement for brokerage services or consulting services with the public agency or its plan. The bill would also require a covered service provider to disclose compensation and material financial interests related to a covered health care benefits arrangement that the covered service provider recommends, places, renews, services, or materially influences for the public agency or its group health plan. Disclosure would be required under these provisions if the covered service provider reasonably expected it would receive $1,000 or more in compensation during the term of the contract or arrangement. The bill would require these disclosures at specified times. This bill would prohibit a covered service provider from requesting, accepting, or receiving direct or indirect compensation in connection with brokerage services or consulting services provided to a public agency or its plan unless the compensation is disclosed, and would prohibit evasion of disclosure requirements.
SB 1252	Durazo	California Resident Taxpayer Health Care Coverage	This bill would state that every person who is a resident subject to a tax and whose income is at or below 138% of the federal poverty level using the modified adjusted gross income methodology, as specified, is entitled to access to the public health care coverage their tax dollars support. The bill would require the State Department of Health Care Services to ensure that these individuals have access to public health care coverage through programs it administers, including Medi-Cal. To the extent that these provisions would alter the population of beneficiaries for Medi-Cal, the bill

			would impose a state-mandated local program. The bill would make related findings and declarations. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.
SB 1221	Stern	Lanterman-Petris-Short Act: Conservatorships	This bill would authorize the district attorney to review all filed documents regarding the investigation, initiation, termination, or modification of, and to be present and represent public safety interests at all hearings that consider, a conservatorship of a person who is gravely disabled, as defined by being found mentally incompetent and meeting the above-described conditions, to provide input to the court about appropriate placement or interim placement by the public conservator. The bill would require a copy of the conservatorship investigation report to be transmitted to the district attorney if the investigation were initiated as part of a determination of mental competence for trial. The bill would authorize the district attorney, if the individual has been appointed a conservator under specified provisions, to challenge the recommendation of the public conservator after the conservatorship investigation for an abuse of discretion in a contested hearing before a judge. The bill would prohibit the district attorney from using the information contained in these reports in subsequent criminal proceedings, except as specified. To the extent the bill imposes a higher level of service on county agencies that prepare and transmit conservatorship investigation reports and

			on a district attorney to receive those reports, the bill would impose a state-mandated local program. This bill would authorize a county with a population size of 750,000 or greater to consider prioritizing the placement of specified conservatees in a state hospital run by the State Department of State Hospitals if at least 40 of those conservatees are waiting for placement in a state hospital. The bill would also authorize the placement to be on an interim basis at a county detention facility pending acceptance into a facility that achieves the purposes of treatment of the conservatee and protection of the public. The bill would require the conservatee to receive treatment services in accordance with the conservatorship plan within the detention facility pending permanent placement and would require the court to review the conservator's placement efforts every 60 calendar days.
SB 1261	Laird	Aging and Disability Resource Connection Program	Existing law establishes an Aging and Disability Resource Connection (ADRC) program, administered by the California Department of Aging, to provide information to consumers and their families on available long-term services and supports (LTSS) programs and to assist older adults, caregivers, and persons with disabilities in accessing LTSS programs at the local level. This bill would prohibit the California Department of Aging from revoking the designation of an ADRC program solely due to the revocation or voluntary termination of a designation, suspension, or temporary inability of either the area agency on aging or the independent living center partner to serve in its operator role, and would authorize the remaining partner to continue to operate the ADRC independently during a transition period, as specified.

SB 1280	Valladares	Health Care Coverage For Mental Health and Substance Use Disorders	This bill would require a health care service plan or disability insurer to reimburse a noncontracting individual health professional the greater of the average contracted rate or 125% of the amount Medicare reimburses for similar services, as specified, for out-of-network services that are provided as described above. The bill would prohibit an enrollee or insured from owing the health professional more than the in-network cost-sharing amount, and would prohibit the health professional from billing or collecting an amount from the enrollee or insured that is more than that amount. The bill would require any communication from the health professional to an enrollee or insured, before the receipt of information about the amount the individual owes for services provided, to include a notice informing the individual that it is not a bill and not to pay until they are informed by their plan or insurer of any applicable cost sharing. The bill would require a plan or insurer to inform an enrollee or insured and the noncontracting individual health professional of the in-network cost-sharing amount owed by the individual at the time of payment by the plan or insurer to the health professional. Under the bill, the payments made by the plan or insurer and enrollee or insured pursuant to these provisions would constitute full payment. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.
SB 1284	Smallwood-Cuevas	Medi-Cal Benefits: Employer Reports	This bill would require the State Department of Health Care Services, after obtaining specified information from the Employment Development Department (EDD), to prepare a report that includes information regarding employers in California that employ 100 or more employees and have any employees who receive benefits from the Medi-Cal program, including, among other things, the estimated total annual cost of Medi-Cal services

			provided to employees, and the dependents of those employees, of each employer, and submit that report to the Legislature no later than September 1, 2027, and annually thereafter. The bill would provide individually identifiable information about employees or Medi-Cal enrollees contained in the report is exempt from disclosure under the California Public Records Act, and would authorize the department and EDD to enter into data-sharing agreements, as provided. The bill would also repeal an obsolete reporting requirement. This bill would additionally prohibit an employer from discharging or in any manner discriminating or retaliating against an employee who applies for, or is enrolled in, the Medi-Cal program. The bill would also prohibit an employer from refusing to hire a person because that person is enrolled in the Medi-Cal program.
SB 1309	Rubio	Health Care Coverage: Lung Cancer	This bill would require a health care service plan contract, except as specified, or health insurance policy issued, amended, or renewed on or after January 1, 2027, to provide coverage for follow-up screening or diagnostic services for lung cancer, as specified. The bill would prohibit a contract or policy from imposing a copayment, coinsurance, deductible, or any other form of cost sharing for this coverage. If a health care service plan contract is a high-deductible health plan, the bill would prohibit the contract from imposing a deductible, coinsurance, or any other cost sharing on this coverage unless not imposing the deductible, coinsurance, or cost sharing would conflict with the federal requirements for high-deductible health plans.

SB 1377	Jones	Immunizations: Medical Exemptions	This bill would exempt a child from immunization requirements if the parent or guardian files with the governing authority a written statement, as described above. The bill would prohibit the department, a local health department, or a third-party review panel from revoking, invalidating, or conditioning a medical exemption duly issued by a licensed physician and surgeon, except by final order of a court upon clear and convincing evidence of fraud. The bill would prohibit the department and local health departments from auditing, disciplining, or referring a physician and surgeon to the Medical Board of California or Osteopathic Medical Board of California based solely on the number of medical exemptions issued. This bill would prohibit a physician and surgeon from being investigated, disciplined, or otherwise acted against by any state department or board based on their issuance of medical exemptions unless the medical exemption is found to be fraudulent or otherwise invalid. The bill would prohibit a medical exemption from being considered in any investigation or action against a physician and surgeon that is otherwise unrelated to medical exemptions. This bill would prohibit a health care service plan or health insurer from denying coverage, imposing higher premiums, canceling a policy, or otherwise penalizing an enrollee or insured because a covered minor holds a medical exemption.
SB 1422	Durazo	Medi-Cal: Eligibility: Immigration Status	This bill would require the Director of the Department of Finance to determine and report to the Legislature and the Governor the cost of implementing eligibility for the full scope of Medi-Cal benefits for individuals who do not have satisfactory immigration status if they are otherwise eligible, and whether including those costs the General Fund would be in a deficit, as defined. The bill would then,

	on January 1 of the year following such a determination, end the above-described limitations on services for those who apply for Medi-Cal after January 1, 2026, or who lose eligibility for the full-scope of Medi-Cal benefits on or after January 1, 2026, thereby making an individual who is 19 years of age or older, who does not have satisfactory immigration status, eligible for the full scope of Medi-Cal benefits subject to certain limitations, such as the payment of premiums and certain dental benefits. The bill would require that the implementation of eligibility for the full-scope of Medi-Cal benefits be done by groups categorized by age, beginning with individuals over 49 years of age.

Executive Dashboard

OPERATIONS DASHBOARD

JUNE 2026

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Financials

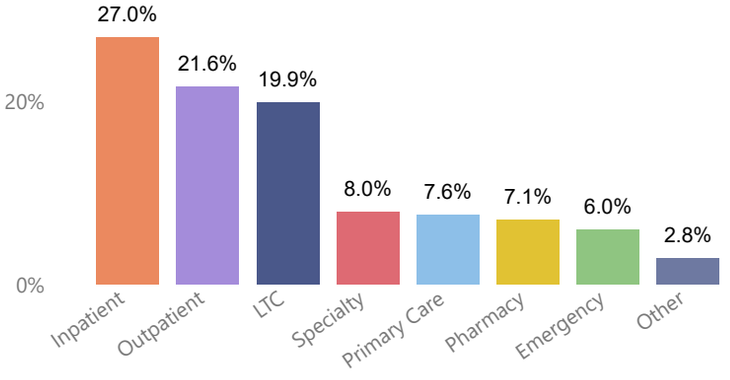
Income & Expenses

	APRIL 2026	FISCAL YTD
REVENUE	$ 251.6 M	$ 2.5 B
MEDICAL EXPENSE	$ (179.5) M	$ (1.8) B
ADMIN EXPENSE	$ (11.4) M	$ (104.6) M
OTHER/TAX	$ (60.2) M	$ (621.6) M
NET INCOME	$ 388 K	$ 67.0 M

Medical Loss % (Fiscal YTD)

92.3%

Medical Expenses



Liquid Reserves

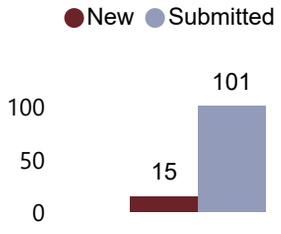
TNE %

296.0%

TNE $

$236.3M

Reinsurance Cases



Balance Sheet

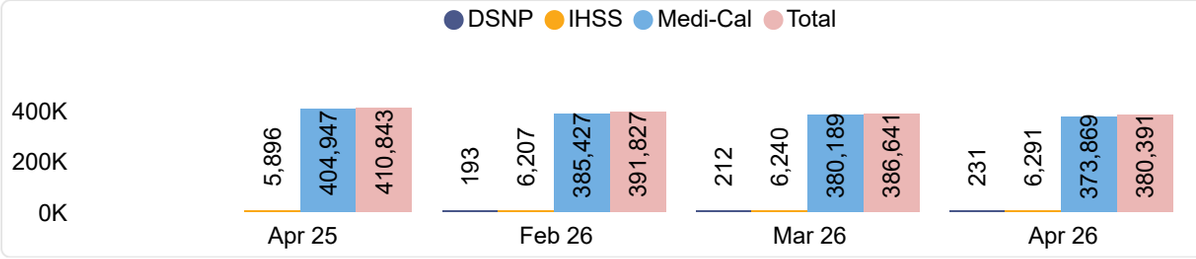
Cash Equivalents	$577.3M
Pass-Through Liabilities	$164.0M
Uncommitted Cash	$413.2M
Working Capital	$182.7M

Current Ratio

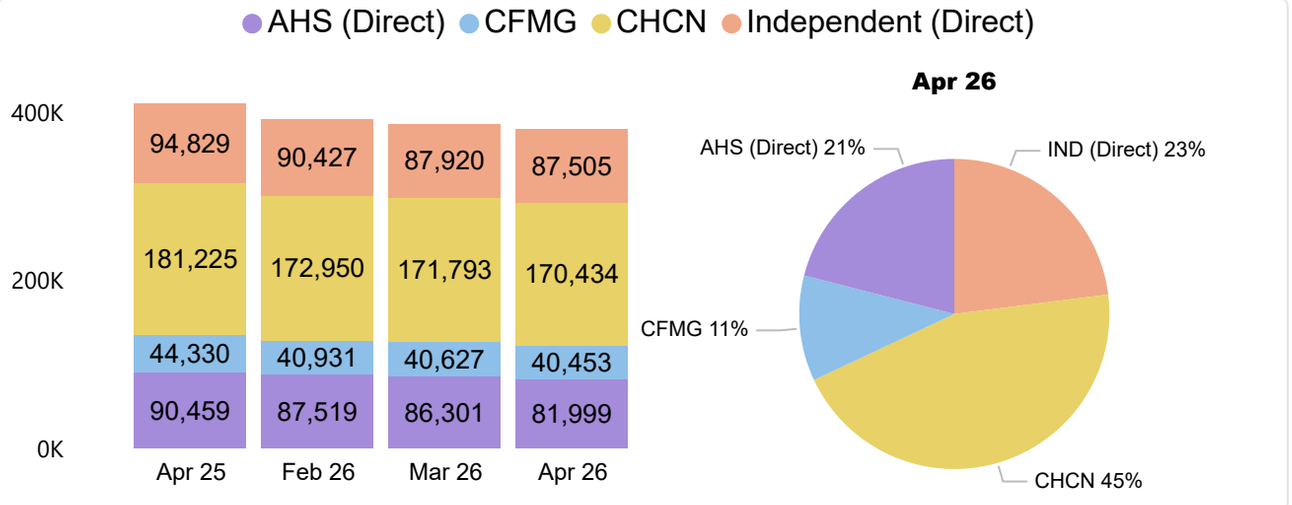
1.23

Membership

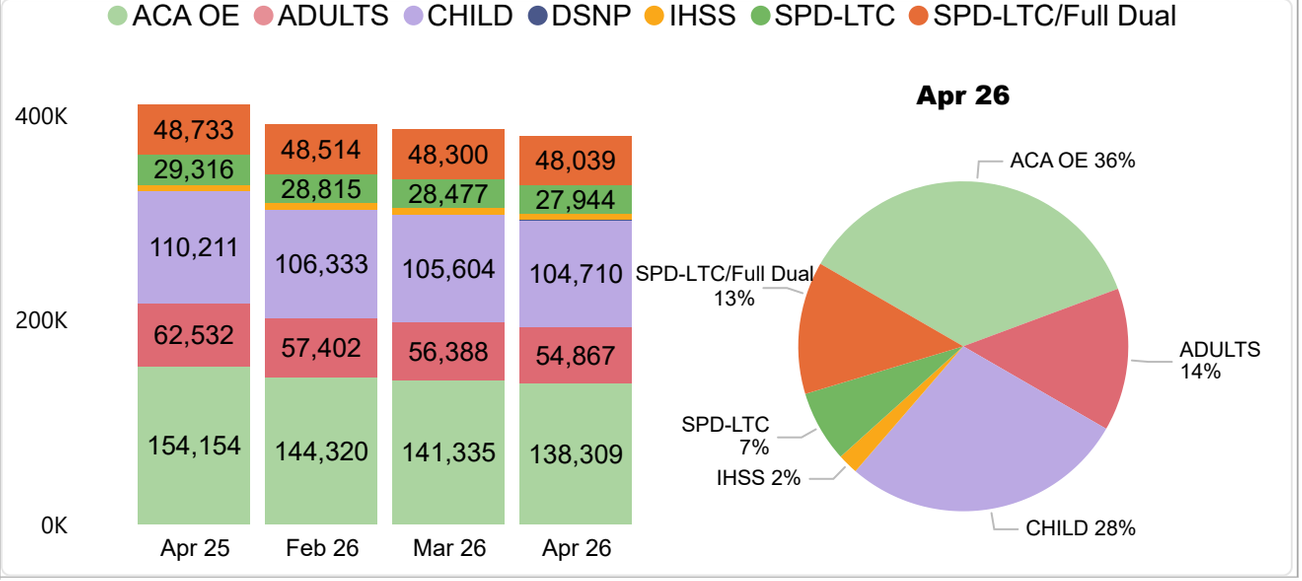
By Plan



By Network



By Category



OPERATIONS DASHBOARD

JUNE 2026

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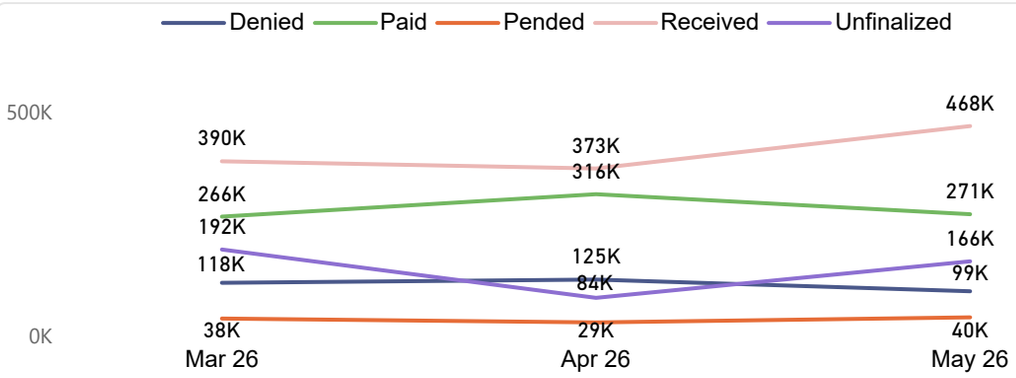
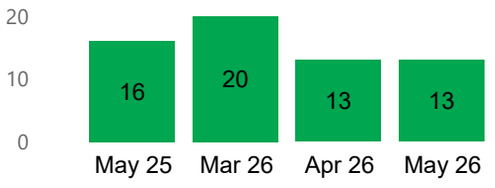
Claims

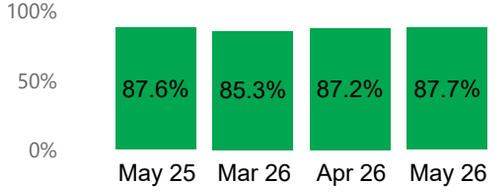
Claims Processing



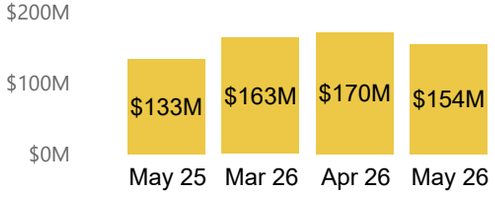
Average Payment TAT (Days)



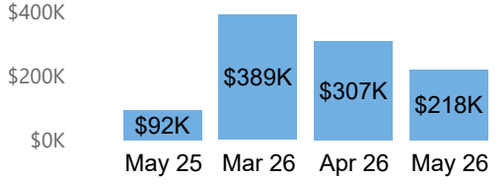
Auto Adjudication Rate (%)



Claims Paid ($)

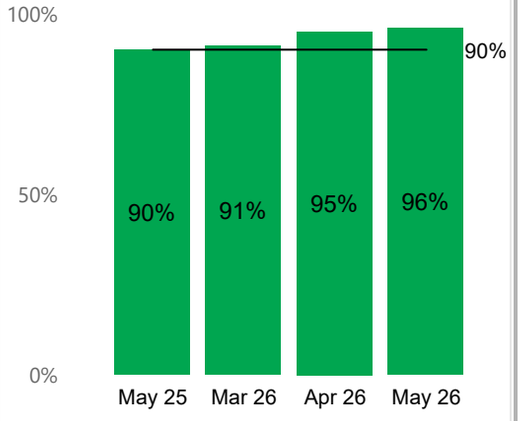


Interest Paid ($)

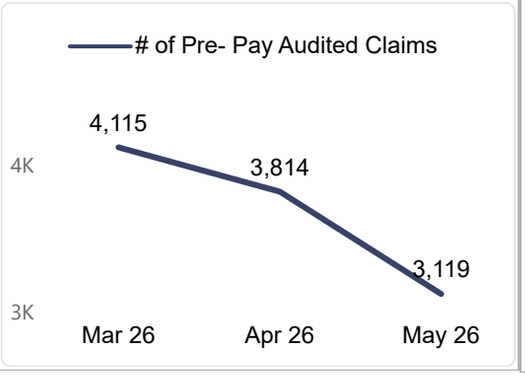


Claims Compliance

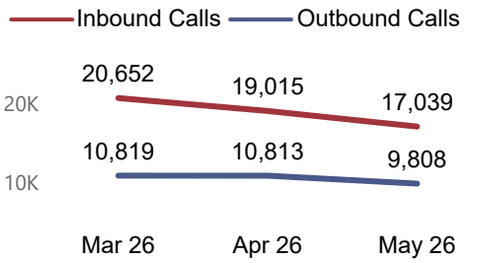
Processed 30 Cal Days (%)



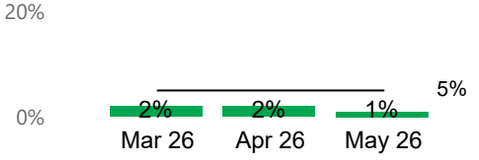
Claims Auditing



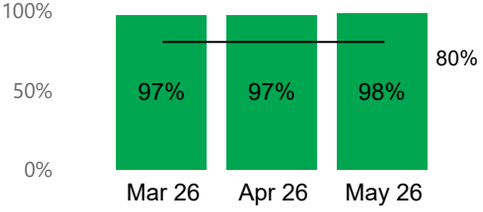
Member Services



Abandoned Call Rate (%)

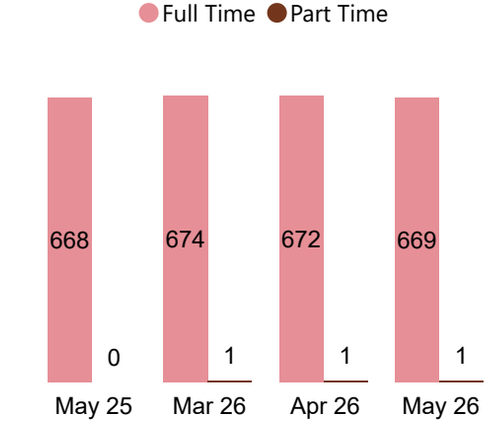


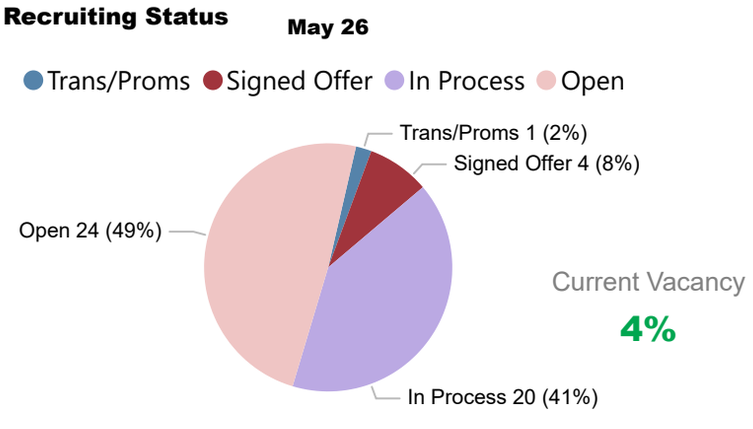
Calls Answered in 30 Seconds (%)

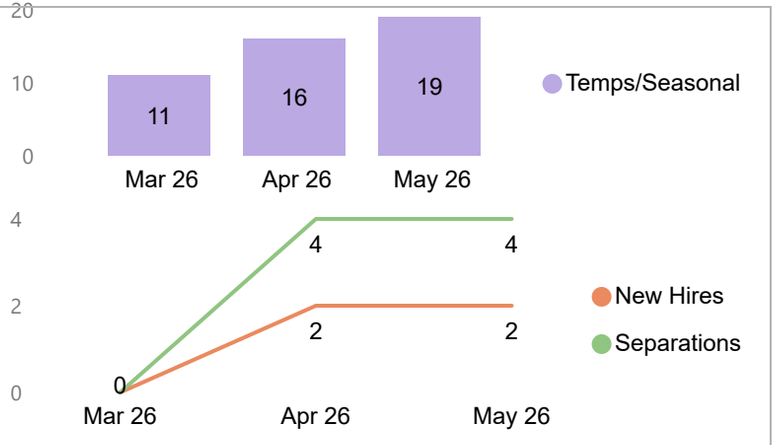


Average Call Times	Mar 26	Apr 26	May 26
Wait Time	00:02	00:08	00:06
Call Duration	07:20	07:28	07:18

Human Resources







OPERATIONS DASHBOARD

JUNE 2026

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Provider Services

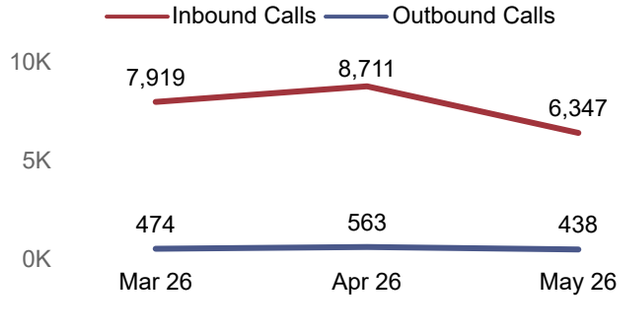
Provider Network

Hospital	17
Specialist	12,276
Primary Care Physician	711
Skilled Nursing Facility	107
Urgent Care	16
Health Centers (FQHCs and Non-FQHCs)	87
TOTAL	**13,214**

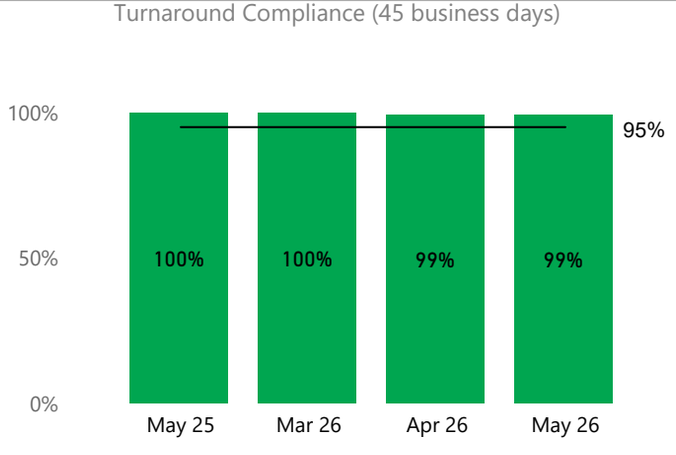
Provider Credentialing

5,898

Provider Call Center

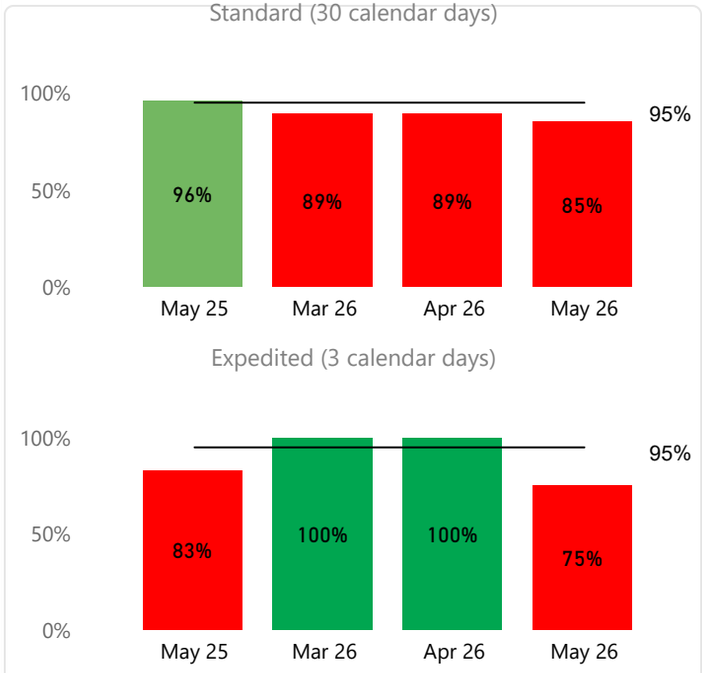


Provider Disputes & Resolutions

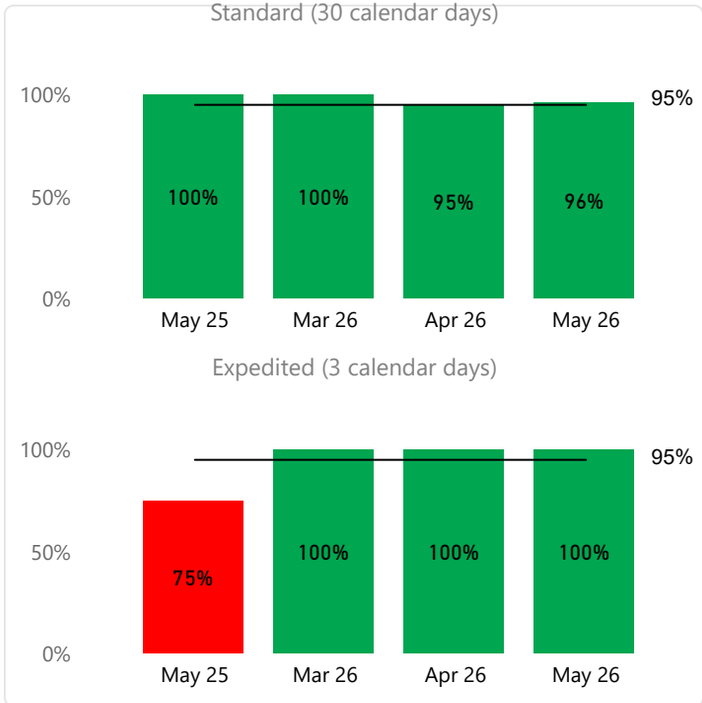


Compliance

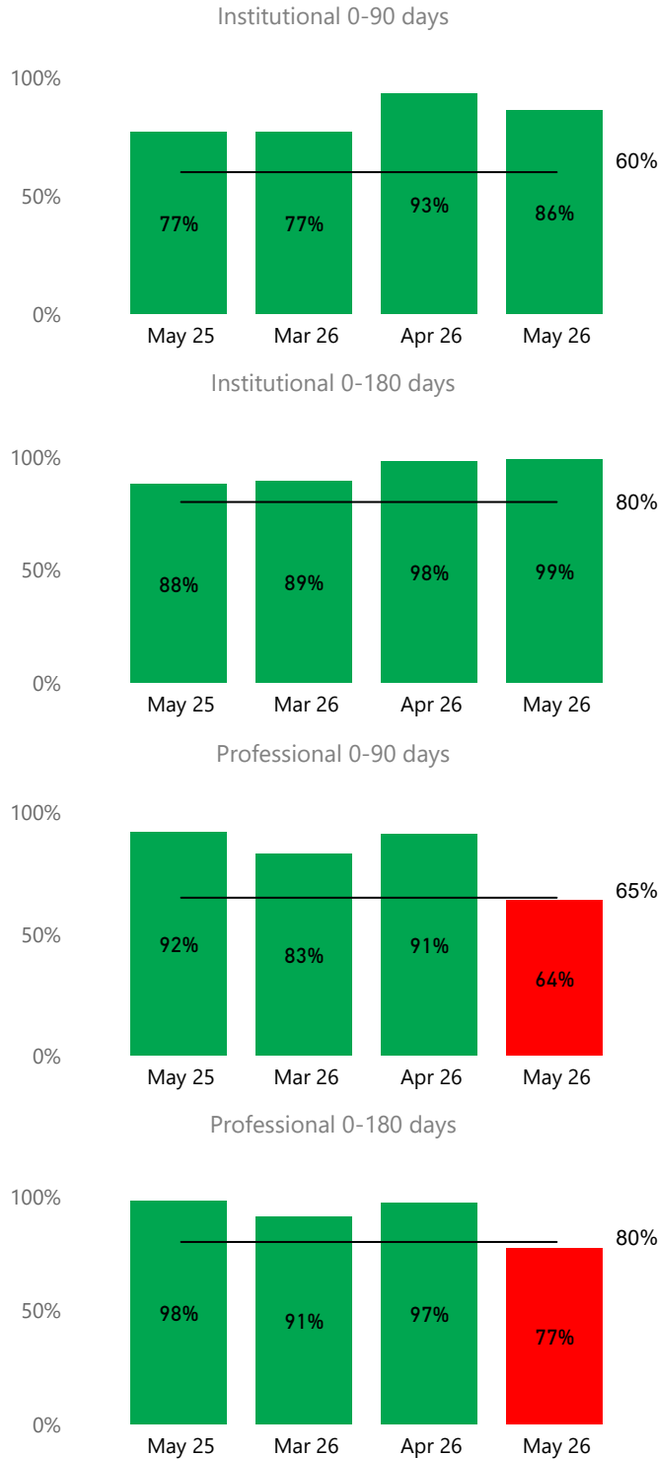
Member Grievances



Member Appeals



Encounter Data



OPERATIONS DASHBOARD

JUNE 2026

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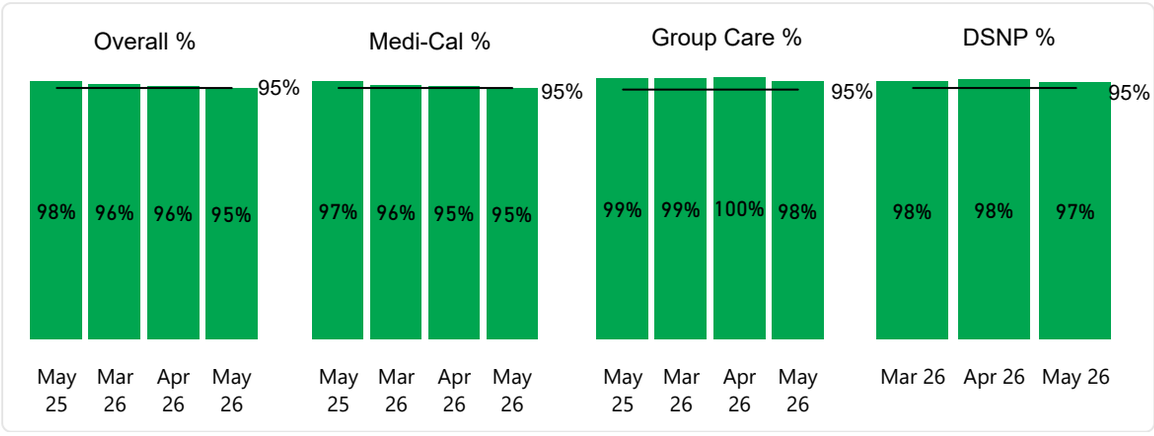
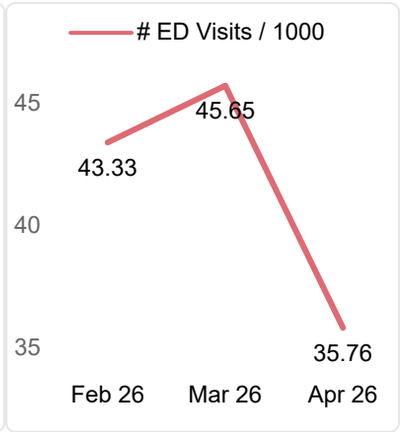
Health Care Services

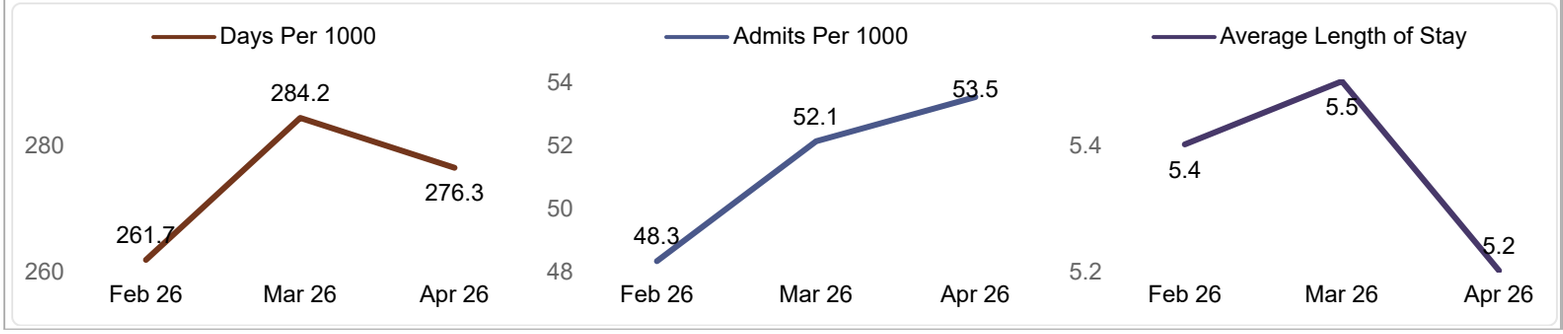
Authorization Turnaround



ED Utilization

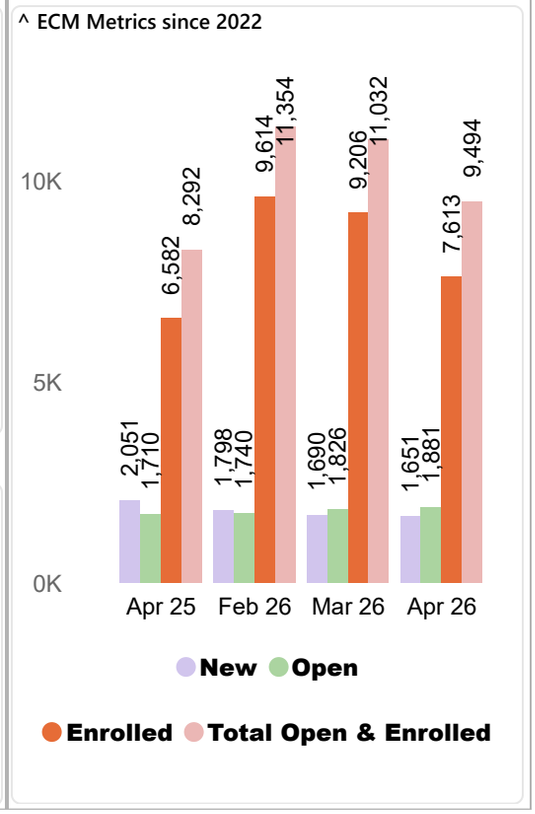


Inpatient Utilization

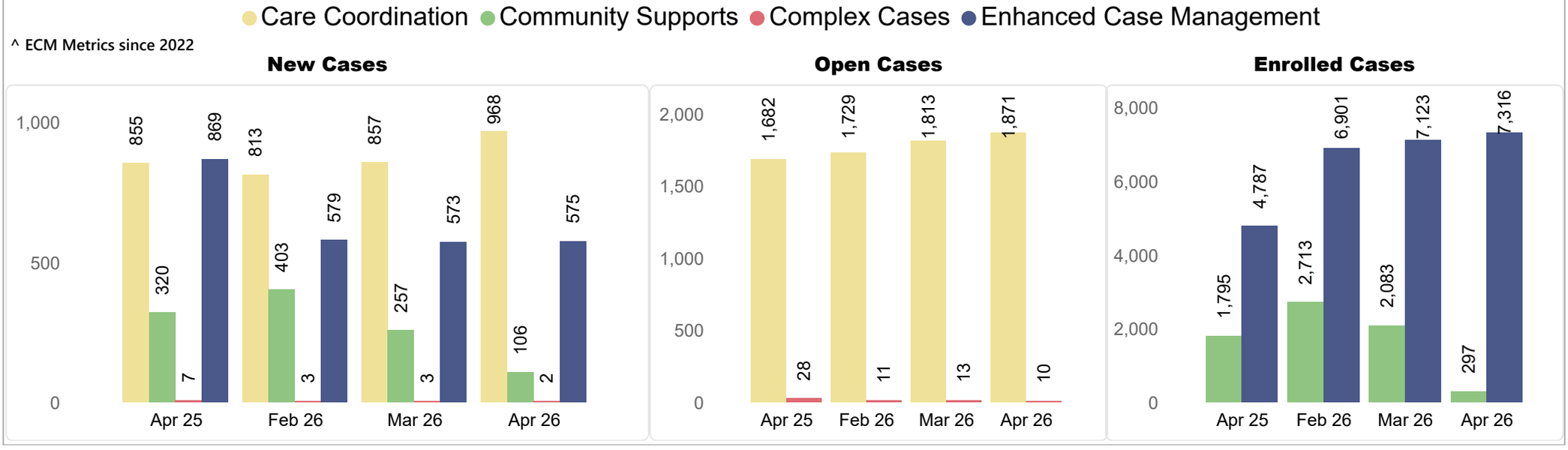


Case Management

Total Cases^



Case Management^



OPERATIONS DASHBOARD

JUNE 2026

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Technology (Business Availability)

Applications	May 25	Mar 26	Apr 26	May 26
HEALTHsuite System	100.0%	99.9%	99.5%	99.5%
Other Applications	100.0%	100.0%	100.0%	99.9%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	May 25	Mar 26	Apr 26	May 26
Denial Rate Excluding Partial Denials (%)	5.2%	4.8%	4.7%	3.8%
Overall Denial Rate (%)	6.3%	5.1%	4.9%	4.2%
Partial Denial Rate (%)	1.1%	0.3%	0.2%	0.3%

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

Pharmacy Authorizations

Authorizations	May 25	Mar 26	Apr 26	May 26
Approved Prior Authorizations	41	52	45	57
Closed Prior Authorizations	23	29	12	19
Denied Prior Authorizations	97	86	97	89
Total Prior Authorizations	161	167	154	165

Board Business

ALAMEDA Alliance FOR HEALTH

Legislative Update

Legislative Update

May Revise Proposals and Advocacy Efforts

Board of Governors Meeting

June 12, 2026

May Revise Overview

- $349.4B total fund ($246.6 billion GF) in 2026-27
- Majority of GF expenditures allocated to K-12 education, higher education, and health and human services.
- $334.2 billion ($90.4 billion GF) for health and human services programs in 2026-27 to maintain a balanced budget and protect California's safety net programs.
- The Medi-Cal budget includes $194.4 billion ($48.6 billion GF) in 2025-26 and $216.7 billion ($44.9 billion GF) in 2026-27.
- Medi-Cal is projected to cover approximately 14.4 million Californians in 2025-26 and 13.9 million in 2026-27, which is more than one-third of the state's population.

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Notable Medi-Cal Budget Proposals

- Transition Medi-Cal members with unsatisfactory immigration status (UIS), out of the managed care delivery system into the FFS.

- UIS monthly premiums - Increases monthly premiums for UIS adults to $50, effective July 1, 2027
  - Senate: Modify. $30 premium, delay 3 months.
  - Assembly: Approve as budgeted.

- Delaying full-scope Medi-Cal to qualified non-citizens due to H.R. 1 and transitioning to restricted scope Medi-Cal starting July 1, 2027.
  - Assembly: Approved as budgeted.
  - Senate: Reject and maintain full-scope Medi-Cal coverage for qualified immigrants ongoing.

- UIS Dental benefit – no access to full-scope dental for UIS 19 years or older effective July 1, 2026.
  - Senate: Modify and delay until October 1, 2027.
  - Assembly: Approved as budgeted.

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Notable Medi-Cal Budget Proposals Cont.

- Medi-Cal Asset Test Limits - Reinstate asset limit for seniors and disabled adults to $2,000 for an individual or $3,000 for a couple, effective no sooner than January 1, 2027
  - Senate: Reject.
  - Assembly: Delay until July 1, 2027.

- Adult Acupuncture Benefit - Eliminates with effective date of January 1, 2027
  - Senate & Assembly: Reject.

- Medical Loss Ratio Remittances - Redirects medical loss ratio remittances to the GF
  - Senate & Assembly: Approve as Budgeted.

- Hospitals in Immediate Financial Distress – $50M GF in FY 26-27 for HCAI for short-term support for hospitals in immediate and significant financial distress.
  - Assembly: Approve
  - Senate: Modify and direct $200M for additional rounds of support.

- MCO Tax – Proposes submission of new tax model

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Notable Medi-Cal Budget Proposals Cont.

- Enhanced Care Management (ECM) – refines eligibility criteria, service definitions, utilization management criteria, and payment adjustments for ECM benefits, effective January 1, 2027
    - Senate & Assembly: Approve as Budgeted.
- Community Supports – Refines referral pathways, eligibility criteria, service definitions, and UM criteria for certain CS services, effective January 1, 2027
    - Senate & Assembly: Approve as Budgeted.
- Medi-Cal Efficiencies - Implements UM for the applied behavioral analysis and transportation benefits
    - Senate: Approve as Budgeted.

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H.R. 1 Impact on Budget

- Medi-Cal coverage losses expected due to H.R. 1 policies.
  - 44,000 Medi-Cal members to lose coverage in 2026-27
  - 1.3 million people to lose coverage by 2029-30

- H.R.1 Impact on Medi-Cal and State Budget:
  - FMAP for Emergency Services
  - Immigrant Eligibility Restrictions
  - Reduced Retroactive Medi-Cal Timeframes
  - ACA Adult Expansion 6-month Redeterminations
  - County Medi-Cal Administration

  - Work and Community Engagement Requirements - CMS released Interim final rule on June 1st.
    - Comments due and effective date is July 31st
    - Includes definition of work, community service, educational programs, combination of activities, etc.
    - On Medical Frailty Exclusions
    - State procedures for assessing compliance
    - Verification of compliance
    - State procedures for noncompliance

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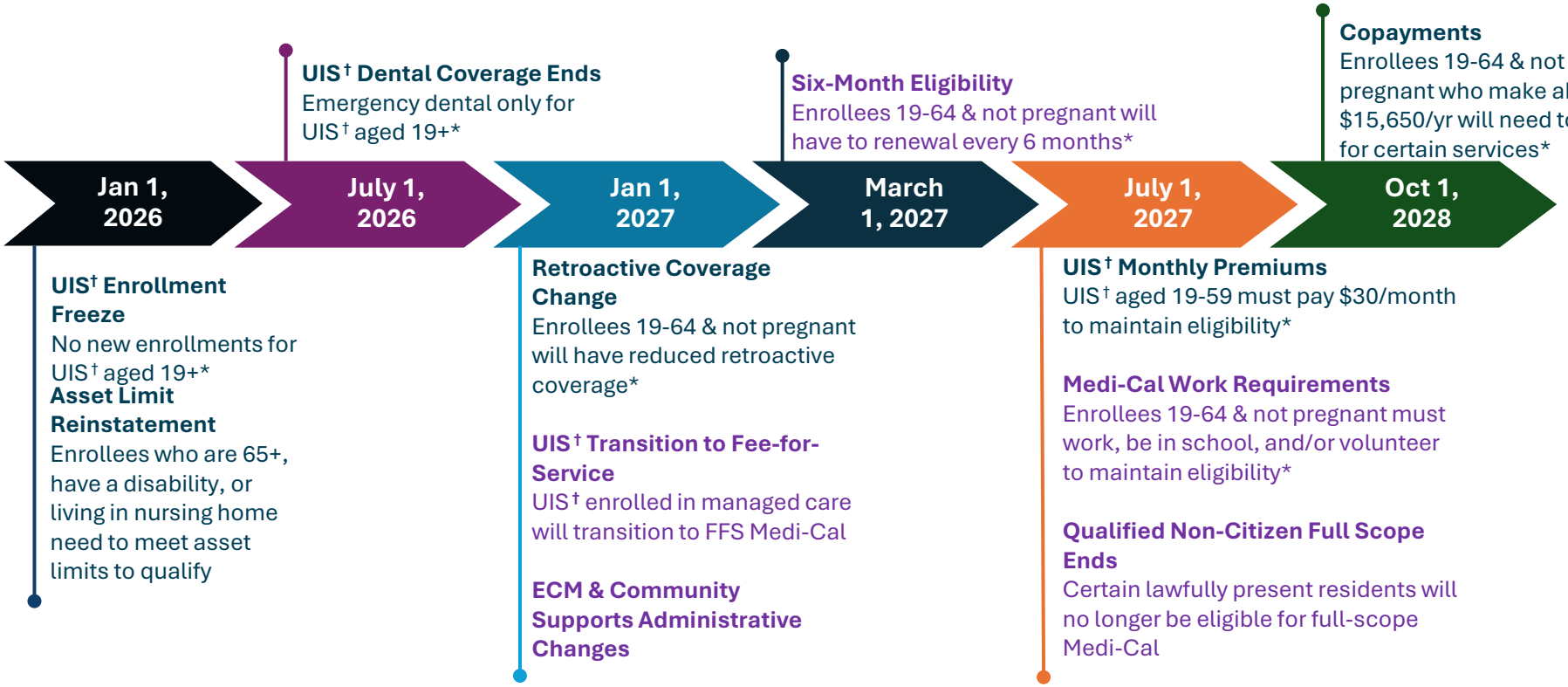
Medi-Cal Changes Timelines (May Revise)



Sources: DHCS Medi-Cal Changes; DHCS-FY-2026-27-May-Revise-Highlights.pdf

* Exceptions apply

† UIS = Unsatisfactory Immigration Status

Timeline created by AC Health

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MCO Tax

- Due to H.R.1 restrictions, California's current MCO tax is not compliant with federal law and will expire at the end of 2026.

- The May Revision proposes a submission of a new tax model that if approved would take effect on January 1, 2027. The proposed tax has two components, including:
  - A substantially similar tax structure to the existing model and compliant with Prop 35 – does not meet H.R. 1 requirements.
  - A tax structure designed to comply with H.R. 1 uniformity requirements that would impose an $8.85 PMPM tax on both Medi-Cal and non-Medi-Cal entities.

- Senate Budget Plan: Reject and replace with Fair Share Charge

- Assembly Budget Plan: Approve as Budgeted

- Update on Advocacy Efforts

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Coverage Changes to UIS Population

- Transition Medi-Cal members (~2 million Californians) with unsatisfactory immigration status (UIS), out of the managed care delivery system into the FFS delivery system.

- Response to federal guidance issued in September 2025 directing states to address an accounting issue for UIS emergency services.

- Transition of UIS members into full-scope Medi-Cal within FFS effective January 1, 2027. Includes cost reduction of $583.8 million ($471.6 million GF) in 2026-2027 and $1.5 billion ($1.2 billion GF) ongoing.

- Senate Budget Plan: Modify with additional $100 for CalAIM benefits

- Assembly Budget Plan: Adopt a placeholder plan to carve out emergency benefits for UIS in FFS, while retaining non-emergency benefits under managed care.

Coverage Changes to UIS Population Cont.

- Senate Budget Subcommittee No. 3 on Health passes Budget Plan
- Assembly Budget plan likely heard during full Budget Committee
- Update on Advocacy efforts
  - Continued daily strategy meetings among local Medi-Cal plan CEOs.
  - Statewide efforts opposing this proposal.
  - Alameda County Coalition Letter – signed on by local safety net partners, including clinics, hospitals, and community-based organizations that serve Medi-Cal members.
  - Statewide Coalition letters.
  - Alliance meetings with state legislators.

Ensure Access/Plan Continuity for UIS Medi-Cal Members Proposal

- DHCS requirements:
  - Must be federally compliant
  - Budget savings – must identify savings given the constrained budget environment.
  - Timing: Must be implementable by January 1, 2027

- Alternative proposal put together in partnership with LHPC, CPCA, CAPH and many other organizations across the State.

- Legislative Request:
  - Reject Administration proposal to move UIS members into FFS

  - Direct the DHCS to implement a state only contract with Meid-Cal plans for UIS with targeted carve-out of federally payable services to FFS

  - Maintains 2/3 of savings scored by Administration and would need legislature to fund the $190M funded shortfall.

Ensure Access/Plan Continuity for UIS Medi-Cal Members Proposal

FY 2026-27 Cost Savings and Cost Assumptions: UIS Transition to FFS vs. LHPC UIS Alternative Proposal

Driver	DHCS Savings & Offsets (as scored in May Revise)	LHPC Savings Only	Difference
Utilization decrease	-$356.1m	$0	-$356.1m
ED/IP increase	$224.7m	$0	$224.7m
Eliminate ECM	-$39.2m	-$39.2m	$0
Eliminate CS	-$50.1m	-$50.1m	$0
MCP Administrative Costs	-$239.3m[1]	-$189m[2]	-$50.3
Unaccounted for savings in May Revision[3]	-$11.6m	$0	-$11.6
Total	**-$471.6m**	**-$278.3**	**$193.3**
DHCS Cost for FFS Transition System Changes (not scored in DHCS proposal, but accounted for in DHCS Medi-Cal Estimate Fiscal Reference Number: 2594, p. 1027 of Medi-Cal Estimate)	$33m	N/A	N/A
Total (inclusive of increased state costs to implement FFS transition)	**-$438.7m**	**N/A**	**N/A**

LHPC saving shortfall from Administration's assumed savings: $131.4m (utilization decreases/members not receiving care) + $50.3m (admin) + $11.6m (unaccounted savings)

Ensure Access/Plan Continuity for UIS Medi-Cal Members Proposal

- Enrollment – UIS members remain with existing health plans to deliver carved-in benefits, continuity with plans, provider network, MS, care coordination and access supports

- State-only contract – execution of separate state-only contract with Medi-Cal health plans for UIS populations. Plans receive prospective state-only capitation for carved-in services, benefit admin, care coordination and population management.

- State-paid carve-out – state assumes financial risk of and pays FFS for federal financial participation eligible services (emergency, OB services, incl. prenatal, labor and delivery).

- Quality and oversight – Plans work with DHCS to develop appropriate access and quality metrics for UIS population.

State Budget Timeline

- Governor's May Revision – updates to his January budget that includes new revenues and cost estimates.

- The California State Legislature host budget hearings and hold meetings with key stakeholders to finalize the budget. Advocacy during budget committees and targeting legislators. (Late May – Early June)

- Legislators negotiate a unified two-house budget which must passed into law by June 15, 2026.
  - Budget Bills AB 109 and SB 109 are in print
  - Final language must be in print by Friday, June 12th.

- Following the passed budget, the Governor can use line-items vetoes. Continued advocacy targeted at Governor's office to influence final changes. (late June)

ALAMEDA Alliance FOR HEALTH

Questions?

ALAMEDA Alliance FOR HEALTH

FY26 Grant Updates

Annual Grants Update

Board of Governors – June 12, 2026

Grant Policy Summary

- Grant policy approved in 2025.
- An update to the Board will be provided every June.
- Grants greater than $1.5M must be approved by action of the Board.
- Incentive and reporting department will review all grant approval requests.
- Grants will require detailed project plans with objectives, timelines, milestones and budgets.

Grant Portfolio Summary

Category	Total Awarded
Alliance Grant Programs	$5.0M
Externally Funded Grant Programs	$23K
Quality Improvement Projects	$1.09M
TOTAL	$6.1M

Alliance Grants

Total Awarded: $5.0M

Item	Duration	Total Available Funds	Amount Awarded
Provider Recruitment Initiative	2024-2025	$2.0M	$1.9M
Doula Scholarship Program	2024-2025	$20K	$19K
Provider Recruitment Initiative	2025-2026	$2.0M	$1.9M
Doula Scholarship Program	2025-2026	$40K	$19K
First 5 Quality Grant	2025-2026	$1.1M	$1.1M

Note: The amount awarded reflects figures as of June 1, 2026, and may change due to awardee withdrawals, unmet deliverables, or awardee change requests.

Anticipated rollover amount for the Doula Scholarship Program for FY 26-27 is $17,750. Any doulas with unmet deliverables from the previous FY will be eligible to complete them with the rollover funding.

Alliance Grants – Detail

Provider Recruitment	FY24-25	FY25-26
MD/DO	4	8
OB/GYN	2	0
NP/PA	8	3
Behavioral Health	4	3
CHWs	34	127
Medical Assistants	N/A	4
Bilingual Positions	5	4
Housing Relocation	0	1

Doula Program	FY24-25	FY25-26
Awarded	20	15
Completed All Deliverables	14	10
Incomplete Deliverables	6*	5**

Overall, the program has funded 18 newly contracted doulas, supported 6 contracted doulas.

*3 working towards completion; 2 unable to complete; 1 withdrawn
**1 pending

First 5 Grant	Measures of Success
Staff Training & Learning Opportunities	Build Community Health Worker (CHW) competencies
Technical Infrastructure	Strengthen data systems for analysis, claims processing, reporting, and financial modeling
Technology Upgrades	Upgrade existing case management system for scalability, sustainability, and data/reporting alignment
Resource Directory	Maintain and update AlamedaKids.org, a trusted directory used by 300+ partners, including health care providers, childcare providers, CBOs, and CHWs
Enhanced Education	Promote the importance of well-child visits and immunizations through targeted outreach

Externally Funded Grants

Total: $22,500

Item	Duration	Amount	Grant Purpose
California Improvement Network (CIN) Grant	2025-2027	$4,500	Selected, along with 24 other partners, to participate in a learning and action community that advances equitable health care experiences and outcomes
CHCF CIN Action Project Grant	Oct 25 – Aug 26	$18,000	In partnership with Alameda Health System, increase well child care visits and immunization rates and reduce maternal depression
CA Maternal Health Task Force (unfunded partner)	Feb 26 – Dec 26	N/A	The Alliance is an unfunded partner on this grant ($50K) which was awarded to Black Women Birthing Justice (BWBJ) to improve how doulas interact with MCPs, particularly around credentialing and claim workflows

QI – Completed

Entity / Program	$ Granted (Awarded)	Expected Outcome	Actual Outcome (if known)
CHCN Lead Screening	$25,903	Improve lead screening rates from 56.8% to 63.8%	Positive clinic feedback and lead screening is now a regular focus during well-child visits. Screening rate at last check-in was up to 72.24%
CHCN Colorectal Cancer Screening	$123,187	Increase the % of eligible AAH adults ages 45-75 who had appropriate screening from 37% to 50%.	Strong community engagement through flyers, provider instruction and digital resources. A total of 255 gift cards across all sites were awarded to members who completed screening.
AHS BH ED Navigator	$110,000	The Behavioral Health Emergency Department (ED) Navigator will increase by 5% (from 39.13% to 41%).	Position was eliminated as part of recent AHS layoffs
CFMG Well-Child Text Messaging	$150,000	By 12/31/2025 approximately 75% of members assigned to CFMG will receive a text message and improvement in all children's health domain measures.	We saw a 20-25% visit completion rate when text message was received.
Roots Barber Shop Project/ Hypertension Screening and Intervention	$67,704	By 12/31/225 Roots shall conduct at least 400 BP screenings and 25 Alliance members in control of BP	5 unique members engaged in the program – 2 members currently at target or graduated; 3 members discharged due to no show or relocating ouside of service area
Roots Clinical Quality Improvement Infrastructure	$150,000	In MY2025, as compared to MY2024, Roots will increase screening rates for Breast Cancer, High BP, Diabetes Control, and Topical Fluoride in Children	Breast Cancer Screening increased 33.09% to 41.48% Blood Pressure Control increased 15.69% to 30.00% Cervical Cancer Screen increased 29.60% to 35.89% Glycemic Status decreased 65.84% to 54.49% *lower is better Topical Fluoride Application increased 8.49% to 11.11%
Washington Medical Foundation Lead Screening	$3,492	By December 31, 2025, increase the lead screening compliance in children from 35.48% to 49.61%.	MY2025 rates indicate lead screening rates improved by 30.87%

QI – In Progress

Entity Program	$ Granted (Awarded)	Expected Outcome
AHS Well-Visit Rates Improvement	$43,200	Alameda Health System will reduce disparities in well-visit rates for African American children by achieving the following improvements: For African American children ages 0–15 months: increase well-visit rates by 5 percentage points from the MY2024 baseline of 63.64% to 68.64% by December 31, 2026.
CHCN IHA Compliance	$104,600	Baseline data from PCP assign date of 1/1/25-5/1/25: Of the 10,481 members, the compliance rate for the IHA measure is 4,856, which is 46%. The goal is to reach 48% by the end of the year and improve to 54% by the end of 2026.
CFMG Childhood Measures	$150,000	SMART Goal: CFMG will increase administrative rate for key childhood quality measures by December 31, 2026 (compared to MY2024 baseline): • CIS 10 from 23.46% to 26.46% • IMA 2 from 40.87% to 45.87% • Lead Screening from 60.02% to 65.02% • W15 51.78% to 56.78% • W30 from 73.92% to 78.92%
Davis St Diabetes Control	$4,857	By December 31, 2026, Davis St Primary Care will increase diabetes HbA1c Control (<8%) from MY2024 rate of 46.63% to MPL 57.42%.
Washington Medical Foundation CCS Improvement	$9,150	Improve Cervical Cancer Screening Rates
Roots QI Expansion	$150,000	CCS and all other HEDIS/MCAS measures to be held to MPL

Questions?

Alliance Grants - Distributions

Provider Recruitment Initiative 2024-2025	• Awarded: $1.9M • Paid: $865,146
Provider Recruitment Initiative 2025-2026	• Awarded: $1.9M • Paid: $272,275
Doula Scholarship Program 2024-2025	• Awarded: $18,500 • Paid: $16,000
Doula Scholarship Program 2025-2026	• Awarded: $18,750 • Paid: $12,750
First 5 Quality Grant 2025-2026	• Awarded: $1.1M • Paid: $310,000

Note: The amounts paid reflects figures as of June 1, 2026.

Member Acuity Analysis

Member Acuity Analysis

Stayers, Leavers & Joiners

Alameda Alliance for Health

Executive Summary

Stayers

Members remaining with the plan — baseline acuity and cost benchmark

Leavers

Members departing the plan — impact of losing higher or lower acuity members

Joiners

Members entering the plan — new enrollment acuity and projected cost impact

This analysis compares PMPM costs across member categories by line of business and category of aid to understand how member movement affects plan acuity and financial performance.

Data & Methodology

Data Sources

- Analysis period covers fiscal year 2025 (July 24–June 25) and December 2025 snapshot of members joining
- Claims and encounter data for baseline PMPM calculation
- Enrollment files identifying stayers, leavers, and joiners
- Category of aid classification from eligibility records
- Lines of business: Medi-Cal and Group Care

Methodology

- Members segmented into stayers, leavers, and joiners based on enrollment status
- PMPM calculated for each segment by category of aid
- Variance measured against baseline PMPM to identify acuity shifts
- Analysis performed across both Medi-Cal and Group Care lines of business

Categories of Aid Analyzed

ACA OE • Adult • Child • Duals • LTC • LTC Duals • SPD • SPD-LTC • SPD LTC Duals

Medi-Cal PMPM Comparison

Category of Aid	Baseline PMPM	Stayers	Leavers	Joiners	Projected
Totals	$340.91	$340.13	$344.84	$411.44	$344.16

Categories of Aid with Significant Acuity Changes

- Seniors and Persons with Disabilities (SPD) data shows materially higher cost for those leaving compared to those staying.
- Duals members also show significantly higher pmpms for those leaving versus those staying.
- Conversely Optional Expansion (OE) and Child members show significantly lower cost for those leaving compared to those staying.
- Joiners in the OE, Adult, Child, Long-Term Care (LTC) categories of aid have higher cost than those staying or leaving.

UIS Medi-Cal Acuity compared to baseline

- In total, projected member acuity for members with Unsatisfactory Immigration Status (UIS) was 6.7% higher than baseline acuity pmpm.
- Optional Expansion (9.7%), Adult (9%) and Child (12.3%) categories of aid reported the largest variance
- UIS membership impacts will change the total medical expense trend if UIS members are disenrolled from managed care or if a portion of managed care benefits remain with the Alliance.

Key Findings

Acuity of Leavers

In total, Leaver PMPM is higher than stayers. At the moment, attrition lowers overall plan costs.

Acuity of Joiners

New members are entering with higher PMPMs than current members. New enrollment mix directly shapes future cost trajectory.

Net Acuity Shift

The combined effect of leavers and joiners on overall plan acuity results in a net increase in acuity level.

Findings should be updated with your specific PMPM data to reflect actual acuity patterns.

Impact on Plan Financial Performance

If Net Acuity Rises

- Higher-acuity joiners and/or lower-acuity leavers drive up average plan PMPM
- Increased medical costs may exceed capitation or rate assumptions
- May require rate adjustment discussions with DHCS or employer groups
- Care management and utilization programs become more critical

If Net Acuity Declines

- Lower-acuity joiners and/or higher-acuity leavers improve overall risk mix
- Plan PMPM trends favorably against rate assumptions
- Opportunity to strengthen reserves or invest in member services
- Monitor for sustainability — favorable mix may not persist

Actual impact depends on the magnitude of PMPM variances and the volume of members in each category.

Recommendations & Next Steps

1. Integrate acuity analysis into bi-annual financial reviews to track PMPM trends over time
2. Consider targeted care management strategies for high-acuity joiners to manage cost upon enrollment
3. Assess retention strategies for member categories where losing members worsens plan acuity
4. Coordinate with actuarial team to factor acuity shift data into future rate development

ALAMEDA Alliance FOR HEALTH

FY 2027 Preliminary Budget

FY 2027 Preliminary Budget

Presented to the Alameda Alliance Board of Governors

June 12, 2026

Budget Process

- FY2027 Preliminary Budget presented to Finance Committee on June 9th and to the Board of Governors on June 12th.
- Final Budget to be presented in December 2026.

Highlights

- FY 2027 Projected Net Loss of $23.7 million.
- Projected Tangible Net Equity (TNE) at year-end is 302% of required TNE.
- June 2027 projected enrollment is 263,000, down 106K from the prior year.
- Revenue is $1.93 billion, $338 million lower than FY 2026 3Q Forecast due to enrollment loss.
- Medical Expense totals $1.8 billion in FY 2027, a decrease of $236.5 million (-11.6%) from FY 2026 3Q Forecast.
- Administrative Department Expenses are $3.8 million less than FY 2026 3Q Forecast, representing 6.4% of revenue.
- Clinical Department Expenses are $2.5 million higher than FY 2026 3Q Forecast and comprise 2.1% of revenue.

Highlights (continued)

- Medicare D-SNP program membership is expected to grow steadily over time.
- D-SNP Revenue risk scores are higher than bid assumptions leading to higher revenue and expenses.
- Infertility services are now included under Group Care in accordance with regulatory requirements.
- Transitional Rent is added to FY2027 Preliminary Budget projections.
- Transitional Care Management is starting July 2026.

Budget Assumptions

Revenue:

- 95.2% of Revenue for Medi-Cal; 2.5% for Group Care, and 2.3% for D-SNP.
- Medi-Cal base rates are expected to rise by 4.3% per member per month.
- Per member per month Group Care premium is assumed to increase in July 2026.
- Medicare Revenue projected to be $44.2 million.

Medical Expense:

- 94.8% of Expense for Medi-Cal; 2.5% for Group Care, and 2.7% for D-SNP.
- Medical Loss Ratio is 96.6%, an increase of 3.9% over FY 2026.
- Inpatient and Long-Term Care costs make up 55% ($900M) of Medical Expense projections.
- New program expenses, Transitional Care Management and Infertility Treatment (Group Care), add $6.2M to total medical expenses.

Budget Assumptions (continued)

Hospital and Provider Rates:

- FY 2027 Hospital contracted rates increased by $45.1 million over FY 2026.
- The most current information was used to capture changes in Hospital and Provider Rates. However, not all rate changes have been finalized.

Staffing:

- The Alliance will maintain a soft hiring freeze to appropriately manage staffing as enrollment declines.

Enrollment:

- Medi-Cal enrollment is projected to materially decrease over FY 2027.
- Group Care enrollment growth is held steady.
- D-SNP member month is projected to grow to 4,250 by July 2027.

Comparison to FY 2027 Preliminary Budget

$ in Thousands	FY 2027 Preliminary Budget				FY 2026 Q3 Forecast				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	252,288	6,379	4,250	262,917	362,287	6,319	271	368,877	(109,999)	60	3,979	(105,960)
Member Months	3,640,400	76,224	23,322	3,739,946	4,653,827	73,861	1,322	4,729,010	(1,013,427)	2,363	22,000	(989,064)
Premium Revenue	1,837,901	48,073	44,170	1,930,145	2,224,998	40,350	2,808	2,268,156	(387,097)	7,723	41,362	(338,011)
MCO Tax Revenue	612,279	0	0	612,279	769,227	0	0	769,227	(156,948)	0	0	(156,948)
Total Revenue	2,450,180	48,073	44,170	2,542,423	2,994,225	40,350	2,808	3,037,383	(544,045)	7,723	41,362	(494,959)
Medical Expense	1,766,243	46,241	51,125	1,863,608	2,054,415	42,127	4,000	2,100,543	288,173	(4,113)	(47,125)	236,934
Gross Margin	683,938	1,832	(6,955)	678,815	939,810	(1,778)	(1,192)	936,840	(255,872)	3,610	(5,763)	(258,025)
Administrative Expense	107,864	3,042	12,746	123,652	114,502	2,486	10,454	127,442	6,638	(556)	(2,292)	3,790
Operating Margin	576,073	(1,209)	(19,700)	555,163	825,308	(4,263)	(11,646)	809,398	(249,234)	3,054	(8,055)	(254,235)
MCO Tax Expense	612,279	0	0	612,279	769,227	0	0	769,227	156,948	0	0	156,948
Other Income / (Expense)	32,146	659	641	33,446	30,219	472	38	30,729	(1,927)	(187)	(603)	(2,717)
Net Income / (Loss)	($4,060)	($550)	($19,060)	($23,670)	$86,300	($3,792)	($11,608)	$70,900	($90,360)	$3,241	($7,452)	($94,570)
Admin. Expense % of Revenue	5.9%	6.3%	28.9%	6.4%	5.1%	6.2%	372.3%	5.6%	0.7%	0.2%	-343.4%	0.8%
Medical Loss Ratio	96.1%	96.2%	115.7%	96.6%	92.3%	104.4%	142.4%	92.6%	3.8%	-8.2%	-26.7%	3.9%
TNE at Year-End				$216,510				$240,180				$23,670
TNE Percent of Required at YE				302%				304%				1%

Department Expenses by Line of Business

FY 2027 Preliminary Budget	Administrative Departments				Clinical Departments				Total
	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total	
Employee Expense	$68,763	$1,412	$6,683	$76,858	$39,578	$811	$970	$41,360	118,218
Member Benefits Admin.	$473	$334	$265	$1,072	$0	$37	$55	$92	1,164
Purchased & Prof. Svcs.	$20,035	$936	$4,873	$25,843	$5,580	$199	$441	$6,221	32,064
Other	$18,593	$360	$925	$19,879	$4,019	$64	$394	$4,478	24,357
Total	**$107,864**	**$3,042**	**$12,746**	**$123,652**	**$49,178**	**$1,112**	**$1,861**	**$52,150**	**$175,802**

- Administrative Department Expenses are $3.8 million lower than FY 2026. Decreases are led by Labor ($2.1 million) and Purchased & Professional Services ($1 million), Other Services ($0.7 million), and offset by Member Benefits Administration ($0.1 million).
- Clinical Department Expenses are $2.4 million higher than FY 2026. Increases led by Labor ($1.5 million), Member Benefits Administration ($2.3 million), Other ($0.4 million), and offset by Purchased & Professional Services ($1.8 million).

Capital Expenditures

FY 2027 Preliminary Budget of $1.2 million in capitalized purchases for IT and Facilities departments.

- This is a decrease of $0.1 million from FY 2026.
- Totals include $0.8 million for IT Hardware and $0.4 million for building improvements.

Areas of Uncertainty

- The Department of Health Care Services intends to adjust CY 2025 & CY 2026 Medi-Cal Rates.
- CY 2027 Medi-Cal Rates used in budget are projections based on FY 2024 RDT. CY 2027 Rates from DHCS are expected at the end of October.
- D-SNP member Risk Scores are higher than in the projected bid; the amount of impact on Revenue or Medical Expense is not yet known.
- Capturing D-SNP utilization costs is challenging, due to limited trend data.

Finance

Gil Riojas

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

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

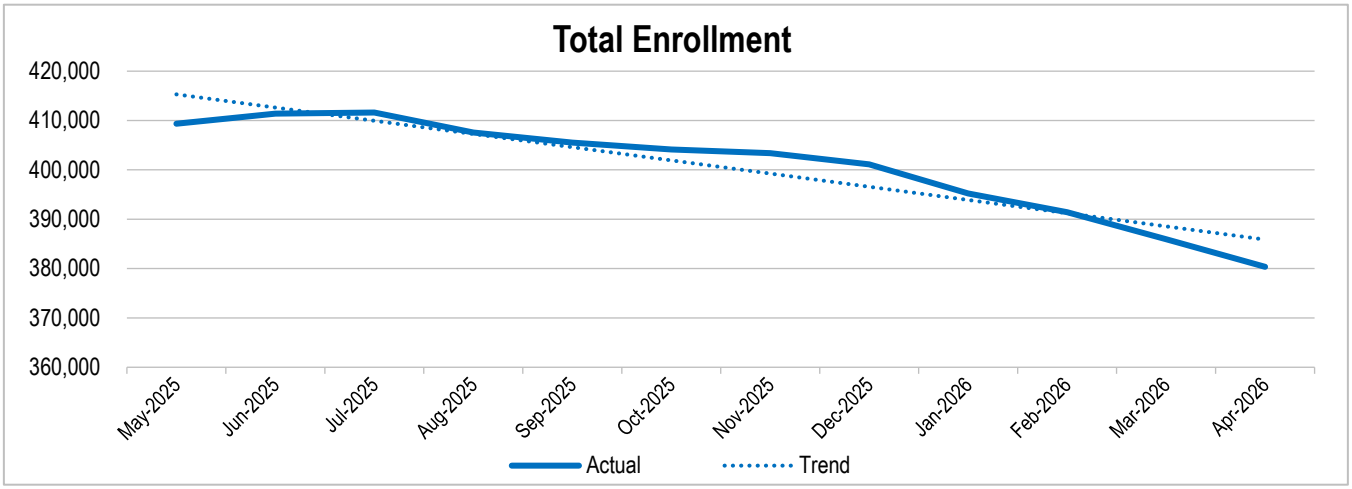
Date: **June 12th, 2026**

Subject: **Finance Report – April 2026 Financials**

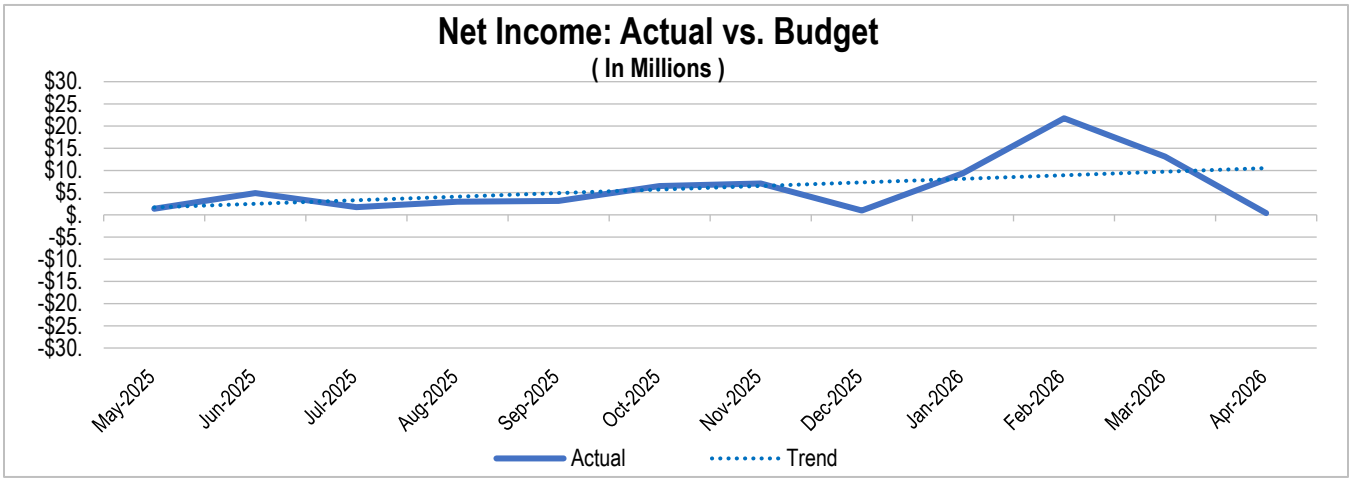
Executive Summary

For the month of April, the Alliance decreased in enrollment, down to 380,353 members. Net Income of $388,000 was reported, and the Plan's Medical Expenses represented 95.5% of Premium Revenue. Alliance reserves increased to 296% of required and continue to remain above minimum requirements.

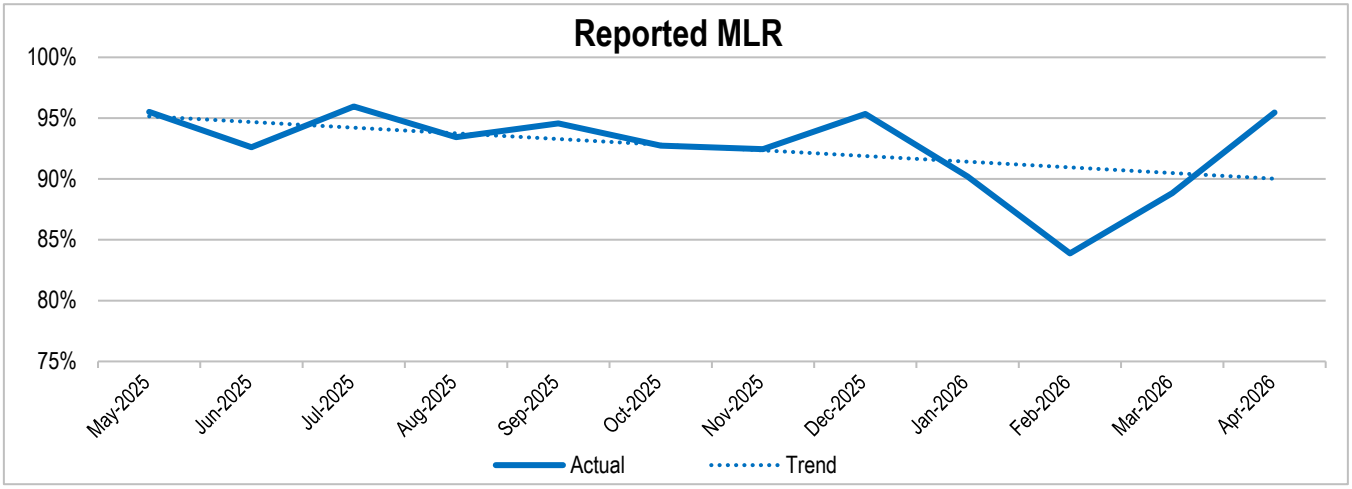
Enrollment – In April, Enrollment decreased by 5,575 members.



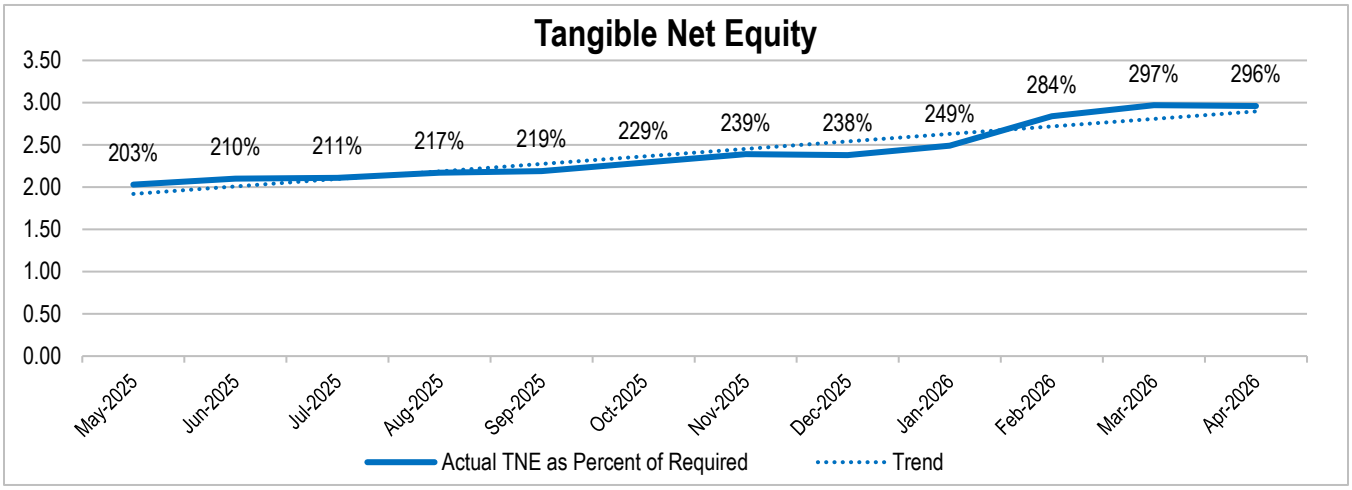
Net Income – For the month ended April, actual Net Income was $388,000 vs. budgeted Net Income of $1.9 million. For the fiscal YTD, actual Net Income was $67.0 million vs. budgeted Net Income of $21.1 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $188.1 million vs. budgeted Revenue of $183.1 million. Premium Revenue favorable variance of $5.0 million is primarily due to current month Medi-Cal and IHSS volume variance. Medicare Part A Buy-In Phase II on "pause" caused the majority of this volume variance. Over 7,000 members were Budgeted to transition from SPD with LTC to Duals with LTC but not reflected in the actual Financial Enrollment.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 95.5% for the month, and 92.3% for fiscal YTD.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $79.8 million in reserves, we reported $236.3 million. Our overall TNE remains above DMHC requirements at 296%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, investments show a gain of $25.0 million and capital assets acquired are $51,000.

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

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

Date: **June 12th, 2026**

Subject: **Finance Report – April 2026**

Executive Summary

- For the month ended April 30th, 2026, the Alliance had enrollment of 380,353 members, a Net Income of $388,000 and 296% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$251,608	$2,546,702
Medical Expense	179,549	1,753,461
Admin. Expense	11,435	104,612
MCO Tax Expense	63,527	646,522
Other Inc. / (Exp.)	3,291	24,896
Net Income	**$388**	**$67,003**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	$1,462	$79,142
Group Care	(77)	(2,877)
Medicare	(997)	(9,262)
	$388	**$67,003**

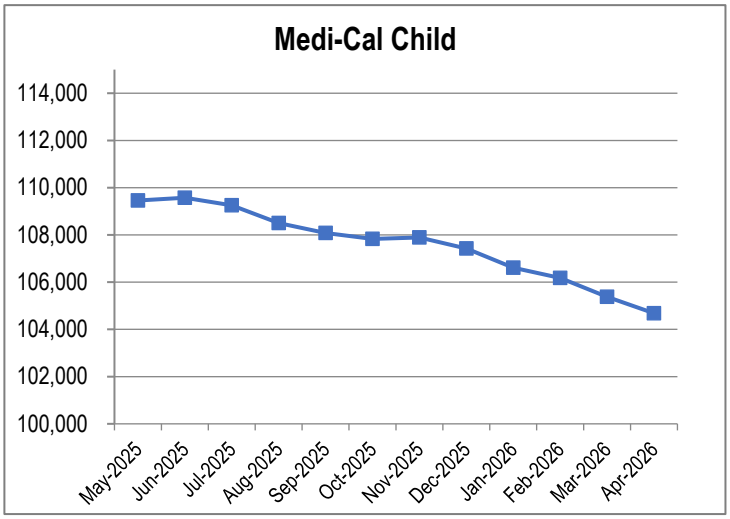
Enrollment

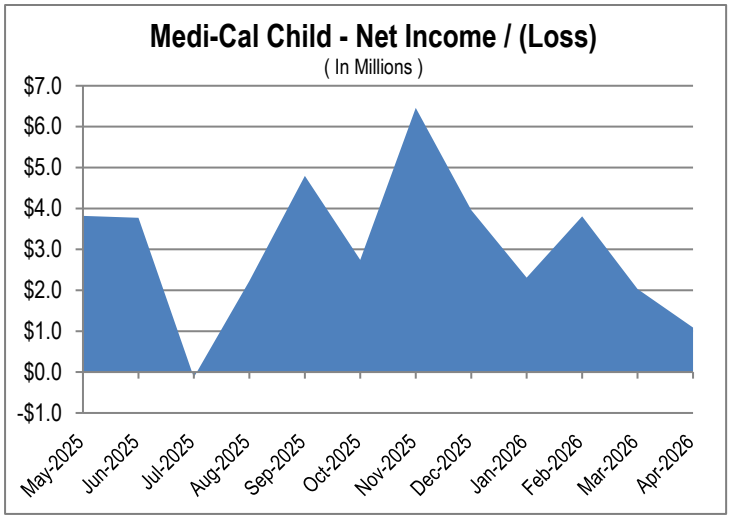
- Total enrollment decreased by 5,575 members since March 2026.
- Total enrollment decreased by 31,030 members since June 2025.

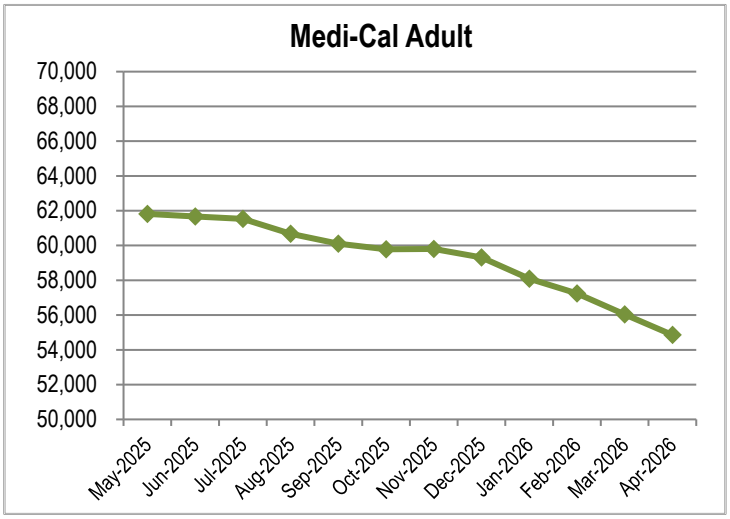
Monthly Membership and YTD Member Months
Actual vs. Budget

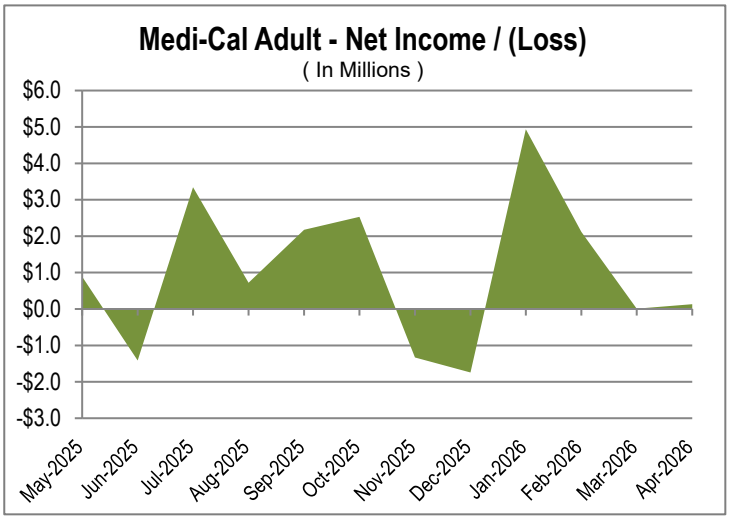
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
104,683	104,615	68	0.1%	Child	1,071,836	1,070,344	1,492	0.1%
54,857	55,659	(802)	(1.4%)	Adult	587,445	587,440	5	0.0%
138,309	135,332	2,977	2.2%	ACA OE	1,482,906	1,474,472	8,434	0.6%
27,944	21,382	6,562	30.7%	SPD with LTC	292,285	264,272	28,013	10.6%
48,038	56,096	(8,058)	(14.4%)	Duals with LTC	489,791	521,067	(31,276)	(6.0%)
373,831	**373,084**	**747**	**0.2%**	**Medi-Cal Total**	**3,924,263**	**3,917,595**	**6,668**	**0.2%**
6,291	6,097	194	3.2%	Group Care	61,229	60,582	647	1.1%
231	619	(388)	(62.7%)	Medicare	804	1,728	(924)	(53.5%)
380,353	**379,800**	**553**	**0.1%**	**Total**	**3,986,296**	**3,979,905**	**6,391**	**0.2%**

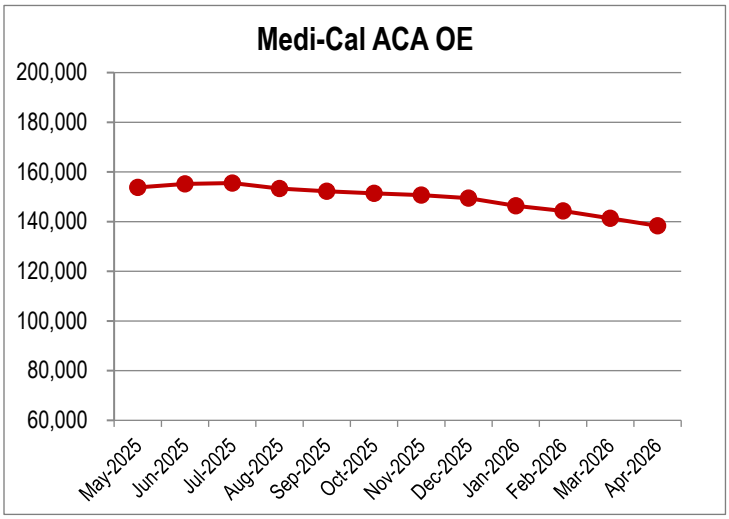
Enrollment and Profitability by Program and Category of Aid

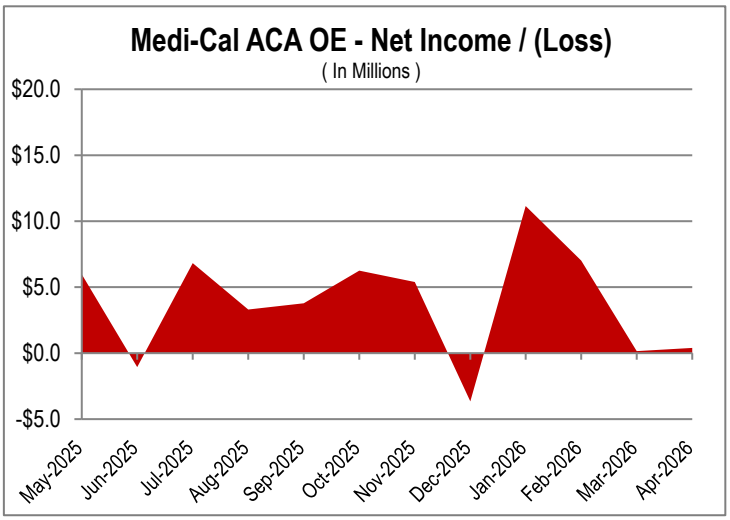




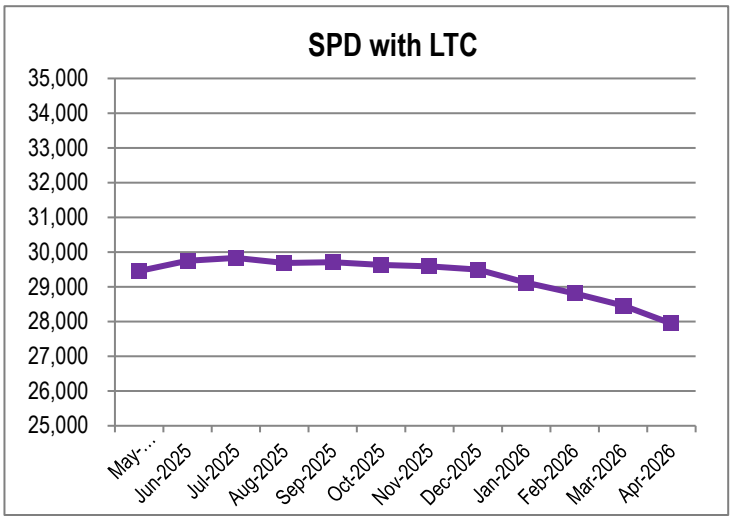


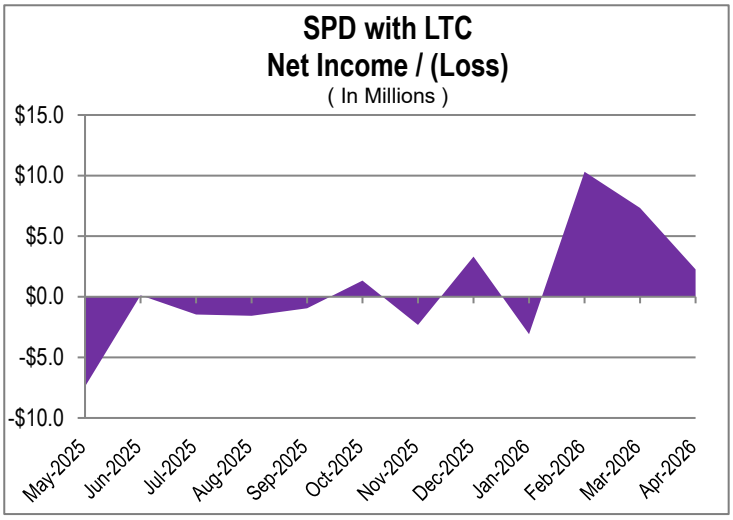


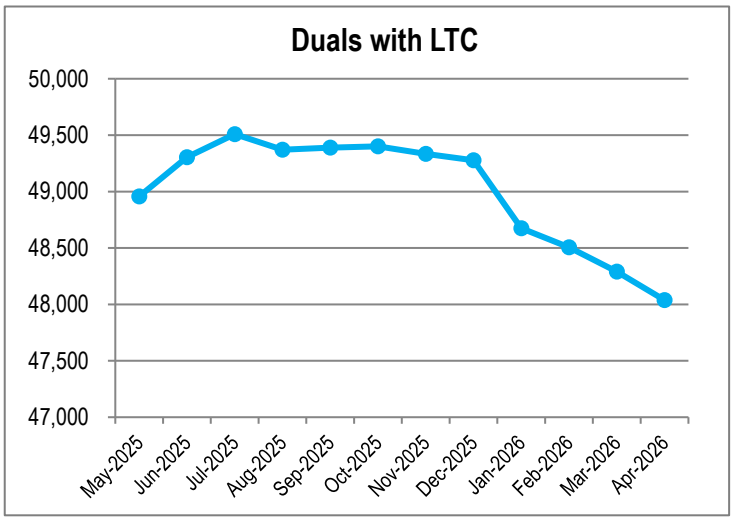


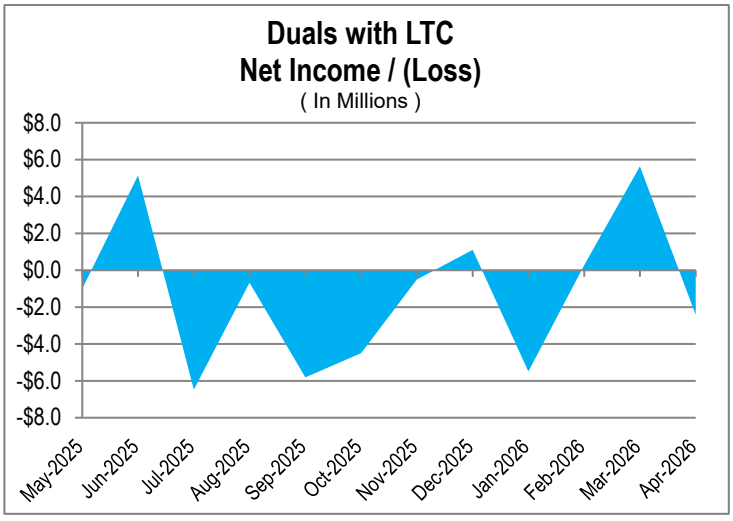


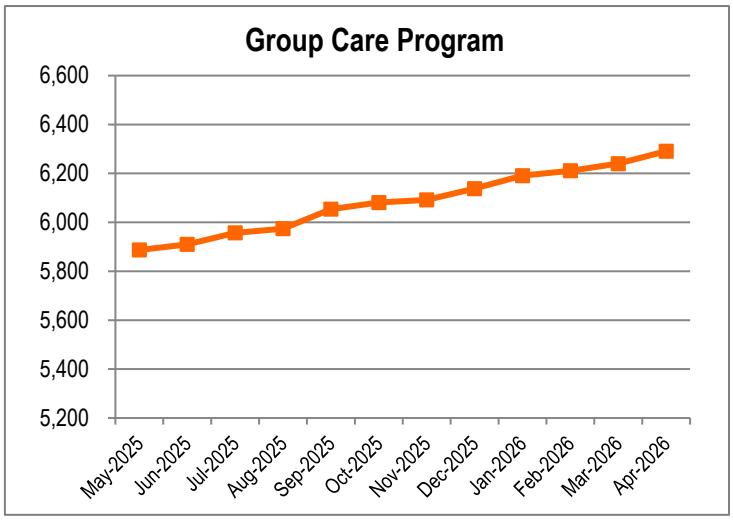
Enrollment and Profitability by Program and Category of Aid

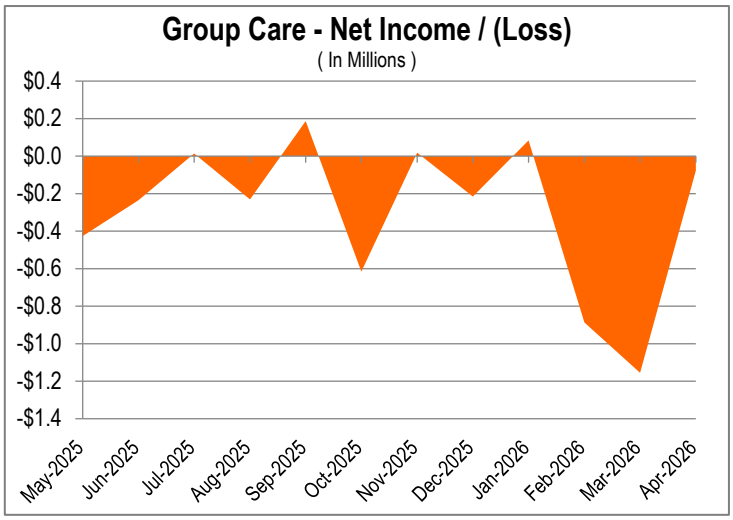




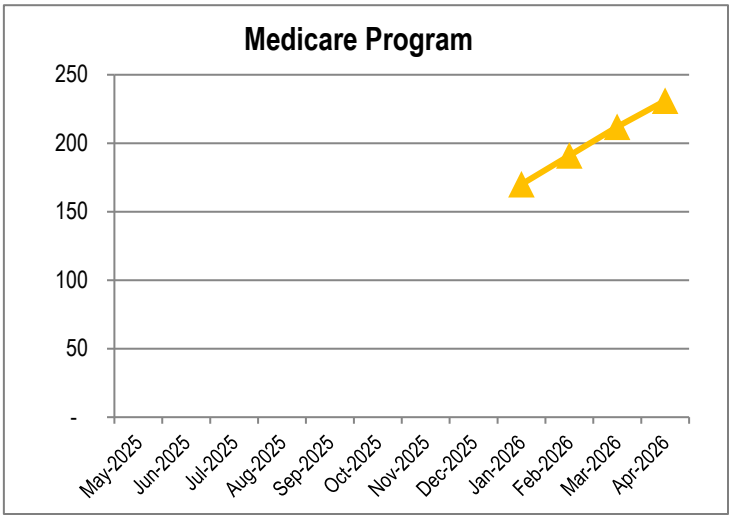


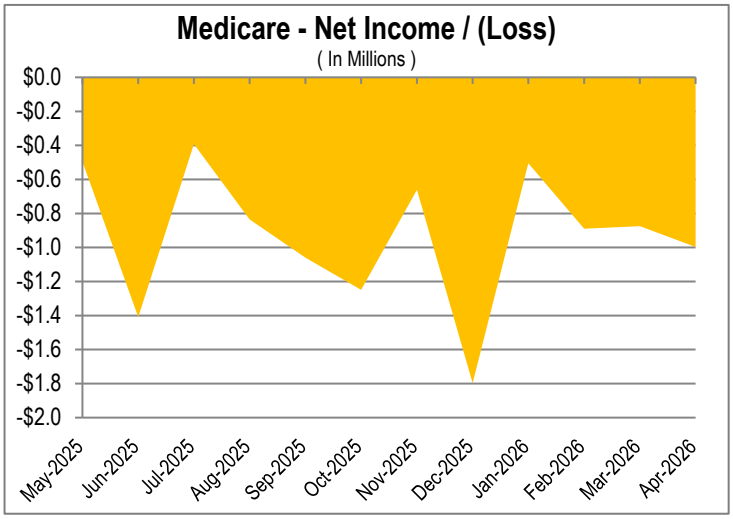


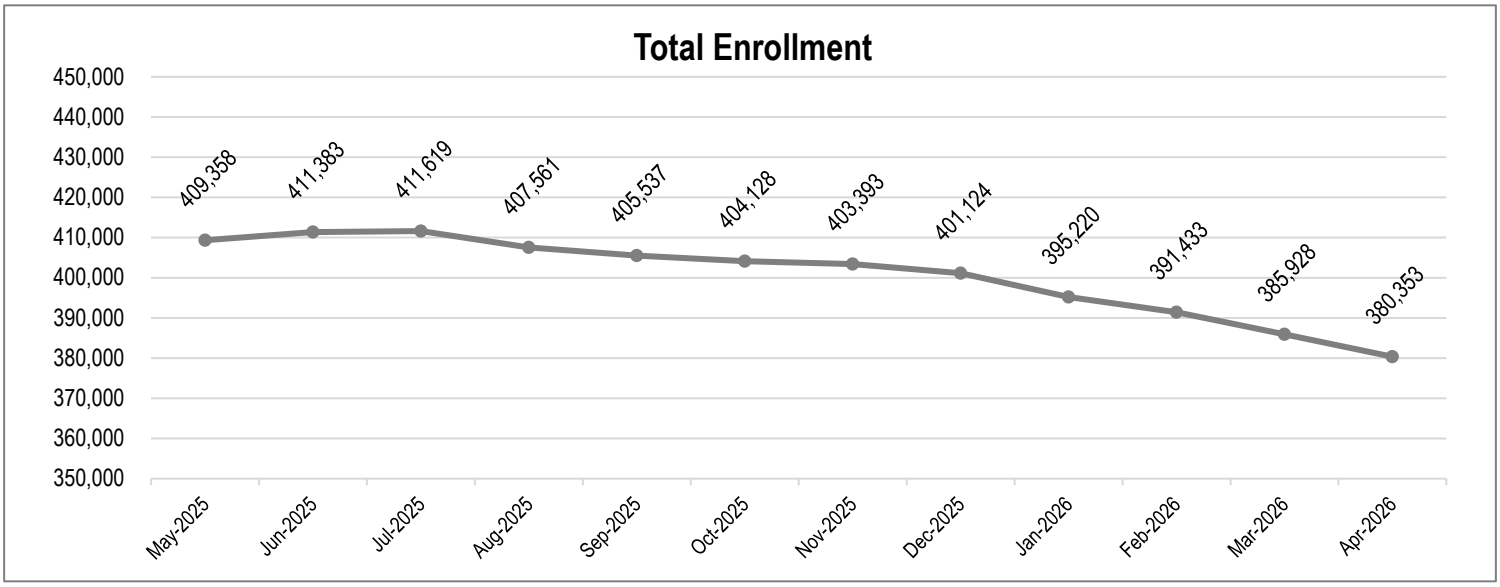


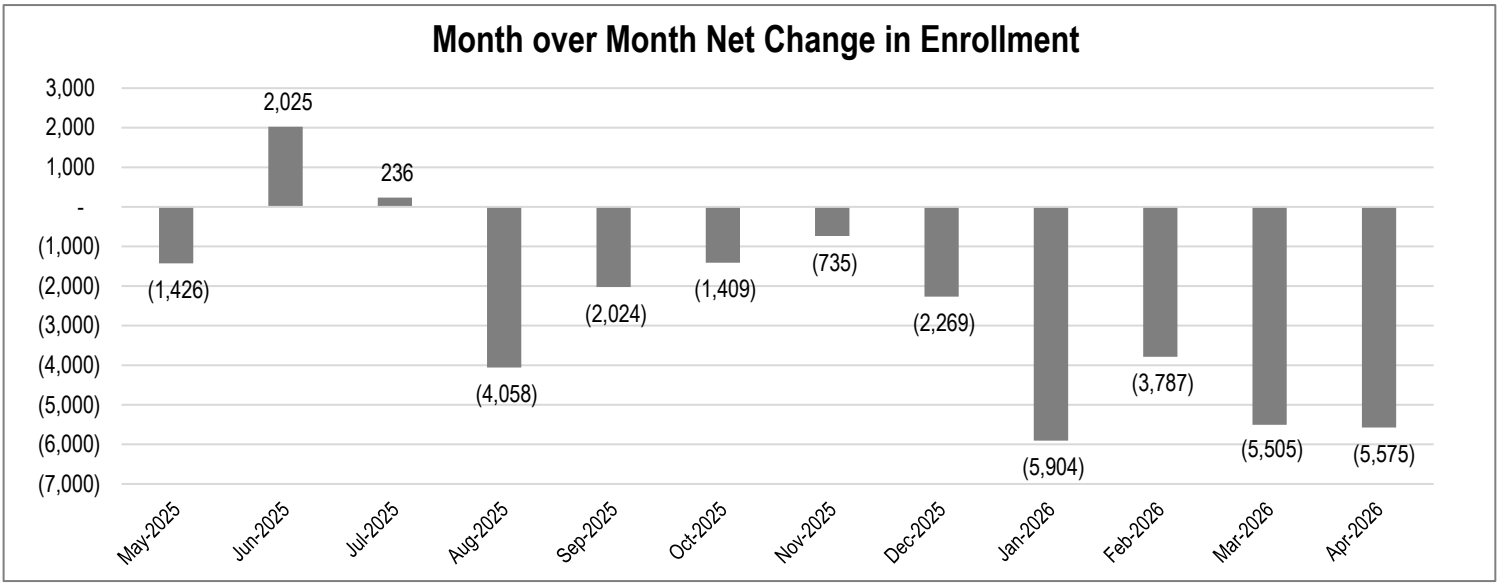


Enrollment and Profitability by Program and Category of Aid



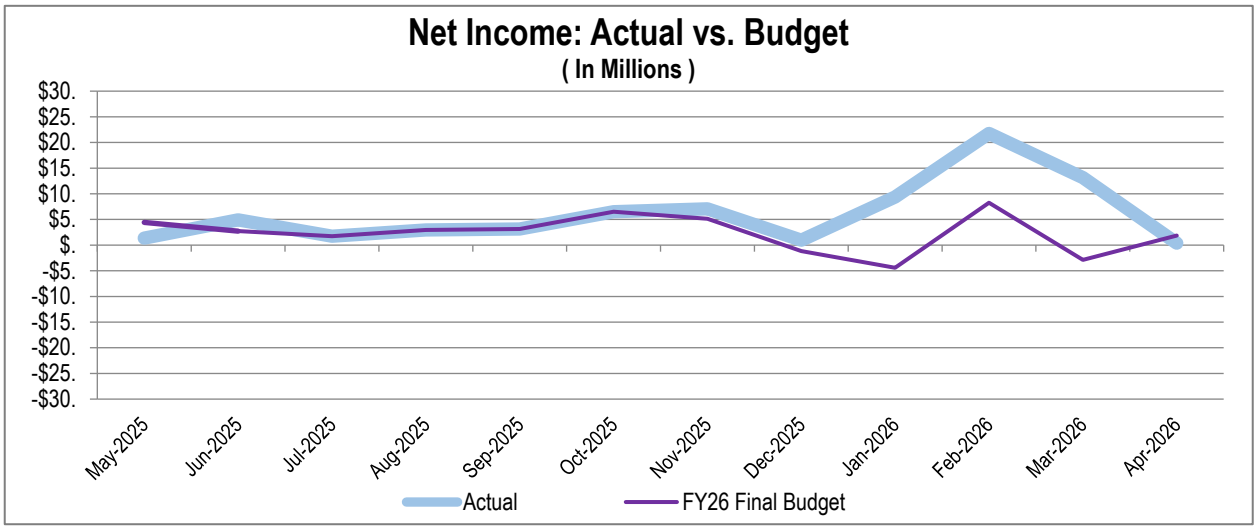






Net Income

- For the month ended April 30th, 2026:
  - Actual Net Income: $388,000.
  - Budgeted Net Income: $1.9 million.
- For the fiscal YTD ended April 30th, 2026:
  - Actual Net Income $67.0 million.
  - Budgeted Net Income $21.1 million.

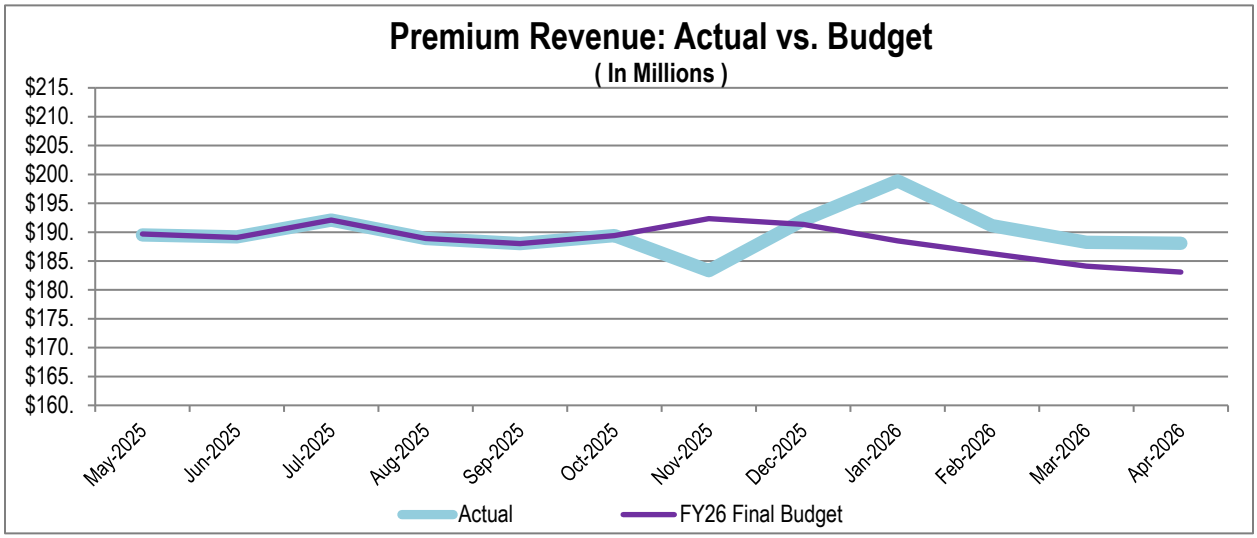


The unfavorable variance of $1.5 million in the current month is primarily due to:

- Unfavorable $6.9 million higher than anticipated Medical Expense.
- Favorable $5.0 million higher than anticipated Premium Revenue.

Premium Revenue

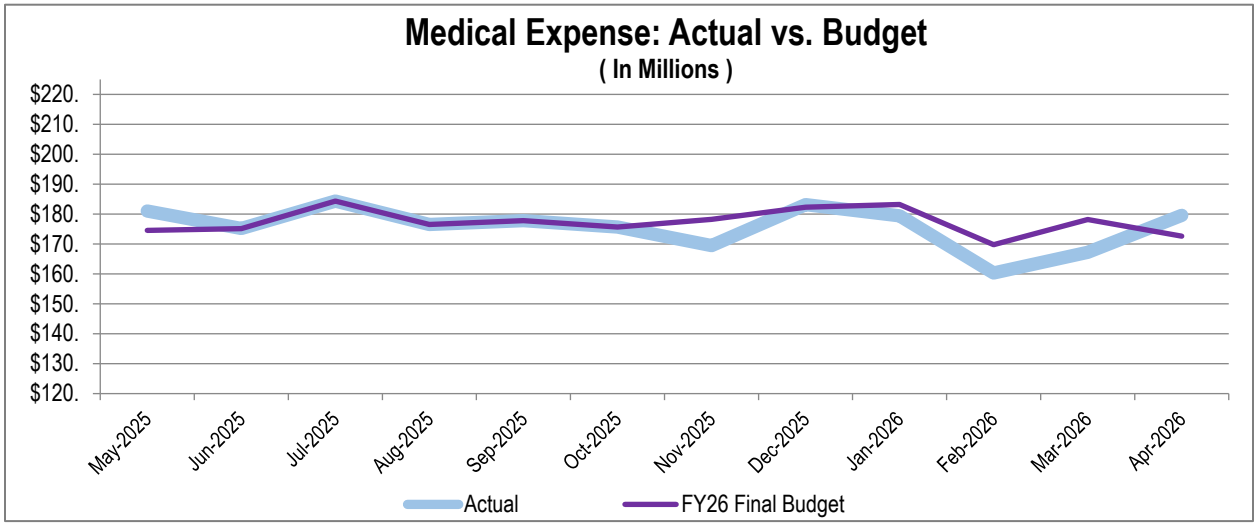
- For the month YTD ended April 30th, 2026:
  - Actual Revenue: $188.1 million.
  - Budgeted Revenue: $183.1 million.
- For the fiscal YTD ended April 30th, 2026:
  - Actual Revenue: $1.9 billion.
  - Budgeted Revenue: $1.9 billion.



- For the month ended April 30th, 2026, the favorable Premium Revenue variance of $5.0 million is primarily due to favorable $5.8 million Medi-Cal and IHSS volume variance for April 2026 which includes favorable $6.2 million budgeted Medicare Part A “buy-in” for April 2026 that did not occur, and favorable $2.7 million retroactive membership for March 2025 through February 2026. This was partially offset by an unfavorable $2.0 million CY26 UIS Risk Corridor accrual.

Medical Expense

- For the month ended April 30th, 2026:
  - Actual Medical Expense: $179.5 million.
  - Budgeted Medical Expense: $172.6 million.
- For the fiscal YTD ended April 30th, 2026:
  - Actual Medical Expense: $1.8 billion.
  - Budgeted Medical Expense: $1.8 billion.



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

- For April, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $4.1 million. Year to date, the estimate for prior years decreased by $13.2 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 Adjusted vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$177,858,200	$0	$177,858,200	$175,455,444	($2,402,757)	(1.4%)
Primary Care FFS	$33,047,862	$10,275,839	$43,323,701	$48,993,043	$15,945,181	32.5%
Specialty Care FFS	$81,850,878	$1,629,140	$83,480,018	$85,297,354	$3,446,475	4.0%
Outpatient FFS	$128,238,360	($165,225)	$128,073,135	$131,073,954	$2,835,594	2.2%
Ancillary FFS	$216,000,815	$3,452,781	$219,453,596	$202,125,880	($13,874,935)	(6.9%)
Pharmacy FFS	$130,421,220	($6,688,929)	$123,732,291	$109,806,433	($20,614,787)	(18.8%)
ER Services FFS	$105,250,319	$268,490	$105,518,808	$103,117,256	($2,133,063)	(2.1%)
Inpatient Hospital FFS	$486,416,358	($12,907,768)	$473,508,590	$485,519,340	($897,018)	(0.2%)
Long Term Care & SNF FFS	$357,787,806	($9,096,807)	$348,690,999	$382,439,281	$24,651,475	6.4%
Other Benefits & Services	$39,185,940	$0	$39,185,940	$44,862,429	$5,676,489	12.7%
Net Reinsurance	$316,201	$0	$316,201	$2,721,368	$2,405,167	88.4%
Provider Incentive	$10,319,099	$0	$10,319,099	$7,279,099	($3,040,000)	(41.8%)
	$1,766,693,057	**($13,232,479)**	**$1,753,460,578**	**$1,778,690,880**	**$11,997,822**	**0.70%**

Medical Expense - Actual vs. Budget (Per Member Per Month)

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

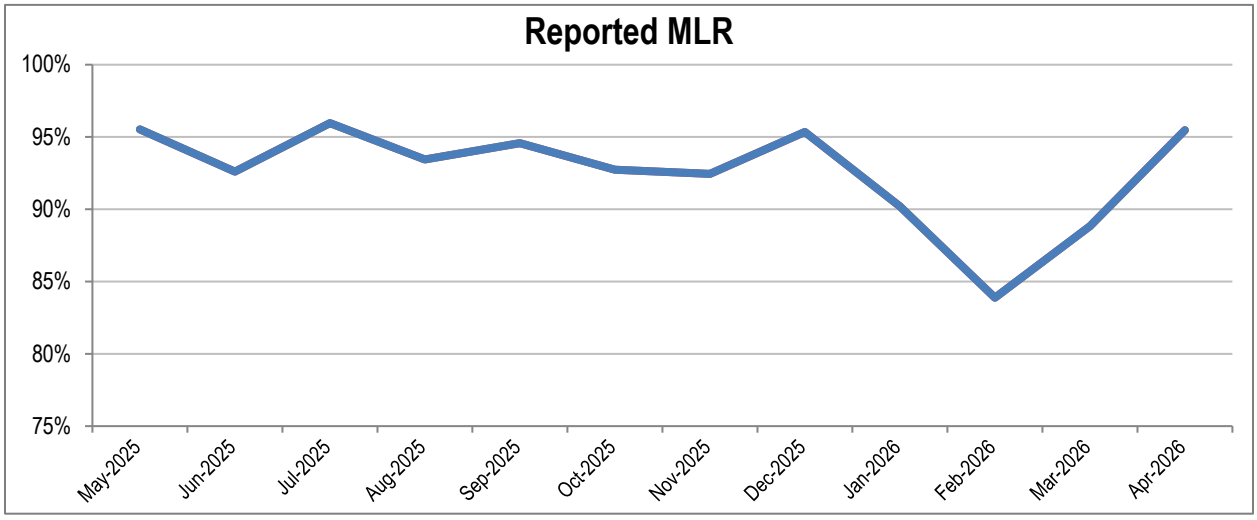
	Actual			Budget	Variance: Actual Adjusted vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$44.62	$0.00	$44.62	$44.09	($0.53)	(1.2%)
Primary Care FFS	$8.29	$2.58	$10.87	$12.31	$4.02	32.7%
Specialty Care FFS	$20.53	$0.41	$20.94	$21.43	$0.90	4.2%
Outpatient FFS	$32.17	($0.04)	$32.13	$32.93	$0.76	2.3%
Ancillary FFS	$54.19	$0.87	$55.05	$50.79	($3.40)	(6.7%)
Pharmacy FFS	$32.72	($1.68)	$31.04	$27.59	($5.13)	(18.6%)
ER Services FFS	$26.40	$0.07	$26.47	$25.91	($0.49)	(1.9%)
Inpatient Hospital & SNF FFS	$122.02	($3.24)	$118.78	$121.99	($0.03)	0.0%
Long Term Care & SNF FFS	$89.75	($2.28)	$87.47	$96.09	$6.34	6.6%
Other Benefits & Services	$9.83	$0.00	$9.83	$11.27	$1.44	12.8%
Net Reinsurance	$0.08	$0.00	$0.08	$0.68	$0.60	88.4%
Provider Incentive	$2.59	$0.00	$2.59	$1.83	($0.76)	(41.5%)
	$443.19	**($3.32)**	**$439.87**	**$446.92**	**$3.73**	**0.8%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $12.0 million favorable to budget. On a PMPM basis, medical expense is 0.8% favorable to budget. For per-member-per-month expense:
    - Capitated Expense is over budget, primarily driven by unfavorable PCP Capitation FQHC expense.
    - Primary Care Expense is under budget due to TRI reclassifications across all populations except for Group Care and Medicare.

- Specialty Care Expense is under budget, driven by lower unit cost and utilization.
- Outpatient Expense is under budget due to lower dialysis unit cost and utilization.
- Ancillary Expense is over budget due to higher utilization in the SPD with LTC, Duals with LTC Duals, Child and ACA OE aid code categories.
- Pharmacy Expense is over budget driven by prior period expense related to overpayments made to UCSF last fiscal year and higher unit cost in the current budget period. The offsetting accruals for the recoveries were already made in a prior accounting period.
- Emergency Expense is over budget driven by higher utilization in the SPD with LTC and Duals with LTC Duals aid code categories.
- Inpatient Expense is under budget driven by lower unit cost and utilization in the Adult, ACA OE, Child and SPD with LTC aid code groups.
- Long Term Care Expense is under budget driven by lower utilization in the SPD with LTC and Duals with LTC Duals aid code categories.
- Other Benefits & Services is under budget, due to lower than expected employee, interpreter, professional services, community reinvestment and relations, licenses and permits expense.
- Net Reinsurance is under budget because more recoveries were received than expected.
- Provider Incentive is over budget, due to timing and accruals.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported Medical Expense divided by Premium Revenue) was 95.5% for the month and 92.3% for the fiscal year-to-date.



Administrative Expense

- For the month ended April 30th, 2026:
  - Actual Administrative Expense: $11.4 million.
  - Budgeted Administrative Expense: $11.5 million.
- For the fiscal YTD ended April 30th, 2026:
  - Actual Administrative Expense: $104.6 million.
  - Budgeted Administrative Expense: $111.6 million.

Summary of Administrative Expense (In Dollars) **For the Month and Fiscal Year-to-Date** **Favorable/(Unfavorable)**								
Current Month					**Year-to-Date**			
Actual	**Budget**	**Variance $**	**Variance %**		**Actual**	**Budget**	**Variance $**	**Variance %**
$7,606,189	$6,913,609	($692,579)	(10.0%)	Personnel Expense	$65,792,443	$68,228,684	$2,436,241	3.6%
245,817	93,574	(152,243)	(162.7%)	Medical Benefits Admin Expense	739,993	947,909	207,916	21.9%
2,219,652	2,813,321	593,669	21.1%	Purchased & Professional Services	21,587,936	24,687,808	3,099,872	12.6%
1,363,223	1,661,958	298,736	18.0%	Other Admin Expense	16,491,605	17,754,315	1,262,711	7.1%
$11,434,880	$11,482,463	$47,582	0.4%	Total Administrative Expense	$104,611,977	$111,618,717	$7,006,740	6.3%

The year-to-date variances include:

- Favorable Supplies and Other expenses primarily due to new account: Community Reinvestment Expense, formerly captured under Printing, Postage & Promotions.
- Other Purchases & Fees are favorable primarily due to favorable costs in Supplies, Commissary, Member Incentives and Miscellaneous activities.
- Favorable in Purchased & Professional Services, primarily due to Consultant Fees and Purchased Services, IT Software Licenses & Subscriptions, and Hardware Purchases.
- Employee Expense ran favorably overall, driven by favorable Salary and Benefits resulted from hiring restrictions.
- Favorable Licenses, Insurance & Fees primarily due to favorable Licenses and Subscriptions.
- Favorable Benefit Administration Expense, primarily for the decreases in Behavioral Health Administration Fees, M3P fees, and Pharmacy Admin Fees.
- Partially offset by unfavorable Building Occupancy costs due to SBITA Amortization.
- Partially offset by unfavorable Printing/Postage/Promotions, result of the realignment of Reinvestment Expenses now covered under Other Expense (above) affecting Community Reinvestment now under Supplies and Other Expenses.

The Administrative Loss Ratio (ALR) is 6.1% of net revenue for the month and 5.5% of 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 $2.2 million.

Other Income / (Expense)

Other Income & Expense is comprised primarily of investment income. Fiscal year-to-date net investments show a gain of $24.9 million.

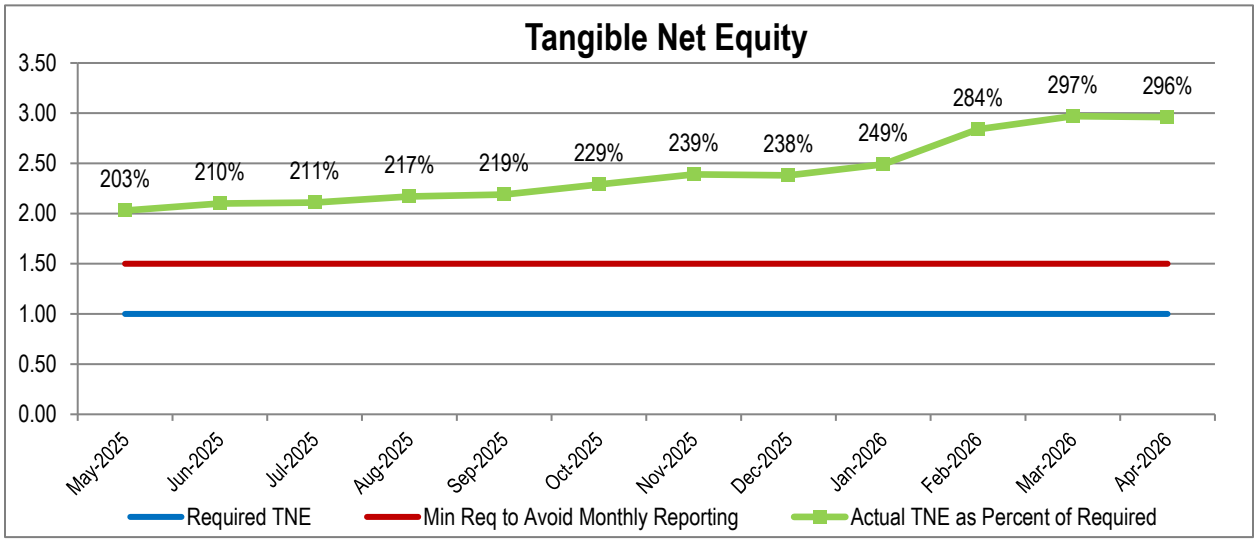
Managed Care Organization (MCO) Provider Tax

- Revenue:
  - For the month ended April 30th, 2026:
    - Actual: $63.5 million.
    - Budgeted: $60.3 million.
  - For the fiscal YTD ended April 30th, 2026:

        - Actual: $646.5 million.
        - Budgeted: $633.5 million.
- Expense:
    - For the month ended April 30th, 2026:
        - Actual: $63.5 million.
        - Budgeted: $60.3 million.
    - For the fiscal YTD ended April 30th, 2026:
        - Actual: $646.5 million.
        - Budgeted: $633.5 million.

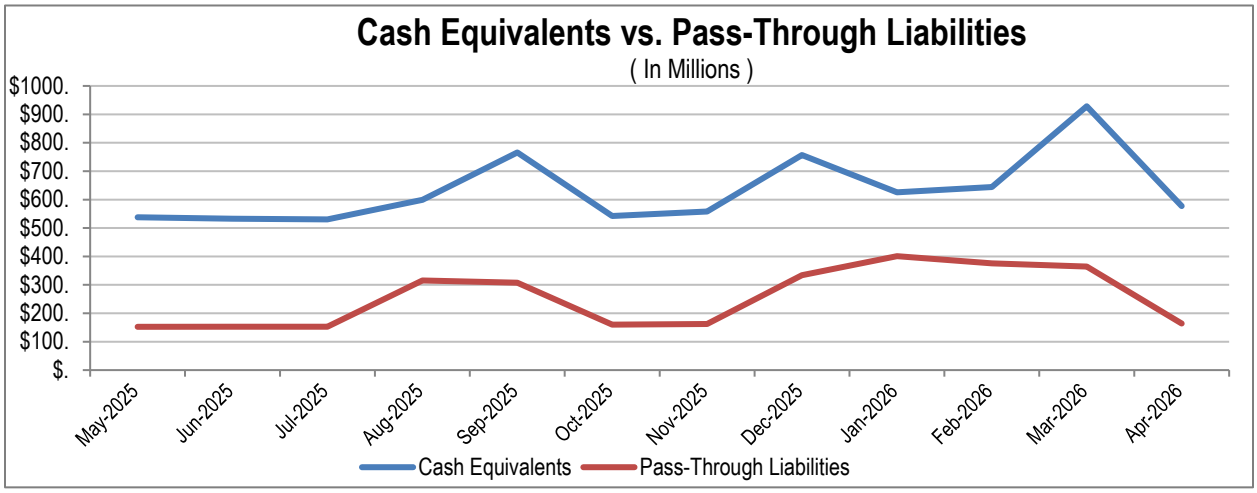
Tangible Net Equity (TNE)

- 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 total liabilities divided by a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
    - Required TNE $79.8 million
    - Actual TNE $236.3 million
    - Excess TNE $156.5 million
    - TNE % of Required TNE 296%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.

- Key Metrics:
    - Cash & Cash Equivalents $577.3 million
    - Pass-Through Liabilities $164.0 million



    - Uncommitted Cash $413.2 million
    - Working Capital $182.7 million
    - Current Ratio 1.23 (regulatory minimum is 1.00)

Capital Investment

- Fiscal year-to-date capital assets acquired: $51,000.
- Annual capital budget: $1.4 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 30 APRIL, 2026

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
373,831	373,084	747	0.2%	1. Medi-Cal	3,924,263	3,917,595	6,668	0.2%
6,291	6,097	194	3.2%	2. GroupCare	61,229	60,582	647	1.1%
231	619	(388)	(62.7%)	3. Medicare SNP	804	1,728	(924)	(53.5%)
380,353	**379,800**	**553**	**0.1%**	**3. TOTAL MEMBER MONTHS**	**3,986,296**	**3,979,905**	**6,391**	**0.2%**
				REVENUE				
$188,081,394	$183,084,527	$4,996,867	2.7%	4. Premium Revenue	$1,900,180,039	$1,884,101,517	$16,078,522	0.9%
$63,526,733	$60,275,451	$3,251,282	5.4%	5. MCO Tax Revenue AB119	$646,521,585	$633,454,455	$13,067,130	2.1%
$251,608,127	**$243,359,978**	**$8,248,149**	**3.4%**	**6. TOTAL REVENUE**	**$2,546,701,623**	**$2,517,555,972**	**$29,145,652**	**1.2%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$16,210,669	$15,513,665	($697,004)	(4.5%)	7. Capitated Medical Expense	$177,858,200	$175,455,444	($2,402,757)	(1.4%)
				Fee for Service Medical Expenses				
$50,587,491	$47,728,733	($2,858,758)	(6.0%)	8. Inpatient Hospital Expense	$473,508,590	$485,519,340	$12,010,751	2.5%
$4,501,080	$4,311,824	($189,256)	(4.4%)	9. Primary Care Physician Expense	$43,323,701	$48,993,043	$5,669,342	11.6%
$9,464,176	$7,796,129	($1,668,046)	(21.4%)	10. Specialty Care Physician Expense	$83,480,018	$85,297,354	$1,817,335	2.1%
$25,257,876	$20,086,218	($5,171,658)	(25.7%)	11. Ancillary Medical Expense	$219,453,596	$202,125,880	($17,327,716)	(8.6%)
$12,268,531	$11,584,781	($683,750)	(5.9%)	12. Outpatient Medical Expense	$128,073,135	$131,073,954	$3,000,819	2.3%
$11,552,033	$9,958,749	($1,593,284)	(16.0%)	13. Emergency Expense	$105,518,808	$103,117,256	($2,401,552)	(2.3%)
$14,260,825	$11,866,080	($2,394,746)	(20.2%)	14. Pharmacy Expense	$123,732,291	$109,806,433	($13,925,859)	(12.7%)
$32,084,593	$38,275,030	$6,190,436	16.2%	15. Long Term Care Expense	$348,690,999	$382,439,281	$33,748,282	8.8%
$159,976,605	$151,607,543	($8,369,062)	(5.5%)	16. Total Fee for Service Expense	$1,525,781,138	$1,548,372,540	$22,591,402	1.5%
$4,077,030	$4,663,345	$586,315	12.6%	17. Other Benefits & Services	$39,185,940	$44,862,429	$5,676,489	12.7%
($1,004,911)	$537,784	$1,542,695	286.9%	18. Reinsurance Expense	$316,201	$2,721,368	$2,405,167	88.4%
$290,000	$290,000	$0	0.0%	19. Risk Pool Distribution	$10,319,099	$7,279,099	($3,040,000)	(41.8%)
$179,549,393	**$172,612,337**	**($6,937,056)**	**(4.0%)**	**20. TOTAL MEDICAL EXPENSES**	**$1,753,460,578**	**$1,778,690,879**	**$25,230,302**	**1.4%**
$72,058,734	**$70,747,642**	**$1,311,093**	**1.9%**	**21. GROSS MARGIN**	**$793,241,046**	**$738,865,092**	**$54,375,954**	**7.4%**
				ADMINISTRATIVE EXPENSES				
$7,606,189	$6,913,609	($692,579)	(10.0%)	22. Personnel Expense	$65,792,443	$68,228,684	$2,436,241	3.6%
$245,817	$93,574	($152,243)	(162.7%)	23. Benefits Administration Expense	$739,993	$947,909	$207,916	21.9%
$2,219,652	$2,813,321	$593,669	21.1%	24. Purchased & Professional Services	$21,587,936	$24,687,808	$3,099,872	12.6%
$1,363,223	$1,661,958	$298,736	18.0%	25. Other Administrative Expense	$16,491,605	$17,754,315	$1,262,711	7.1%
$11,434,880	**$11,482,463**	**$47,582**	**0.4%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$104,611,977**	**$111,618,717**	**$7,006,740**	**6.3%**
$63,526,733	**$60,275,451**	**($3,251,282)**	**(5.4%)**	**27. MCO TAX EXPENSES**	**$646,521,585**	**$633,454,455**	**($13,067,130)**	**(2.1%)**
($2,902,879)	**($1,010,272)**	**($1,892,607)**	**(187.3%)**	**28. NET OPERATING INCOME / (LOSS)**	**$42,107,484**	**($6,208,080)**	**$48,315,564**	**778.3%**
				OTHER INCOME / EXPENSES				
$3,290,531	**$2,875,464**	**$415,067**	**14.4%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$24,895,524**	**$27,319,671**	**($2,424,147)**	**(8.9%)**
$387,651	**$1,865,192**	**($1,477,541)**	**(79.2%)**	**30. NET SURPLUS (DEFICIT)**	**$67,003,009**	**$21,111,592**	**$45,891,417**	**217.4%**
95.5%	94.3%	(1.2%)	(1.3%)	31. Medical Loss Ratio	92.3%	94.4%	2.1%	2.2%
6.1%	6.3%	0.2%	3.2%	32. Administrative Expense Ratio	5.5%	5.9%	0.4%	6.8%
0.2%	0.8%	(0.6%)	(75.0%)	33. Net Surplus (Deficit) Ratio	2.6%	0.8%	1.8%	225.0%

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED 30 APRIL, 2026

	4/30/2026	3/31/2026	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$38,803,262	$28,655,573	$10,147,689	35.4%
CNB Short-Term Investment	538,461,270	899,766,475	(361,305,205)	(40.2%)
Interest Receivable	2,567,688	2,591,070	(23,381)	(0.9%)
Premium Receivables	369,828,884	370,197,254	(368,371)	(0.1%)
Reinsurance Recovery Receivable	15,427,507	12,585,285	2,842,222	22.6%
Other Receivables	1,819,688	1,935,266	(115,578)	(6.0%)
Prepaid Expenses	784,800	878,611	(93,810)	(10.7%)
TOTAL CURRENT ASSETS	**967,693,099**	**1,316,609,533**	**(348,916,435)**	**(26.5%)**
OTHER ASSETS				
CNB Long-Term Investment	37,458,394	27,934,001	9,524,394	34.1%
CalPERS Net Pension Asset	(6,465,233)	(6,465,233)	0	0.0%
Deferred Outflow	15,271,214	15,271,214	0	0.0%
Restricted Asset-Bank Note	363,852	362,821	1,031	0.3%
GASB 87-Lease Assets (Net)	45,850	49,125	(3,275)	(6.7%)
GASB 96-SBITA Assets (Net)	7,552,000	7,865,978	(313,978)	(4.0%)
TOTAL OTHER ASSETS	**54,226,076**	**45,017,905**	**9,208,171**	**20.5%**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,893,508	9,893,508	0	0.0%
Furniture And Equipment	13,400,309	13,400,309	0	0.0%
Leasehold Improvement	902,447	902,447	0	0.0%
Internally Developed Software	14,824,002	14,824,002	0	0.0%
Fixed Assets at Cost	39,020,265	39,020,265	0	0.0%
Less: Accumulated Depreciation	(34,015,137)	(33,952,438)	(62,699)	0.2%
PROPERTY AND EQUIPMENT (NET)	**5,005,128**	**5,067,827**	**(62,699)**	**(1.2%)**
TOTAL ASSETS	**1,026,924,303**	**1,366,695,265**	**(339,770,962)**	**(24.9%)**
CURRENT LIABILITIES				
Trade Accounts Payable	11,973,779	11,755,389	218,390	1.9%
Incurred But Not Reported Claims	324,464,820	343,479,453	(19,014,633)	(5.5%)
Other Medical Liabilities	150,744,348	148,401,912	2,342,436	1.6%
Pass-Through Liabilities	164,043,127	364,293,943	(200,250,816)	(55.0%)
MCO Tax Liabilities	118,815,233	243,663,499	(124,848,267)	(51.2%)
GASB 87 and 96 ST Liabilities	2,941,215	3,039,479	(98,264)	(3.2%)
Payroll Liabilities	12,012,751	10,296,806	1,715,945	16.7%
TOTAL CURRENT LIABILITIES	**784,995,272**	**1,124,930,481**	**(339,935,209)**	**(30.2%)**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	2,406,356	2,629,761	(223,405)	(8.5%)
Deferred Inflow	3,240,306	3,240,306	0	0.0%
TOTAL LONG TERM LIABILITIES	**5,646,661**	**5,870,066**	**(223,405)**	**(3.8%)**
TOTAL LIABILITIES	**790,641,934**	**1,130,800,547**	**(340,158,614)**	**(30.1%)**
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	168,439,128	168,439,128	0	0.0%
Year-To-Date Net Surplus (Deficit)	67,003,009	66,615,357	387,651	0.6%
TOTAL NET WORTH	**236,282,369**	**235,894,718**	**387,651**	**0.2%**
TOTAL LIABILITIES AND NET WORTH	**1,026,924,303**	**1,366,695,265**	**(339,770,962)**	**(24.9%)**
Cash Equivalents	577,264,531	928,422,048	(351,157,516)	(37.8%)
Pass-Through	164,043,127	364,293,943	(200,250,816)	(55.0%)
Uncommitted Cash	413,221,405	564,128,105	(150,906,700)	(26.8%)
Working Capital	182,697,826	191,679,052	(8,981,226)	(4.7%)
Current Ratio	123.3%	117.0%	6.3%	5.4%

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **April 30, 2026**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,444,210	$10,219,857	$20,290,618	$33,443,673
GroupCare Receivable	(3,433,401)	(3,423,073)	(3,431,940)	(3,431,833)
Total	10,809	6,796,784	16,858,678	30,011,840
Medicare Premiums				
Medicare Premiums	480,605	1,366,306	1,730,359	1,730,358
Deferred Premium Revenue	0	(358,999)	0	0
Medicare Receivable	-	-	-	-
Total	480,605	1,007,307	1,730,359	1,730,358
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	247,683,312	748,198,386	1,506,453,120	2,511,527,591
Premium Receivable	3,801,772	225,056,891	121,996,204	131,875,621
Total	251,485,084	973,255,277	1,628,449,324	2,643,403,212
Investment & Other Income Cash Flows				
Other Revenues	(475,526)	(42,714)	744,674	542,946
Interest Income	3,781,247	8,346,342	14,256,444	24,452,777
Interest Receivable	23,381	845,403	594,260	1,019,270
Total	3,329,102	9,149,031	15,595,378	26,014,993
Medical & Hospital Cash Flows				
Total Medical Expenses	(179,549,392)	(507,088,786)	(1,039,129,162)	(1,753,460,577)
Other Health Care Receivables	(2,731,758)	(828,775)	1,067,402	(7,064,728)
Capitation Payable	-	-	(6,403,056)	-
IBNP Payable	(19,014,633)	(86,451,150)	(59,097,734)	(87,652,475)
Other Medical Payable	(198,198,379)	(227,409,290)	29,186,822	38,673,910
Risk Share Payable	290,000	2,620,000	5,660,000	5,710,856
New Health Program Payable	-	-	-	-
Total	(399,204,162)	(819,158,001)	(1,068,715,728)	(1,803,793,014)
Administrative Cash Flows				
Total Administrative Expenses	(11,450,073)	(33,387,716)	(64,924,874)	(104,712,175)
Prepaid Expenses	93,809	213,618	220,228	(66,990)
Other Receivables	5,115	10,997	12,175	(1,341)
CalPERS Pension	-	-	-	-
Trade Accounts Payable	218,389	33,290	1,344,413	456,856
Payroll Liabilities	1,715,944	2,692,816	3,831,160	2,648,836
GASB Assets and Liabilities	(4,415)	781,574	(317,693)	(178,128)
Depreciation Expense	62,699	188,097	375,138	622,543
Total	(9,358,532)	(29,467,324)	(59,459,453)	(101,230,399)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(63,526,733)	(192,330,946)	(386,725,683)	(646,521,585)
MCO Tax Liabilities	(124,848,267)	3,955,946	(115,607,650)	(107,003,171)
Total	(188,375,000)	(188,375,000)	(502,333,333)	(753,524,756)
Net Cash Flows from Operating Activities	**(341,632,094)**	**(46,791,926)**	**32,125,225**	**42,612,234**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **April 30, 2026**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(9,524,391)	(1,433,388)	3,086,079	1,696,972
Total	(9,524,391)	(1,433,388)	3,086,079	1,696,972
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(1,031)	(2,985)	(6,012)	(9,986)
Total	(1,031)	(2,985)	(6,012)	(9,986)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	(26,407)	(50,860)	(50,860)
Depreciation expense				
Change in A/D				
Purchases of Property and Equipment	-	(26,407)	(50,860)	(50,860)
Net Cash Flows from Investing Activities	**(9,525,422)**	**(1,462,780)**	**3,029,207**	**1,636,126**
Financing Cash Flows				
Subordinated Debt Proceeds	-	-	-	-
Net Change in Cash	**(351,157,516)**	**(48,254,706)**	**35,154,432**	**44,248,360**
Rounding	-	-	-	-
Cash @ Beginning of Period	928,422,047	625,519,237	542,110,099	533,016,171
Cash @ End of Period	**$577,264,531**	**$577,264,531**	**$577,264,531**	**$577,264,531**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **April 30, 2026**

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$387,650	$35,280,728	$52,695,495	$67,003,008
Add back: Depreciation & Amortization	62,699	188,097	375,138	622,543
Receivables				
Premiums Receivable	3,801,772	225,056,891	121,996,204	131,875,621
Interest Receivable	23,381	845,403	594,260	1,019,270
Other Health Care Receivables	(2,731,758)	(828,775)	1,067,402	(7,064,728)
Other Receivables	5,115	10,997	12,175	(1,341)
GroupCare Receivable	(3,433,401)	(3,423,073)	(3,431,940)	(3,431,833)
Total	(2,334,891)	221,661,443	120,238,101	122,396,989
Prepaid Expenses	93,809	213,618	220,228	(66,990)
Trade Payables	218,389	33,290	1,344,413	456,856
Claims Payable and Shared Risk Pool				
IBNP Payable	(19,014,633)	(86,451,150)	(59,097,734)	(87,652,475)
Capitation Payable & Other Medical Payable	(198,198,379)	(227,409,290)	22,783,766	38,673,910
Risk Share Payable	290,000.00	2,620,000.00	5,660,000	5,710,856
Claims Payable				
Total	(216,923,012)	(311,240,440)	(30,653,968)	(43,267,709)
Unearned Revenue				
Deferred Premium Revenue				
Deferred Revenue - IHSS				
Deferred Revenue - Medicare (DSNP)	0	(358,999)	0	0
Total	-	(358,999.00)	-	-
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	1,715,944	2,692,817	3,831,161	2,648,836
GASB Assets and Liabilities	(4,415)	781,574	(317,693)	(178,128)
New Health Program	-	-	-	-
MCO Tax Liabilities	(124,848,267)	3,955,946	(115,607,650)	(107,003,171)
Total	(123,136,738)	7,430,337	(112,094,182)	(104,532,463)
Rounding	-	-	-	-
Cash Flows from Operating Activities	**(341,632,094)**	**(46,791,926)**	**32,125,225**	**42,612,234**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **April 30, 2026**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$251,485,084	$973,255,277	$1,628,449,324	$2,643,403,212
Medicare Revenue	$480,605	$1,007,307	$1,730,359	$1,730,358
GroupCare Premium Revenue	10,809	6,796,784	16,858,678	30,011,840
Other Income	(475,526)	(42,714)	744,674	542,946
Interest Income	3,804,628	9,191,745	14,850,704	25,472,047
Less Cash Paid				
Medical Expenses	(399,204,162)	(819,158,001)	(1,068,715,728)	(1,803,793,014)
Vendor & Employee Expenses	(9,358,532)	(29,467,324)	(59,459,453)	(101,230,399)
MCO Tax Expense AB119	(188,375,000)	(188,375,000)	(502,333,333)	(753,524,756)
Net Cash Flows from Operating Activities	**(341,632,094)**	**(46,791,926)**	**32,125,225**	**42,612,234**
Cash Flows from Investing Activities:				
Long Term Investments	(9,524,391)	(1,433,388)	3,086,079	1,696,972
Restricted Assets-Treasury Account	(1,031)	(2,985)	(6,012)	(9,986)
Purchases of Property and Equipment	0	(26,407)	(50,860)	(50,860)
Net Cash Flows from Investing Activities	**(9,525,422)**	**(1,462,780)**	**3,029,207**	**1,636,126**
Net Change in Cash	**(351,157,516)**	**(48,254,706)**	**35,154,432**	**44,248,360**
Rounding	-	-	-	-
Cash @ Beginning of Period	928,422,047	625,519,237	542,110,099	533,016,171
Cash @ End of Period	**$577,264,531**	**$577,264,531**	**$577,264,531**	**$577,264,531**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$387,650	$35,280,729	$52,695,494	$67,003,008
Add Back: Depreciation	62,699	188,097	375,138	622,543
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(2,334,891)	221,661,443	120,238,101	122,396,989
Prepaid Expenses	93,809	213,617	220,229	(66,990)
Trade Payables	218,389	33,290	1,344,413	456,856
Claims Payable, IBNP and Risk Sharing	(216,923,012)	(311,240,440)	(30,653,968)	(43,267,709)
Deferred Revenue- Medicare (DSNP)	0	(358,999)	0	0
Other Liabilities	(123,136,738)	7,430,337	(112,094,182)	(104,532,463)
Total	(341,632,094)	(46,791,926)	32,125,225	42,612,234
Rounding	-	-	-	-
Cash Flows from Operating Activities	**($341,632,094)**	**($46,791,926)**	**$32,125,225**	**$42,612,234**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF APRIL 2026

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal ACA OE	Medi-Cal SPD with LTC	Medi-Cal Duals with LTC	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	104,683	54,857	138,309	27,944	48,038	373,831	6,291	231	380,353
Revenue	$34,503,233	$30,265,282	$88,821,373	$50,174,758	$43,918,666	$247,683,312	$3,444,210	$480,605	$251,608,127
Medical Expense	$15,159,694	$19,973,739	$62,515,722	$41,238,105	$36,722,170	$175,609,430	$3,339,825	$600,138	$179,549,393
Gross Margin	$19,343,539	$10,291,542	$26,305,651	$8,936,653	$7,196,496	$72,073,882	$104,385	($119,533)	$72,058,734
Administrative Expense	$595,104	$1,246,244	$3,560,570	$2,880,138	$2,042,622	$10,324,678	$230,268	$879,934	$11,434,880
MCO Tax Expense	$17,818,646	$9,294,802	$23,424,716	$4,799,717	$8,188,853	$63,526,733	$0	$0	$63,526,733
Operating Income / (Expense)	$929,789	($249,503)	($679,635)	$1,256,799	($3,034,979)	($1,777,529)	($125,883)	($999,467)	($2,902,879)
Other Income / (Expense)	$159,682	$379,548	$1,081,911	$1,001,576	$616,392	$3,239,109	$48,953	$2,469	$3,290,531
Net Income / (Loss)	$1,089,472	$130,045	$402,276	$2,258,375	($2,418,587)	$1,461,580	($76,931)	($996,998)	$387,651
PMPM Metrics:									
Revenue PMPM	$329.60	$551.71	$642.20	$1,795.55	$914.25	$662.55	$547.48	$2,080.54	$661.51
Medical Expense PMPM	$144.82	$364.11	$452.00	$1,475.74	$764.44	$469.76	$530.89	$2,598.00	$472.06
Gross Margin PMPM	$184.78	$187.61	$190.19	$319.81	$149.81	$192.80	$16.59	($517.46)	$189.45
Administrative Expense PMPM	$5.68	$22.72	$25.74	$103.07	$42.52	$27.62	$36.60	$3,809.24	$30.06
MCO Tax Expense PMPM	$170.22	$169.44	$169.37	$171.76	$170.47	$169.93	$0.00	$0.00	$167.02
Operating Income / (Expense) PMPM	$8.88	($4.55)	($4.91)	$44.98	($63.18)	($4.75)	($20.01)	($4,326.70)	($7.63)
Other Income / (Expense) PMPM	$1.53	$6.92	$7.82	$35.84	$12.83	$8.66	$7.78	$10.69	$8.65
Net Income / (Loss) PMPM	$10.41	$2.37	$2.91	$80.82	($50.35)	$3.91	($12.23)	($4,316.01)	$1.02
Ratio:									
Medical Loss Ratio	90.9%	95.2%	95.6%	90.9%	102.8%	95.4%	97.0%	124.9%	95.5%
Administrative Expense Ratio	3.6%	5.9%	5.4%	6.3%	5.7%	5.6%	6.7%	183.1%	6.1%
Net Income Ratio	3.2%	0.4%	0.5%	4.5%	-5.5%	0.6%	-2.2%	-207.4%	0.2%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE APRIL 2026

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal ACA OE	Medi-Cal SPD with LTC	Medi-Cal Duals with LTC	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	1,071,836	587,445	1,482,906	292,285	489,791	3,924,263	61,229	804	3,986,296
Revenue	$350,177,407	$318,653,767	$913,099,729	$496,998,503	$432,598,185	$2,511,527,592	$33,443,673	$1,730,359	$2,546,701,623
Medical Expense	$140,327,373	$201,055,890	$604,393,173	$412,836,424	$357,776,931	$1,716,389,790	$34,615,682	$2,455,106	$1,753,460,578
Gross Margin	$209,850,035	$117,597,877	$308,706,556	$84,162,079	$74,821,254	$795,137,802	($1,172,009)	($724,747)	$793,241,046
Administrative Expense	$4,973,456	$11,078,807	$33,074,188	$27,870,764	$17,000,351	$93,997,567	$2,075,604	$8,538,806	$104,611,977
MCO Tax Expense	$176,795,071	$96,498,021	$243,194,577	$48,694,667	$81,339,249	$646,521,585	$0	$0	$646,521,585
Operating Income / (Expense)	$28,081,508	$10,021,049	$32,437,790	$7,596,648	($23,518,345)	$54,618,650	($3,247,613)	($9,263,553)	$42,107,484
Other Income / (Expense)	$1,209,135	$2,874,159	$8,190,751	$7,581,785	$4,667,165	$24,522,995	$370,629	$1,900	$24,895,524
Net Income / (Loss)	$29,290,643	$12,895,208	$40,628,541	$15,178,433	($18,851,180)	$79,141,645	($2,876,984)	($9,261,653)	$67,003,009
PMPM Metrics:									
Revenue PMPM	$326.71	$542.44	$615.75	$1,700.39	$883.23	$640.00	$546.21	$2,152.19	$638.86
Medical Expense PMPM	$130.92	$342.25	$407.57	$1,412.44	$730.47	$437.38	$565.35	$3,053.61	$439.87
Gross Margin PMPM	$195.79	$200.19	$208.18	$287.95	$152.76	$202.62	($19.14)	($901.43)	$198.99
Administrative Expense PMPM	$4.64	$18.86	$22.30	$95.35	$34.71	$23.95	$33.90	$10,620.41	$26.24
MCO Tax Expense PMPM	$164.95	$164.27	$164.00	$166.60	$166.07	$164.75	$0.00	$0.00	$162.19
Operating Income / (Expense) PMPM	$26.20	$17.06	$21.87	$25.99	($48.02)	$13.92	($53.04)	($11,521.83)	$10.56
Other Income / (Expense) PMPM	$1.13	$4.89	$5.52	$25.94	$9.53	$6.25	$6.05	$2.36	$6.25
Net Income / (Loss) PMPM	$27.33	$21.95	$27.40	$51.93	($38.49)	$20.17	($46.99)	($11,519.47)	$16.81
Ratio:									
Medical Loss Ratio	80.9%	90.5%	90.2%	92.1%	101.9%	92.0%	103.5%	141.9%	92.3%
Administrative Expense Ratio	2.9%	5.0%	4.9%	6.2%	4.8%	5.0%	6.2%	493.5%	5.5%
Net Income Ratio	8.4%	4.0%	4.4%	3.1%	-4.4%	3.2%	-8.6%	-535.2%	2.6%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 April, 2026

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)				
$7,606,189	$6,913,609	($692,579)	(10.0%)	Personnel Expenses	$65,792,443	$68,228,684	$2,436,241	3.6%
$245,817	$93,574	($152,243)	(162.7%)	Benefits Administration Expense	$739,993	$947,909	$207,916	21.9%
$2,219,652	$2,813,321	$593,669	21.1%	Purchased & Professional Services	$21,587,936	$24,687,808	$3,099,872	12.6%
$520,122	$490,572	($29,550)	(6.0%)	Occupancy	$5,021,623	$4,867,977	($153,646)	(3.2%)
$175,598	$237,527	$61,929	26.1%	Printing Postage & Promotion	$3,264,464	($400,370)	($3,664,833)	915.4%
$150,341	$381,413	$231,072	60.6%	Licenses Insurance & Fees	$3,170,278	$5,041,187	$1,870,909	37.1%
$517,161	$552,446	$35,285	6.4%	Other Administrative Expense	$5,035,240	$8,245,521	$3,210,280	38.9%
$3,828,692	$4,568,854	$740,162	16.2%	Total Other Administrative Expenses (excludes Personnel Expenses)	$38,819,534	$43,390,033	$4,570,499	10.5%
$11,434,880	$11,482,463	$47,582	0.4%	Total Administrative Expenses	$104,611,977	$111,618,717	$7,006,740	6.3%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 April, 2026

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
5,030,473	4,384,211	(646,262)	(14.7%)	Salaries & Wages	42,984,182	43,783,270	799,088	1.8%
598,194	374,140	(224,053)	(59.9%)	Paid Time Off	4,284,268	4,049,704	(234,563)	(5.8%)
50	56,359	56,309	99.9%	Compensated Incentives	7,851	258,566	250,715	97.0%
0	0	0	0.0%	Severence	0	400,000	400,000	100.0%
66,351	63,919	(2,432)	(3.8%)	Payroll Taxes	839,542	951,904	112,362	11.8%
31,221	47,845	16,624	34.7%	Overtime	633,500	602,910	(30,590)	(5.1%)
53,244	0	(53,244)	0.0%	Commission Pay	53,244	0	(53,244)	0.0%
392,419	326,274	(66,145)	(20.3%)	CalPERS ER Match	3,624,964	3,405,200	(219,764)	(6.5%)
1,194,674	1,262,650	67,976	5.4%	Employee Benefits	11,439,050	11,878,652	439,601	3.7%
22,451	0	(22,451)	0.0%	Personal Floating Holiday	227,495	218,795	(8,700)	(4.0%)
19,797	46,000	26,203	57.0%	Language Pay	220,606	333,272	112,666	33.8%
3,480	0	(3,480)	0.0%	Med Ins Opted Out Stipend	36,740	12,100	(24,640)	(203.6%)
96,040	0	(96,040)	0.0%	Sick Leave	674,130	77,895	(596,235)	(765.4%)
200	27,656	27,456	99.3%	Compensated Employee Relations	(52)	208,439	208,491	100.0%
21,760	26,090	4,330	16.6%	Work from Home Stipend	221,230	235,520	14,290	6.1%
1,126	5,428	4,302	79.3%	Mileage, Parking & LocalTravel	11,862	31,580	19,718	62.4%
2,244	21,745	19,502	89.7%	Travel & Lodging	33,541	208,141	174,600	83.9%
63,599	165,336	101,737	61.5%	Temporary Help Services	305,932	940,279	634,347	67.5%
7,926	45,932	38,006	82.7%	Staff Development/Training	141,997	382,718	240,722	62.9%
941	60,025	59,084	98.4%	Staff Recruitment/Advertisement	52,362	249,740	197,379	79.0%
7,606,189	**6,913,609**	**(692,579)**	**(10.0%)**	**Personnel Expense**	**65,792,443**	**68,228,684**	**2,436,241**	**3.6%**
79,522	33,909	(45,613)	(134.5%)	Pharmacy Administrative Fees	318,256	285,789	(32,466)	(11.4%)
0	0	0	0.0%	Behavioral Hlth Administration	(236,422)	0	236,422	0.0%
115,000	10,000	(105,000)	(1,050.0%)	M3P Admin Fees	115,000	145,000	30,000	20.7%
2,043	371	(1,672)	(450.2%)	OTC Administrative	27,333	1,037	(26,296)	(2,536.2%)
130	0	(130)	0.0%	Capitation Admin Fees	316	0	(316)	0.0%
49,122	49,294	172	0.3%	Telemedicine Admin. Fees	515,511	516,083	572	0.1%
245,817	**93,574**	**(152,243)**	**(162.7%)**	**Benefits Administration Expense**	**739,993**	**947,909**	**207,916**	**21.9%**
732,419	746,083	13,664	1.8%	Consultant Fees - Non Medical	5,576,711	7,253,813	1,677,102	23.1%
309,532	465,582	156,049	33.5%	Computer Support Services	4,081,611	4,539,425	457,813	10.1%
11,750	11,750	0	0.0%	Audit Fees	138,370	136,955	(1,415)	(1.0%)
0	0	0	0.0%	Consultant Fees - Medical	17,593	117,593	100,000	85.0%
380,707	383,305	2,598	0.7%	Other Purchased Services	2,679,128	2,952,791	273,664	9.3%
0	1,879	1,879	100.0%	Maint.&Repair-Office Equipment	0	11,274	11,274	100.0%
45,712	62,267	16,555	26.6%	Legal Fees	426,163	572,573	146,410	25.6%
0	0	0	0.0%	Member Health Education	(25)	(17)	8	(50.0%)
46,477	26,000	(20,477)	(78.8%)	Translation Services	538,650	403,523	(135,127)	(33.5%)
172,046	151,900	(20,146)	(13.3%)	Medical Refund Recovery Fees	1,977,680	1,737,550	(240,130)	(13.8%)
439,095	867,419	428,324	49.4%	Software - IT Licenses & Subsc	5,330,831	5,978,988	648,157	10.8%
1,986	36,737	34,751	94.6%	Hardware (Non-Capital)	292,175	604,007	311,833	51.6%
79,928	60,400	(19,528)	(32.3%)	Provider Credentialing	529,050	379,333	(149,717)	(39.5%)
2,219,652	**2,813,321**	**593,669**	**21.1%**	**Purchased & Professional Services**	**21,587,936**	**24,687,808**	**3,099,872**	**12.6%**
62,699	79,876	17,177	21.5%	Depreciation	622,543	676,971	54,428	8.0%
8,092	9,235	1,143	12.4%	Lease Rented Office Equipment	59,261	94,060	34,798	37.0%
17,682	19,265	1,583	8.2%	Utilities	179,968	186,083	6,115	3.3%
86,709	108,156	21,447	19.8%	Telephone	892,777	1,024,952	132,175	12.9%
30,961	24,040	(6,921)	(28.8%)	Building Maintenance	191,216	259,757	68,541	26.4%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 April, 2026

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
313,979	250,000	(63,979)	(25.6%)	GASB96 SBITA Amort. Expense	3,075,857	2,626,154	(449,703)	(17.1%)
520,122	**490,572**	**(29,550)**	**(6.0%)**	**Occupancy**	**5,021,623**	**4,867,977**	**(153,646)**	**(3.2%)**
43,587	98,235	54,648	55.6%	Postage	951,935	981,067	29,132	3.0%
9,912	5,700	(4,212)	(73.9%)	Design & Layout	81,828	53,742	(28,086)	(52.3%)
42,101	54,793	12,692	23.2%	Printing Services	1,684,320	1,470,830	(213,490)	(14.5%)
23,016	15,600	(7,416)	(47.5%)	Mailing Services	280,169	107,065	(173,104)	(161.7%)
6,152	19,204	13,052	68.0%	Courier/Delivery Service	67,816	110,382	42,566	38.6%
1,313	2,345	1,032	44.0%	Pre-Printed Materials & Public	1,922	8,070	6,148	76.2%
24,290	0	(24,290)	0.0%	Promotional Products	34,845	35,000	155	0.4%
0	150	150	100.0%	Promotional Services	358	6,258	5,900	94.3%
25,228	41,500	16,272	39.2%	Community Relations	161,271	(3,172,782)	(3,334,053)	105.1%
175,598	**237,527**	**61,929**	**26.1%**	**Printing Postage & Promotion**	**3,264,464**	**(400,370)**	**(3,664,833)**	**915.4%**
0	0	0	0.0%	Regulatory Penalties	0	225,000	225,000	100.0%
43,438	45,500	2,062	4.5%	Bank Fees	378,425	441,638	63,214	14.3%
99,960	94,898	(5,062)	(5.3%)	Insurance Premium	1,143,841	1,139,779	(4,062)	(0.4%)
225	224,456	224,231	99.9%	License,Permits, & Fee - NonIT	1,048,964	2,366,793	1,317,829	55.7%
6,718	16,559	9,842	59.4%	Subscriptions and Dues - NonIT	599,048	867,977	268,929	31.0%
150,341	**381,413**	**231,072**	**60.6%**	**License Insurance & Fees**	**3,170,278**	**5,041,187**	**1,870,909**	**37.1%**
4,992	6,385	1,393	21.8%	Office and Other Supplies	37,752	48,261	10,509	21.8%
0	1,000	1,000	100.0%	Furniture & Equipment	0	5,000	5,000	100.0%
4,354	34,740	30,386	87.5%	Ergonomic Supplies	91,360	219,458	128,099	58.4%
33,228	9,430	(23,798)	(252.4%)	Meals and Entertainment	141,960	174,192	32,231	18.5%
1	0	(1)	0.0%	Miscellaneous	(865,606)	(245,248)	620,358	(253.0%)
1,400	3,125	1,725	55.2%	Member Incentive	1,400	18,750	17,350	92.5%
306,520	164,432	(142,088)	(86.4%)	Provider Interest (All Depts)	2,204,204	1,921,849	(282,355)	(14.7%)
166,667	333,334	166,667	50.0%	Community Reinvestment Expense	3,424,170	6,103,259	2,679,089	43.9%
517,161	**552,446**	**35,285**	**6.4%**	**Other Administrative Expense**	**5,035,240**	**8,245,521**	**3,210,280**	**38.9%**
3,828,692	**4,568,854**	**740,162**	**16.2%**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**38,819,534**	**43,390,033**	**4,570,499**	**10.5%**
11,434,880	**11,482,463**	**47,582**	**0.4%**	**TOTAL ADMINISTRATIVE EXPENSES**	**104,611,977**	**111,618,717**	**7,006,740**	**6.3%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED JUNE 30, 2026

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Routers	IT-FY26-01	$ -	$ -	**$ -**	$ 45,000	$ 45,000
	Firewall AAH Location	IT-FY26-02	$ -	$ -	**$ -**	$ 110,000	$ 110,000
	Firewall Roseville Location	IT-FY26-03	$ -	$ -	**$ -**	$ 110,000	$ 110,000
	VPN Device	IT-FY26-04	$ -	$ -	**$ -**	$ 115,000	$ 115,000
	CISCO UCS Blades	IT-FY26-05	$ -	$ -	**$ -**	$ 300,000	$ 300,000
	CISCO UCS Blades	IT-FY26-05	$ -	$ -	**$ -**	$ 275,000	$ 275,000
	Pure Storage	IT-FY26-06	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Teams Meeting Hardware	IT-FY26-07	$ -	$ -	**$ -**	$ 100,000	$ 100,000
	Network Cabeling and WIFI Access	IT-FY26-08	$ -	$ -	**$ -**	$ 40,000	$ 40,000
Hardware Subtotal			**$ -**	**$ -**	**$ -**	**$ 1,245,000**	**$ 1,245,000**
3. Building Improvement:							
	1240 Exterior lighting update	FA-FY26-01	**$ -**	$ -	**$ -**	$ 30,000	$ 30,000
	1240 Secured Fencing for Warehouse	FA-FY26-02	**$ 19,727**	$ -	**$ 19,727**	$ 30,000	$ 10,273
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	**$ -**	$ -	**$ -**	$ 10,000	$ 10,000
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	**$ -**	$ -	**$ -**	$ 5,000	$ 5,000
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	**$ -**	$ -	**$ -**	$ 10,000	$ 10,000
	1240 Exterior Landscaping	FA-FY26-04	**$ 1,133**	$ -	**$ 1,133**	$ 6,500	$ 5,367
	1240 Exterior Landscaping	FA-FY26-04	**$ 15,000**	$ -	**$ 15,000**	$ 15,000	$ -
	1240 Exterior Landscaping	FA-FY26-04	**$ 15,000**	$ -	**$ 15,000**	$ 15,000	$ -
Building Improvement Subtotal			**$ 50,860**	**$ -**	**$ 50,860**	**$ 121,500**	**$ 70,640**
GRAND TOTAL			**$ 50,860**	**$ -**	**$ 50,860**	**$ 1,366,500**	**$ 1,315,640**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 4/30/26	**$ 39,020,265**
Fixed Assets @ Cost - 6/30/25	**$ 38,969,405**
Fixed Assets Acquired YTD	**$ 50,860**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
FOR THE MONTH AND FISCAL YTD ENDED APRIL 30, 2026

TANGIBLE NET EQUITY (TNE)	**QRT. END Jun-25**	**Jul-25**	**Aug-25**	**QRT. END Sep-25**	**Oct-25**	**Nov-25**	**QRT. END Dec-25**	**Jan-26**	**Feb-26**	**QRT. END Mar-26**	**Apr-26**
Current Month Net Income / (Loss)	$ 4,912,222	$ 1,727,933	$ 2,950,359	$ 3,127,768	$ 6,501,450	$ 7,058,478	$ 967,656	$ 9,388,630	$ 21,757,529	$ 13,135,534	$ 387,650
YTD Net Income / (Loss)	$ (86,095,783)	$ 1,727,938	$ 4,678,300	$ 7,806,066	$ 14,307,514	$ 21,365,998	$ 22,333,655	$ 31,722,281	$ 53,479,813	$ 66,615,357	$ 67,003,009
Net Assets	$ 169,279,360	$ 171,007,298	$ 173,957,660	$ 177,085,426	$ 183,586,874	$ 190,645,358	$ 191,613,015	$ 201,001,641	$ 222,759,173	$ 235,894,717	$ 236,282,369
Subordinated Debt & Interest	-	-	-	-	-	-	-	-	-	-	-
Total Actual TNE	**$ 169,279,360**	**$ 171,007,298**	**$ 173,957,660**	**$ 177,085,426**	**$ 183,586,874**	**$ 190,645,358**	**$ 191,613,015**	**$ 201,001,641**	**$ 222,759,173**	**$ 235,894,717**	**$ 236,282,369**
Increase/(Decrease) in Actual TNE	$ 4,912,222	$ 1,727,933	$ 2,950,359	$ 3,127,768	$ 6,501,450	$ 7,058,478	$ 967,656	$ 9,388,630	$ 21,757,529	$ 13,135,534	$ 387,650
Required TNE (1)	**$ 80,653,661**	**$ 81,235,858**	**$ 80,224,390**	**$ 80,693,435**	**$ 80,147,121**	**$ 79,750,550**	**$ 80,436,968**	**$ 80,592,303**	**$ 78,360,003**	**$ 79,446,994**	**$ 79,829,374**
Min. Req'd to Avoid Monthly Reporting at 150% of Required TNE	$ 120,980,491	$ 121,853,786	$ 120,336,585	$ 121,040,152	$ 120,220,681	$ 119,625,824	$ 120,655,452	$ 120,888,454	$ 117,540,005	$ 119,170,490	$ 119,744,061
TNE Excess / (Deficiency)	$ 88,625,699	$ 89,771,440	$ 93,733,270	$ 96,391,991	$ 103,439,753	$ 110,894,808	$ 111,176,047	$ 120,409,338	$ 144,399,170	$ 156,447,723	$ 156,452,995
Actual TNE as a Multiple of Required	**2.10**	**2.11**	**2.17**	**2.19**	**2.29**	**2.39**	**2.38**	**2.49**	**2.84**	**2.97**	**2.96**
LIQUID TANGIBLE NET EQUITY											
Net Assets	$ 169,279,360	$ 171,007,298	$ 173,957,660	$ 177,085,426	$ 183,586,874	$ 190,645,358	$ 191,613,015	$ 201,001,641	$ 222,759,173	$ 235,894,717	$ 236,282,369
Less: Fixed Assets at Net Book Value	(5,576,811)	(5,514,960)	(5,453,108)	(5,391,257)	(5,329,406)	(5,291,335)	(5,229,076)	(5,166,817)	(5,115,549)	(5,067,826)	(5,005,127)
Net Lease Assets	(2,072,151)	(1,979,137)	(1,678,452)	(1,751,482)	(1,932,587)	(1,672,654)	(1,426,385)	(3,031,854)	(2,673,163)	(2,245,863)	(2,250,278)
CD Pledged to DMHC	(353,866)	(354,839)	(355,847)	(356,859)	(357,840)	(358,857)	(359,844)	(360,866)	(361,892)	(362,821)	(363,852)
Liquid TNE (Liquid Reserves)	**$ 161,276,532**	**$ 163,158,362**	**$ 166,470,253**	**$ 169,585,828**	**$ 175,967,041**	**$ 183,322,512**	**$ 184,597,710**	**$ 192,442,104**	**$ 214,608,569**	**$ 228,218,207**	**$ 228,663,112**
Liquid TNE as Multiple of Required	**2.00**	**2.01**	**2.08**	**2.10**	**2.20**	**2.30**	**2.29**	**2.39**	**2.74**	**2.87**	**2.86**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2026

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,251	108,503	108,083	107,831	107,894	107,424	106,611	106,175	105,381	104,683			1,071,836
Adult	61,536	60,679	60,106	59,780	59,806	59,312	58,090	57,240	56,039	54,857			587,445
ACA OE	155,533	153,348	152,196	151,404	150,677	149,473	146,364	144,297	141,305	138,309			1,482,906
SPD with LTC	29,833	29,686	29,708	29,631	29,590	29,500	29,119	28,813	28,461	27,944			292,285
Duals with LTC	49,509	49,371	49,390	49,401	49,334	49,277	48,675	48,506	48,290	48,038			489,791
Medi-Cal Program	405,662	401,587	399,483	398,047	397,301	394,986	388,859	385,031	379,476	373,831			3,924,263
Group Care Program	5,957	5,974	6,054	6,081	6,092	6,138	6,191	6,211	6,240	6,291			61,229
Medicare Program	0	0	0	0	0	0	170	191	212	231			804
Total	**411,619**	**407,561**	**405,537**	**404,128**	**403,393**	**401,124**	**395,220**	**391,433**	**385,928**	**380,353**			**3,986,296**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change:													
Child	(323)	(748)	(420)	(252)	63	(470)	(813)	(436)	(794)	(698)			(4,891)
Adult	(133)	(857)	(573)	(326)	26	(494)	(1,222)	(850)	(1,201)	(1,182)			(6,812)
ACA OE	357	(2,185)	(1,152)	(792)	(727)	(1,204)	(3,109)	(2,067)	(2,992)	(2,996)			(16,867)
SPD with LTC	83	(147)	22	(77)	(41)	(90)	(381)	(306)	(352)	(517)			(1,806)
Duals with LTC	205	(138)	19	11	(67)	(57)	(602)	(169)	(216)	(252)			(1,266)
Medi-Cal Program	189	(4,075)	(2,104)	(1,436)	(746)	(2,315)	(6,127)	(3,828)	(5,555)	(5,645)			(31,642)
Group Care Program	47	17	80	27	11	46	53	20	29	51			381
Medicare Program	0	0	0	0	0	0	170	21	21	19			231
Total	**236**	**(4,058)**	**(2,024)**	**(1,409)**	**(735)**	**(2,269)**	**(5,904)**	**(3,787)**	**(5,505)**	**(5,575)**			**(31,030)**
Enrollment Percentages:													
Medi-Cal Program % of Total:													
Child % of Medi-Cal	26.9%	27.0%	27.1%	27.1%	27.2%	27.2%	27.4%	27.6%	27.8%	28.0%			27.3%
Adult % of Medi-Cal	15.2%	15.1%	15.0%	15.0%	15.1%	15.0%	14.9%	14.9%	14.8%	14.7%			15.0%
ACA OE % of Medi-Cal	38.3%	38.2%	38.1%	38.0%	37.9%	37.8%	37.6%	37.5%	37.2%	37.0%			37.8%
SPD with LTC % of Medi-Cal	7.4%	7.4%	7.4%	7.4%	7.4%	7.5%	7.5%	7.5%	7.5%	7.5%			7.4%
Duals with LTC % of Medi-Cal	12.2%	12.3%	12.4%	12.4%	12.4%	12.5%	12.5%	12.6%	12.7%	12.9%			12.5%
Medi-Cal Program % of Total	98.6%	98.5%	98.5%	98.5%	98.5%	98.5%	98.4%	98.4%	98.3%	98.3%			98.4%
Group Care Program % of Total	1.4%	1.5%	1.5%	1.5%	1.5%	1.5%	1.6%	1.6%	1.6%	1.7%			1.5%
Medicare Program % of Total	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%			0.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**			**1000.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2026

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted:													
Directly Contracted (DCP)	93,933	93,268	93,599	92,670	93,415	91,466	90,039	90,223	87,617	87,480			913,710
Alameda Health System	92,861	91,758	91,032	91,084	90,621	90,714	88,985	87,443	86,119	81,995			892,612
Directly-Contracted Subtotal	186,794	185,026	184,631	183,754	184,036	182,180	179,024	177,666	173,736	169,475			1,806,322
Delegated:													
CFMG	43,381	42,852	42,253	42,053	41,790	41,683	41,247	40,893	40,565	40,449			417,166
CHCN	181,444	179,683	178,653	178,321	177,567	177,261	174,949	172,874	171,627	170,429			1,762,808
Delegated Subtotal	224,825	222,535	220,906	220,374	219,357	218,944	216,196	213,767	212,192	210,878			2,179,974
Total	**411,619**	**407,561**	**405,537**	**404,128**	**403,393**	**401,124**	**395,220**	**391,433**	**385,928**	**380,353**			**3,986,296**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(518)	(1,768)	(395)	(877)	282	(1,856)	(3,156)	(1,358)	(3,930)	(4,261)			(17,837)
Delegated:													
CFMG	(128)	(529)	(599)	(200)	(263)	(107)	(436)	(354)	(328)	(116)			(3,060)
CHCN	882	(1,761)	(1,030)	(332)	(754)	(306)	(2,312)	(2,075)	(1,247)	(1,198)			(10,133)
Delegated Subtotal	754	(2,290)	(1,629)	(532)	(1,017)	(413)	(2,748)	(2,429)	(1,575)	(1,314)			(13,193)
Total	**236**	**(4,058)**	**(2,024)**	**(1,409)**	**(735)**	**(2,269)**	**(5,904)**	**(3,787)**	**(5,505)**	**(5,575)**			**(31,030)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	45.4%	45.4%	45.5%	45.5%	45.6%	45.4%	45.3%	45.4%	45.0%	44.6%			45.3%
Delegated:													
CFMG	10.5%	10.5%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	10.5%	10.6%			10.5%
CHCN	44.1%	44.1%	44.1%	44.1%	44.0%	44.2%	44.3%	44.2%	44.5%	44.8%			44.2%
Delegated Subtotal	54.6%	54.6%	54.5%	54.5%	54.4%	54.6%	54.7%	54.6%	55.0%	55.4%			54.7%
Total	**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 2026	FINAL BUDGET												
	Budget Jul-25	Budget Aug-25	Budget Sep-25	Budget Oct-25	Budget Nov-25	Budget Dec-25	Budget Jan-26	Budget Feb-26	Budget Mar-26	Budget Apr-26	Budget May-26	Budget Jun-26	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,251	108,503	108,083	107,831	107,623	107,014	106,408	105,806	105,210	104,615	104,025	103,439	1,277,808
Adult	61,536	60,679	60,106	59,780	59,301	58,778	57,982	57,197	56,422	55,659	54,907	54,167	696,514
ACA OE	155,533	153,348	152,196	151,404	150,461	149,482	145,792	142,205	138,719	135,332	132,040	128,840	1,735,352
SPD with LTC	29,833	29,686	29,708	29,631	29,574	29,456	21,811	21,666	21,525	21,382	21,241	21,100	306,613
Duals with LTC*	49,509	49,371	49,390	49,401	49,195	49,072	56,469	56,344	56,220	56,096	55,973	55,850	632,890
Medi-Cal Program	405,662	401,587	399,483	398,047	396,154	393,802	388,462	383,218	378,096	373,084	368,186	363,396	4,649,177
Group Care Program	5,957	5,974	6,054	6,081	6,079	6,085	6,079	6,085	6,091	6,097	6,103	6,109	72,794
Medicare Program	0	0	0	0	0	0	266	370	473	619	722	825	3,275
Total	**411,619**	**407,561**	**405,537**	**404,128**	**402,233**	**399,887**	**394,807**	**389,673**	**384,660**	**379,800**	**375,011**	**370,330**	**4,725,246**
Month Over Month Enrollment Change:													
Medi-Cal Program:													
Child	(1,402)	(748)	(420)	(252)	(208)	(609)	(606)	(602)	(596)	(595)	(590)	(586)	(7,214)
Adult	(1,546)	(857)	(573)	(326)	(479)	(523)	(796)	(785)	(775)	(763)	(752)	(740)	(8,915)
ACA OE	3,222	(2,185)	(1,152)	(792)	(943)	(979)	(3,690)	(3,587)	(3,486)	(3,387)	(3,292)	(3,200)	(23,471)
SPD with LTC	(97)	(147)	22	(77)	(57)	(118)	(7,645)	(145)	(141)	(143)	(141)	(141)	(8,830)
Duals with LTC	2,092	(138)	19	11	(206)	(123)	7,397	(125)	(124)	(124)	(123)	(123)	8,433
Medi-Cal Program	2,269	(4,075)	(2,104)	(1,436)	(1,893)	(2,352)	(5,340)	(5,244)	(5,122)	(5,012)	(4,898)	(4,790)	(39,997)
Group Care Program	188	17	80	27	(2)	6	(6)	6	6	6	6	6	340
Medicare Program	0	0	0	0	0	0	266	104	103	146	103	103	825
Total	**2,457**	**(4,058)**	**(2,024)**	**(1,409)**	**(1,895)**	**(2,346)**	**(5,080)**	**(5,134)**	**(5,013)**	**(4,860)**	**(4,789)**	**(4,681)**	**(38,832)**
													0
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	26.9%	27.0%	27.1%	27.1%	27.2%	27.2%	27.4%	27.6%	27.8%	28.0%	28.3%	28.5%	27.5%
Adult % of Medi-Cal	15.2%	15.1%	15.0%	15.0%	15.0%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	15.0%
ACA OE % of Medi-Cal	38.3%	38.2%	38.1%	38.0%	38.0%	38.0%	37.5%	37.1%	36.7%	36.3%	35.9%	35.5%	37.3%
SPD with LTC % of Medi-Cal	7.4%	7.4%	7.4%	7.4%	7.5%	7.5%	5.6%	5.7%	5.7%	5.7%	5.8%	5.8%	6.6%
Duals with LTC % of Medi-Cal	12.2%	12.3%	12.4%	12.4%	12.4%	12.5%	14.5%	14.7%	14.9%	15.0%	15.2%	15.4%	13.6%
Medi-Cal Program % of Total	98.6%	98.5%	98.5%	98.5%	98.5%	98.5%	98.4%	98.3%	98.3%	98.2%	98.2%	98.1%	98.4%
Group Care Program % of Total	1.4%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.6%	1.6%	1.6%	1.6%	1.6%	1.5%
Medicare Program	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%	0.2%	0.2%	0.1%
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 2026	FINAL BUDGET												
	Budget Jul-25	Budget Aug-25	Budget Sep-25	Budget Oct-25	Budget Nov-25	Budget Dec-25	Budget Jan-26	Budget Feb-26	Budget Mar-26	Budget Apr-26	Budget May-26	Budget Jun-26	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	93,933	93,268	93,599	92,670	93,410	92,946	94,780	93,808	92,860	91,962	91,058	90,177	1,114,471
Alameda Health System	92,861	91,758	91,032	91,084	90,325	89,753	87,421	85,899	84,414	82,969	81,558	80,181	1,049,255
Directly-Contracted Subtotal	186,794	185,026	184,631	183,754	183,735	182,699	182,201	179,707	177,274	174,931	172,616	170,358	2,163,726
Delegated:													
CFMG	43,381	42,852	42,253	42,053	41,673	41,447	40,713	40,456	40,203	39,951	39,701	39,454	494,137
CHCN	181,444	179,683	178,653	178,321	176,825	175,741	171,893	169,510	167,183	164,918	162,694	160,518	2,067,383
Delegated Subtotal	224,825	222,535	220,906	220,374	218,498	217,188	212,606	209,966	207,386	204,869	202,395	199,972	2,561,520
Total	**411,619**	**407,561**	**405,537**	**404,128**	**402,233**	**399,887**	**394,807**	**389,673**	**384,660**	**379,800**	**375,011**	**370,330**	**4,725,246**
													0
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	1,762	(665)	331	(929)	740	(464)	1,834	(972)	(948)	(898)	(904)	(881)	(1,994)
Alameda Health System	1,869	(1,103)	(726)	52	(759)	(572)	(2,332)	(1,522)	(1,485)	(1,445)	(1,411)	(1,377)	(10,811)
Directly-Contracted Subtotal	3,631	(1,768)	(395)	(877)	(19)	(1,036)	(498)	(2,494)	(2,433)	(2,343)	(2,315)	(2,258)	(12,805)
Delegated:													
CFMG	(640)	(529)	(599)	(200)	(380)	(226)	(734)	(257)	(253)	(252)	(250)	(247)	(4,567)
CHCN	(534)	(1,761)	(1,030)	(332)	(1,496)	(1,084)	(3,848)	(2,383)	(2,327)	(2,265)	(2,224)	(2,176)	(21,460)
Delegated Subtotal	(1,174)	(2,290)	(1,629)	(532)	(1,876)	(1,310)	(4,582)	(2,640)	(2,580)	(2,517)	(2,474)	(2,423)	(26,027)
Total	**2,457**	**(4,058)**	**(2,024)**	**(1,409)**	**(1,895)**	**(2,346)**	**(5,080)**	**(5,134)**	**(5,013)**	**(4,860)**	**(4,789)**	**(4,681)**	**(38,832)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	22.8%	22.9%	23.1%	22.9%	23.2%	23.2%	24.0%	24.1%	24.1%	24.2%	24.3%	24.4%	23.6%
Alameda Health System	22.6%	22.5%	22.4%	22.5%	22.5%	22.4%	22.1%	22.0%	21.9%	21.8%	21.7%	21.7%	22.2%
Directly-Contracted Subtotal	45.4%	45.4%	45.5%	45.5%	45.7%	45.7%	46.1%	46.1%	46.1%	46.1%	46.0%	46.0%	45.8%
Delegated:													
CFMG	10.5%	10.5%	10.4%	10.4%	10.4%	10.4%	10.3%	10.4%	10.5%	10.5%	10.6%	10.7%	10.5%
CHCN	44.1%	44.1%	44.1%	44.1%	44.0%	43.9%	43.5%	43.5%	43.5%	43.4%	43.4%	43.3%	43.8%
Delegated Subtotal	54.6%	54.6%	54.5%	54.5%	54.3%	54.3%	53.9%	53.9%	53.9%	53.9%	54.0%	54.0%	54.2%
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 2026

	Variance Jul-25	Variance Aug-25	Variance Sep-25	Variance Oct-25	Variance Nov-25	Variance Dec-25	Variance Jan-26	Variance Feb-26	Variance Mar-26	Variance Apr-26	Variance May-26	Variance Jun-26	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	271	410	203	369	171	68			1,492
Adult	0	0	0	0	505	534	108	43	(383)	(802)			5
ACA OE	0	0	0	0	216	(9)	572	2,092	2,586	2,977			8,434
Total	0	0	0	0	16	44	7,308	7,147	6,936	6,562			28,013
Duals with LTC*	0	0	0	0	139	205	(7,794)	(7,838)	(7,930)	(8,058)			(31,276)
Medi-Cal Program	0	0	0	0	1,147	1,184	397	1,813	1,380	747			6,668
Group Care Program	0	0	0	0	13	53	112	126	149	194			647
Medicare Program	0	0	0	0	0	0	(96)	(179)	(261)	(388)			(924)
Total	**0**	**0**	**0**	**0**	**1,160**	**1,237**	**413**	**1,760**	**1,268**	**553**			**6,391**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	5	(1,480)	(4,741)	(3,585)	(5,243)	(4,482)			(19,526)
Alameda Health System	0	0	0	0	296	961	1,564	1,544	1,705	(974)			5,096
Directly-Contracted Subtotal	0	0	0	0	301	(519)	(3,177)	(2,041)	(3,538)	(5,456)			(14,430)
Delegated:													
CFMG	0	0	0	0	117	236	534	437	362	498			2,184
CHCN	0	0	0	0	742	1,520	3,056	3,364	4,444	5,511			18,637
Delegated Subtotal	0	0	0	0	859	1,756	3,590	3,801	4,806	6,009			20,821
Total	**0**	**0**	**0**	**0**	**1,160**	**1,237**	**413**	**1,760**	**1,268**	**553**			**6,391**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2026

MEDICARE SUPPLEMENT

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Current Direct/Provider Network Enrollment:													
Directly-Contracted:													
Directly Contracted (DCP)	0	0	0	0	0	0	74	67	59	68			268
Alameda Health System	0	0	0	0	0	0	15	16	25	27			83
Directly-Contracted Subtotal	0	0	0	0	0	0	89	83	84	95			351
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0			0
CHCN	0	0	0	0	0	0	81	108	128	136			453
Provider Network Subtotal	0	0	0	0	0	0	81	108	128	136			453
Total	**0**	**0**	**0**	**0**	**0**	**0**	**170**	**191**	**212**	**231**			**804**
Direct/Provider Network Month Over Month Enrollment Change:													
Directly-Contracted	0	0	0	0	0	0	89	(6)	1	11			95
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0			0
CHCN	0	0	0	0	0	0	81	27	20	8			136
Provider Network Subtotal	0	0	0	0	0	0	81	27	20	8			136
Total	**0**	**0**	**0**	**0**	**0**	**0**	**170**	**21**	**21**	**19**			**231**
Direct/Provider Network Enrollment Percentages:													
Directly-Contracted	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	52.4%	43.5%	39.6%	41.1%			43.7%
Provider Network:													
CFMG	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			0.0%
CHCN	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	47.6%	56.5%	60.4%	58.9%			56.3%
Provider Network Subtotal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	47.6%	56.5%	60.4%	58.9%			56.3%
Total	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**			**100.0%**

	Final Budget Jul-25	Final Budget Aug-25	Final Budget Sep-25	Final Budget Oct-25	Final Budget Nov-25	Final Budget Dec-25	Final Budget Jan-26	Final Budget Feb-26	Final Budget Mar-26	Final Budget Apr-26	Final Budget May-26	Final Budget Jun-26	YTD Member Months
Current Direct/Provider Network Enrollment:													
Directly-Contracted:													
Directly Contracted (DCP)	0	0	0	0	0	0	172	240	307	402	469	536	2,126
Alameda Health System	0	0	0	0	0	0	19	26	33	43	50	57	228
Directly-Contracted Subtotal	0	0	0	0	0	0	191	266	340	445	519	593	2,354
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	0	0	0	0	0	0	75	104	133	174	203	232	921
Provider Network Subtotal	0	0	0	0	0	0	75	104	133	174	203	232	921
Total	**0**	**0**	**0**	**0**	**0**	**0**	**266**	**370**	**473**	**619**	**722**	**825**	**3,275**
Direct/Provider Network Month Over Month Enrollment Change:													
Directly-Contracted	0	0	0	0	0	0	191	75	74	105	74	74	593
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	0	0	0	0	0	0	75	29	29	41	29	29	232
Provider Network Subtotal	0	0	0	0	0	0	75	29	29	41	29	29	232
Total	**0**	**0**	**0**	**0**	**0**	**0**	**266**	**104**	**103**	**146**	**103**	**103**	**825**
Direct/Provider Network Enrollment Percentages:													
Directly-Contracted	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	71.8%	71.9%	71.9%	71.9%	71.9%	71.9%	71.9%
Provider Network:													
CFMG	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%
CHCN	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	28.2%	28.1%	28.1%	28.1%	28.1%	28.1%	28.1%
Provider Network Subtotal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	28.2%	28.1%	28.1%	28.1%	28.1%	28.1%	28.1%
Total	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

	Variance Jul-25	Variance Aug-25	Variance Sep-25	Variance Oct-25	Variance Nov-25	Variance Dec-25	Variance Jan-26	Variance Feb-26	Variance Mar-26	Variance Apr-26	Variance May-26	Variance Jun-26	YTD Member Variance
Current Direct/Provider Network Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	0	0	(98)	(173)	(248)	(334)			(853)
Alameda Health System	0	0	0	0	0	0	(4)	(10)	(8)	(16)			(38)
Directly-Contracted Subtotal	0	0	0	0	0	0	(102)	(183)	(256)	(350)			(891)
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0			0
CHCN	0	0	0	0	0	0	6	4	(5)	(38)			(33)
Provider Network Subtotal	0	0	0	0	0	0	6	4	(5)	(38)			(33)
Total	**0**	**0**	**0**	**0**	**0**	**0**	**(96)**	**(179)**	**(261)**	**(388)**			**(924)**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 APRIL, 2026

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
$1,523,458	$1,485,444	($38,014)	(2.6%)	PCP Capitation	$20,228,511	$20,032,992	($195,519)	(1.0%)
6,172,885	5,786,332	(386,553)	(6.7%)	PCP Capitation FQHC	70,281,111	68,502,919	(1,778,192)	(2.6%)
448,770	438,175	(10,595)	(2.4%)	Specialty Capitation	4,624,376	4,568,941	(55,435)	(1.2%)
5,085,087	4,975,091	(109,996)	(2.2%)	Specialty Capitation FQHC	51,434,329	51,758,670	324,341	0.6%
757,532	709,922	(47,611)	(6.7%)	Laboratory Capitation	7,841,443	7,580,888	(260,555)	(3.4%)
327,956	318,997	(8,960)	(2.8%)	Vision Capitation	3,377,176	3,326,274	(50,903)	(1.5%)
102,070	99,662	(2,407)	(2.4%)	CFMG Capitation	1,051,811	1,039,207	(12,604)	(1.2%)
808,524	769,150	(39,374)	(5.1%)	ANC IPA Admin Capitation FQHC	8,828,165	8,715,642	(112,523)	(1.3%)
0	0	0	0.0%	Kaiser Capitation	(16,872)	(12,511)	4,361	(34.9%)
983,709	929,085	(54,624)	(5.9%)	DME Capitation	10,205,816	9,937,377	(268,439)	(2.7%)
677	1,807	1,130	62.5%	Dental Capitation	2,333	5,046	2,713	53.8%
16,210,669	**15,513,665**	**(697,004)**	**(4.5%)**	**7. TOTAL CAPITATED EXPENSES**	**177,858,200**	**175,455,444**	**(2,402,757)**	**(1.4%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
(2,112,754)	0	2,112,754	0.0%	IBNR Inpatient Services	(42,083,938)	(20,241,559)	21,842,379	(107.9%)
(63,383)	0	63,383	0.0%	IBNR Settlement (IP)	(1,262,520)	(607,245)	655,275	(107.9%)
(169,020)	0	169,020	0.0%	IBNR Claims Fluctuation (IP)	(3,366,716)	(1,619,325)	1,747,391	(107.9%)
46,235,049	43,005,434	(3,229,615)	(7.5%)	Inpatient Hospitalization FFS	469,957,049	458,218,324	(11,738,725)	(2.6%)
4,210,708	3,269,580	(941,127)	(28.8%)	IP OB - Mom & NB	33,742,714	34,178,368	435,654	1.3%
191,492	136,932	(54,559)	(39.8%)	IP Behavioral Health	2,549,960	1,772,206	(777,754)	(43.9%)
2,295,400	1,316,786	(978,614)	(74.3%)	Inpatient Facility Rehab FFS	13,972,040	13,818,571	(153,469)	(1.1%)
50,587,491	**47,728,733**	**(2,858,758)**	**(6.0%)**	**8. Inpatient Hospital Expense**	**473,508,590**	**485,519,340**	**12,010,751**	**2.5%**
34,545	0	(34,545)	0.0%	IBNR PCP	1,186,662	3,433,331	2,246,669	65.4%
1,037	0	(1,037)	0.0%	IBNR Settlement (PCP)	35,599	103,000	67,401	65.4%
2,762	0	(2,762)	0.0%	IBNR Claims Fluctuation (PCP)	94,932	274,669	179,737	65.4%
3,017,505	3,058,682	41,177	1.3%	PCP FFS	28,330,985	32,456,189	4,125,204	12.7%
0	0	0	0.0%	Special Needs Medical Expense	278	278	0	0.0%
576,474	388,249	(188,225)	(48.5%)	PCP FQHC FFS	5,144,768	4,238,885	(905,884)	(21.4%)
0	0	0	0.0%	Prop 56 Physician Pmt	(3,778)	(3,778)	0	0.0%
21,036	0	(21,036)	0.0%	Prop 56 Hyde	181,758	64,417	(117,342)	(182.2%)
103,010	0	(103,010)	0.0%	Prop 56 Trauma Screening	870,601	303,469	(567,133)	(186.9%)
108,353	0	(108,353)	0.0%	Prop 56 Developmentl Screening	977,696	361,844	(615,852)	(170.2%)
636,358	864,894	228,536	26.4%	Prop 56 Family Planning	6,504,458	7,760,999	1,256,541	16.2%
0	0	0	0.0%	Prop 56 VBP	(259)	(259)	0	0.0%
4,501,080	**4,311,824**	**(189,256)**	**(4.4%)**	**9. Primary Care Physician Expense**	**43,323,701**	**48,993,043**	**5,669,342**	**11.6%**
143,222	0	(143,222)	0.0%	IBNR Specialist	(1,581,689)	(334,249)	1,247,440	(373.2%)
4,296	0	(4,296)	0.0%	IBNR Settlement (SCP)	(47,451)	(10,026)	37,425	(373.3%)
11,457	0	(11,457)	0.0%	IBNR Claims Fluctuation (SCP)	(126,538)	(26,743)	99,795	(373.2%)
761,245	7,593	(753,652)	(9,925.9%)	Psychiatrist FFS	6,641,274	2,760,829	(3,880,445)	(140.6%)
3,915,807	7,662,245	3,746,438	48.9%	Specialty Care FFS	34,620,057	63,522,669	28,902,612	45.5%
334,756	0	(334,756)	0.0%	Specialty Anesthesiology	3,011,939	1,349,666	(1,662,272)	(123.2%)
1,860,009	0	(1,860,009)	0.0%	Specialty Imaging FFS	17,745,086	6,999,284	(10,745,802)	(153.5%)
40,761	0	(40,761)	0.0%	Obstetrics FFS	478,469	236,824	(241,646)	(102.0%)
442,513	0	(442,513)	0.0%	Specialty IP Surgery FFS	4,383,302	1,954,243	(2,429,059)	(124.3%)
1,062,204	0	(1,062,204)	0.0%	Specialty OP Surgery FFS	10,259,947	4,456,894	(5,803,054)	(130.2%)
687,955	0	(687,955)	0.0%	Speciality IP Physician	6,404,007	2,930,480	(3,473,527)	(118.5%)
199,950	126,292	(73,658)	(58.3%)	Specialist FQHC FFS	1,691,615	1,457,482	(234,133)	(16.1%)
9,464,176	**7,796,129**	**(1,668,046)**	**(21.4%)**	**10. Specialty Care Physician Expense**	**83,480,018**	**85,297,354**	**1,817,335**	**2.1%**
(182,394)	0	182,394	0.0%	IBNR Ancillary (ANC)	(1,400,133)	(3,205,959)	(1,805,826)	56.3%
(5,471)	0	5,471	0.0%	IBNR Settlement (ANC)	(42,007)	(96,181)	(54,174)	56.3%

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 APRIL, 2026

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(14,593)	0	14,593	0.0%	IBNR Claims Fluctuation (ANC)	(112,011)	(256,479)	(144,468)	56.3%
432,809	0	(432,809)	0.0%	IBNR Transportation FFS	516,079	(320,108)	(836,187)	261.2%
4,042,882	2,440,497	(1,602,385)	(65.7%)	Behavioral Health Therapy FFS	31,752,316	27,952,564	(3,799,752)	(13.6%)
3,015,441	0	(3,015,441)	0.0%	Psychologist & Other MH Prof	27,720,965	10,562,380	(17,158,585)	(162.4%)
1,068,238	0	(1,068,238)	0.0%	Other Medical Professional	7,412,067	2,326,374	(5,085,693)	(218.6%)
157,940	1,919	(156,021)	(8,130.8%)	Hearing Devices	1,682,428	688,633	(993,795)	(144.3%)
26,905	0	(26,905)	0.0%	ANC Imaging	288,091	138,286	(149,804)	(108.3%)
3,549	0	(3,549)	0.0%	Vision FFS	525,657	330,028	(195,629)	(59.3%)
0	0	0	0.0%	Family Planning	5	5	0	0.0%
1,088,400	787,952	(300,448)	(38.1%)	Laboratory FFS	7,879,410	7,852,971	(26,438)	(0.3%)
224,106	0	(224,106)	0.0%	ANC Therapist	1,764,333	667,783	(1,096,550)	(164.2%)
10,756	18,570	7,814	42.1%	OTC Card	10,756	51,840	41,084	79.3%
2,017,138	1,621,634	(395,504)	(24.4%)	Transp/Ambulance FFS	18,041,852	17,400,480	(641,373)	(3.7%)
0	77	77	100.0%	Worldwide Emergency Benefit	0	216	216	100.0%
4,170,295	2,664,939	(1,505,355)	(56.5%)	Non-ER Transportation FFS	28,282,321	25,737,980	(2,544,340)	(9.9%)
1,871,630	2,114,651	243,021	11.5%	Hospice FFS	18,397,040	19,997,824	1,600,784	8.0%
2,927,542	3,207,974	280,432	8.7%	Home Health Services	26,422,369	29,646,238	3,223,869	10.9%
0	76,907	76,907	100.0%	Other Medical FFS	4,900	217,144	212,244	97.7%
(127,733)	0	127,733	0.0%	Medical Refunds through HMS	(1,480,924)	(883,969)	596,955	(67.5%)
53,375	1,817,322	1,763,946	97.1%	DME & Medical Supplies FFS	263,846	11,478,971	11,215,125	97.7%
3,429,227	3,267,215	(162,012)	(5.0%)	ECM Base/Outreach FFS ANC	29,409,514	28,430,019	(979,495)	(3.4%)
137,762	177,918	40,155	22.6%	CS Housing Deposits FFS ANC	1,573,652	1,745,316	171,664	9.8%
(303,678)	698,486	1,002,164	143.5%	CS Housing Tenancy FFS ANC	6,000,132	7,871,495	1,871,363	23.8%
(39,078)	419,226	458,304	109.3%	CS Housing Navi Servic FFS ANC	3,857,587	4,873,215	1,015,627	20.8%
346,967	367,607	20,640	5.6%	CS Medical Respite FFS ANC	3,113,420	3,566,616	453,196	12.7%
296,358	269,894	(26,464)	(9.8%)	CS Med. Tailored Meals FFS ANC	2,199,194	2,505,382	306,189	12.2%
3,556	11,318	7,762	68.6%	CS Asthma Remediation FFS ANC	188,809	217,829	29,021	13.3%
0	0	0	0.0%	MOT Wrap Around (Non Med MOT)	6,868	6,868	0	0.0%
2,158	2,582	424	16.4%	CS Home Modifications FFS ANC	5,083	15,541	10,459	67.3%
32,650	96,243	63,593	66.1%	CS P.Care & Hmker Svcs FFS ANC	526,737	856,742	330,005	38.5%
12,673	6,466	(6,207)	(96.0%)	CS Cgiver Respite Svcs FFS ANC	25,156	46,458	21,302	45.9%
0	(11)	(11)	100.0%	CS ST PostHospital Housing FFS	0	(28)	(28)	100.0%
840	998	158	15.8%	CS Housing Outreach	6,650	7,159	509	7.1%
557,624	0	(557,624)	0.0%	CommunityBased Adult Svc(CBAS)	4,457,618	1,519,540	(2,938,078)	(193.4%)
0	10,831	10,831	100.0%	CS LTC to ALF Transition FFS ANC	134,952	128,834	(6,118)	(4.7%)
0	5,003	5,003	100.0%	CS LTC to Home Transition FFS ANC	18,866	47,871	29,005	60.6%
25,257,876	**20,086,218**	**(5,171,658)**	**(25.7%)**	**11. Ancillary Medical Expense**	**219,453,596**	**202,125,880**	**(17,327,716)**	**(8.6%)**
(2,317,981)	0	2,317,981	0.0%	IBNR Outpatient	(4,016,716)	1,452,995	5,469,711	376.4%
(69,540)	0	69,540	0.0%	IBNR Settlement (OP)	(120,504)	43,588	164,092	376.5%
(185,438)	0	185,438	0.0%	IBNR Claims Fluctuation (OP)	(321,335)	116,241	437,576	376.4%
3,924,210	5,441,749	1,517,539	27.9%	Outpatient FFS	31,418,595	46,427,980	15,009,385	32.3%
3,582,865	128,734	(3,454,131)	(2,683.1%)	OP Ambul Surgery FFS	31,215,938	13,951,206	(17,264,732)	(123.8%)
2,664,921	3,261,739	596,818	18.3%	Imaging Services FFS	27,503,906	32,918,197	5,414,291	16.4%
121,176	0	(121,176)	0.0%	Behavioral Health FFS	1,230,488	493,539	(736,949)	(149.3%)
1,102,895	0	(1,102,895)	0.0%	Outpatient Facility Lab FFS	8,785,652	3,448,349	(5,337,304)	(154.8%)
347,549	0	(347,549)	0.0%	Outpatient Facility Cardio FFS	2,505,711	1,028,586	(1,477,125)	(143.6%)
165,336	0	(165,336)	0.0%	OP Facility PT/OT/ST FFS	1,235,408	461,172	(774,236)	(167.9%)
2,932,538	2,752,558	(179,980)	(6.5%)	OP Facility Dialysis Ctr FFS	28,635,991	30,732,101	2,096,110	6.8%
12,268,531	**11,584,781**	**(683,750)**	**(5.9%)**	**12. Outpatient Medical Expense**	**128,073,135**	**131,073,954**	**3,000,819**	**2.3%**
(1,364,807)	0	1,364,807	0.0%	IBNR Emergency	(4,106,398)	(2,513,669)	1,592,729	(63.4%)
(40,943)	0	40,943	0.0%	IBNR Settlement (ER)	(123,187)	(75,408)	47,779	(63.4%)
(109,184)	0	109,184	0.0%	IBNR Claims Fluctuation (ER)	(328,511)	(201,094)	127,417	(63.4%)
11,474,283	9,958,749	(1,515,535)	(15.2%)	ER Facility	97,630,333	100,955,649	3,325,316	3.3%
1,592,684	0	(1,592,684)	0.0%	Specialty ER Physician FFS	12,446,572	4,951,779	(7,494,793)	(151.4%)
11,552,033	**9,958,749**	**(1,593,284)**	**(16.0%)**	**13. Emergency Expense**	**105,518,808**	**103,117,256**	**(2,401,552)**	**(2.3%)**

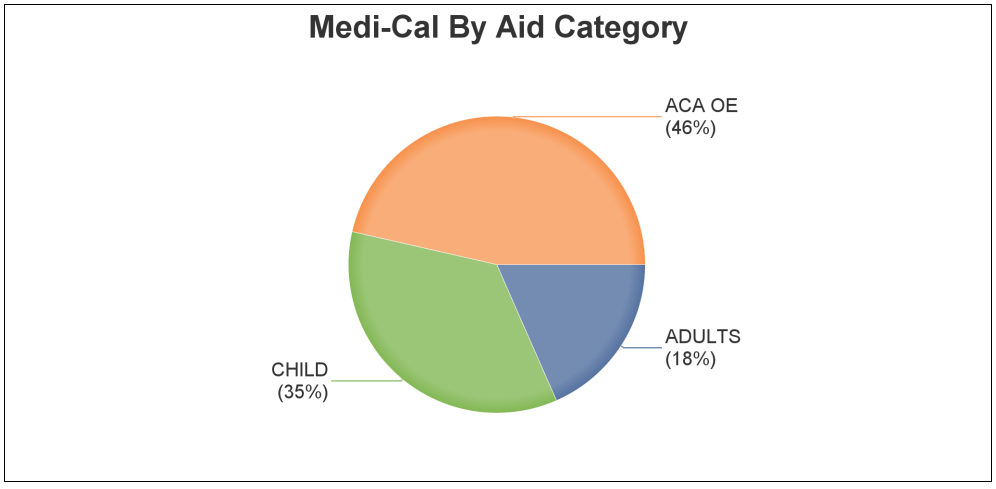
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 APRIL, 2026

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(2,337,008)	0	2,337,008	0.0%	IBNR Pharmacy (OP)	(2,756,644)	(2,257,911)	498,733	(22.1%)
(70,108)	0	70,108	0.0%	IBNR Settlement Rx (OP)	(82,695)	(67,734)	14,961	(22.1%)
(186,960)	0	186,960	0.0%	IBNR Claims Fluctuation Rx(OP)	(220,530)	(180,633)	39,897	(22.1%)
857,847	1,004,547	146,701	14.6%	Pharmacy FFS (OP)	7,647,567	8,352,959	705,392	8.4%
295,485	0	(295,485)	0.0%	Pharmacy Non PBM FFS Other-ANC	1,543,112	479,027	(1,064,085)	(222.1%)
10,821,987	10,948,129	126,142	1.2%	Pharmacy Non PBM FFS OP-FAC	79,832,350	91,162,779	11,330,429	12.4%
574,521	0	(574,521)	0.0%	Pharmacy Non PBM FFS PCP	3,712,555	1,140,883	(2,571,673)	(225.4%)
4,253,774	0	(4,253,774)	0.0%	Pharmacy Non PBM FFS SCP	33,986,414	11,779,726	(22,206,687)	(188.5%)
135,879	0	(135,879)	0.0%	Pharmacy Non PBM FFS FQHC	720,318	165,336	(554,982)	(335.7%)
12,054	0	(12,054)	0.0%	Pharmacy Non PBM FFS HH	150,426	78,426	(72,000)	(91.8%)
(96,646)	(86,597)	10,049	(11.6%)	Medical Expenses Pharm Rebate	(800,581)	(846,425)	(45,844)	5.4%
14,260,825	**11,866,080**	**(2,394,746)**	**(20.2%)**	**14. Pharmacy Expense**	**123,732,291**	**109,806,433**	**(13,925,859)**	**(12.7%)**
(7,708,836)	0	7,708,836	0.0%	IBNR LTC	(17,239,979)	(5,530,063)	11,709,916	(211.8%)
(231,266)	0	231,266	0.0%	IBNR Settlement (LTC)	(517,201)	(165,902)	351,299	(211.8%)
(616,707)	0	616,707	0.0%	IBNR Claims Fluctuation (LTC)	(1,379,202)	(442,407)	936,795	(211.7%)
1,898,574	1,930,967	32,393	1.7%	LTC - ICF/DD	18,305,763	19,485,885	1,180,123	6.1%
29,298,758	28,613,633	(685,125)	(2.4%)	LTC Custodial Care	262,777,918	285,158,987	22,381,069	7.8%
9,444,071	7,730,430	(1,713,641)	(22.2%)	LTC SNF	86,743,700	83,932,781	(2,810,919)	(3.3%)
32,084,593	**38,275,030**	**6,190,436**	**16.2%**	**15. Long Term Care Expense**	**348,690,999**	**382,439,281**	**33,748,282**	**8.8%**
159,976,605	**151,607,543**	**(8,369,062)**	**(5.5%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**1,525,781,138**	**1,548,372,540**	**22,591,402**	**1.5%**
0	(261,310)	(261,310)	100.0%	Clinical Vacancy #102	0	(470,268)	(470,268)	100.0%
88,434	103,111	14,677	14.2%	Quality Analytics #123	2,005,506	2,681,195	675,688	25.2%
379,677	412,034	32,357	7.9%	LongTerm Services and Support #139	3,908,596	3,976,416	67,821	1.7%
900,975	1,073,561	172,586	16.1%	Utilization Management #140	9,345,502	9,999,133	653,630	6.5%
670,832	882,755	211,924	24.0%	Case & Disease Management #185	7,316,717	8,267,956	951,239	11.5%
251,140	381,087	129,947	34.1%	Medical Management #230	(168,189)	213,333	381,523	178.8%
1,261,129	1,374,713	113,584	8.3%	Quality Improvement #235	11,432,729	13,755,850	2,323,121	16.9%
405,650	434,915	29,265	6.7%	HCS Behavioral Health #238	3,995,543	4,296,904	301,361	7.0%
119,194	262,479	143,285	54.6%	Pharmacy Services #245	1,353,562	2,147,199	793,637	37.0%
0	0	0	0.0%	Regulatory Readiness #268	(4,027)	(5,289)	(1,262)	23.9%
4,077,030	**4,663,345**	**586,315**	**12.6%**	**17. Other Benefits & Services**	**39,185,940**	**44,862,429**	**5,676,489**	**12.7%**
(3,291,109)	(1,613,351)	1,677,758	(104.0%)	Reinsurance Recoveries	(23,793,286)	(20,831,283)	2,962,003	(14.2%)
2,286,198	2,151,135	(135,063)	(6.3%)	Reinsurance Premium	24,109,487	23,552,651	(556,836)	(2.4%)
(1,004,911)	**537,784**	**1,542,695**	**286.9%**	**18. Reinsurance (Net)**	**316,201**	**2,721,368**	**2,405,167**	**88.4%**
290,000	290,000	0	0.0%	P4P Risk Pool Provider Incenti	10,319,099	7,279,099	(3,040,000)	(41.8%)
290,000	**290,000**	**0**	**0.0%**	**19. Risk Pool Distribution**	**10,319,099**	**7,279,099**	**(3,040,000)**	**(41.8%)**
179,549,393	**172,612,337**	**(6,937,056)**	**(4.0%)**	**20. TOTAL MEDICAL EXPENSES**	**1,753,460,578**	**1,778,690,879**	**25,230,302**	**1.4%**

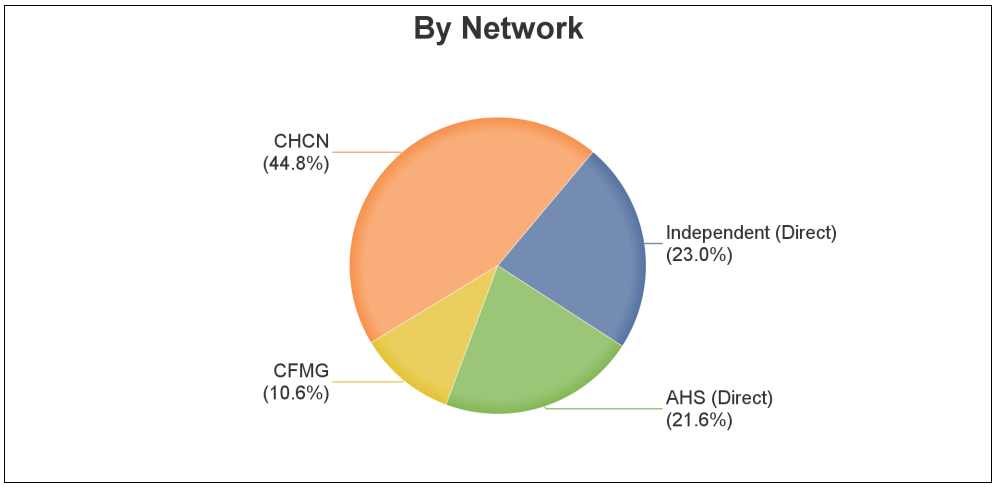
Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Apr 2026	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	54,867	15%	11,181	13,286	0	30,400
CHILD	104,710	28%	9,404	13,686	37,508	44,112
SPD	0	0%	0	0	0	0
ACA OE	138,309	37%	25,571	45,292	1,445	66,001
DUALS	0	0%	0	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	27,944	7%	8,043	5,076	1,500	13,325
SPD-LTC/Full Dual	48,039	13%	30,968	3,441	0	13,630
Other	0		0	0	0	0
Medi-Cal	373,869		85,167	80,781	40,453	167,468
Group Care	6,291		2,270	1,191	0	2,830
D-SNP	231		68	27	0	136
Total	**380,391**	**100%**	**87,505**	**81,999**	**40,453**	**170,434**
Other %	0.0%		0.0%	0.0%	0.0%	0.0%
Medi-Cal %	98.3%		97.3%	98.5%	100.0%	98.3%
Group Care %	1.7%		2.6%	1.5%	0.0%	1.7%
D-SNP %	0.1%		0.1%	0.0%	0.0%	0.1%
	Network Distribution		**23.0%**	**21.6%**	**10.6%**	**44.8%**
			% Direct:	**45%**	**% Delegated:**	**55%**



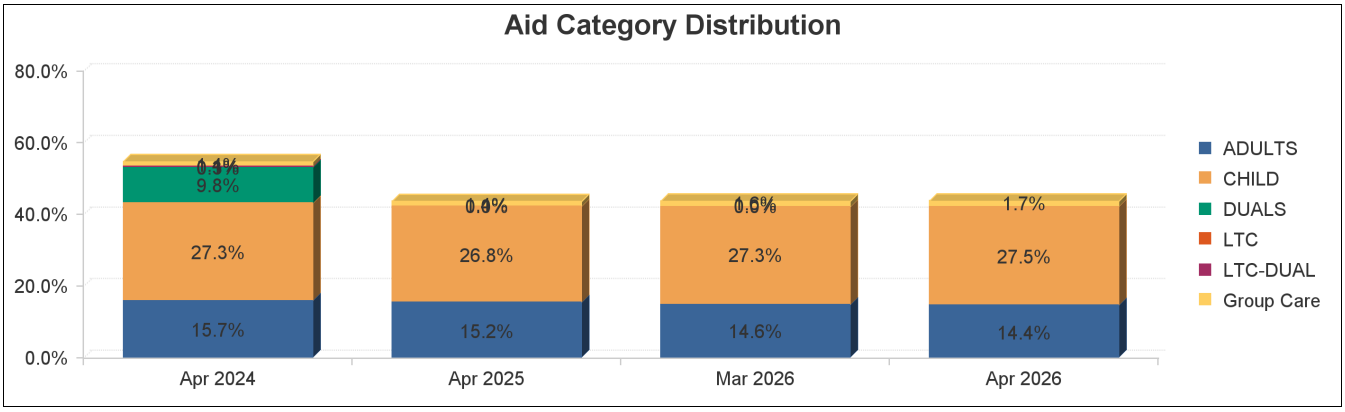
Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

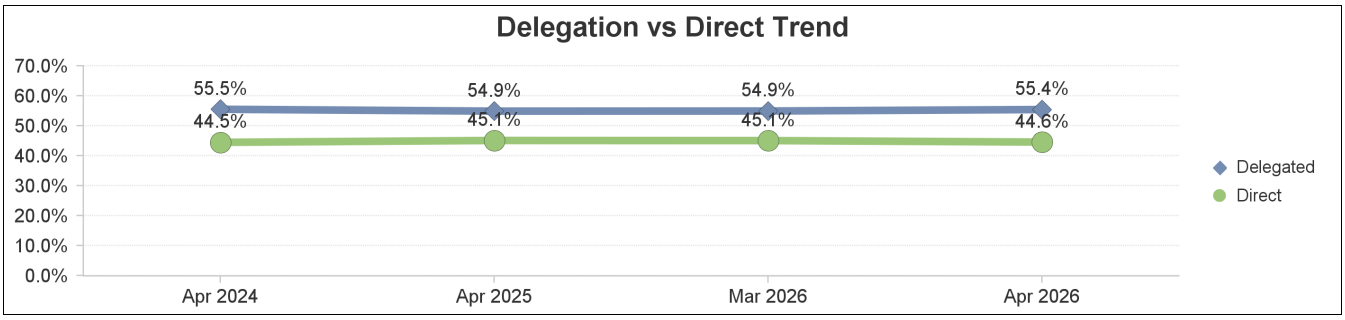
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
ADULTS	63,551	62,532	56,388	**54,867**	15.7%	15.2%	14.6%	14.4%	-1.6%	-14.0%	-2.8%
CHILD	110,566	110,211	105,604	**104,710**	27.3%	26.8%	27.3%	27.5%	-0.3%	-5.3%	-0.9%
SPD	34,887	0	0	**0**	8.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ACA OE	149,154	154,154	141,335	**138,309**	36.8%	37.5%	36.6%	36.4%	3.2%	-11.5%	-2.2%
DUALS	39,912	1	85	**0**	9.8%	0.0%	0.0%	0.0%	##########	0.0%	0.0%
LTC	223	0	0	**0**	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LTC-DUAL	1,291	0	0	**0**	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SPD-LTC	0	29,316	28,477	**27,944**	0.0%	7.1%	7.4%	7.3%	100.0%	-4.9%	-1.9%
SPD-LTC/ Full Dual	0	48,733	48,300	**48,039**	0.0%	11.9%	12.5%	12.6%	100.0%	-1.4%	-0.5%
Other	0	0	0	**0**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medi-Cal	399,584	404,947	380,189	**373,869**	98.6%	98.6%	98.3%	98.3%	1.3%	-8.3%	-1.7%
Group Care	5,643	5,896	6,240	**6,291**	1.4%	1.4%	1.6%	1.7%	4.3%	6.3%	0.8%
D-SNP	0	0	212	**231**	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
Total	**405,227**	**410,843**	**386,641**	**380,391**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**1.4%**	**-8.1%**	**-1.6%**



Delegation vs Direct Trend

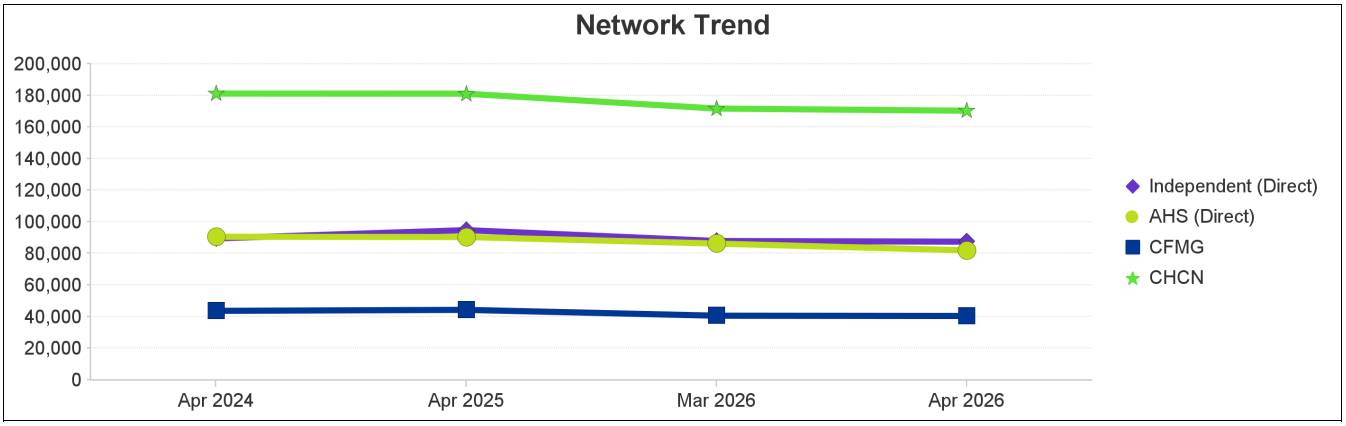
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
Delegated	225,002	225,555	212,420	**210,887**	55.5%	54.9%	54.9%	55.4%	0.2%	-7.0%	-0.7%
Direct	180,225	185,288	174,221	**169,504**	44.5%	45.1%	45.1%	44.6%	2.7%	-9.4%	-2.8%
Total	**405,227**	**410,843**	**386,641**	**380,391**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**1.4%**	**-8.1%**	**-1.6%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Network Trend

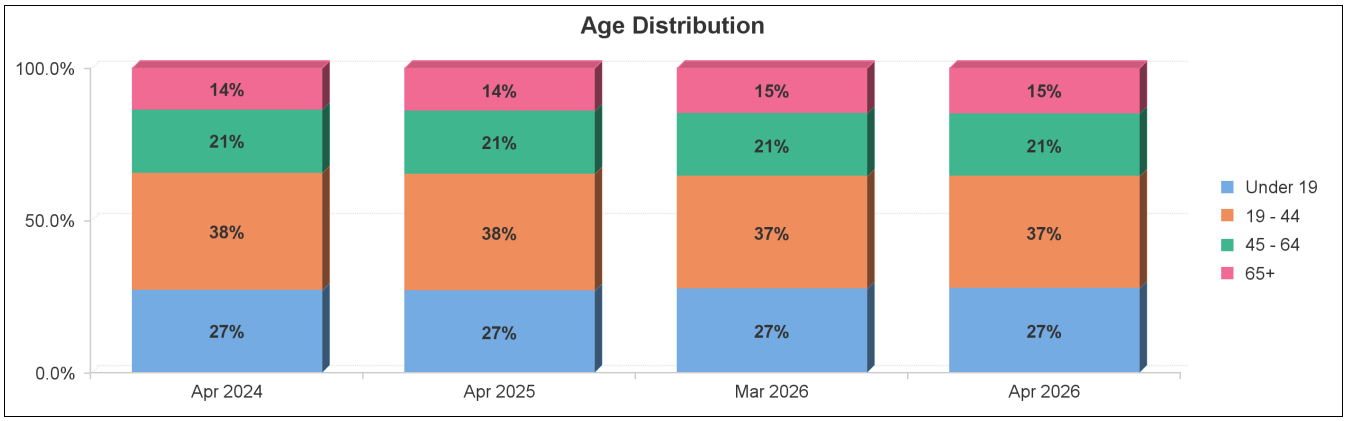
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
Independent (Direct)	89,595	94,829	87,920	**87,505**	22.1%	23.1%	22.7%	23.0%	5.5%	-8.5%	-0.5%
AHS (Direct)	90,630	90,459	86,301	**81,999**	22.4%	22.0%	22.3%	21.6%	-0.2%	-10.4%	-5.3%
CFMG	43,702	44,330	40,627	**40,453**	10.8%	10.8%	10.5%	10.6%	1.4%	-9.6%	-0.4%
CHCN	181,300	181,225	171,793	**170,434**	44.7%	44.1%	44.4%	44.8%	0.0%	-6.4%	-0.8%
KAISER	0	0	0	**0**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**405,227**	**410,843**	**386,641**	**380,391**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**1.4%**	**-8.1%**	**-1.6%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

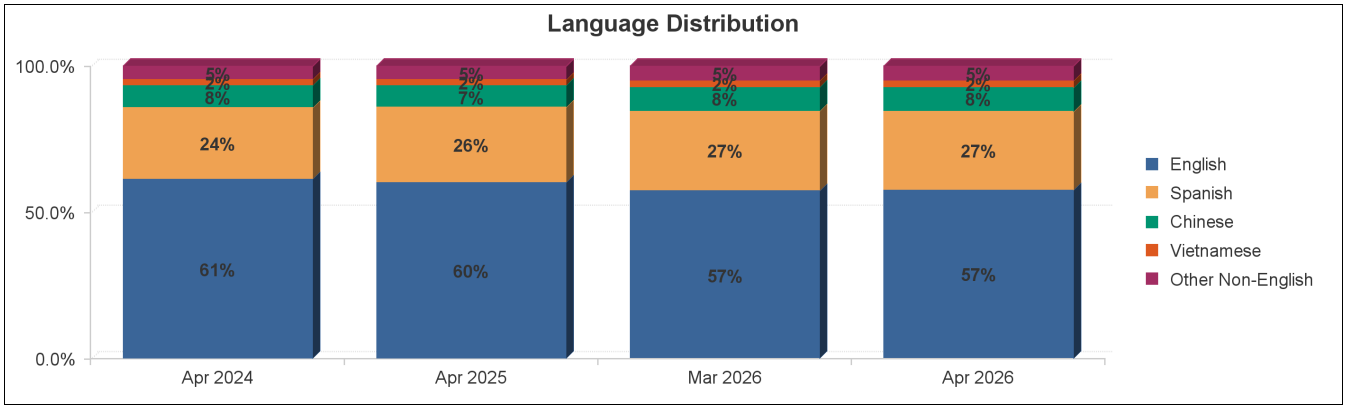
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
Under 19	108,917	109,618	105,461	**104,534**	27%	27%	27%	27%	1%	-5%	-1%
19 - 44	156,001	157,592	143,052	**139,860**	38%	38%	37%	37%	1%	-13%	-2%
45 - 64	84,128	84,775	79,641	**78,293**	21%	21%	21%	21%	1%	-8%	-2%
65+	56,181	58,858	58,275	**57,473**	14%	14%	15%	15%	5%	-2%	-1%
Total	**405,227**	**410,843**	**386,429**	**380,160**	**100%**	**100%**	**100%**	**100%**	**1%**	**-8%**	**-2%**



Language Trend

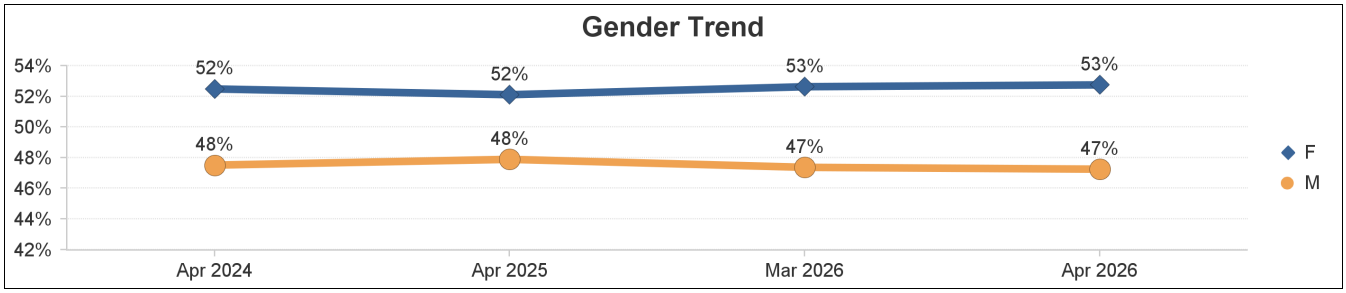
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Apr 2024	Apr 2025	Mar 2026	Apr 2026	pr 2024	pr 2025	Mar 2026	pr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
English	247,927	246,716	221,048	**218,138**	61%	60%	57%	57%	0%	-13%	-1%
Spanish	98,970	105,652	105,190	**102,453**	24%	26%	27%	27%	6%	-3%	-3%
Chinese	30,725	30,517	31,146	**30,854**	8%	7%	8%	8%	-1%	1%	-1%
Vietnamese	8,548	8,174	8,804	**8,730**	2%	2%	2%	2%	-5%	6%	-1%
Other Non-English	19,057	19,784	20,241	**19,985**	5%	5%	5%	5%	4%	1%	-1%
Total	**405,227**	**410,843**	**386,429**	**380,160**	**100%**	**100%**	**100%**	**100%**	**1%**	**-8%**	**-2%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

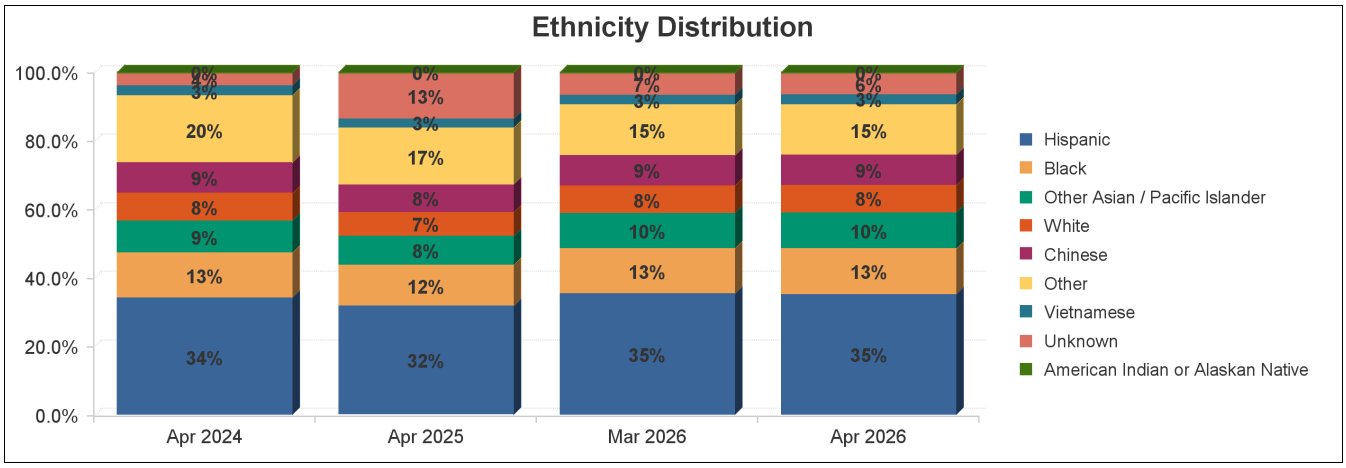
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
F	212,693	214,090	203,499	**200,666**	52%	52%	53%	53%	1%	-7%	-1%
M	192,534	196,753	183,142	**179,725**	48%	48%	47%	47%	2%	-10%	-2%
Total	**405,227**	**410,843**	**386,641**	**380,391**	**100%**	**100%**	**100%**	**100%**	**1%**	**-8%**	**-2%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
Hispanic	138,080	130,033	136,346	**133,496**	34%	32%	35%	35%	-6%	3%	-2%
Black	53,580	49,313	51,132	**50,764**	13%	12%	13%	13%	-9%	3%	-1%
Other Asian / Pacific Islander	37,409	34,386	39,844	**39,738**	9%	8%	10%	10%	-9%	13%	0%
White	32,949	28,815	31,056	**30,622**	8%	7%	8%	8%	-14%	6%	-1%
Chinese	35,847	33,056	33,831	**33,486**	9%	8%	9%	9%	-8%	1%	-1%
Other	79,277	68,358	57,391	**56,149**	20%	17%	15%	15%	-16%	-22%	-2%
Vietnamese	12,050	10,834	10,991	**10,863**	3%	3%	3%	3%	-11%	0%	-1%
Unknown	15,231	55,315	25,308	**24,531**	4%	13%	7%	6%	72%	-126%	-3%
American Indian or Alaskan Native	804	733	742	**742**	0%	0%	0%	0%	-10%	1%	0%
Total	**405,227**	**410,843**	**386,641**	**380,391**	**100%**	**100%**	**100%**	**100%**	**1%**	**-8%**	**-2%**



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

Medi-Cal By City

City	Apr 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	148,472	40%	22,100	38,834	15,912	71,626
HAYWARD	48,202	13%	11,297	13,035	5,327	18,543
FREMONT	35,800	10%	15,116	5,862	1,953	12,869
SAN LEANDRO	23,526	6%	6,332	3,806	2,922	10,466
UNION CITY	13,499	4%	5,463	2,305	749	4,982
ALAMEDA	12,894	3%	3,174	2,393	1,987	5,340
BERKELEY	15,425	4%	3,309	2,555	1,664	7,897
LIVERMORE	12,279	3%	1,981	365	1,963	7,970
NEWARK	8,524	2%	2,661	3,405	444	2,014
CASTRO VALLEY	10,481	3%	3,077	1,586	1,642	4,176
SAN LORENZO	5,672	2%	1,202	1,289	661	2,520
PLEASANTON	7,540	2%	2,212	274	807	4,247
DUBLIN	7,394	2%	2,468	285	867	3,774
EMERYVILLE	2,925	1%	555	654	512	1,204
ALBANY	2,446	1%	471	283	556	1,136
PIEDMONT	425	0%	89	162	64	110
SUNOL	88	0%	30	9	7	42
ANTIOCH	25	0%	8	8	3	6
Other	18,252	5%	3,622	3,671	2,413	8,546
Total	373,869	100%	**85,167**	**80,781**	**40,453**	**167,468**

Group Care By City

City	Apr 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,887	30%	338	444	0	1,105
HAYWARD	711	11%	328	196	0	187
FREMONT	716	11%	450	89	0	177
SAN LEANDRO	698	11%	281	112	0	305
UNION CITY	297	5%	179	53	0	65
ALAMEDA	326	5%	95	40	0	191
BERKELEY	161	3%	39	16	0	106
LIVERMORE	99	2%	28	0	0	71
NEWARK	152	2%	88	39	0	25
CASTRO VALLEY	225	4%	91	36	0	98
SAN LORENZO	178	3%	55	42	0	81
PLEASANTON	81	1%	33	4	0	44
DUBLIN	135	2%	49	8	0	78
EMERYVILLE	43	1%	9	8	0	26
ALBANY	24	0%	11	2	0	11
PIEDMONT	5	0%	0	2	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	26	0%	8	5	0	13
Other	526	8%	187	95	0	244
Total	**6,291**	**100%**	**2,270**	**1,191**	**0**	**2,830**

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

D-SNP By City

City	Apr 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	89	39%	17	9	0	63
HAYWARD	27	12%	10	3	0	14
FREMONT	17	7%	9	1	0	7
SAN LEANDRO	16	7%	6	4	0	6
UNION CITY	2	1%	1	0	0	1
ALAMEDA	16	7%	2	5	0	9
BERKELEY	14	6%	0	1	0	13
LIVERMORE	13	6%	2	1	0	10
NEWARK	6	3%	6	0	0	0
CASTRO VALLEY	3	1%	2	1	0	0
SAN LORENZO	3	1%	3	0	0	0
PLEASANTON	5	2%	3	0	0	2
DUBLIN	4	2%	0	0	0	4
EMERYVILLE	2	1%	1	0	0	1
ALBANY	0	0%	0	0	0	0
PIEDMONT	0	0%	0	0	0	0
SUNOL	0	0%	0	0	0	0
ANTIOCH	0	0%	0	0	0	0
Other	14	6%	6	2	0	6
Sum:			**2,270**	**1,191**	**0**	**2,830**

Total By City

City	Apr 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	150,359	40%	22,438	39,278	15,912	72,731
HAYWARD	48,913	13%	11,625	13,231	5,327	18,730
FREMONT	36,516	10%	15,566	5,951	1,953	13,046
SAN LEANDRO	24,224	6%	6,613	3,918	2,922	10,771
UNION CITY	13,796	4%	5,642	2,358	749	5,047
ALAMEDA	13,220	3%	3,269	2,433	1,987	5,531
BERKELEY	15,586	4%	3,348	2,571	1,664	8,003
LIVERMORE	12,378	3%	2,009	365	1,963	8,041
NEWARK	8,676	2%	2,749	3,444	444	2,039
CASTRO VALLEY	10,706	3%	3,168	1,622	1,642	4,274
SAN LORENZO	5,850	2%	1,257	1,331	661	2,601
PLEASANTON	7,621	2%	2,245	278	807	4,291
DUBLIN	7,529	2%	2,517	293	867	3,852
EMERYVILLE	2,968	1%	564	662	512	1,230
ALBANY	2,470	1%	482	285	556	1,147
PIEDMONT	430	0%	89	164	64	113
SUNOL	89	0%	31	9	7	42

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

ANTIOCH	51	0%	16	13	3	19
Other	18,778	5%	3,809	3,766	2,413	8,790
Total	380,160	100%	**87,437**	**81,972**	**40,453**	**170,298**

ALAMEDA Alliance FOR HEALTH

Operations

Chief Operating Officer

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

From: **Operations Department**

Date: **June 12th, 2026**

Subject: **Operations Report**

Member Services

- The Member Services Department received 17,039 calls in May 2026 compared to 17,427 in May 2025 and represents a 2% decrease in calls.
- The abandonment rate for May 2026 was 1% compared to 5% in May 2025.
- The Department's service level was 98% in May 2026, compared to 95% in May 2025. The average speed to answer (ASA) was six seconds (00:06) in 2026, compared to eleven seconds (00:11) in May 2025. 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 eighteen seconds (7:18) for May 2026 compared to seven minutes and thirty-three seconds (7:33) for May 2025.
- 100% of calls were answered within 10 minutes for May 2026 and 100% of calls were answered within 10 minutes for May 2025.
- Outbound calls totaled 9,808 in May 2026 compared to 8,700 in May 2025.
- The top five (5) call reasons for May 2026 were 1) Grievances/Appeals, 2), Eligibility/Enrollment, 3) Change of PCP, 4) Benefits, and 5) Provider Network Information. The top five (5) call reasons for May 2025 were: 1) Change of PCP, 2) Eligibility/Enrollment, 3) Grievances/Appeals, 4) Benefits, and 5) Provider Network Information.
- May 2026 utilization of the member automated eligibility IVR system totaled 1,112, compared to 1,448 in May 2025.
- The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests, and in-person). The Department responded to 776 web-based requests in May 2026 compared to 1,049 in May 2025. The top three (3) web reason requests for May 2026 were: 1) Change of PCP, 2) ID Card Requests, and 3) Update Contact Information. 55 members were assisted in-person in May 2026 compared to 43 in May 2025.

- MS Behavioral Health:

  - The Member Services Behavioral Health (MS BH) Unit received a total of 964 calls in May 2026 compared to 1,157 in May 2025.
  - The abandonment rate was 1% in May 2026 compared to 3% in May 2025.
  - The service level was 95% in May 2026 and 92% in May 2025.
  - The average speed to answer (ASA) was eleven seconds (00:11) compared to twenty-three seconds (00:23) in May 2025.

- In both May 2025 and May 2026, 100% of calls were answered within 10 minutes.
- The Average Talk Time (ATT) was nine minutes and twenty-four seconds (9:24) compared to eight minutes and twenty-four seconds (08:24) in May 2025. The 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.
- 1,604 outbound calls were completed in May 2026 compared to 1,012 in May 2025.
- 103 screenings were completed in May 2026 compared to 118 in May 2025.
- 27 referrals were made to the County (ACCESS) in May 2026 compared to 31 May 2025.
- 25 members were referred to Center Point for SUD services in May 2026 compared to 17 in May 2025.

- D-SNP Member Services blended:

  - The Member Services D-SNP Unit received a total of 593 calls in May 2026.
  - The abandonment rate was 2%.
  - The Average Speed to Answer (ASA) was six seconds (00:06).
  - The service level was 99%.
  - The Average Talk Time (ATT) was six minutes and fifty-five seconds (6:55).
  - The top five (5) call reasons were: 1) Eligibility/Enrollment, 2) Appeals/Grievances, 3) Benefits, 4) ID Card Request, and 5) Change of PCP.

Claims

- 12-Month Trend Summary:
  - The Claims Department received 468,360 claims for all lines of business in May 2026 compared to 387,564 in May 2025.
  - The Auto Adjudication rate was 87.7% in May 2026 compared to 87.6% in May 2025.
  - Claims compliance for the 30-day turn-around time was 96.4% in May 2026 compared to 90.4% in May 2025.
  - Routine training is being conducted remotely and onsite by the Claims Trainer.

- Medi-Cal/Group Care Monthly Analysis:
  - In May, we received a total of 467,324 claims in the HEALTHsuite system, which represents an increase of 25% from April 2026. It is also 21% higher than the number of claims received in May 2025 (387,564).
  - 90% of claims were received via EDI, and 10% of claims via paper during May.
  - The Auto Adjudication rate was 87.7% for May.

- D-SNP Monthly Analysis:
  - In May, we received a total of 1,036 claims in the HEALTHsuite system, which represents a 70% increase from April 2026, when 609 claims were received.
  - 828 claims (80%) were received via EDI, and 208 claims (20%) were received via paper in May.
  - Out of 1,036 claims, 917 claims have been finalized.
  - The Auto Adjudication rate was 54% for May.

- D-SNP YTD Analysis
  - A total of 3,303 D-SNP claims have been received since the January 1st, 2026, go live, and 2,763 claims have been finalized.

Provider Dispute Resolution

- 12-Month Trend Summary:
  - In May 2026, the Provider Dispute Resolution (PDR) team received 2,648 PDRs versus 2,462 in May 2025.
  - The PDR team resolved 2,131 cases in May 2026 compared to 2,517 cases in May 2025.
    - In May 2026, the PDR team upheld 71% of cases versus 79% in May 2025.
    - The PDR team resolved 98.8% of cases within the compliance standard of 95% within 45 working days in May 2026, compared to 99.6% in May 2025.

- Monthly Analysis:
  - In May 2026, the Provider Dispute Resolution (PDR) team received 2,648 PDRs versus 3,393 in April 2026. This represents a 28% decrease from April 2026.
  - In May 2026, 2,131 PDRs were resolved, with 1,520 upheld and 611 overturned.
  - 2,106 of 2,131 cases were resolved within 45 working days, resulting in a 98.8% compliance rate.
  - The average turnaround time for resolving PDRs in May was 39 days.
  - There were 4,242 PDRs pending resolution as of 05/31/2026, with no cases older than 45 working days.
  - The overturn rate for PDRs was 29%, which did not meet our goal of 25% or less.
  - Primary reasons for the missed goal include:
    - Member OHC corrections – 144 cases with incorrect claim denials.
    - Authorization issues – 90 cases with incorrect claim denials (claim denied in error; authorization was on file).
    - Incorrect Rate Configuration – 62 cases were underpaid due to the contract not being loaded in the system correctly.
  - The full breakdown of all **611** overturned PDRs is:

Category	# of Cases	% of Cases	Comments
System Related Issues	**104**	**16%**	
General configuration issues	20	3%	Non-covered code, modifier, NDC etc.
Financial responsibility	70	11%	Member Not Found, Eligibility
Claims Editing System (CES)	14	2%	
Authorization Issues	**148**	**25%**	
Processor error	90	15%	Authorization was on file
UM/retro auth review	48	8%	Retro medical necessity review
Auth System error	10	2%	
OHC Issues	**144**	**24%**	Inaccurate OHC Member TPL data
Incorrect Rates	**110**	**18%**	
Incorrect rate - System	62	10%	Contract not updated in the system at the time of claim processing
Letter of Agreement (LOA)	9	1%	Underpaid; LOA on file
COB calculation	22	4%	Incorrectly calculated
Incorrect rate – Processor	17	3%	The processor did not calculate the rate correctly according to the contract or rate sheet
Claim Processing Error	**65**	**11%**	
Duplicate claim	22	4%	The claim was not a duplicate; the processor denied it in error
Incorrect Manual Denial	34	6%	The claim was manually denied incorrectly
Overpayment	9	1%	Provider requests recoupment due to overpayment
Additional Documentation	**40**	**6%**	
Provider duplicate claim	27	4%	The documentation received confirmed that the claim was not a duplicate
Timely filing	13	2%	The documentation received confirmed that the claim was submitted on time
PDR Overturn Totals	**600**	**100%**	

Grievances & Appeals (MCAL & IHSS)

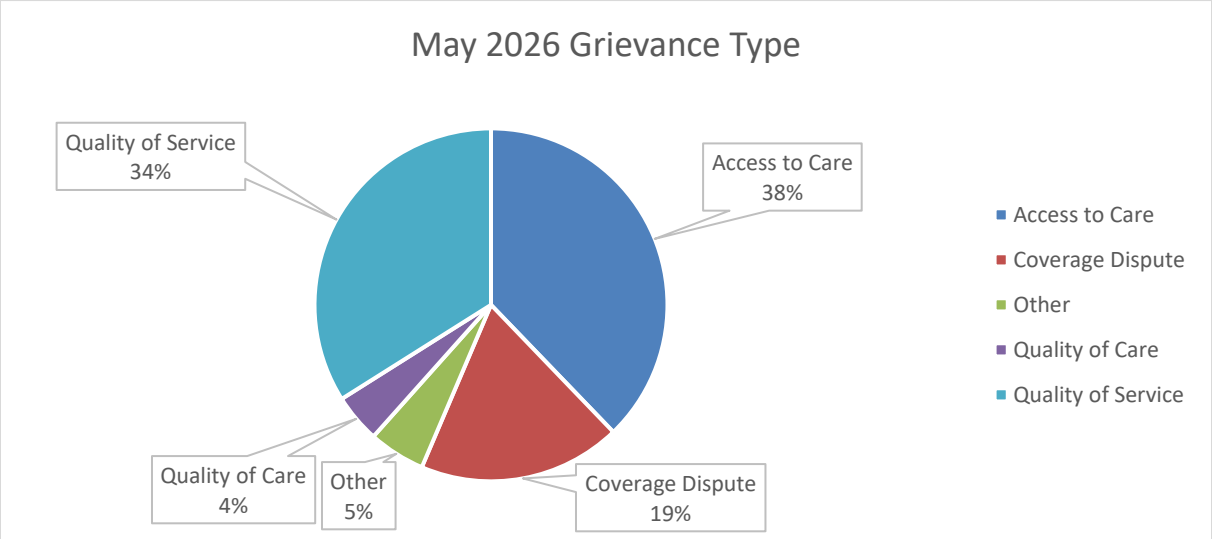
- Standard Grievance and Expedited Grievance cases were not resolved within the goal of 95% of regulatory timeframes.
- Exempt Grievance cases were resolved within the goal of 95% of regulatory timeframes.

- Standard Appeal and Expedited Appeal cases were resolved within the goal of 95% of regulatory timeframes.
- Total Unique grievances resolved in May were 9.8 complaints per 1,000 members.

May 2026 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,538	30 Calendar Days	95% compliance within standard	2,145	84.5%	5.6
Expedited Grievance	4	72 Hours	95% compliance within standard	3	75.00%	0.0
Exempt Grievance	1,727	Next Business Day	95% compliance within standard	1,725	99.9%	3.9
Standard Appeal	96	30 Calendar Days	95% compliance within standard	92	95.8%	0.3
Expedited Appeal	2	72 Hours	95% compliance within standard	2	100.0%	0.0
Total Cases:	4,367		95% compliance within standard	3,967	90.8%	9.8

*Calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1,000.

<u>Standard Grievances:</u>
There were 2,093 unique grievance cases resolved during the reporting period, with a total of 2,538 grievances including 445 shadow cases.



- **961** of 2,542 (38%) cases were related to Access to Care; the following are the top four (4) categories:
  - Timely Access – 297
  - Technology/telephone – 270
  - Authorization – 145
  - Provider Availability – 122

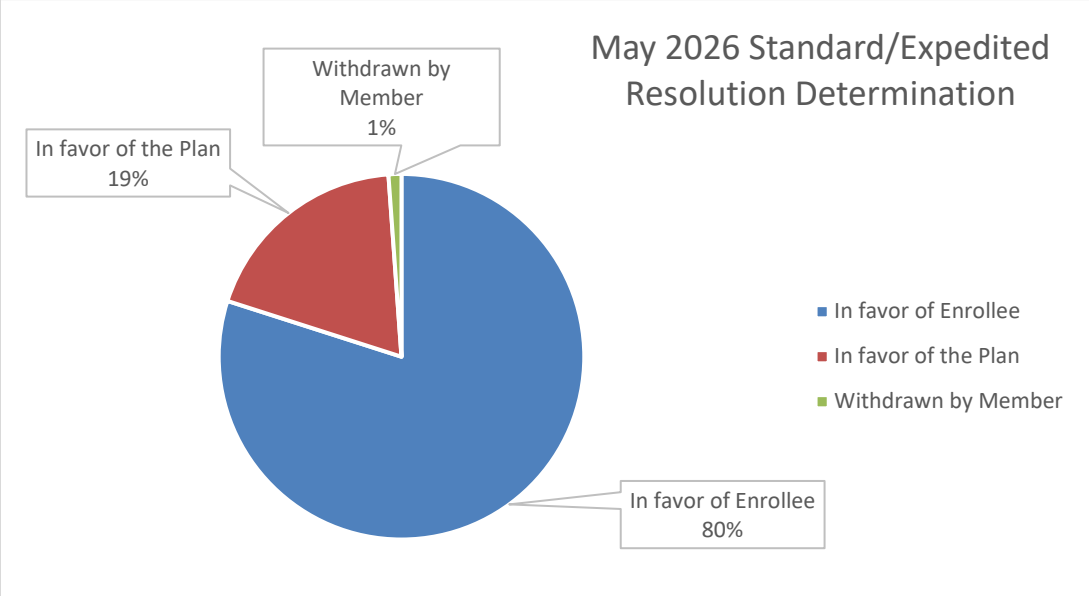
- **863** of 2,542 (34%) cases were related to Quality of Service; the following are the top four (4) categories:
  - Plan Customer Service – 208
  - Authorization – 174
  - Provider / Staff Attitude – 156
  - Referral – 102

- **473** of 2,542 (19%) cases were related to Coverage Dispute; the following are the top two (2) categories:
  - Provider Direct Member Billing – 234
  - Provider Balance Billing – 158

- **132** of 2,542 (5%) cases were related to Other; the following are the top two (2) categories:
  - Enrollment – 78
  - Eligibility – 44

- **113** of 2,542 (4%) cases were related to Quality of Care; the top category was:
  - Quality of Care – 97

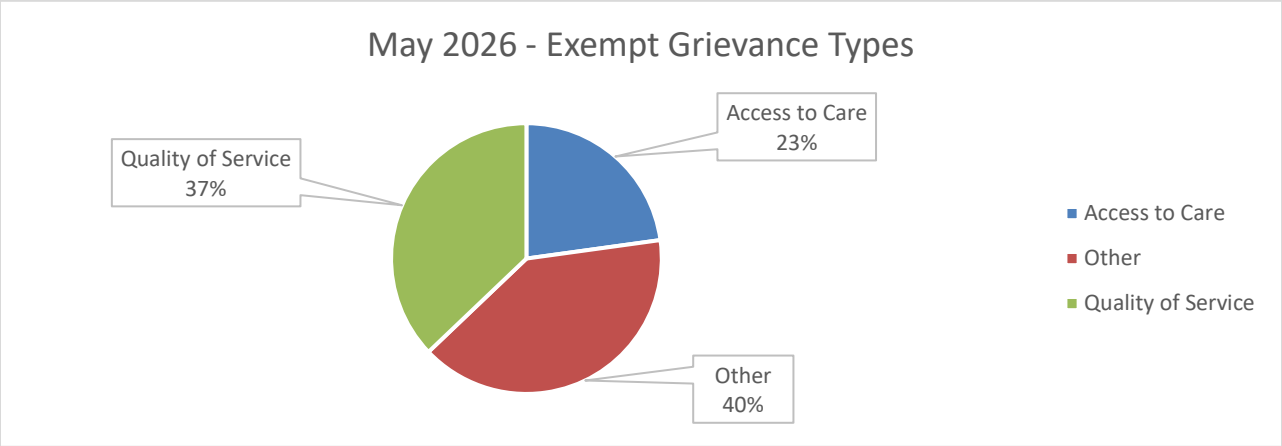
<u>Resolution Determination:</u>



  - **2,032** of 2,542 (80%) cases were resolved In Favor of Enrollee
  - **481** of 2,542 (19%) cases were resolved In Favor of the Plan
  - 29 of 2,542 (1%) cases were Withdrawn by Member

<u>Exempt Grievances:</u>

There were 1,469 unique exempt grievance cases resolved during the reporting period, with a total of 1,727 exempt grievances including 258 shadow cases.

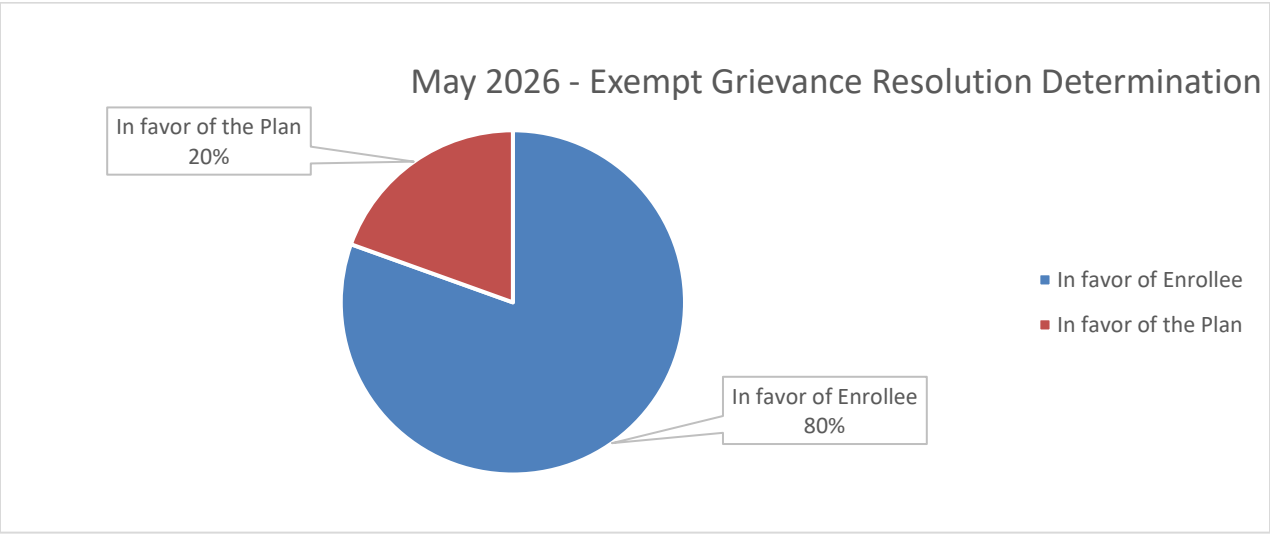


- **692** of 1,727 (40%) cases were related to Other; the following are the top two (2) categories:
  - Enrollment – 651
  - Eligibility – 41

- **641** of 1,727 (37%) cases were related to Quality of Service; the following are the top two (2) categories:
  - Plan Customer Service – 379
  - Provider/Staff Attitude – 224

- **394** of 1,727 (23%) cases were related to Access to Care; the following are the top two (2) categories:
  - Provider Availability – 171
  - Technology / Telephone – 116

<u>Resolution Determination:</u>

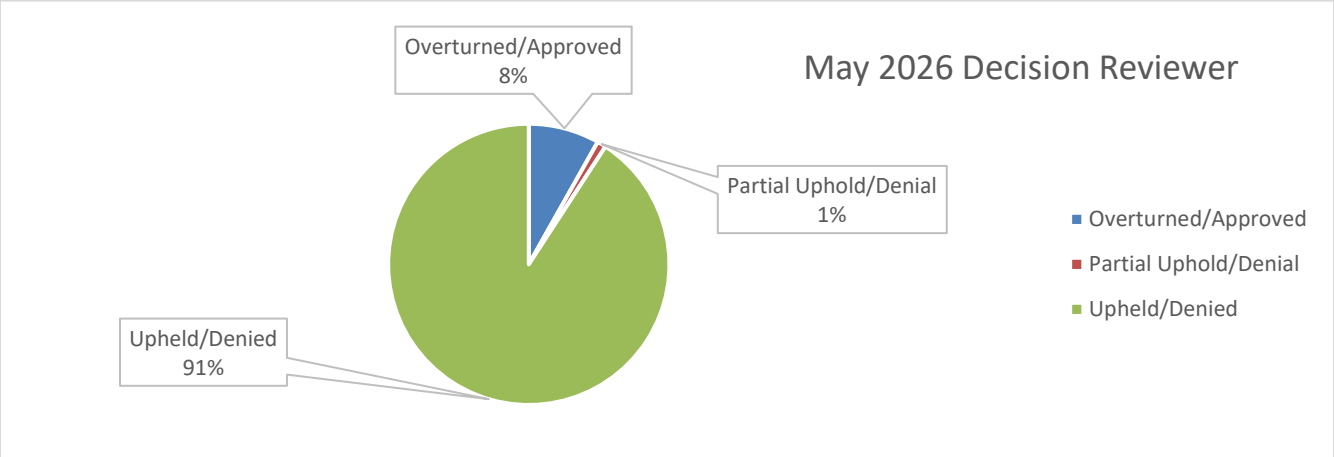


  - **1,390** of 1,727 (80%) cases were resolved In Favor of Enrollee

- **337** of 1,727 (20%) cases were resolved In Favor of the Plan

Appeals:

The Alliance's goal is to have an overturn rate of less than 25%; for the reporting period of May 2026, we met our goal with an 8% overturn/approved rate.



- **89** out of 98 (91%) cases had an upheld/denied decision for the month of May 2026:
  - Disputes Involving Medical Necessity – 76
  - Out of Network – 13

- **8** out of 98 (8%) cases had an overturn/approved decision for the month of May 2026:
  - Disputes Involving Medical Necessity – 7
  - Out of Network – 1

- **1** out of 98 (1%) cases had a partial uphold/denial decision for the month of May 2026:
  - Disputes Involving Medical Necessity – 1

D-SNP Grievances & Appeals (Resolved)

- Standard Grievance cases were resolved within the goal of 95% of regulatory timeframes.
- First Call Resolution cases were not resolved within the goal of 95% of regulatory timeframes.
- There were no Standard or Expedited Appeal cases filed in May 2026.

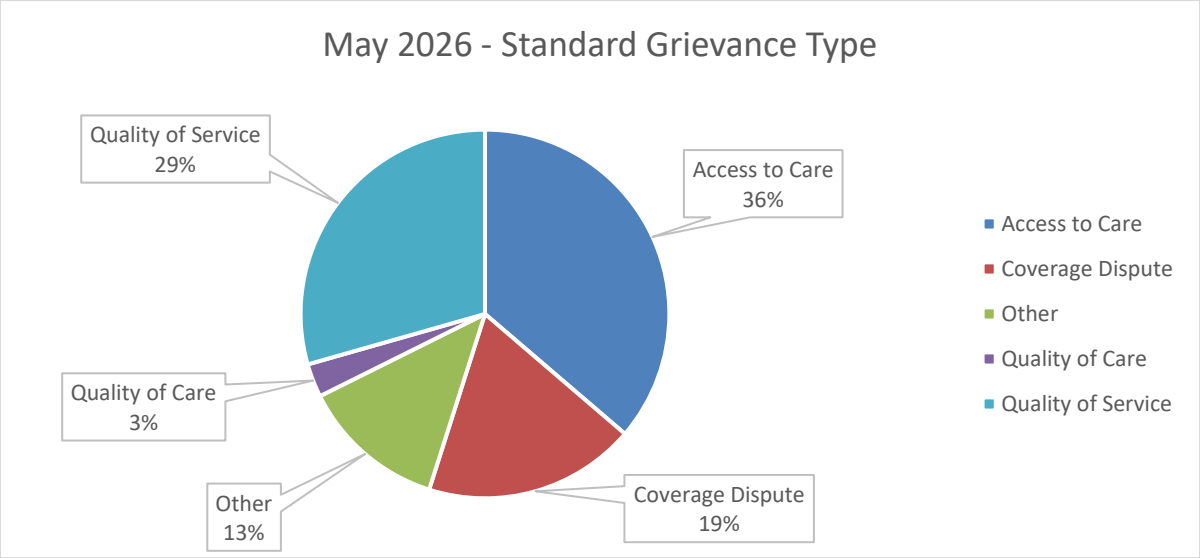
May 2026 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate
Standard Grievance	102	30 Calendar Days	95% compliance within standard	101	99.0%
Expedited Grievance	0	72 Hours	95% compliance within standard		N/A

First Call Resolution	24	Next Business Day	95% compliance within standard	18	75.0%
Standard Appeal	0	30 Calendar Days	95% compliance within standard	0	N/A
Expedited Appeal	0	72 Hours	95% compliance within standard	0	N/A
Total Cases:	126		95% compliance within standard	119	94.4%

*Per 1,000 not calculated for DSNP because enrollment is below 1000.

Standard Grievances:

There were 98 unique grievance cases resolved during the reporting period, with a total of 126 grievances including 28 shadow cases.



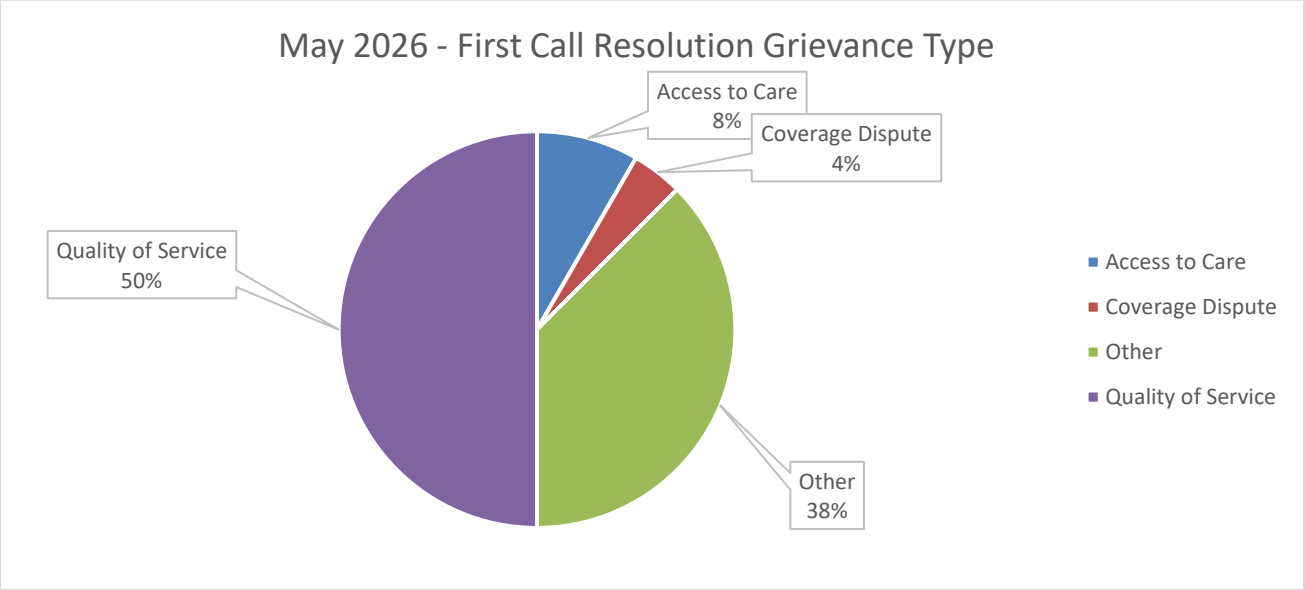
- **37** of 102 (36%) cases were related to Access to Care; the top category was:
  - Technology/Telephone – 21
- **30** of 102 (29%) cases were related to Quality of Service; the top categories were:
  - Plan Customer Service – 13
    - Case Management – 3
    - Grievance and Appeals – 3
    - Member Services – 3
    - Nations – 1
    - PerformRx – 1
    - Sales – 1
    - Xaqt – 1
  - Case Management / Care Coordination – 7
  - Member Informing Materials – 4
  - Referral – 4
  - Provider / Staff Attitude – 1
  - Transportation – 1

- **19** of 102 (19%) cases were related to Coverage Dispute; the top categories were:
  - Provider Balance Billing – 8
  - Benefit – 5
  - Provider Direct Member Billing – 4
  - Reimbursement – 2

- **13** of 102 (13%) cases were related to Other, the top categories were:
  - Enrollment – 9
  - Eligibility – 4

- 3 of 102 (3%) cases were related to Quality of Care; the top category was:
  - Quality of Care – 3

<u>First Call Resolution (FCR) Grievances:</u>
There were 20 unique exempt grievance cases resolved during the reporting period, with a total of 24 cases, including 4 shadow cases



- **12** of 24 (50%) cases were related to Quality of Service; the top category was:
  - Plan Customer Service – 7
    - Member Services 4
    - Xaqt – 2
    - ModivCare – 1
  - Member Informing Materials – 2
  - Authorization – 1
  - Case Management / Care Coordination – 1
  - Provider / Staff Attitude – 1

- **9** of 24 (38%) cases were related to Other; the top 2 categories were:
  - Enrollment – 6
  - Eligibility – 3

- **2** of 24 (8%) cases were related to Access to Care; the top category was:
  - Out of Network – 2

- **1** of 24 (4%) cases were related to Coverage Dispute; the top category was:
  - Benefit – 1

Appeals:

- There were no appeals filed in the month of May 2026.

CTM Information for May 2026:

- There were no CTMs filed in the month of May 2026.

Provider Services

- 12-Month Trend Summary:

  - The Provider Services department's call volume in May 2026 was 6,347 calls compared to 7,861 calls in May 2025.

- Monthly Analysis:

  - The Provider Services department completed 534 calls/visits during May 2026.
  - The Provider Services department answered 5,337 calls for May 2026 and made 438 outbound calls.
  - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.

Credentialing

- Monthly Analysis:

  - At the Peer Review and Credentialing (PRCC) meeting held on May 19th, 2026, there were 175 initial network providers approved; 3 primary care providers, 9 specialists, 17 ancillary providers, 11 midlevel providers, and 135 behavioral health providers. Additionally, 95 providers were re-credentialed at this meeting; 8 primary care providers, 21 specialists, 5 ancillary providers, 19 midlevel providers and 42 behavioral health providers.

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

ALAMEDA Alliance FOR HEALTH

Integrated Planning

Community Relations and Outreach

- 12-Month Trend Summary:

    - In May 2026, the Alliance completed 722 member orientation outreach calls and 73 member orientations by phone compared to 1,083 member orientation outreach calls and 92 member orientations by phone in May 2025.
    - The C&O Department reached 875 people (45% identified as Alliance members) during outreach activities, compared to 358 individuals (61% self-identified as Alliance members) in May 2025.
    - The C&O Department spent a total of $518.53 on donations, fees, and/or sponsorships, compared to $0.00 in May 2025.
    - The C&O Department reached members in 15 cities/unincorporated areas throughout Alameda County compared to 12 cities in May 2025.

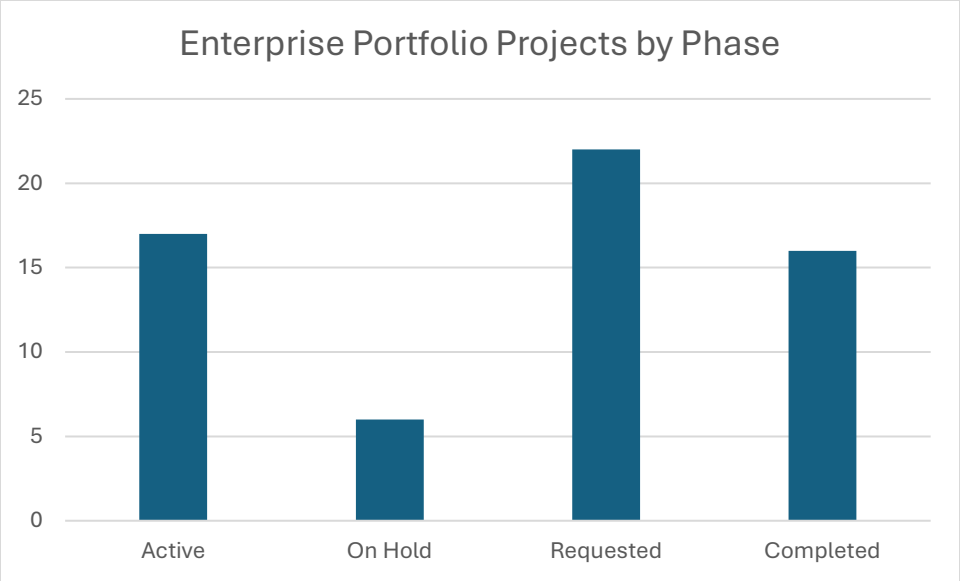
- Monthly Analysis:

    - In May 2026, the C&O Department completed 722 member orientation outreach calls, 73 member orientations by phone, and 3 Alliance website inquiries.
    - Among the 875 people reached during outreach activities, 45% identified as Alliance members.
    - In May 2026, the C&O Department reached members in 15 locations throughout Alameda County, the Bay Area, and the U.S.
    - Please see attached **Addendum A**.

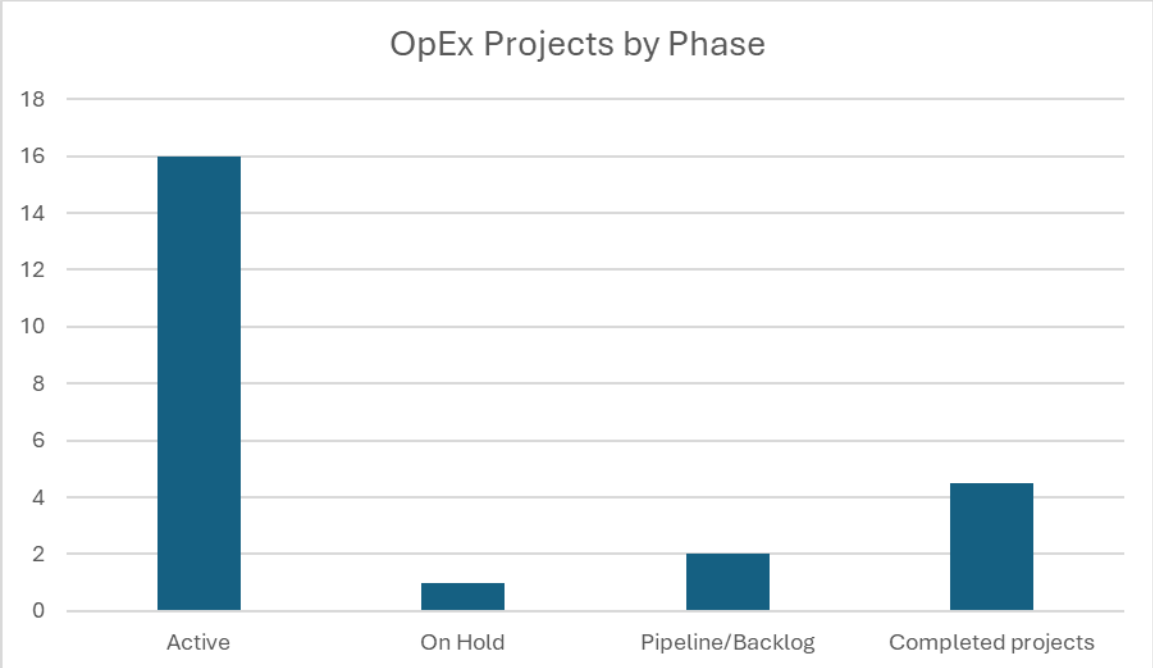
Incentives & Reporting – moved under Analytics Department

Integrated Planning

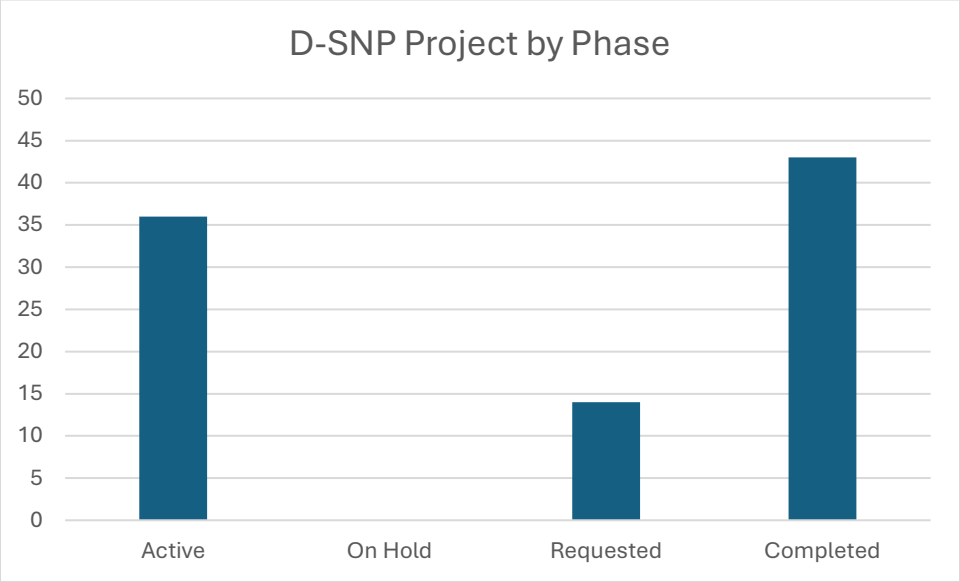
- Enterprise Portfolio
    - 45 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
        - 17 Active projects (discovery, initiation, planning, execution, warranty)
        - 6 On Hold projects
        - 22 Requested and Approved Projects
        - 16 Completed Projects (F-YTD)



- Operational Excellence (OpEx) Portfolio
  - 19 initiatives on the Alameda Alliance for Health (AAH) OpEx portfolio
    - 16 Active projects (discovery, initiation, planning, execution, warranty)
    - 1 On hold project
    - 2 Pipeline/Backlog
    - 4 Completed projects



- D-SNP Portfolio
  - 50 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 36 Active projects (discovery, initiation, planning, execution, warranty)
    - 0 On Hold
    - 14 Requested Projects
    - 43 Completed in Total



- **<u>Enterprise Portfolio (Active Projects) for all Lines of Business (includes projects in Initiation, Planning, and Execution)</u>**
  - <u>(CMS-0057-F) Interoperability and Prior Authorization Final Rule (TDX ID 5816</u>**<u>)</u>**
    - Project Phase: *Planning
    - Project Health: **Yellow
      - Decision 4832: Alliance will develop a new FHIR Gateway application called SPARK to interface between Edifecs and internal Alliance systems
        - This decision is still being vetted by IT. Tacit approval is given to move forward
      - Risk 4831: Alignment on connectivity approach to internal systems has taken longer than expected, may impact delivery date
    - High Level Milestones (Completed in May):
      - None
    - High Level Milestones (In Flight in May):
      - Fit Gap Analysis completed for all four APIs.
  - <u>2026 PBM Transition – PerformRx to MedImpact (TDX 14906)</u>
    - Project Phase: *Planning
    - Project Health: **Green
    - High Level Milestones (Completed in May):
      - Project Kickoff call with MedImpact was held on 5/4

        - Initial formulary files to support bid submission activities completed on 5/15
        - LOA with MedImpact was executed on 5/26
        - Access to HPMS for MedImpact was established to support bid submission activities for Part D
    - High Level Milestones (In Flight in May):
        - Technical Requirements review and approval in progress
        - Benefit business requirements review and documentation in progress
        - Project charter and project plan buildout is in progress
- AOR Workflow Optimization and Systems Integration (TDX 11260)
    - Project Phase: *Executing
    - Project Health: **Green
    - High Level Milestones (Completed in May):
        - Project reopened
        - BRD Approved
        - CR Submitted for Development Work
    - High Level Milestones (In Flight in May):
        - Enhanced requirements requiring new development of AOR Data File
        - AOR Data File being redesigned to filter by LOB
- Coordination of Care between BH Providers & Primary Care Physician (TDX ID 8323)
    - Project Phase: *Executing
    - Project Health: **Green
    - High Level Milestones (Completed in May):
        - User Stories Documented and entered in JIRA
    - High Level Milestones (In Flight in May):
        - Development Sprint for EREx
- CYBHI Fee Schedule (TDX ID 4186)
    - Project Phase: *Executing
    - Project Health: **Yellow
        - Risk 4736: BAA - A fully executed BAA is required before AAH can proceed with the transfer of member data; a test file was scheduled for submission to Carelon on 4/20. Without the BAA, this will delay project efforts
    - High Level Milestones (Completed in May):
        - None
    - High Level Milestones (In Flight in May):
        - Requirements Elicitation
        - Forecasted Sprint Development
        - Eligibility Test File Development
- D-SNP: 1A Contracting & Credentialing (TDX ID 6924)
    - Project Phase: *Executing
    - Project Health: **Red

        - Issue 4735: Provider Contract Termination and Provider Preclusion were missed requirements prior to 1/1/26 deployment. Efforts actively in progress.
        - Issue 4861: Additional scope: Three provider exclusion lists originally identified under DSNP Claims Workstream during requirements gathering, are now being transitioned for management of business process and subsequent requirements development in alignment with the Provider Preclusion Project. As a result, the scope has expanded and a formal scope change is in progress.
    - High Level Milestones (Completed in May):
        - Provider Contracting Termination Requirements completed and approved
        - Live Agent Call Script and Robo Call Script developed by Medicare Ops - currently with translation vendor with a due date of 5/15. Status pending
        - Sprint planning sessions completed
        - Provider Preclusion: Process flow in progress but must pause due to:
            - Identification of three new lists which will add/change scope of project
            - PR Flag for precluded providers - meeting held to discuss this new requirement with the Business and IT
        - Requirements will be impacted
    - High Level Milestones (In Flight in May):
        - None
- <u>D-SNP: 2B Quality Program (TDX ID 6919)</u>
    - Project Phase: *Execution
    - Project Health: **Green
    - High Level Milestones (Completed in May):
        - MOC annual review tool and timeline document created and reviewed with business for future use
    - High Level Milestones (In Flight in May):
        - Finalized MOC annual review tool and timelines
        - Project Closure - early June
- <u>D-SNP: 2D Chronic Care Improvement Program (TDX ID 6936)</u>
    - Project Phase: *Execution
    - Project Health: **Green
    - High Level Milestones (Completed in May):
        - CCIP Member Welcome Letter draft created
        - Decisions made on CCIP diagnoses, goals and interventions
        - CCIP Policy presented at the Quality Committee
    - High Level Milestones (In Flight in May):
        - Identifying Care Plan Interventions for CCIP Program and discussions with IT department
        - Drafting CCIP Plan

- D-SNP: 6G Organizational Training (TDX ID 6908)
  - Project Phase: *Execution
  - Project Health: **Yellow
    - Risk 4774: Case Management (CM) Content not received has been updated as the team has received the CM content. We are working on converting the content into HR Percipio training format. Once completed we will close out Risk 4774
  - High Level Milestones (Completed in May):
    - Received UM and CM training content
  - High Level Milestones (In Flight in May):
    - Complete conversion of UM and CM training into HR Percipio format and assign training to the respective departments
- D-SNP: 6J Liberty Dental (TDX ID 12526)
  - Project Phase: *Execution
  - Project Health: **Green
  - High Level Milestones (Completed in May):
    - Project Team is waiting for Dental claims to be paid to complete Encounter Testing. So far, no paid claims are in Liberty Dental's System. This scope will be transitioned to Encounters workstream and project closure is in progress
  - High Level Milestones (In Flight in May):
    - Project closure document created and review in progress
- D-SNP: 7D Audit Monitoring & Readiness (TDX ID 6946)
  - Project Phase: *Closing
  - Project Health: **Green
  - High Level Milestones (Completed in May):
    - Internal Audit Plan approval by Compliance Leadership
    - Presented to Compliance Committee
  - High Level Milestones (In Flight in May):
    - None
- D-SNP: 8A (TDX ID 6996) and 16K Claims (TDX ID 10170)
  - Project Phase: *Closing
  - Project Health: **Green
  - High Level Milestones (Completed in May):
    - Project Closeout Form
  - High Level Milestones (In Flight in May):
    - The WES form to be added to the DSNP Member Portal is in process
    - The MOOP letter configuration work will be initiated after the RAM June enhancement
- D-SNP: 10A PBM Implementation (TDX ID 7046)
    - Project Phase: *Execution
    - Project Health: **Yellow
      - Issue 4510: Ongoing delays with receiving letter proofs for the M3P program from Echo Health (PerformRx's M3P Vendor). Global feedback on letter formatting was

provided to Echo Health via PerformRx on 5/18 to make across all language versions. Awaiting update from Echo whether they accept the changes and an ETA for revised files

- High Level Milestones (Completed in May):
  - DMP Program Lock-in/Lock-out process in development with PerformRx and Abarca; waiting on final business validation from Luke Lim (ETC 6/1)
- High Level Milestones (In Flight in May):
  - Revised M3P Program member letter proofs received from Echo Health in all threshold languages, reviewed & approved by C&O, and then configured in Echo Health's platform. See issue above for more information

- <u>D-SNP: 13A – Health Equity (Phase II) (TDX 7021)</u>
  - Project Phase: *Executing
  - Project Health: **Green
  - High Level Milestones (Completed in May):
    - None
  - High Level Milestones (In Flight in May):
    - Confirmed AOC Approval of new HE Oversight Policy
- <u>D-SNP: 16B Enrollment Process & Nations Benefits / D-SNP Member Incentives (TDX ID 9945)</u>
  - Project Phase: *Execution
  - Project Health: **Green
  - High Level Milestones (Completed in May):
    - Completed implementation of automated fulfillment processes supporting D-SNP member onboarding materials, including ID cards and welcome kits
    - Continued coordination with NationsBenefits to support sales and enrollment operational processes
  - High Level Milestones (In Flight in May):
    - Complete remaining Day 2 enrollment operational readiness activities, including onsite temporary ID card printing
    - Finalize automated agent commission and incentive administration processes
    - Transition project deliverables into ongoing operational support and project closeout
- <u>D-SNP: 16L Encounters (TDX ID 11343)</u>
  - Project Phase: *Execution
  - Project Health: **Green
    - Issue 4728: Liberty Dental has not yet supplied an encounter file to be used for testing
  - High Level Milestones (Completed in May):
    - None
  - High Level Milestones (In Flight in May):
    - Liberty Dental UAT – Complete

        - Liberty Dental System Go-Live
        - Liberty Dental Production Verification
- D-SNP: 17E Stars Pharmacy (TDX ID 13447)
    - Project Phase: *Execution
    - Project Health: **Green
    - High Level Milestones (Completed in May):
        - SOP created for how to handle member disenrollments
    - High Level Milestones (In Flight in May):
        - Working sessions in progress to Develop Process for Conducting Pharmacist Reviews to Ensure Appropriateness and Document Exclusions
- D-SNP: CHCN Delegation (TDX 14333)
    - Project Phase: *Initiation
    - Project Health: **Yellow
        - Issue 4801: CHCN has open items on the Corrective Action Plan (2025)
        - Risk 4898: Identified UM, CM, and Claims business issues must be resolved or on a path to resolution by 8/31/26
        - Risk 4790: CHCN's Core Administrative Systems upgrade – targeted to be completed 10/1/26
    - High Level Milestones (Completed in May):
        - Project Initiation Meeting with CHCN
        - TDX Workplan initiation and confirmation of milestone timeliness
    - High Level Milestones (In Flight in May):
        - Create Stakeholder Registry
        - Begin meeting with business stakeholders at CHCN to assess baseline D-SNP readiness
        - Scheduling meetings with the various departments to understand dependencies and timeliness for Delegation Amendment, DoFR and Delegation Audit
- D-SNP: IT HEALTHsuite Program (RAM) (TDX ID 7211)
    - Project Phase: *Execution
    - Project Health: **Green
    - High Level Milestones (Completed in May):
        - Project Team has regular check-in meetings to review open production incidents
            - 30 Total incidents; 28 resolved
    - High Level Milestones (In Flight in May):
        - Team will continue to monitor production incidents
- D-SNP Medicare Reporting (TDX ID 14876)
    - Project Phase: *Executing
    - Project Health: **Red
        - Issue 4723: Reporting Identification and Development – Lateness
            - New project has kicked off to begin planning and identifying regulatory reporting required to comply with

DSNP/Medicare Reporting. Identification of the priority reports are in progress within Compliance and IPD. AAH is at risk of not making some upcoming deadlines as there are many reports which need to be developed internally then ultimately be submitted to regulators

- High Level Milestones (Completed in May):
  - Request for report development by HealthCare Services – In progress with Analytics
  - Refinement of internal reporting tracker: Medicare Ops Tracker shall be the source of truth
  - Scope Change: Focus will be on development of identified reports for Medicare
- High Level Milestones (In Flight in May):
  - Refinement of Charter to support scope change
  - Development of training for Business
  - Review and Approval of Process Flow

- DHCS APL 25-015 Data Sharing and Quality Rate Production (TDX ID 14146)
  - Project Phase: *Planning
  - Project Health: **Green
  - High Level Milestones (Completed in May):
    - This month the team completed the workflows for Analytics
  - High Level Milestones (In Flight in May):
    - The team is in process of completing the workflows for IT
- DHCS APL 26-004 Medi-Cal MCP Responsibilities for BH (TDX 15101)
  - Project Phase: *Planning
  - Project Health: **Green
  - High Level Milestones (Completed in May):
    - Discussion and understanding of APL requirements
    - TDX Project Plan development
    - MOU updates requirements discussion with Legal
  - High Level Milestones (In Flight in May):
    - Redline MOU with updates per APL 26-004
    - Mapping activity to source the data elements that will be exchanged in real time
    - ASCMI Form requirements session
- DMHC APL 25-021 Infertility and Fertility Services [SB 729] (TDX ID 14637)
  - Project Phase: *Execution
  - Project Health: **Green
  - High Level Milestones (Completed in May):
    - Draft Policies and Procedures, as well as the draft Evidence of Coverage (EOC) sent to DMHC for redline review on 5/13
  - High Level Milestones (In Flight in May):
    - Operational workflows for impacted departments have been documented and are in review for final approval
    - Confirmed provider(s) to support Infertility/Fertility Services; LOA and/or contracting process is underway

        - Documentation of billing strategy and approach, as well as confirmation of billing codes is in progress
- ECM Billing – Encounter and RTF Process (TDX 14826)
    - Project Phase: *Planning
    - Project Health: **Yellow
        - Risk 4625: Provider Capability and Turnover
        - Risk 4624: Compliance/Regulatory Risk
        - Risk 4623: ECM Process Design
        - Risk 4622: Provider Dissatisfaction
    - High Level Milestones (Completed in May):
        - Defined scope
    - High Level Milestones (In Flight in May):
        - Design sessions for current and future state ECM billing process
- Member Correspondence (TDX ID 12697)
    - Project Phase: *Planning
    - Project Health: **Green
    - High Level Milestones (Completed in May):
        - Business Requirements Document (BRD) Complete
        - Business Requirements Document (BRD) Approved
    - High Level Milestones (In Flight in May):
        - Complete BRD Review with IT partners
        - Decision on next steps for solutioning
- PY2026-D-SNP: Centralized Medicare Website Enhancement (TDX ID 14617)
    - Project Phase: *Initiating
    - Project Health: **Yellow
        - Risk 4840: CMS Model regulations coming in after requirements deadline has been mitigated. We plan to submit CMS model changes once they are received with a separate C&O request with a high priority to meet CMS requirements
        - Risk 4828: DSNP Website C&O 6/1/26 Content submission deadline. We will mitigate this risk by going to phase approach to submit C&O content and move some requirement submission date to 6/18/26
        - Risk 4881: This Risk can be closed out as we have worked on a web design approach that works for both AAH and meets CMS requirements
    - High Level Milestones (Completed in May):
        - The team has completed the first draft review of CMS and business requirements
    - High Level Milestones (In Flight in May):
        - Scheduled first round of business requirement sessions. Also, the team has finalized the measures of performance for the project charter. Project charter will be finalized this month
- PY2027-D-SNP Bid Strategy, Submission & Approval (TDX ID 14636)
    - Project Phase: *Execution

        - Project Health: **Green
        - High Level Milestones (Completed in May):
            - Completed development and review of the CY2027 D-SNP bid package across Product and Medicare Operations, Finance, Compliance, and Pharmacy teams
            - Finalized key benefit, formulary, and operational bid components to support bid submission
            - Successfully completed CMS validation activities and submission readiness reviews
            - Submitted the CY2027 bid package by the June 1st CMS deadline
        - High Level Milestones (In Flight in May):
            - CY2027 Medication Therapy Management (MTM) program filing
            - Support CMS review and response activities during the bid evaluation period
            - Monitor release of CMS benchmark expected by early August
            - Transition from bid submission activities into ongoing bid monitoring and benefit implementation planning
    - Readily AI Platform Implementation (TDX ID 13788)
        - Project Phase: *Execution
        - Project Health: **Green
        - High Level Milestones (Completed in May):
            - IT published AI governance policy
            - Regular status check meetings in progress to check if team has any open questions on Readily AI modules
        - High Level Milestones (In Flight in May):
            - Integration with Readily and Navex (PolicyTech) is in progress
    - Receiving, Storing, and Retrieving SOGI Data (TDX ID 6623)
        - Project Phase: *Planning
        - Project Health: **Yellow
            - Risk 4885: SOPs not being completed is causing risk with NCQA look back period not being compliant. The team is in the final stages of finalizing the SOPs
            - Issue 4886: To finalize the SOPs, we need to have a final review by consultants TMG which will take approximately five working days and will cause further delay in completing the SOPs
        - High Level Milestones (Completed in May):
            - Completed first draft of four SOPs
        - High Level Milestones (In Flight in May):
            - In process of completing project charter
            - Project workflow completion in process
    - Security Remediation (TDX ID 11339)
        - Project Phase: *Execution
        - Project Health: **Green
        - High Level Milestones (Completed in May):

            - Fixed thirteen (13) Penetration Testing Issues
                - Critical (2)
                - High (6)
                - Medium (5)
            - Fixed eight (8) 2025 Security Risk Assessment (SRA) Issues
                - High (1)
                - Medium (7)
        - High Level Milestones (In Flight in May):
            - Team to continue resolving identified security issues
    - <u>sPayer Contracting Repository (TDX 1283)</u>
        - Project Phase: * Planning
        - Project Health: **Yellow
            - Issue 4887: The Alliance is requesting a collaborative approach on the development of a comprehensive plan that includes the tasks, duration, predecessors/successors, and resource assignments for both of our teams, that align with major milestones supporting critical path to confirm a proposed go live date for the kickoff meeting. Symplr's proposed timeline was reviewed with their PM, which identified lack of appropriate milestones with an unrealistic implementation schedule
        - High Level Milestones (Completed in May):
            - None
        - High Level Milestones (In Flight in May):
            - Reactivation of Project within TDX

- **<u>Operational Excellence (OpEx) Portfolio</u>**
    - <u>Claims Provider Not Found (PNF) Optimization (TDX ID 13050) (OPEX: 267)</u>
        - Project Phase: *Executing
        - Project Health: **Red
            - Issue 4409: PNF Report Errors – The CR 05764 did not resolve all report errors resulting in the continuation of manual processing of claim submissions where the TIN is missing in the PR. The additional logic needed will be addressed with CR 07032, scheduled for deployment the week of 6/8/26
        - High Level Milestones (Completed in May):
            - CR 05764 – Added additional logic to check for the W-9 and TIN in PR and the TIN HS before writing to PNF report
        - High Level Milestones (In Flight in May):
            - CR 07032 will add an additional layer of logic to check W-9 in HS when the TIN is not found in PR and is scheduled for deployment the week of 6/8/26
    - <u>Credentialing Optimization (TDX 14700) (OPEX: 240)</u>
        - Project Phase: *Initiating (Define)
        - Project Health: **Yellow
        - High Level Milestones (Completed in May):

        - Project transitioned to Linell; non-platform-specific recommendations outlined
        - Opportunities for process improvement have potential dependencies on the credentialing platform
        - Introductory/Transition meeting completed 5/28/26
    - High Level Milestones (In Flight in May):
        - Meeting with Credentialing on 5/28/26 to confirm project transition and scope next steps and priorities for deployment. Donna Ceccanti determined that she does not require OpEx support at this time
- <u>ECM Referral/Auth Automation (TDX 12829) (OPEX: 266)</u>
    - Project Phase: *Executing (Improve)
    - Project Health: **Green
    - High Level Milestones (Completed in May):
        - BRD completed; QA in progress
            - Results from QA/UAT have identified areas for further technical development refinements and will need to go back to QA and UAT once complete
    - High Level Milestones (In Flight in May):
        - IT development work
        - Expected deployment ETA 6/4/2026
- <u>HRA Expansion Configuration for CM (TDX 14953)</u>
    - Project Phase: *Executing (Improve)
    - Project Health: **Green
    - High Level Milestones (Completed in May):
        - BRD complete and approved by the business; in review by IT
    - High Level Milestones (In Flight in May):
        - Confirmation of scope/requirements by the business (expansion of HRA configuration from TDX 12521)
- <u>IP TruCare HEALTHsuite with Contractual Alignment (TDX ID 7183) (OPEX: 233)</u>
    - Project Phase: *Executing (Improve)
    - Project Health: **Yellow
        - *Risk 3424: HS Enhancement to support accurate claims payment still in development (will need to undergo further internal QA/UAT before deployment, release from vendor RAM TBD).*
          Claims QA report to capture monthly savings requires extensive time to reconcile current manual claims payment calculations.
          Claims team to outline requirements for analytics to support setting up dashboard or tracker to capture savings more quickly.
          PDRs being filed on these claims that are manually priced so that they're paid per contract and authorized stay level; lack of clarity on volume of PDRs being reversed and impact to true ROI (savings)

        - High Level Milestones (Completed in May):
            - None
        - High Level Milestones (In Flight in May):
            - None
    - MCG Cite Auto Auth expansion of HH Pilot (TDX 14756) (OPEX: 241)
        - Project Phase: *Initiating
        - Project Health: **Green
        - High Level Milestones (Completed in May):
            - Resolved new pilot issues that arose from CareWebQI upgrade
                - Updated provider training materials (training deck and FAQ) with the business and submitted to C&O for approval before dissemination to home health providers
                - Working with provider relations to put in-service training holds on the calendar so that HCS can attend and address changes/updates real time with providers
            - Following up with HCS to provide CareWebQI reports to support scope expansion for additional services/guidelines to be covered based on current utilization patterns and outcomes
        - High Level Milestones (In Flight in May):
            - Updated provider training materials and pending: C&O approval and training
            - HCS to provide reports and additional codes/services to be covered in the expansion
    - OpEx: Alliance Communications & Outreach Department Workflow Process Improvement (TDX 14751) (OPEX: 261)
        - Project Phase: *Planning
        - Project Health: **Red
            - Approval Bottleneck Risk: High dependency on leadership approvals may limit pilot effectiveness if not temporarily adjusted
            - Tool Dependency Risk: Pilot progress may be delayed if Smartsheet automation or logic/workflow support is not available in the proposed timeline
            - Expectation Management Risk: Without clear communication to requestors on response SLA and SLA changes during the transition, customer dissatisfaction may persist during the transition
            - Risk 4800: Pilot Readiness Risk: The pilot cannot be initiated without an agreed upon pilot plan and implementation approach, which may delay project timelines if alignment is not achieved
            - Decision Alignment Risk: Delay in alignment or feedback on the pilot plan and tier framework is impacting readiness and timeline for pilot execution

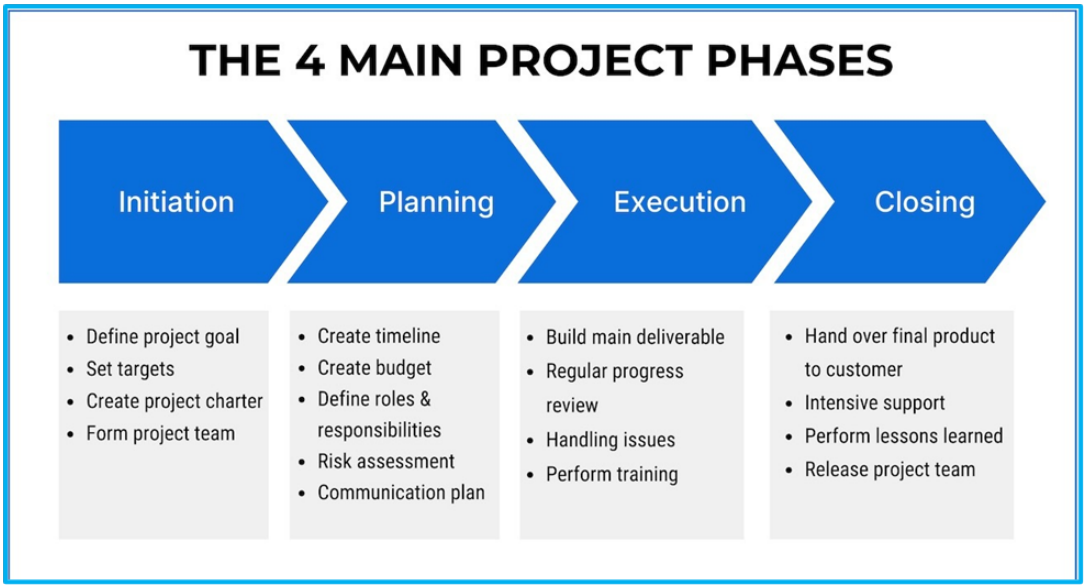
        - Transition Risk: Departure of the project sponsor and reassignment may delay decision-making and project momentum
    - High Level Milestones (Completed in May):
        - Transitioned project to new OpEx lead and sponsor; engaged leadership to reassess project status and next steps
    - High Level Milestones (In Flight in May):
        - Alignment with C&O leadership and new sponsor on pilot direction, timeline, and next steps
        - Review and refinement of Tiered SLA Pilot Plan and implementation approach
        - Re-establishment of project governance, roles, and meeting cadence
        - Determination of survey visibility, KPI tracking approach, and integration into pilot design
- <u>OpEx: CHCN Authorization Data Mapping (TDX 14882) (OPEX: 262)</u>
    - Project Phase: *Planning
    - Project Health: **Green
    - High Level Milestones (Completed in May):
        - Consolidated CHCN-related workstreams (LOU, 25-line item, and OpEx efforts) under a single aligned project
        - Received 6-month error report to identify and prioritize highest-volume error types
        - Rendering Provider solution; developed and moved into QA/testing with 5/21 deployment target
        - Reassessed discharge date issue and identified potential internal data flow/workflow gap
    - High Level Milestones (In Flight in May):
        - Deployment and monitoring of Rendering Provider automation (target 5/21)
        - Investigation of EREx to TruCare data flow for discharge date issue
        - Engagement with CHCN for additional data elements (provider address)
        - Evaluation of automation options for discharge date (internal and/or Zyter)
        - Alignment with IT on change requests and timing
- <u>OpEx: Provider Repository PAR/NON-PAR Provider Status and HCS Auto Auth (TDX ID 13263) (OPEX: 264)</u>
    - Project Phase: *Planning
    - Project Health: **Yellow
        - Issue 3713: CMS Mandates Radiology services should not be Auto-Auth. Radiology services require PA and a review
        - Risk 4070: IT Resource Constraint
        - Risk 3707: Potential lack of Sufficient Documentation for Medical Necessity

        - Risk 3701: Potential Overpayments Due to Misconfigured PAR services
        - Risk 3708: Non-Compliance with Medicare Coverage Policies
    - High Level Milestones (Completed in May):
        - Aligned HCS and Provider Repository teams on root cause of misalignment (systemic across delegated partners)
        - Confirmed PR constraints (network field cannot be modified due to reporting and contractual requirements)
        - Validated key use cases (LTC, Home Health, BH) demonstrating consistent issue pattern
        - Decision made to proceed with PR remediation now (not wait for Symplr Launch)
        - Identified IT SMEs (Smita, Guneet) and initiated engagement for solutioning
    - High Level Milestones (In Flight in May):
        - Collaborating with IT (PR/ETL SMEs) to evaluate solution options (alternate fields, ETL logic, TruCare configuration)
        - Validating comprehensive use cases
        - Assessing technical feasibility of introducing logic without impacting regulatory reporting
        - Defining solution approach and ownership for PR updates and downstream integration
        - Preparing inputs to ensure alignment with future Symplr implementation
- <u>SNF ADT Feeds Implementation with PCC (Auth Intake Channel) (TDX 8036) (OPEX: 238)</u>
    - Project Phase: *Executing
    - Project Health: **Yellow
        - Risk 4620: Missing Facility/Provider NPI in feeds could impact current loading into ADT tables and downstream utility for UM (Phase 2) activities in TruCare. Mitigation: exception handling logic development and current AAH PR information on NPIs used for initial Trading Partner setup
        - Risk 4382: For the non-standard event types, volume inconsistencies, or availability of certain information components (e.g. level of care or bed information) may exist depending on availability. May impact downstream UM activities in TruCare (Phase 2). Mitigation: Requirements will need to account for this variability
        - Risk 4399: The project timeline remains dependent on the completion of upstream IT requirements. Given current enterprise-wide IT demand, there is risk to the delivery schedule as additional time will be required for ETL development and QA once requirements are finalized. The team is working closely with IT partners to monitor progress, align priorities, and minimize downstream schedule impacts
    - High Level Milestones (Completed in May):

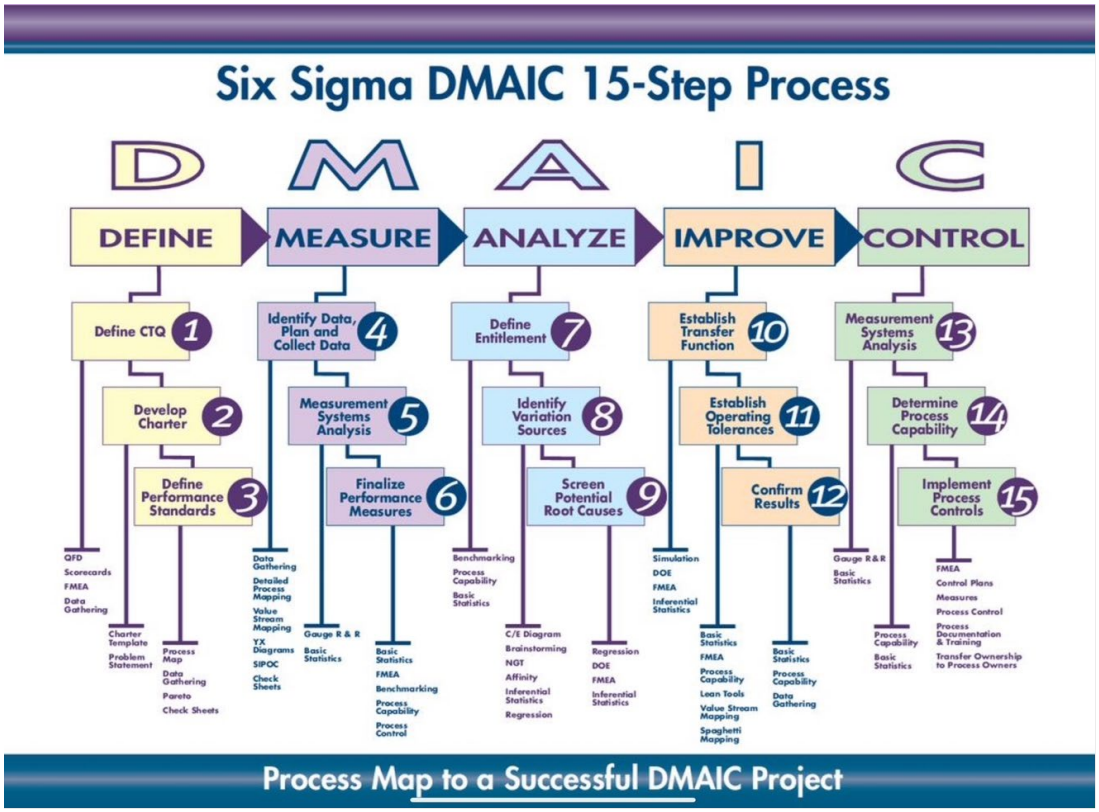
        - AAH is receiving SNF ADT feeds; currently receiving but not loading due to pending development work that is still outstanding
        - Additional clarifications on ADT feeds including new field for level of care/bed information
        - Requirements for ETL development on ADT feed handling/processing including error handling/exception handling clarified
    - High Level Milestones (In Flight in May):
        - ETL Development and concurrent QA
- <u>QS Automation Enhancement (TDX None) (OPEX: 273)</u>
    - Project Phase: *Planning
    - Project Health: **Green
    - High Level Milestones (Completed in May):
        - Transitioned Phase II project tracking from TDX to Jira
        - Conducted Quality Suite Automation Roadmap discussion session led by IT
        - Held leadership alignment meetings and provided updates
        - Identified and began consolidation of existing CRs in Jira to align with roadmap efforts
        - Established next steps for requirements gathering and technical planning with IT and SMEs
    - High Level Milestones (In Flight in May):
        - Initiating requirements gathering sessions
        - Finalizing Quality Suite Automation Roadmap timeline and prioritization
        - Consolidating and aligning existing and new CRs within Jira
        - Defining technical specifications and data requirements for dashboards
        - Continuing weekly cross-functional alignment meetings (G&A, OpEx, IT)

- **<u>Recruiting and Staffing</u>**
    - Integrated Planning Open position(s):
        - Sr. Business Analyst, Integrated Planning – Posting request in process
        - Backfill Business Process Analyst, Integrated Planning – on hold

- ***Project Phases**
  - PMO



  - OpEx



- ****Project Health**

Project Health Legend

Health	Schedule	Budget	Resources	Scope	Overall
	Ahead or on target for all Milestones and less than 5% delay to estimated time of completion (ETC).	Actual total expense is on or below budget.	Required resources & skills are available as planned.	The project scope has not changed this period.	If one of the key indicators is temporarily yellow, the project may retain the green indicator score.
	A milestone is missed or between 5 – 15% increase in ETC.	Actual total expense is within 10% of budget.	Planned resources and skills are not available but a mitigation strategy is in place.	Minor scope change(s).	The project is experiencing problems with one or more key indicators. Or the project requires management attention to prevent major issues from negatively impacting the project.
	A **KEY** milestone is missed that will impact the project or greater than 15% increase in ETC.	Actual total expense is greater than 10%.	Project resource levels and skills are not adequate to complete the project.	Major scope change(s).	The project is experiencing problems with more than 2 key indicators. Or the project is at risk and requires immediate management attention to help resolve.

Medicare Operations

- **D-SNP Key Initiatives and Dates:**
  - CMS Formulary & Bid Submission – June 1st, 2026.
  - Medication Therapy Management (MTM) program submission – June 3rd, 2026.
  - CMS SMAC and Contract Matrices Submission – July 6th, 2026.
  - Rebate Allocation with CMS and Health Plan – July / August 2026.
  - Annual Enrollment Period (AEP) – October through December 2026.
  - Open Enrollment Period (OEP) Begins – January 1st, 2027.

- **D-SNP Activities – May 2026**
  - Medicare Product Updates:
    - Liberty Dental:
      - Liberty Dental Operations & Encounter Readiness - The Liberty Dental implementation is active and processing claims, but the team is still waiting to complete encounter testing.
      - CMS / Regulatory Updates – Dental Encounter Data Phase 2 - CMS (via HPMS) issued a memo on Dental Encounter Data Phase 2, effective for submissions starting May 21st, 2026. Introduces new dental-specific edits. Expands EDPS validation requirements. Builds on Phase 1 (837D submissions).
      - Member Materials & Compliance Language (Medi-Cal Dental) - Active review and edits to EOC/Member Handbook language

related to dental. Clarifying Medi-Cal Dental FFS vs. Dental Managed Care by incorporating county-specific rules and exceptions effective July 1st, 2026.

- VSP:
  - Ongoing VSP Operational Governance (Bi-Weekly Cadence) - Regular bi-weekly meetings are occurring with VSP covering Medi-Cal and D-SNP vision benefits. Vision operations are in a steady-state governance phase with consistent oversight and structured communication.
  - Member Communications & Materials - VSP shared sample member outreach materials, including Diabetic Exam Reminder Letter. Vision vendor is supporting proactive member engagement and preventive care compliance.
- Nations OTC and Hearing:
  - Vendor Governance & Joint Operations Oversight - A Quarterly Joint Operations Meeting (JOM) was held with Nations to review Q1 2026 performance reports (D-SNP and Medi-Cal), as well as G&A reports and vendor presentations.
  - Encounter / File Processing & Testing - Production file readiness and data exchange processes are in progress.
  - Monitoring member questions, complaints, and grievances to identify trends, recurring issues, and potential operational or compliance risks. Coordinating with Member Services, Operations, and Compliance teams to support timely resolution, ensure regulatory turnaround requirements are met, and inform process improvements to enhance the overall member experience.
- Medicare Online Enrollment Center (OEC):
  - Evaluating the feasibility and timeline of implementing the Medicare Online Enrollment Center (OEC) functionality so that prospective members can enroll in Alameda Alliance Wellness (D-SNP) via medicare.gov.
- Reporting Project:
  - Conducting a review of CMS and State of California reporting requirements, including applicable regulations, submission timelines, and required metrics. Assessing existing reporting, identifying needs and gaps, and collaborating with internal stakeholders. Submitting requests for the development and enhancement of required reports to support ongoing compliance and regulatory reporting obligations.
- 2027 Medicare Bid Submission:
  - On track for CMS bid submission (June 1) - All major workstreams (Product, Actuarial, PBM, Compliance, and Vendor teams) are actively aligned to meet the submission deadline, with weekly bid workgroup governance ensuring coordination, issue resolution, and timeline adherence. Remaining activities are concentrated on final validations, approvals, and submission packaging.

- Final execution phase with targeted decision closure - The bid has progressed from planning and modeling into final execution, with a focused set of high-impact decisions still being actively managed. These decisions are time-bound and directly tied to both financial performance and compliance with CMS requirements.
- PBM readiness remains a critical dependency—now largely mitigated. Risks have been actively mitigated, allowing downstream activities to proceed.
- Benefit design nearing finalization. These decisions reflect a balance between member affordability, market competitiveness, and financial sustainability.
- Regulatory and HPMS submission readiness progressing as required - Key HPMS submissions have been completed or are in progress, with active coordination on remaining submission components.
- Leadership alignment (SLT) is the final gating step before submission - the bid package (including PBP, product narrative, and plan design decisions) is being finalized for Senior Leadership Team (SLT) review and approval. This represents the final governance checkpoint to confirm alignment on strategy, financial assumptions, and benefit design before submission to CMS.

▪ Medicare Projects:
- Kick off with the new pharmacy benefit manager (PBM), MedImpact, occurred on Tuesday, May 5th, 2026.
  - LOA between AAH & MedImpact is executed.
- CHCN delegation projection initiation occurred on May 21st, 2026, between the Alliance and CHCN.

o <u>Medicare Sales & Retention Updates:</u>

▪ Staffing Updates:
- Medicare Field Sales Agent (Bilingual) requisition removed, Medicare Field Sales & Community Agent (Non-Bilingual) requisition approved.
- Approval for four (4) additional licensed Medicare Field Sales and Community Agents.

▪ Sales/IT Enhancements and Projects:
- Continued development of Cirrus reporting dashboards for enrollment and retention data.
- Translation of all sale scripts in threshold languages completed.
- PerformRx enhancements requested.
- Alameda Alliance for Health Caller ID implemented for higher connect rate with prospective members completed.
- New PCP assignment process implemented during D-SNP enrollment initiated.

- Individual D-SNP Sales queues created within Finesse for improved prospective member experience.
- Data field requirements completed for PowerBI Dashboard (enrollment/disenrollment and retention).
- Finesse Disposition List created and ready for implementation.
- Cirrus Retention Dashboard finalized and implemented.
- Online Enrollment Form review completed and sent to C&O for approval.
- Online Enrollment Form corrections sent to Nations for approval.
- Voicemail transcription functionality for threshold languages complete.
- Call disposition list completed and ready for implementation.
- IVR Disclosure Recording enhancement initiated, compiled necessary disclosures to be played.
- First Commission and Bonus audit and payout completed to Sales Team (manual).
- Individual agent queues created and implemented.
- Began testing for new Sales IVR functionality.
- D-SNP Sales Training Manual created.
- D-SNP Call Scoring Sheet created.

▪ Policies and SOPs:
- FQHC on-site visit SOP finalized.
- Sales disciplinary policy update.

▪ SOPs for Commission, Retention, and HRA payouts initiated.
▪ New AOR process created and implemented into Sales Process SOP.

o <u>Medicare Marketing, Communications & Branding Updates:</u>

▪ Marketing Vendor Assessment & Selection:
- Marketing has narrowed the list of qualified vendors to two (2) top vendors, both of whom are now developing final proposals and go to market approach for our review.
- The goal is to select a preferred vendor week of 6/1 and begin onboarding to ensure readiness for 7/1 implementation.

▪ Enrollment and Onboarding Experience Improvement:
- Enhancements to the enrollment kit and welcome materials are underway to improve the overall enrollment and onboarding experience, with updates scheduled to launch for AEP 10/1.

▪ D-SNP Centralized Website:
- Marketing has defined a strategic framework for reorganizing and refreshing the D-SNP website, ensuring the site becomes a centralized compliant and sustainable source of information. In parallel, the team is developing prospect-facing pages to support acquisition and plan enrollment.
- The official project kickoff with IPD took place the week of 5/20, marking the start of the engagement.

        - Partnering with C&O to finalize the strategic framework guiding the rollout of new prospect-facing pages.
        - Prospect-facing pages are currently in stakeholder/SME review. Updated member-resource pages will be delivered for stakeholder/SME review the week of 6/1.
- FQHC Clinic Branding:
    - Clinic branding work is underway to refine our visual identity, messaging, and patient-facing experience.
    - D-SNP branded materials and promotional items are being developed for sales use in clinic settings.
    - Alignment received 5/19 from clinic chiefs on co-branding campaign strategy and plan/timeline.
    - Will partner with AHC for ongoing alignment on priorities, timelines, and deliverables for the co-branding campaign.
- D-SNP Organizational Training:
    - Assessing enterprise-wide training needs in preparation for the 2026 learning strategy.
    - Partnering with external consultants to shape the 2026 training calendar.
    - Engaging trainer content owners to refresh existing materials and develop new training assets.
- CHCN Marketing Blitz:
    - Completed three (3) waves of postcard marketing blitz to CHCN leads, which drove up sales and brand awareness.
- Unplanned Regulator Required Notices:
    - Continued monitoring and communication of regulatory notices that may impact coverage, benefits, or plan rules.
    - Medi-Cal Dental Changes (Effective July 1, 2026):
        - Mid-Year Change Notification: Member notice drafted and approved by Compliance; currently in C&O review. Targeted for member distribution by the July 1st, 2026, deadline.
        - Integrated Materials: Evidence of Coverage (EOC), Summary of Benefits (SOB), and Provider Directory updates completed and approved by Compliance. Submission to regulators scheduled by the June 5th, 2026, deadline.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	May 2026
Incoming Calls (R/V)	17,039
Abandoned Rate (R/V)	1%
Answered Calls (R/V)	16,791
Average Speed to Answer (ASA)	00:06
Calls Answered in 30 Seconds (R/V)	98%
Average Talk Time (ATT)	07:18
Calls Answered in 10 minutes	100%
Outbound Calls	9,808

Top 5 Call Reasons (Medi-Cal and Group Care) May 2026
Grievances and Appeals
Eligibility/Enrollment
Change of PCP
Benefits
Provider Network Information

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) May 2026
Change PCP
ID Card Requests
Update Contact Information

Member Services Behavioral Health	May 2026
Incoming Calls (R/V)	964
Abandoned Rate (R/V)	1%
Answered Calls (R/V)	953
Average Speed to Answer (ASA)	00:11
Calls Answered in 30 Seconds (R/V)	95%
Average Talk Time (ATT)	09:24
Calls Answered in 10 minutes	100%
Outbound Calls	1,604
Screenings Completed	103
ACBH Referrals	27
SUD referrals to Center Point	25

Blended Call Results

DSNP Blended Results	May 2026
Incoming Calls (R/V)	593
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	583
Average Speed to Answer (ASA)	00:06
Calls Answered in 30 Seconds (R/V)	99%
Average Talk Time (ATT)	06:55
Calls Answered in 2 minutes	99%

Top 5 Call Reasons (D-SNP) May 2026
Eligibility/Enrollment
Appeals/Grievances
Benefits/Org Determinations
ID Card Request
Change of PCP

Claims Department
April 2026 Final and May 2026 Final

METRICS

Claims Compliance	Apr-26	May-26
90% of clean claims processed within 30 calendar days	95.2%	96.4%

Claims Volume (Received)	Apr-26	May-26
Paper claims	35,584	46,760
EDI claims	337,888	421,600
Claim Volume Total	**373,472**	**468,360**
	(includes D-SNP)	(includes D-SNP)

Percentage of Claims Volume by Submission Method	Apr-26	May-26
% Paper	9.5%	10.0%
% EDI	90.5%	90.0%

Claims Processed	Apr-26	May-26
HEALTHsuite Paid (original claims)	315,947	271,175
HEALTHsuite Denied (original claims)	124,967	98,814
HEALTHsuite Original Claims Sub-Total	**440,914**	**369,989**
HEALTHsuite Adjustments	25,159	22,021
HEALTHsuite Total	**466,073**	**392,010**

Claims Expense	Apr-26	May-26
Medical Claims Paid	$170,326,467	$153,904,105
Interest Paid	$306,527	$218,482

Auto Adjudication	Apr-26	May-26
Claims Auto Adjudicated	384,404	324,577
% Auto Adjudicated	87.2%	87.7%

Average Days from Receipt to Payment	Apr-26	May-26
HEALTHsuite	13	13

Pended Claim Age	Apr-26	May-26
0-30 calendar days	27,783	38,172
HEALTHsuite		
31-62 calendar days	1,323	2,291
HEALTHsuite		
Over 63 calendar days	0	4
HEALTHsuite		

Overall Denial Rate	Apr-26	May-26
Claims denied in HEALTHsuite	124,967	98,814
% Denied	26.8%	25.2%

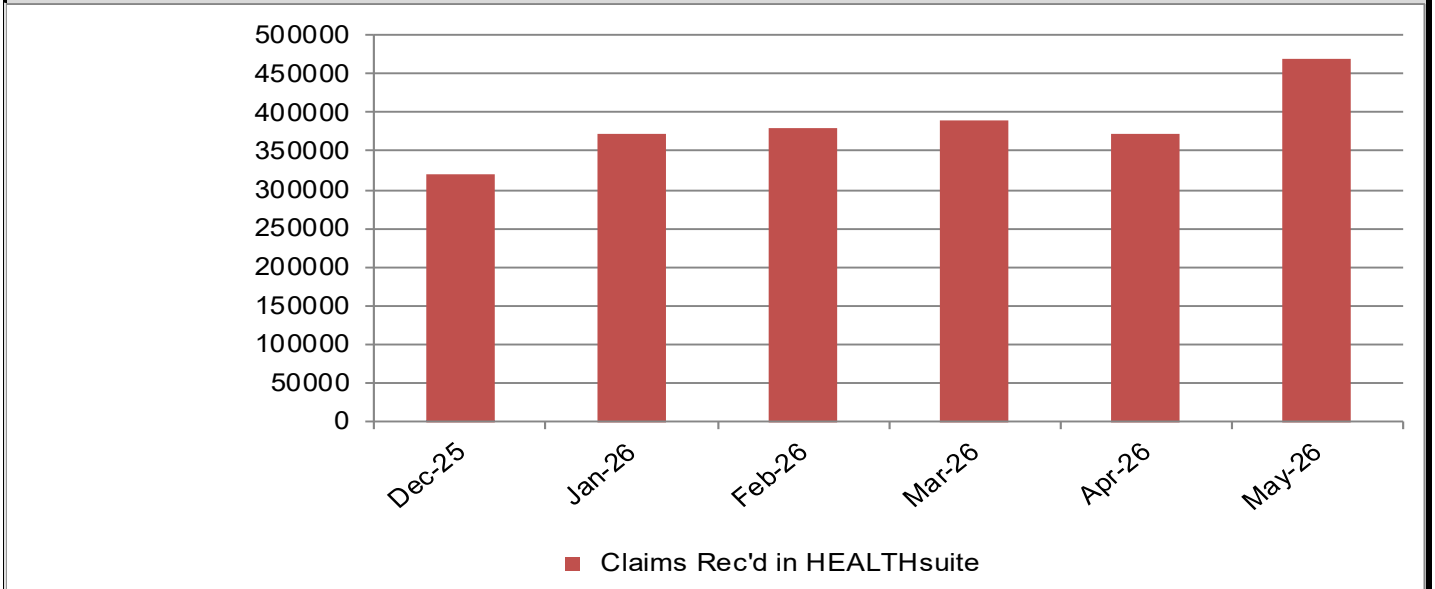
Claims Department
April 2026 Final and May 2026 Final

May-26

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	18%
No Benefits Found For Dates Of Service	14%
Non-Covered Benefit For This Plan	13%
Must Submit Paper Claim With Copy of Primary Payor EOB	12%
Duplicate Claim	9%
% Total of all denials	**66%**

Claims Received By Month

	1/1/2026	2/1/2026	3/1/2026	4/1/2026	5/1/2026	6/1/2026
Claims Received Through	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Apr-26**	**May-26**
Claims Rec'd in HEALTHsuite	320,327	373,154	378,925	389,550	373,472	468,360



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing May 2026 to May 2025 as follows: 30 Days - 96.4% (2026) vs 90.4% (2025)	* 90% of clean claims in 30 calendar days (effective 1/1/2026) * 99% of all claims in 90 calendar days *(interest is required on any claim paid after 30 calendar days)*	* 90% of clean claims in 30 calendar days (effective 1/1/2026) * 99% of all claims in 90 calendar days *(interest is required on any claim paid after 30 calendar days)*
Claims Received - AAH received 468,360 claims for all lines of business in May 2026 vs 387,564 in May 2025	N/A	N/A
EDI - the volume of EDI submissions was 90% which is slightly above the normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 396,142 in May 2026 (21 working days) vs 330,755 in May 2025 (22 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in May 2026 was $153,904,105 (4 check runs) vs $133,062,018 in May 2025 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in May 2026 was $218,482 vs $92,371 in May 2025	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in May 2026 was 87.7% vs 87.6% in May 2025	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in May 2026 was 13 days vs 16 days in May 2025	N/A	<= 25 days
Pended Claim Age - comparing May 2026 to May 2025 as follows: 0-30 calendar days - 38,172 (2026) vs 52,859 (2025) 31-62 calendar days - 2,291 (2026) vs 31,491 (2025) Over 63 calendar days - 4 (2026) vs 57,931 (2025)	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 May 2026 to May 2025	N/A	N/A

Provider Dispute Resolution
April 2026 and May 2026

METRICS

PDR Compliance	Apr-26	May-26
# of PDRs Resolved	2,245	2,131
# Resolved Within 45 Working Days	2,220	2,106
% of PDRs Resolved Within 45 Working Days	99.8%	98.8%

PDRs Received	Apr-26	May-26
# of PDRs Received	3,393	2,648
PDR Volume Total	**3,393**	**2,648**

PDRs Resolved	Apr-26	May-26
# of PDRs Upheld	1,645	1,520
% of PDRs Upheld	73%	71%
# of PDRs Overturned	600	611
% of PDRs Overturned	27%	29%
Total # of PDRs Resolved	**2,245**	**2,245**

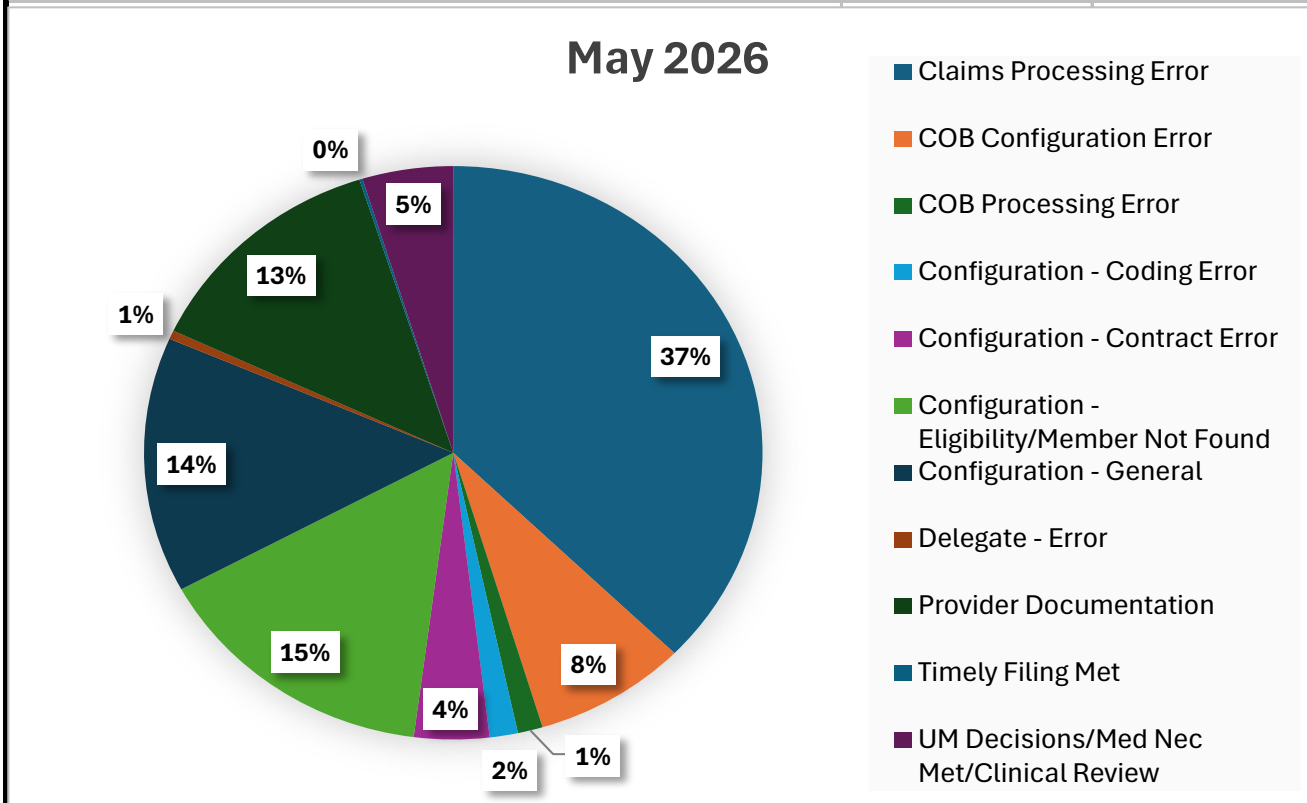
Average Turnaround Time	Apr-26	May-26
Average # of Days to Resolve PDRs	37	39
Oldest Resolved PDR in Days	208	171

Unresolved PDR Age	Apr-26	May-26
0-45 Working Days	4,319	4,242
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**4,319**	**4,242**

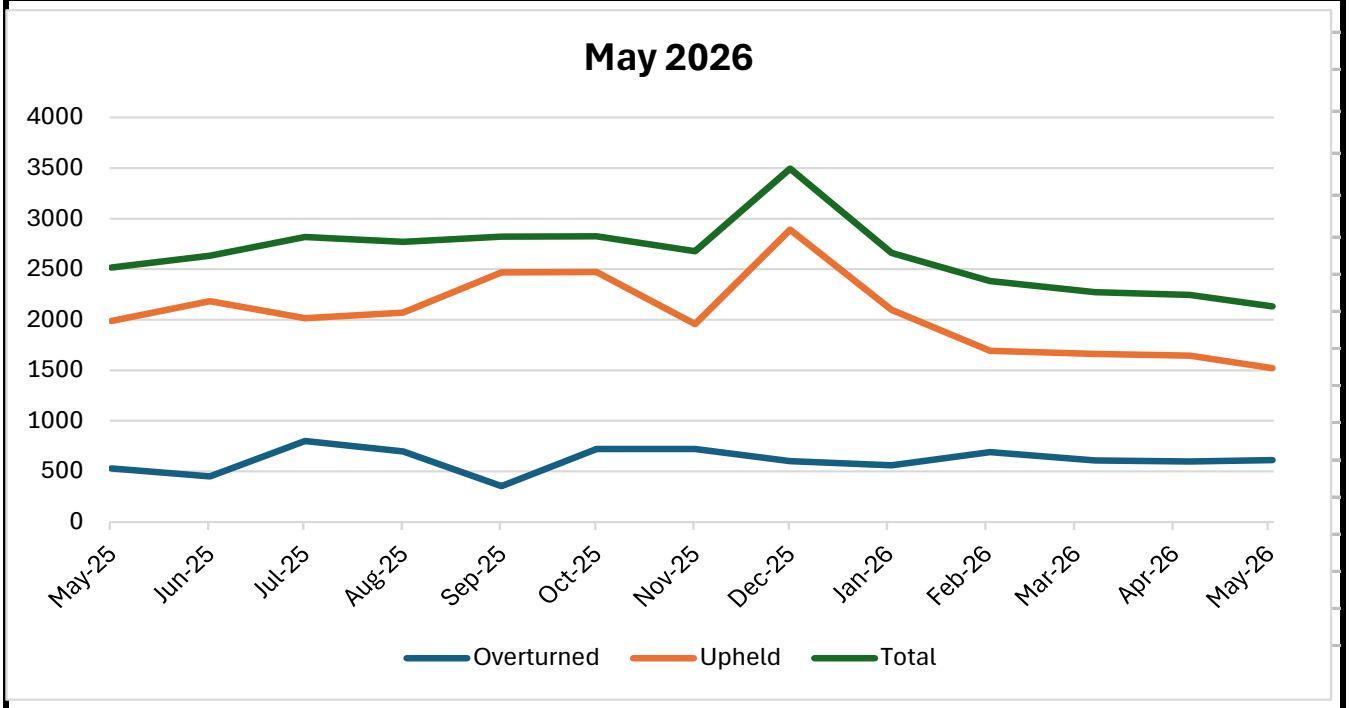
Provider Dispute Resolution
April 2026 and May 2026

May-26

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Provider Dispute Resolution Year Over Year Summary		
# of PDRs Resolved - 2,131 in May 2026 vs 2,517 in May 2025	N/A	N/A
# of PDRs Received - 2,648 in May 2026 vs 2,462 in May 2025	N/A	N/A
# of PDRs Resolved within 45 working days 2,106 in May 2026 vs 2,508 in May 2025	N/A	N/A
% of PDRs Resolved within 45 working days - 98.8% in May 2026 vs 99.6% in May 2025	95%	95%
Average # of Days to Resolve PDRs - 38 days in May 2026 vs 37 days in May 2025	N/A	30
Oldest Resolved PDR in Days - 171 days in May 2026 vs 286 days in May 2025	N/A	N/A
# of PDRs Upheld - 1,520 in May 2026 vs 1,988 in May 2025	N/A	N/A
% of PDRs Upheld - 71% in May 2026 vs 79% in May 2025	N/A	> 75%
# of PDRs Overturned - 611 in May 2026 vs 529 in May 2025	N/A	N/A
% of PDRs Overturned - 29% in May 2026 vs 21% in May 2025	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 37% (2026) vs 36% (2025) Configuration errors - 35% (2026) vs 31% (2025) COB - 9% (2026) vs 10% (2025) Clinical Review/UM Decisions/Medical Necessity Met - 5% (2026) vs 23% (2025)	N/A	N/A

Provider Relations Call Center Dashboard

Alliance Wellness D-SNP

Alliance Provider Relations Staff	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls	1,295	1,152							
Answered Calls	950	962							
Abandoment Calls	345	190							
Outbound Calls	56	43							
Voicemails Received	0	0							
Agent Answered Rate ≥ 85% or above	96%	96%							
Average Speed of Answer ≤ 30 seconds	215 seconds	119 seconds							
Call Abandonment Rate ≤ 15% or less	26%	16%							
Totals	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	1,351	1,195							
Total Abandoned Calls	345	190							
Total Answered Incoming, R/V, Outbound Calls	1,006	1,005							

Medi-Cal and Group Care

Alliance Provider Relations Staff	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls	7,416	5,195							
Answered Calls	5,410	4,375							
Abandoment Calls	2,006	820							
Outbound Calls	507	395							
Voicemails Received	21	3							
Agent Answered Rate ≥ 85% or above	96%	96%							
Average Speed of Answer ≤ 30 seconds	207 seconds	133 seconds							
Call Abandonment Rate ≤ 15% or less	27%	13%							
Totals	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	7,944	5,593							
Total Abandoned Calls	2,006	820							
Total Answered Incoming, R/V, Outbound Calls	5,938	4,773							

Total All Lines of Business	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Incoming Calls	8,711	6,347							
Total Answered Calls	6,360	5,337							
Total Abandoment Calls	2,351	1,010							
Total Outbound Calls	563	438							
Total Voicemails Received	21	3							
Total Incoming, R/V, Outbound Calls	9,295	6,788							
Total Answered Incoming, R/V, Outbound Calls	6,944	5,778							

Provider Relations Call Reasons & Field Visits Dashboard

D-SNP Call Reasons

Category	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
D-SNP Authorizations	3%	1%							
D-SNP Benefits	4%	3%							
D-SNP Claims	59%	53%							
D-SNP Eligibility	18%	27%							
D-SNP Enrollment	1%	0%							
D-SNP PCP Assignment	4%	8%							
D-SNP PDR/Reconsideration	8%	3%							
D-SNP Check Tracer	1%	0%							
D-SNP Provider Portal	1%	2%							
D-SNP Contracts / Credentialing	1%	1%							
D-SNP Interpreter Request	0%	0%							
D-SNP Member Call	1%	0%							
D-SNP Transportation Services	1%	0%							
D-SNP Provider Information Updates / W9	0%	0%							
D-SNP Pharmacy	0%	0%							
TOTAL	100%	100%							

Medi-Cal and Group Care Call Reasons

Category	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	6%	6.1%							
Benefits	5%	4.1%							
Claims Inquiry	39%	41.9%							
Change of PCP	3%	2.2%							
Check Tracer	1%	0.9%							
Complaint/Grievance (includes PDRs)	10%	12.2%							
Contracts/Credentialing	0.7%	0.6%							
Demographic Change	0.1%	0.0%							
Disconnected Calls	4.7%	4.9%							
Eligibility - Call from Provider	19.6%	17.7%							
Exempt Grievance/ G&A	2.3%	0.0%							
Intrepreter Services Request	0.5%	0.4%							
Provider Portal Assistance	1.0%	3.1%							
Pharmacy	0.3%	0.1%							
Prop 56	0.0%	0.1%							
Provider Information Updates/ W9	1.0%	0.5%							
Transportation Services	0.1%	0.1%							
All Other Calls	5.1%	5.0%							
TOTAL	100.0%	100.0%							

Field Visit Activity Details

Alliance Provider Relations Staff	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	47	33							
Contracting/Credentialing	87	70							
Drop-ins	72	142							
JOM's	1	2							
New Provider Orientation	172	246							
Quarterly Visits	0	40							
UM Issues	0	1							
Total Field Visits	379	534	0	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS - May 2026						
Practitioners		PCP 413	SPEC 795	AHP 875	BH/ABA 3,803	PCP/SPEC 12
Direct Network vs Delegated Network Breakdown			AAH 4,595	AHS 296	CHCN 667	COMBINATION OF GROUPS 340
Facilities	431					

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	33	8	Y	Y	Y
Recred Files in Process	34	15	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**67**				
		*** 25 business days = 35 calendar days**			

May 2026 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	3
SPEC	9
ANCILLARY	17
MIDLEVEL/AHP	11
BH/ABA	135
Sub-total	**175**
Recredentialing	
PCP	8
SPEC	21
ANCILLARY	5
MIDLEVEL/AHP	19
BH/ABA	42
Sub-total	**95**
TOTAL	**270**

May 2026 Facility Approvals	
Initial Credentialing	3
Recredentialing	11
Sub-total	**14**
Facility Files in Process	**49**

May 2026 Employee Metrics (6 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 RECRED	CRED DATE
Aguilar	Rosemarie	BH/ABA-Telehealth	INITIAL	5/19/2026
Akpan	Rebecca	BH/ABA-Telehealth	INITIAL	5/19/2026
Alfaro Ruiz	Grecia	BH/ABA	INITIAL	5/19/2026
Ali	Saneaah	BH/ABA-Telehealth	INITIAL	5/19/2026
Arellano	Natalie	BH/ABA	INITIAL	5/19/2026
Banks	Tiffany	Doula	INITIAL	5/19/2026
Banta	Kelly	Specialist	INITIAL	5/19/2026
Barajas-Sanchez	Paulina	BH/ABA	INITIAL	5/19/2026
Barbarovich	Angela	Ancillary	INITIAL	5/19/2026
Barker	Brooke	BH/ABA-Telehealth	INITIAL	5/19/2026
Bauerle	Kaleigh	BH/ABA-Telehealth	INITIAL	5/19/2026
Beachler	Brian	Primary Care Physician	INITIAL	5/19/2026
Berger	Jeff	BH/ABA-Telehealth	INITIAL	5/19/2026
Beutel	Michelle	Doula	INITIAL	5/19/2026
Bibbo	Sarah	BH/ABA-Telehealth	INITIAL	5/19/2026
Blumenfeld	Eric	BH/ABA-Telehealth	INITIAL	5/19/2026
Botts	James	BH/ABA-Telehealth	INITIAL	5/19/2026
Bowman	Danielle	BH/ABA-Telehealth	INITIAL	5/19/2026
Brown	Daniell	BH/ABA-Telehealth	INITIAL	5/19/2026
Brugel	Jessica	BH/ABA	INITIAL	5/19/2026
Campos Perez	Corny	BH/ABA-Telehealth	INITIAL	5/19/2026
Caputy	Gregory	Specialist	INITIAL	5/19/2026
Carey	Jessica	BH/ABA-Telehealth	INITIAL	5/19/2026
Carey	Regan	BH/ABA-Telehealth	INITIAL	5/19/2026
Casillas-Ta	Brittany	BH/ABA-Telehealth	INITIAL	5/19/2026
Chan	Chia-Hua	Ancillary	INITIAL	5/19/2026
Chan	Wai Wai	BH/ABA-Telehealth	INITIAL	5/19/2026
Chang	Jee Hei	Allied Health	INITIAL	5/19/2026
Chapman	Regina	BH/ABA-Telehealth	INITIAL	5/19/2026
Chavers	James	BH/ABA-Telehealth	INITIAL	5/19/2026
Chernick	Spencer	BH/ABA-Telehealth	INITIAL	5/19/2026
Ching	Veronikka	Doula	INITIAL	5/19/2026
Clavell	Ariana	BH/ABA-Telehealth	INITIAL	5/19/2026
Concepcion	Michelle	BH/ABA-Telehealth	INITIAL	5/19/2026
Costa	Suzanne	BH/ABA-Telehealth	INITIAL	5/19/2026
Creer	Dominique	BH/ABA	INITIAL	5/19/2026
Crisp	Courtney	BH/ABA-Telehealth	INITIAL	5/19/2026
De Faria	Danielle	BH/ABA-Telehealth	INITIAL	5/19/2026
Decker	Carolyn	BH/ABA	INITIAL	5/19/2026
DeHoyos	Leticia	BH/ABA-Telehealth	INITIAL	5/19/2026
Dilley	Brianna	BH/ABA	INITIAL	5/19/2026
Dooley	Vernon	BH/ABA-Telehealth	INITIAL	5/19/2026
Dyer	Julia	BH/ABA-Telehealth	INITIAL	5/19/2026
Edell	Aimee	Specialist	INITIAL	5/19/2026
Edwards	Kameron	BH/ABA	INITIAL	5/19/2026
Elegino	Junali	BH/ABA-Telehealth	INITIAL	5/19/2026
Farr	Morteza	Specialist	INITIAL	5/19/2026
Finkelstein	Ann	Primary Care Physician	INITIAL	5/19/2026
Firat	Deniz	BH/ABA-Telehealth	INITIAL	5/19/2026
Flores	Samuel	BH/ABA-Telehealth	INITIAL	5/19/2026
Ford	Courtney	BH/ABA-Telehealth	INITIAL	5/19/2026
Foster	Letoshia	Allied Health	INITIAL	5/19/2026
Fried	Max	BH/ABA-Telehealth	INITIAL	5/19/2026
Garcia	Marianna	BH/ABA-Telehealth	INITIAL	5/19/2026
Garibaldo	Ruben	BH/ABA	INITIAL	5/19/2026

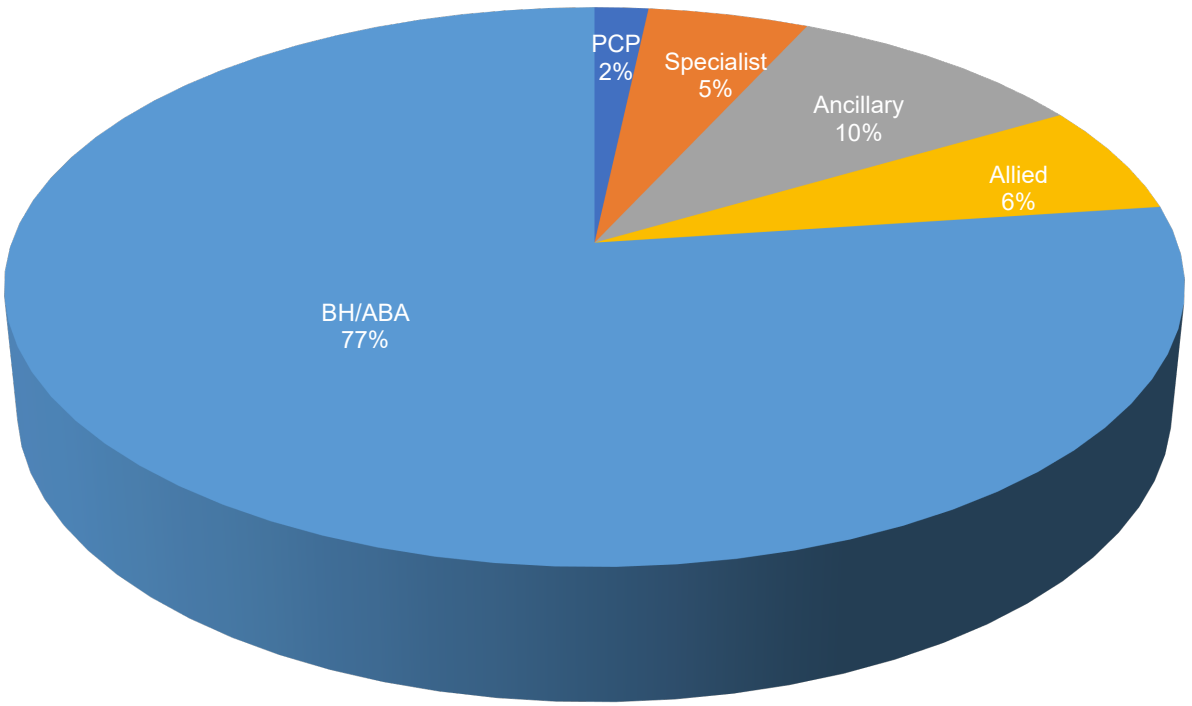
LAST NAME	FIRST NAME	CATEGORY	INITIAL RECRED	CRED DATE
George	Bashari	Doula	INITIAL	5/19/2026
George	Holly	BH/ABA-Telehealth	INITIAL	5/19/2026
Giol	Maria	BH/ABA-Telehealth	INITIAL	5/19/2026
Gonzalez Arman	Jesus	BH/ABA-Telehealth	INITIAL	5/19/2026
Gonzalez Chavez	Marianna	Ancillary	INITIAL	5/19/2026
Gracian	Enrique	BH/ABA-Telehealth	INITIAL	5/19/2026
Grant	Elizabeth	BH/ABA-Telehealth	INITIAL	5/19/2026
Greub	Eston	BH/ABA-Telehealth	INITIAL	5/19/2026
Guardado	Pastora	BH/ABA-Telehealth	INITIAL	5/19/2026
Gutierrez	Rebecca	BH/ABA-Telehealth	INITIAL	5/19/2026
Gutridge	Serena	BH/ABA	INITIAL	5/19/2026
Harrison	Tamara	BH/ABA-Telehealth	INITIAL	5/19/2026
Hauser	Maxwill	BH/ABA-Telehealth	INITIAL	5/19/2026
Heck	Emmalin	BH/ABA-Telehealth	INITIAL	5/19/2026
Henning	Maryjane	BH/ABA-Telehealth	INITIAL	5/19/2026
Hermle	Felicia	BH/ABA-Telehealth	INITIAL	5/19/2026
Hines	Diamond	BH/ABA-Telehealth	INITIAL	5/19/2026
Hobdy	Lisa	BH/ABA-Telehealth	INITIAL	5/19/2026
Holmes	Destiny	Ancillary	INITIAL	5/19/2026
Howry	Savarra	BH/ABA-Telehealth	INITIAL	5/19/2026
Hughes	Lyndsay	BH/ABA	INITIAL	5/19/2026
Huskey	Susanne	BH/ABA-Telehealth	INITIAL	5/19/2026
Johnson	Alfred	Specialist	INITIAL	5/19/2026
Juarez	Maria	BH/ABA-Telehealth	INITIAL	5/19/2026
Kang	Young	Specialist	INITIAL	5/19/2026
Kessel	Samuel	BH/ABA	INITIAL	5/19/2026
Lam	Vanessa	BH/ABA-Telehealth	INITIAL	5/19/2026
Lewis	E'jypt	BH/ABA-Telehealth	INITIAL	5/19/2026
Lewis	Tanaucha	BH/ABA-Telehealth	INITIAL	5/19/2026
Liberato	Michael	Allied Health	INITIAL	5/19/2026
Loong	Jocelyn	BH/ABA-Telehealth	INITIAL	5/19/2026
Lossing	Zachary	BH/ABA-Telehealth	INITIAL	5/19/2026
Lowman	Jacquelyn	Allied Health	INITIAL	5/19/2026
Lyons	Crystal	Doula	INITIAL	5/19/2026
Madsen-Pixler	Stephanie	BH/ABA-Telehealth	INITIAL	5/19/2026
Magana-Chung	Miriam	BH/ABA-Telehealth	INITIAL	5/19/2026
Malik	Majid	BH/ABA-Telehealth	INITIAL	5/19/2026
Manrriquez	Karina	BH/ABA-Telehealth	INITIAL	5/19/2026
Martinez	Destiny	BH/ABA-Telehealth	INITIAL	5/19/2026
Mastrobuono	Julia	BH/ABA-Telehealth	INITIAL	5/19/2026
McPhillips	Katie	BH/ABA-Telehealth	INITIAL	5/19/2026
Medellin	Elizabeth	BH/ABA-Telehealth	INITIAL	5/19/2026
Miller	Jaclyn	BH/ABA-Telehealth	INITIAL	5/19/2026
Mills	Megan	BH/ABA-Telehealth	INITIAL	5/19/2026
Miyamoto	Kenji	BH/ABA-Telehealth	INITIAL	5/19/2026
Montenegro	Ivan	BH/ABA-Telehealth	INITIAL	5/19/2026
Moreno	Natalie	BH/ABA-Telehealth	INITIAL	5/19/2026
Mussio	Jessica	BH/ABA-Telehealth	INITIAL	5/19/2026
Nace	Emma	Allied Health	INITIAL	5/19/2026
Nambo	Jennifer	BH/ABA-Telehealth	INITIAL	5/19/2026
Newman	Michele	Allied Health	INITIAL	5/19/2026
Nguyen	Angelo	BH/ABA	INITIAL	5/19/2026
Nguyen	Annie Thuy Van	Ancillary	INITIAL	5/19/2026
Nguyen	Justina	BH/ABA-Telehealth	INITIAL	5/19/2026
Offiaeli	Ogochukwu	BH/ABA-Telehealth	INITIAL	5/19/2026

LAST NAME	FIRST NAME	CATEGORY	INITIAL RECRED	CRED DATE
Offill	Yvonne	BH/ABA-Telehealth	INITIAL	5/19/2026
Oh-Liverant	Sindy	BH/ABA-Telehealth	INITIAL	5/19/2026
Olguin	Rebeca	BH/ABA-Telehealth	INITIAL	5/19/2026
Olmos	Aimee	Doula	INITIAL	5/19/2026
Ortiz	Ana	BH/ABA-Telehealth	INITIAL	5/19/2026
Panchal	Avni	BH/ABA	INITIAL	5/19/2026
Patel	Megha	Allied Health	INITIAL	5/19/2026
Payne	Christina	BH/ABA	INITIAL	5/19/2026
Paz	Jessica	BH/ABA-Telehealth	INITIAL	5/19/2026
Perez Guerrero	Maria	Doula	INITIAL	5/19/2026
Poon	Oanh	BH/ABA-Telehealth	INITIAL	5/19/2026
Prieto	Laura	Ancillary	INITIAL	5/19/2026
Provencher	Kallie	BH/ABA-Telehealth	INITIAL	5/19/2026
Quan	Maria	Specialist	INITIAL	5/19/2026
Quevedo	Stacia	BH/ABA-Telehealth	INITIAL	5/19/2026
Quintyne-Bent	Kizie	Ancillary	INITIAL	5/19/2026
Raghu	Rahul	Specialist	INITIAL	5/19/2026
Rangel	Aliyah	BH/ABA-Telehealth	INITIAL	5/19/2026
Ray	Kyra	Primary Care Physician	INITIAL	5/19/2026
Rea	Kathryn	Allied Health	INITIAL	5/19/2026
Reed	LaTonya	BH/ABA	INITIAL	5/19/2026
Reutercrona	Claudia	BH/ABA-Telehealth	INITIAL	5/19/2026
Reyes	Erika Mae	BH/ABA-Telehealth	INITIAL	5/19/2026
Roberts	Elisa	BH/ABA-Telehealth	INITIAL	5/19/2026
Roberts	Keyon	BH/ABA-Telehealth	INITIAL	5/19/2026
Rodriguez	Marion	BH/ABA-Telehealth	INITIAL	5/19/2026
Rojas Aguilera	Nelida	Doula	INITIAL	5/19/2026
Rosales	Nancy	BH/ABA-Telehealth	INITIAL	5/19/2026
Rutherford	Jordain	BH/ABA-Telehealth	INITIAL	5/19/2026
Salazar	Janet	BH/ABA-Telehealth	INITIAL	5/19/2026
Schieferstein	Sarina	Doula	INITIAL	5/19/2026
Serrano	Maria	BH/ABA-Telehealth	INITIAL	5/19/2026
Sheppard	Christina	BH/ABA-Telehealth	INITIAL	5/19/2026
Shin	Hannah	BH/ABA-Telehealth	INITIAL	5/19/2026
Song	Da	BH/ABA	INITIAL	5/19/2026
Spezzacatena	Conrad	BH/ABA-Telehealth	INITIAL	5/19/2026
Stancil	Nancy	BH/ABA-Telehealth	INITIAL	5/19/2026
Swindell	Laura	BH/ABA-Telehealth	INITIAL	5/19/2026
Tanaka	Lucia	Allied Health	INITIAL	5/19/2026
Tanner	Marisa	BH/ABA	INITIAL	5/19/2026
Taurek	Davida	BH/ABA-Telehealth	INITIAL	5/19/2026
Taylor	Desree	BH/ABA-Telehealth	INITIAL	5/19/2026
Taylor	Douglas	BH/ABA	INITIAL	5/19/2026
Taylor	Eric	BH/ABA-Telehealth	INITIAL	5/19/2026
Toal	Jacqueline	BH/ABA-Telehealth	INITIAL	5/19/2026
Towns	Hannah	BH/ABA-Telehealth	INITIAL	5/19/2026
Trombla	Laurie	Allied Health	INITIAL	5/19/2026
Tubbs	Stephanie	BH/ABA-Telehealth	INITIAL	5/19/2026
Van Lingen	Alexandra	BH/ABA-Telehealth	INITIAL	5/19/2026
Vang	Yang	BH/ABA-Telehealth	INITIAL	5/19/2026
Vasquez	George	BH/ABA-Telehealth	INITIAL	5/19/2026
Vasquez Lopez	Dalia	Doula	INITIAL	5/19/2026
Vasquez-Salazar	Jessica	BH/ABA-Telehealth	INITIAL	5/19/2026
Vaughn	Dylan	BH/ABA-Telehealth	INITIAL	5/19/2026
Velazquez	Isabella	BH/ABA-Telehealth	INITIAL	5/19/2026
Vestil	Lana	BH/ABA	INITIAL	5/19/2026

LAST NAME	FIRST NAME	CATEGORY	INITIAL RECRED	CRED DATE
Vien	Tammy	Allied Health	INITIAL	5/19/2026
Wahlig	Nancy	BH/ABA-Telehealth	INITIAL	5/19/2026
Walker	Destiny	BH/ABA	INITIAL	5/19/2026
Warda	Shauna	BH/ABA-Telehealth	INITIAL	5/19/2026
Wilson	AnnaLisa	BH/ABA-Telehealth	INITIAL	5/19/2026
Wolf	Matthew	BH/ABA-Telehealth	INITIAL	5/19/2026
Won	Connie	BH/ABA-Telehealth	INITIAL	5/19/2026
Zaman	Warda	Specialist	INITIAL	5/19/2026
Zuckerbrow	Mark	BH/ABA-Telehealth	INITIAL	5/19/2026
Abraham	Jennifer	BH/ABA	RECRED	5/19/2026
Ahmed	Hiba	Ancillary	RECRED	5/19/2026
Alvarez	Mayra	Allied Health	RECRED	5/19/2026
Anderson	Portia	BH/ABA	RECRED	5/19/2026
Apriletti	Tara	Allied Health	RECRED	5/19/2026
Asuquo	Stella	Specialist	RECRED	5/19/2026
Baxter	Carson	BH/ABA	RECRED	5/19/2026
Beal	Madison	Allied Health	RECRED	5/19/2026
Behera	Sujata	Allied Health	RECRED	5/19/2026
Behrman	Victoria	Primary Care Physician	RECRED	5/19/2026
Belmondo	Christopher	BH/ABA	RECRED	5/19/2026
Bravo	Maria	BH/ABA	RECRED	5/19/2026
Bullard	Madelyn	BH/ABA	RECRED	5/19/2026
Burroughs	Richard	Specialist	RECRED	5/19/2026
Cain	Ke'Aarre	BH/ABA	RECRED	5/19/2026
Campos-Pantoja	Marc	BH/ABA	RECRED	5/19/2026
Chacon	Elizabeth	Allied Health	RECRED	5/19/2026
Chen	Kevin	Ancillary	RECRED	5/19/2026
Cheung	Norman	Specialist	RECRED	5/19/2026
Chong	Erica	Allied Health	RECRED	5/19/2026
Clark	Melissa	Ancillary	RECRED	5/19/2026
Danishwar	Shireen	Ancillary	RECRED	5/19/2026
Dashe	Jesse	Specialist	RECRED	5/19/2026
Desai	Rini	Specialist	RECRED	5/19/2026
Dobroff	Christie	BH/ABA	RECRED	5/19/2026
Drury	Jessica	Allied Health	RECRED	5/19/2026
Dy	Lalaine	Allied Health	RECRED	5/19/2026
Eck	Ivan	Specialist	RECRED	5/19/2026
Edmunds	Magdalen	Primary Care Physician	RECRED	5/19/2026
Elias	Christine	Specialist	RECRED	5/19/2026
Ewing	Mya	BH/ABA	RECRED	5/19/2026
Fallin	Donald	BH/ABA	RECRED	5/19/2026
Fisher	Orna	Specialist	RECRED	5/19/2026
Ford	Lauren	BH/ABA	RECRED	5/19/2026
Franco	Diana	BH/ABA	RECRED	5/19/2026
Ganti	Shashi	Specialist	RECRED	5/19/2026
Gonzalez	Catalina	Allied Health	RECRED	5/19/2026
Gray	Carl	Primary Care Physician	RECRED	5/19/2026
Grewal	Jaskirandeep	Allied Health	RECRED	5/19/2026
Guo	Yanhong	BH/ABA	RECRED	5/19/2026
Gupta	Vanshika	BH/ABA-Telehealth	RECRED	5/19/2026
Hodge	Aaliyah	Primary Care Physician	RECRED	5/19/2026
Hussain	Ahmed	Specialist	RECRED	5/19/2026
Huynh	Vivian	BH/ABA	RECRED	5/19/2026
Isariuz	Alexsa	BH/ABA-Telehealth	RECRED	5/19/2026
Japra	Romesh	Specialist	RECRED	5/19/2026

LAST NAME	FIRST NAME	CATEGORY	INITIAL RECRED	CRED DATE
Jaros	Allegra	BH/ABA-Telehealth	RECRED	5/19/2026
Jehtara	Amreen	BH/ABA	RECRED	5/19/2026
Karamloo	Sara	Specialist	RECRED	5/19/2026
Kasberger	Kate	Primary Care Physician	RECRED	5/19/2026
Kelsen	Kenneth	Specialist	RECRED	5/19/2026
Keyashian	Brian	Specialist	RECRED	5/19/2026
Kim	Amy	Allied Health	RECRED	5/19/2026
Kumelachew	Hiruth	Allied Health	RECRED	5/19/2026
Lai	Eric	Specialist	RECRED	5/19/2026
Lam	Carmen	Specialist	RECRED	5/19/2026
Lam	Wingsze	BH/ABA	RECRED	5/19/2026
Lang	John	BH/ABA	RECRED	5/19/2026
Leung	Karla	BH/ABA	RECRED	5/19/2026
Lo	Daphne	Primary Care Physician	RECRED	5/19/2026
Martin Palley	Emile	BH/ABA	RECRED	5/19/2026
McAlear	Matthew	BH/ABA	RECRED	5/19/2026
McDougal	Tiffany	BH/ABA-Telehealth	RECRED	5/19/2026
McKee	Katherine	Allied Health	RECRED	5/19/2026
Mendoza	Denisse	BH/ABA-Telehealth	RECRED	5/19/2026
Michaels	Samuel	BH/ABA-Telehealth	RECRED	5/19/2026
Mojarro	Alyssa	BH/ABA	RECRED	5/19/2026
Mokaya	Diana	Primary Care Physician	RECRED	5/19/2026
Morris	Caretta	BH/ABA	RECRED	5/19/2026
Newmark	Jordan	Specialist	RECRED	5/19/2026
Nguyen	Chinh	BH/ABA-Telehealth	RECRED	5/19/2026
Oatman	Annalise	BH/ABA-Telehealth	RECRED	5/19/2026
Oliveira-Maxfield	Dawn	BH/ABA	RECRED	5/19/2026
Ortiz	Ofelia	Specialist	RECRED	5/19/2026
Park	Amos	Ancillary	RECRED	5/19/2026
Patel	Bijal	Specialist	RECRED	5/19/2026
Patel	Bimal	Specialist	RECRED	5/19/2026
Perkins	Carissa	Allied Health	RECRED	5/19/2026
Pineros	Dwan	Primary Care Physician	RECRED	5/19/2026
Rieken	Nicholas	Allied Health	RECRED	5/19/2026
Rizzo	Theresa	BH/ABA	RECRED	5/19/2026
Sachdev	Neelam	BH/ABA-Telehealth	RECRED	5/19/2026
Samuel	Lysa	Allied Health	RECRED	5/19/2026
Sands	Sophie	BH/ABA	RECRED	5/19/2026
Shang	Heping	BH/ABA	RECRED	5/19/2026
Shaw-Zak	Ian	BH/ABA	RECRED	5/19/2026
Shiver	Sheba	BH/ABA-Telehealth	RECRED	5/19/2026
Sommers	Mathew	Allied Health	RECRED	5/19/2026
Stoddard	Lisa	BH/ABA-Telehealth	RECRED	5/19/2026
Strack	Janine	BH/ABA-Telehealth	RECRED	5/19/2026
Suri	Krishna	Specialist	RECRED	5/19/2026
Sutton	Chandler	BH/ABA-Telehealth	RECRED	5/19/2026
Tarbox	Courtney	BH/ABA-Telehealth	RECRED	5/19/2026
Tjandra	Cornelia	Allied Health	RECRED	5/19/2026
Torres-Ramos	Sonia	Allied Health	RECRED	5/19/2026

MAY PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	3
SPECIALIST	9
ANCILLARY	17
ALLIED HEALTH	11
BH/ABA	135
TOTAL	175

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2025-2026 | **MAY 2026 OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY
FY 2025-2026 | **MAY 2026 OUTREACH REPORT**

Alliance in the Community Events and Activities:
In May 2026, the Alliance completed **722** member orientation outreach calls among net new and non-utilizer members and conducted **64** net new member orientations and **9** non-utilizer member orientations (**10%** member participation rate). In addition, the Outreach team completed **5** service requests, **3** website inquiries, **6** community events, and **2** member education events. The Alliance reached a total of **802** people and spent a total of **$518.53** on donations, fees, and/or sponsorships at the following events and activities: Oakland Community Block Party, 5th Annual Block Party & Resource Fair, 35th Convention Exhibitor Information, 2026 Livermore Downtown Street Festival, Annual Free Children's Fair, BOSS Hayward Mental Wealth Block Party, and the Father Friendly Providers Network.

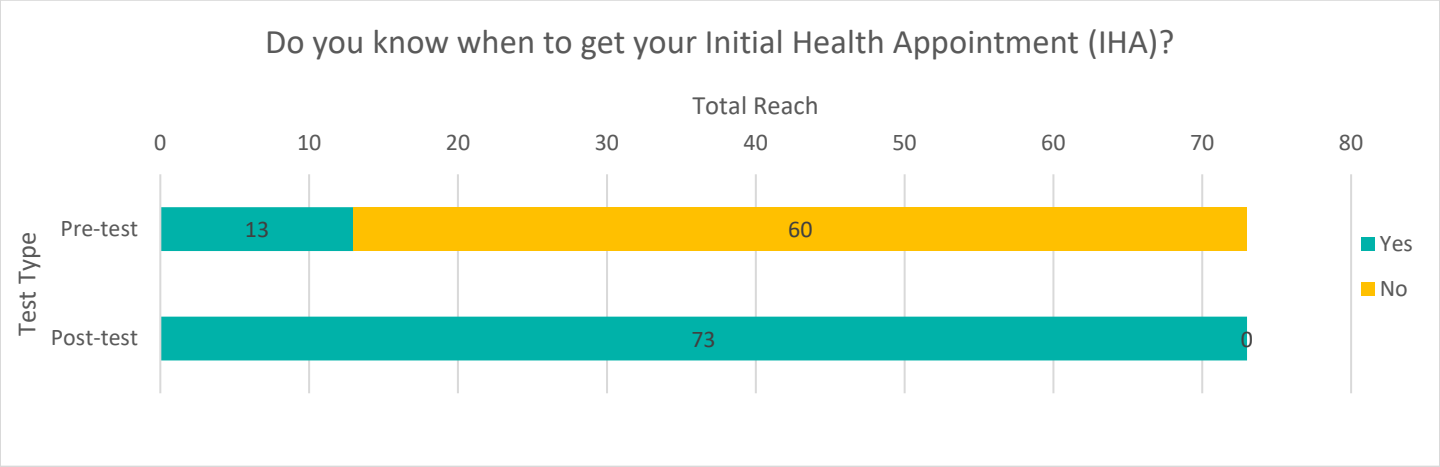
Since July 2018, **46,581** self-identified Alliance members have been reached during outreach activities.

Alliance Member Orientation Program:

The Alliance Member Orientation (MO) program, launched in 2016, is recognized as a promising practice by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD) to increase member knowledge and awareness about the Initial Health Appointment (IHA).

On Wednesday, March 18, 2020**,** the Alliance began conducting member orientations by phone. As of May 31, 2026, the Outreach Team has completed **57,600** member orientation outreach calls and conducted **10,505** member orientations (**18.2%** member participation rate).

Between May 1, through May 31, 2026 (20 working days) **73** members completed an MO by phone. After completing the MO, **100%** of members who completed the post-test survey in May 2026 reported knowing when to get their IHA, compared to only **18%** 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 25-26\Q4\May 2026**

ALLIANCE IN THE COMMUNITY
FY 2025-2026 | **MAY 2026 OUTREACH REPORT**

FY 2025-2026 MAY 2026 TOTALS

6 COMMUNITY EVENTS
2 MEMBER EDUCATION EVENTS
73 MEMBER ORIENTATIONS
0 MEETINGS/ PRESENTATIONS
0 COMMUNITY TRAINING
10 TOTAL INITIATED/ INVITED EVENTS
81 TOTAL COMPLETED **EVENTS**

15 CITIES**

Alameda
Ashland
Berkeley
Cherryland
Dublin
Fairview
Fremont
Hayward
Livermore
Newark
Oakland
Pleasanton
San Leandro
San Lorenzo
Union City

733 TOTAL REACHED AT COMMUNITY EVENTS
69 TOTAL REACHED AT MEMBER EDUCATION EVENTS
73 TOTAL REACHED AT MEMBER ORIENTATIONS
0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
0 COMMUNITY TRAINING
398 MEMBERS REACHED AT ALL EVENTS
875 **TOTAL REACHED AT ALL EVENTS**

$518.53 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2024-2025 MAY 2025 TOTALS

0 COMMUNITY EVENTS
4 MEMBER EDUCATION EVENTS
92 MEMBER ORIENTATIONS
0 MEETINGS/ PRESENTATIONS/
0 COMMUNITY TRAINING
12 TOTAL INITIATED/ INVITED EVENTS
96 TOTAL COMPLETED **EVENTS**

12 CITIES**

Alameda
Ashland
Berkeley
Dublin
Fremont
Hayward
Livermore
Oakland
Pleasanton
San Leandro
San Lorenzo
Union City

0 TOTAL REACHED AT COMMUNITY EVENTS
266 TOTAL REACHED AT MEMBER EDUCATION EVENTS
92 TOTAL REACHED AT MEMBER ORIENTATIONS
0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
0 TOTAL REACHED AT COMMUNITY TRAINING
217 MEMBERS REACHED AT ALL EVENTS
358 **TOTAL REACHED AT ALL EVENTS**

$0.00 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

***Cities represent the mailing address designations for members who completed a member orientation by phone and community event. The italicized cities are outside of Alameda County.*

COMMUNICATIONS & OUTREACH DEPARTMENT

SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | **May 2026**

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 **May 1, 2026**, and **May 31, 2026**:

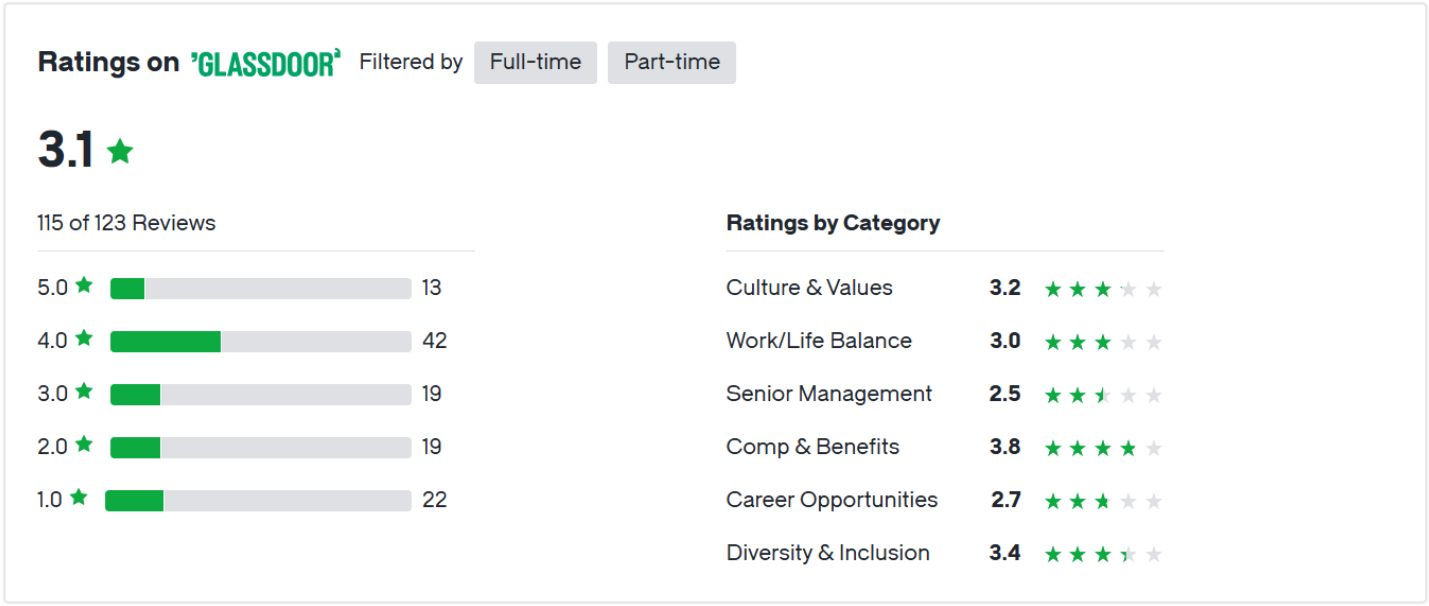
1. Alliance Website:
    - Received **186,100** unique visits
    - Served more than **1**,**200,000** page visits
    - The top **10** website page visits were:
        i. Homepage
        ii. Providers
        iii. Find a Doctor
        iv. Provider Portal
        v. Medi-Cal
        vi. Benefits and Covered Services
        vii. Members
        viii. Get a New ID Card
        ix. Contact Us
        x. Careers
2. Facebook Page:
    - Increased followers from **700** to **702**
    - Did not receive any reviews in **May 2026**
3. Glassdoor Page:
    - Maintained **3.1** out of a **5-star** overall rating
    - Did not receive any reviews in **May 2026**
4. Google Page:
    - **1,754** website clicks were made from the business profile
    - **1,682** calls were made from the business profile
    - Receive one (1) review in **May 2026**
5. Instagram Page:
    - Increased in followers from **738** to **746**
6. LinkedIn Page:
    - Increased followers from **7.5k to 7.6k**
    - Received **63** page clicks
7. X (previously Twitter) Page:
    - Slight decrease in followers from **353 to 351**
8. Yelp Page:
    - Page visits **49**
    - Appeared in Yelp searches **67** times
    - Did not receive any reviews in **May 2026**

COMMUNICATIONS & OUTREACH DEPARTMENT

SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | **May 2026**

GLASSDOOR OVERVIEW

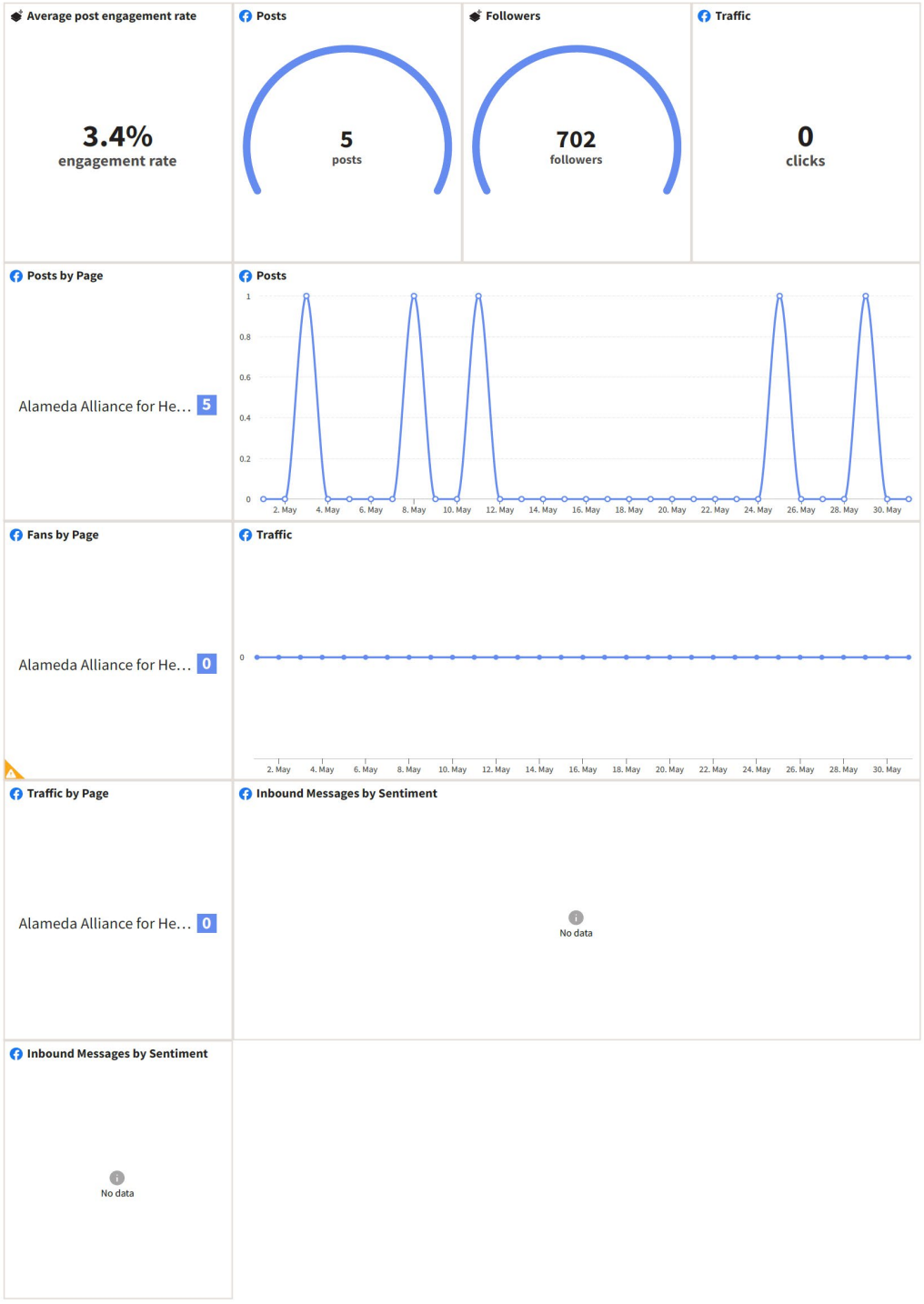


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q4\2. May 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | **May 2026**

FACEBOOK OVERVIEW



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q4\2. May 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | **May 2026**

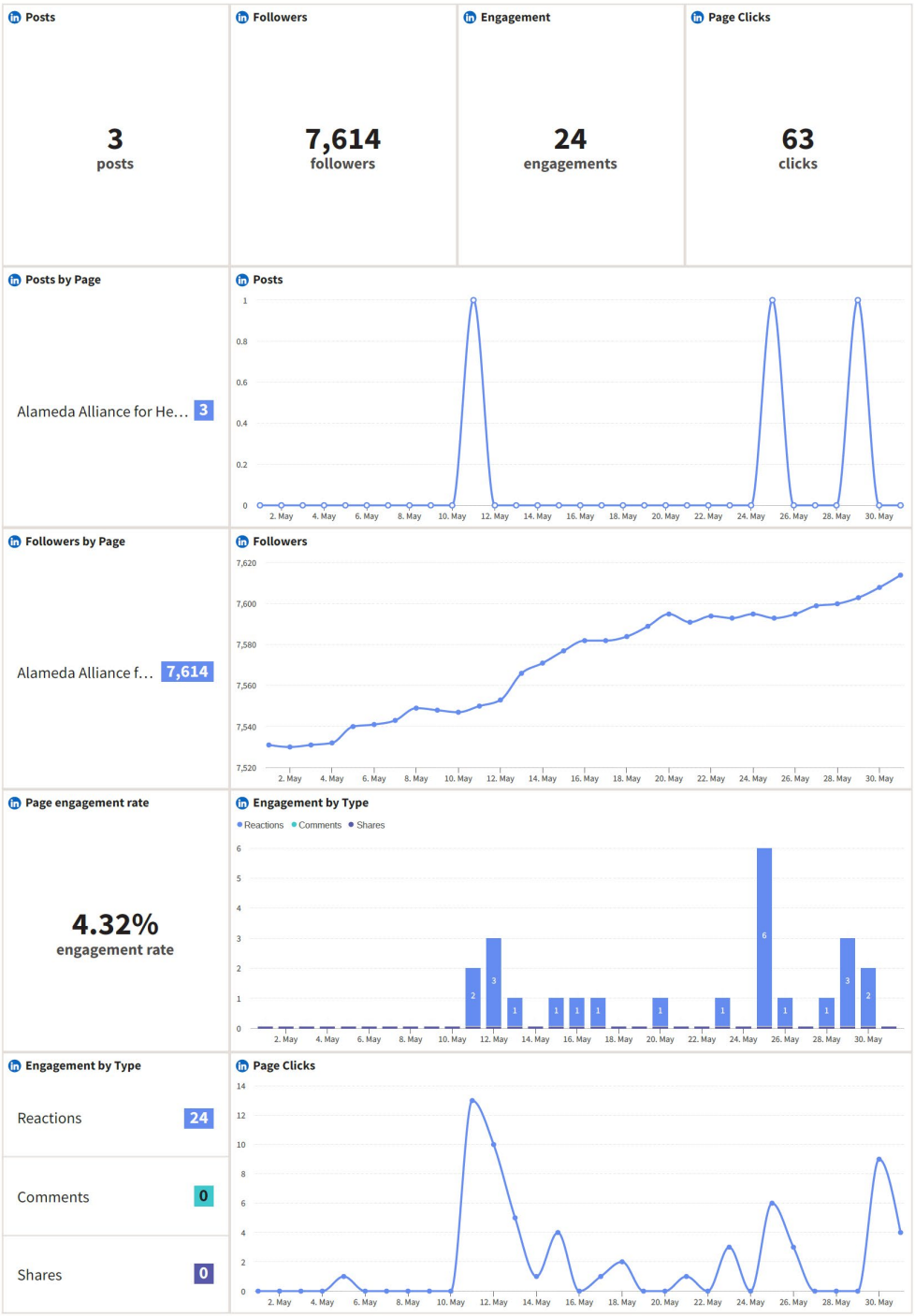
X (previously TWITTER) OVERVIEW

All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q4\2. May 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | **May 2026**

LINKEDIN OVERVIEW



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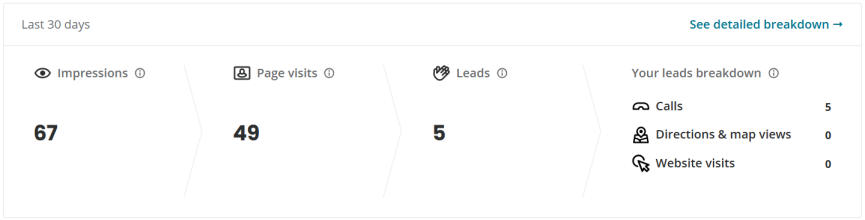
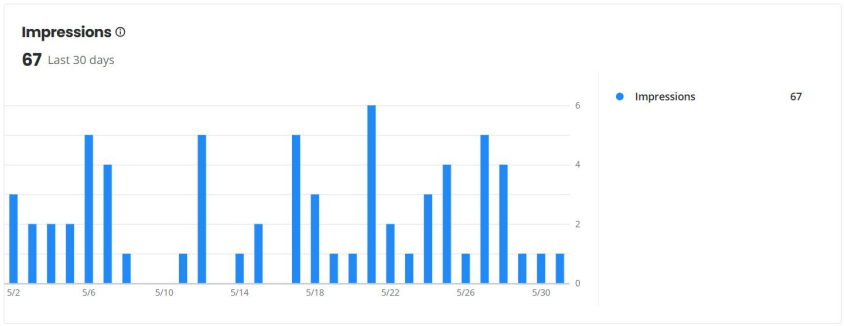
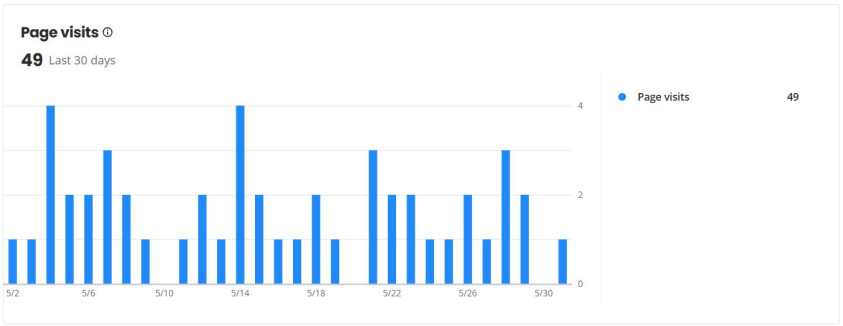
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

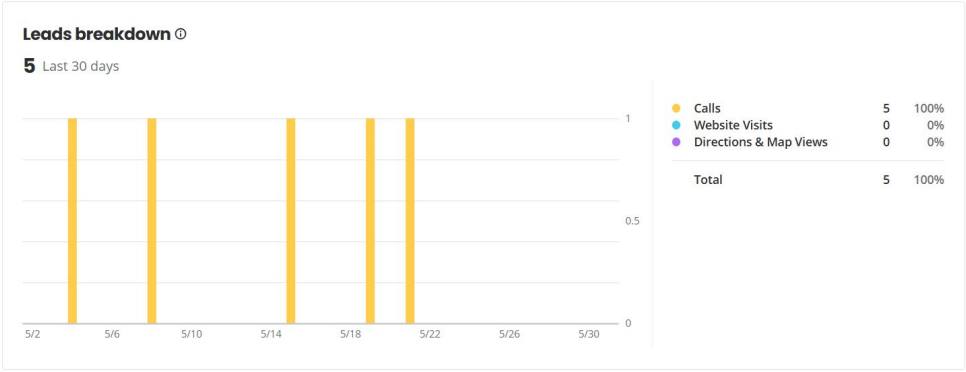
FY 2025-2026 | **May 2026**

YELP OVERVIEW









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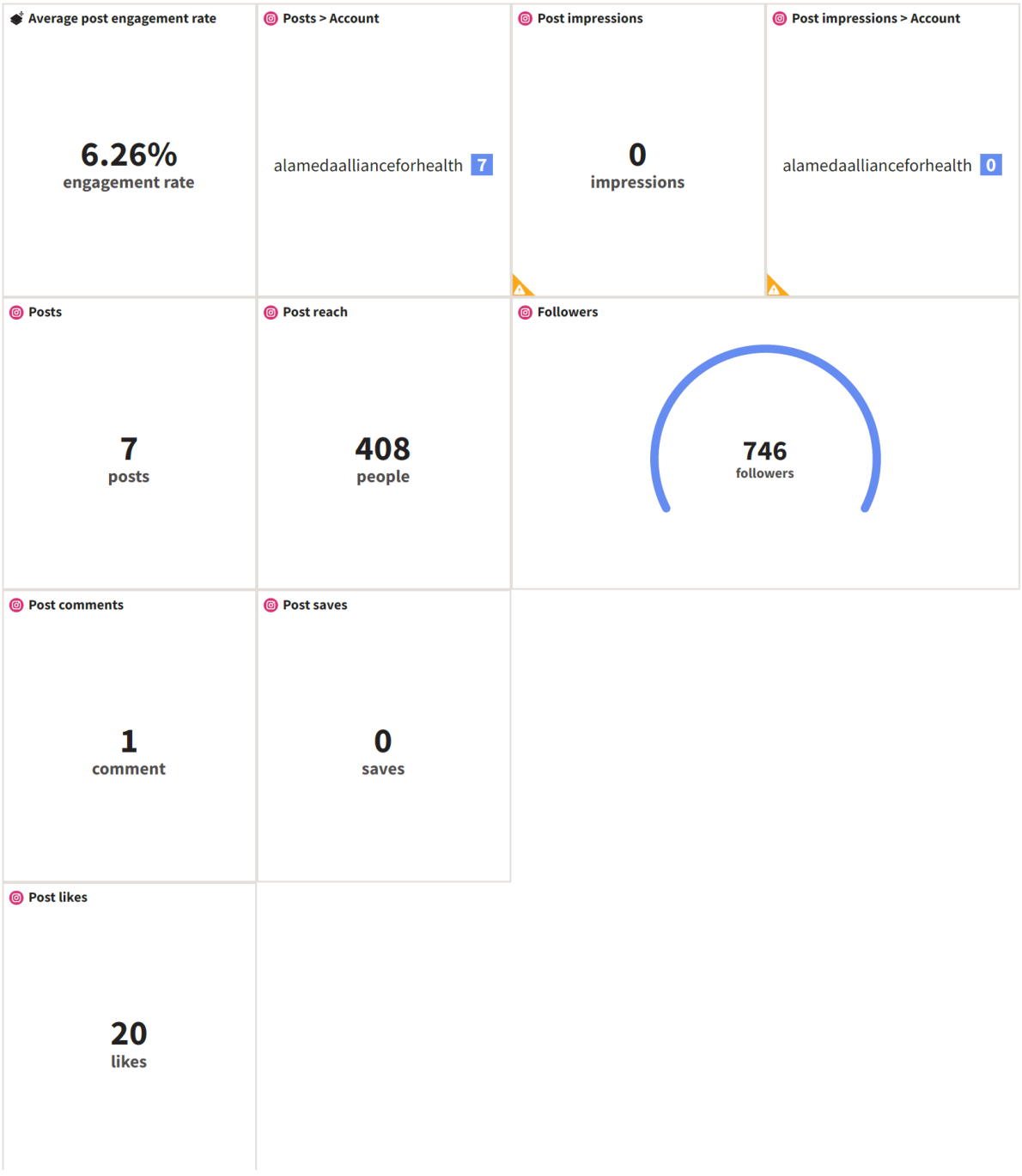
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | **May 2026**

INSTAGRAM OVERVIEW:



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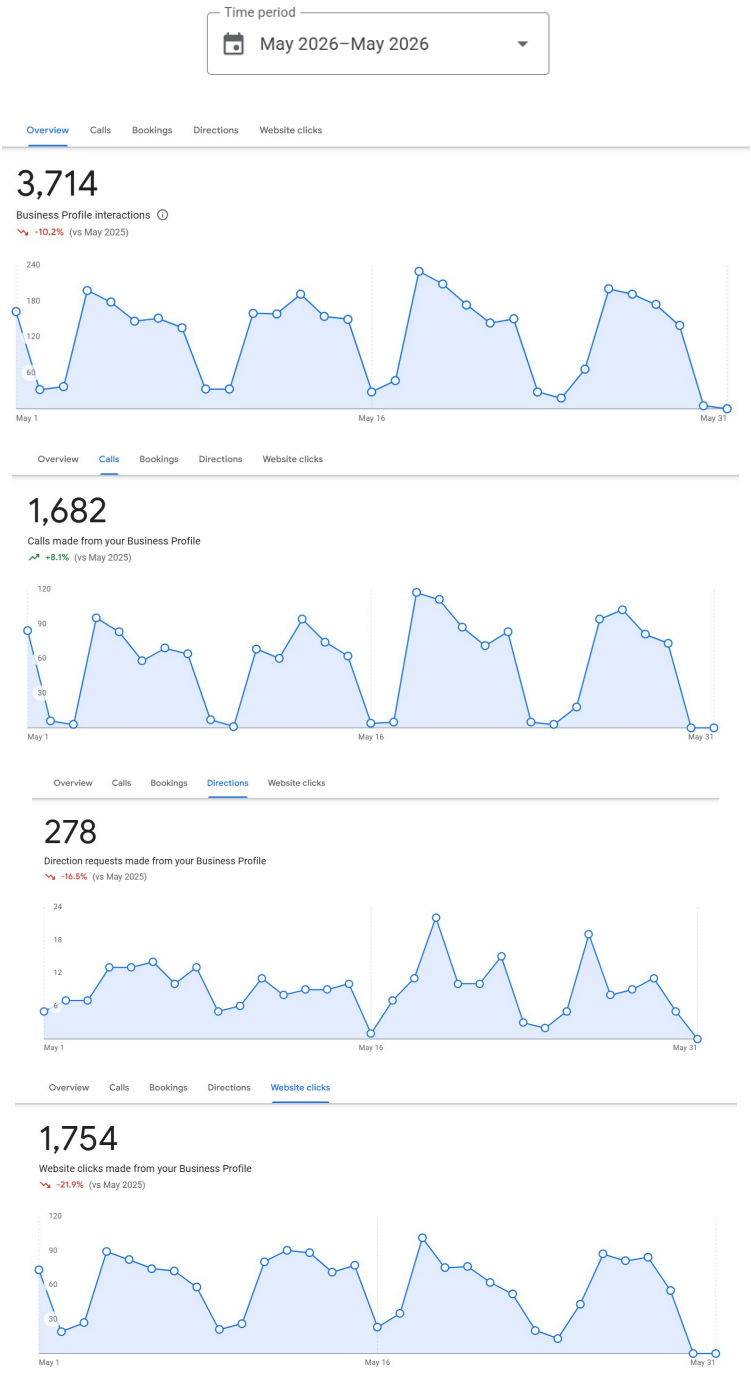
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | **May 2026**

GOOGLE OVERVIEW:



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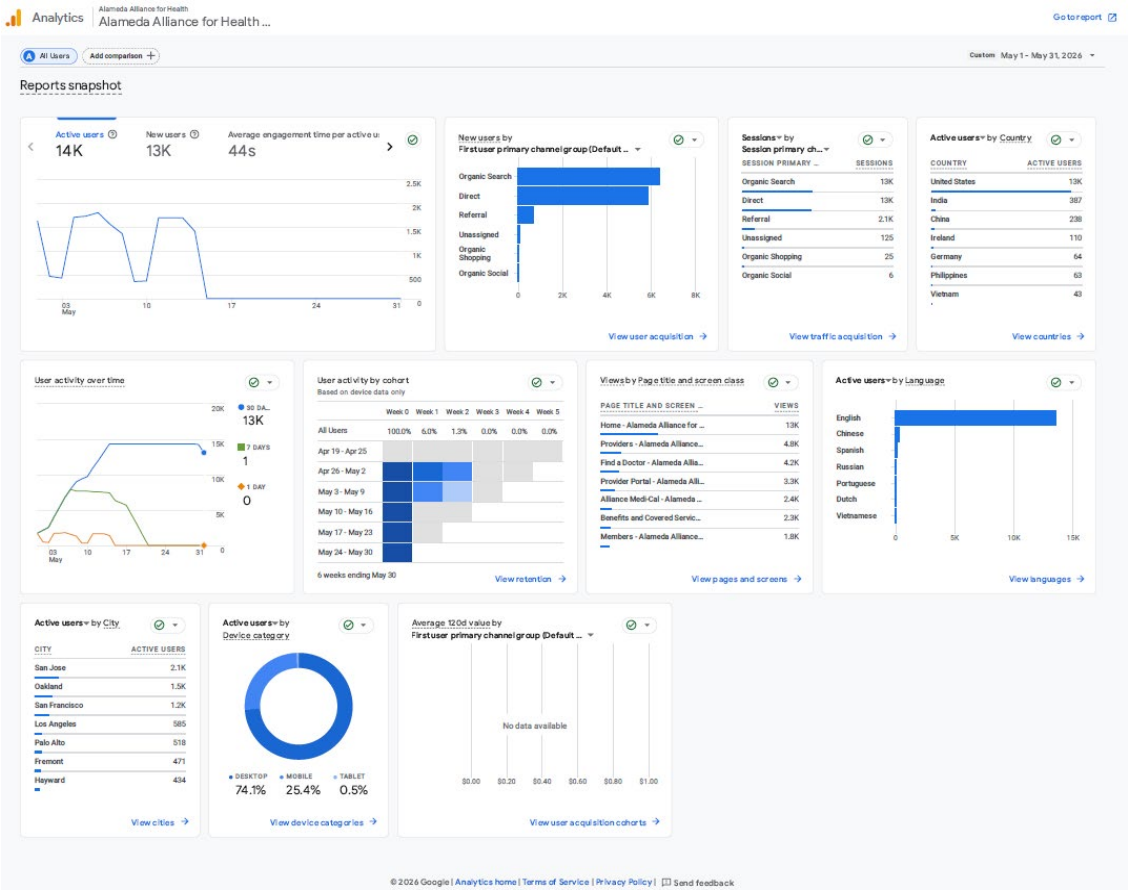
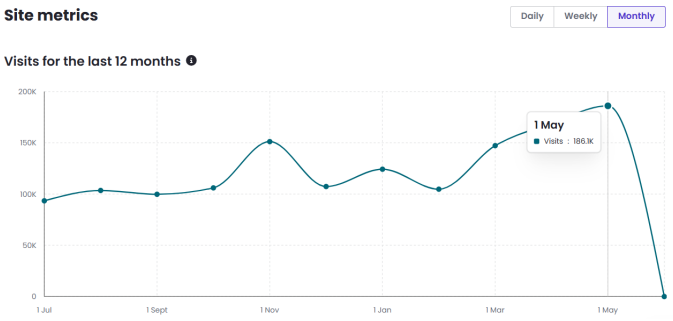
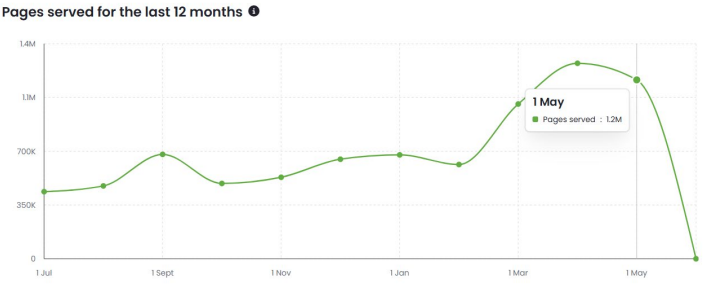
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | **May 2026**

ALLIANCE WEBSITE OVERVIEW:







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Compliance

Stephen Smythe

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

From: **Stephen A Smythe, Interim Chief Compliance & Privacy Officer**

Date: **June 12th, 2026**

Subject: **Compliance Division Report**

Enterprise Audit Updates

- 2025 Department of Managed Health Care (DMHC) Routine Full Medical Survey
    - The Plan received the Department's final report on May 19th, 2026. There was a total of sixteen (16) deficiencies identified, four (4) were determined to be corrected based on the Plan's CAP response and documents submitted on February 17th, 2026. Twelve (12) deficiencies remain unmitigated, which will require continued oversight and a follow-up survey within nine (9) months. The Department requested supplemental information and a status update on two (2) deficiencies. The Plan's response to the supplemental request is due July 18th, 2026.
- 2026 Department of Health Care Services (DHCS) Routine Audit
    - The Plan has completed its annual audit with DHCS. The Department held an initial preliminary exit conference with the Plan on March 23rd, 2026. The DHCS identified twelve (12) preliminary findings: Utilization Management three (3), Enhanced Case Management two (2), Claims one (1), Grievance & Appeals six (6). There is one (1) repeat finding under Appeals and one area of concern related to Quality. The Department is still conducting quality review of the draft audit reports. Upon completion DHCS will contact the Plan to confirm the date for the exit conference.

Compliance Program Activity

- Vision Service Plan Material Modification
    - The Plan selected Vision Service Plan (VSP) as its vision provider for both the D-SNP and Medi-Cal lines of business. DMHC required both the Plan and VSP to submit Material Modification e-Filings for review and approval. Prior to the D-SNP launch, DMHC granted conditional approval. On May

28th, 2026, the Plan received additional comments and submitted a response on June 2nd, 2026.

- Compliance Support of Pharmacy Benefit Manager Transition
    - The Alliance is preparing to engage with the Department of Managed Health Care (DMHC) through a pre-filing conference to support a forthcoming Material Modification related to the transition from PerformRx to MedImpact as the Plan's pharmacy benefit manager (PBM). This transition is required as PerformRx is exiting the PBM business by the end of 2026, impacting both Group Care and D-SNP lines of business.
- Network Adequacy Submissions
    - Subcontractor Network Certification (SNC) - DHCS completed its review of the Plan's 2025 SNC Landscape Analysis and provided approval in advance of the SNC Exhibits submission. The Compliance Division submitted all 2025 SNC Exhibits to DHCS on February 13th, 2026, and continues to work with internal resources to respond to DHCS' follow up requests. The submission is pending DHCS' final review.
    - Annual Network Certification (ANC) - DHCS requires Medi-Cal managed care plans to demonstrate compliance with time and distance standards, mandatory provider types, and related policies and procedures. The Compliance team submitted all 2025 ANC Exhibits to DHCS on February 16th, 2026. For this cycle, DHCS continues to apply a weighted population point methodology, requiring a minimum of 99% compliance with time or distance standards. DHCS also expanded the use of ArcGIS-based mapping and clarified telehealth and Alternative Access Standard (AAS) documentation expectations. The Plan elected to participate in a full review process and coordinated with internal subject matter experts to support submission. The submission is pending DHCS' final review.
- Legislative and Regulatory Implementation
    - On December 19th, 2025, DMHC published APL 25-020 which provides guidance and outlines compliance requirements related to twelve (12) newly enacted statutes. Of the twelve statues, one is not applicable to the Alliance and two statues for which the Plan is awaiting additional DMHC guidance. On April 14th, 2026, the Plan received and responded to its first round of comments on May 13th, 2026.

- DMHC published APL 25-021 on December 30th, 2025. The APL provides guidance and outlines Senate Bill (SB) 729 - Treatment for Infertility and Fertility Services compliance requirements. Although it is only applicable to Group Care, implementation of SB 729 is operationally complex, as a result implementation has been elevated to an enterprise-wide project. The internal workgroup continues to meet on a weekly basis and is expecting to go-live by January 1st, 2027. On May 13th, 2026, the Plan submitted updated Policies and Procedures to DMHC.

- CY 2027 Medicare Final Rule – Implementation Planning
    - On April 2nd, 2026, CMS (Centers for Medicare and Medicaid Services) published CY 2027 Medicare Final Rule. Review of the final rule identified minimal policy and process gaps.
    -

Alameda Alliance Privacy Office (The Privacy Office): Operational Updates

- 2026 Notice of Privacy Practices (NPP) Update
    - Completed and submitted Notice of Privacy Practices updates for DHCS and DMHC CMS filing with expansion and clarification of confidential communications, substance use disorder, and sensitive services sections.
    - Reduced NPP readability from college prep to eighth-grade level while maintaining regulatory accuracy, supporting member comprehension, and compliance expectations.
- Q1 2026 Executive Summary Reports Prepared to include:
    - The Alliance HIPAA Trends
    - HIPAA Incidents Referred to Covered Entities (CE's)
    - Physical and Operational PHI Protection
- 2026 Minor Consent to Medical Care Policy Update
    - Clarifies minor consent and confidentiality. Defines when minors may consent to care, limits parental access, and standardizes identity/authority verification and confidentiality protections across departments and delegates; aligned with federal privacy rules and California minor consent law, with enhanced safeguards for Substance Abuse Disorder (SUD) and outpatient mental health services.

- Strengthens disclosure controls by adding practical safeguards to prevent unintended disclosures, including suppressing certain member communications when required, tightening the release of information controls, and reinforcing members' rights to request confidential communications.

Alameda Alliance Special Investigations Unit: Operational Updates

- Fraud, Waste, and Abuse Program Overview and Performance
  - The Special Investigations Unit (SIU) continues to receive and evaluate potential fraud, waste, and abuse (FWA) allegations from both internal and external sources, with ongoing efforts focused on timely investigation, appropriate case disposition, and optimizing the use of investigative resources.
  - In May 2026, the SIU received six (6) new referrals that were determined to be potentially FWA-related and reportable to DHCS.
  - Since the previous reporting period, the SIU has continued to advance enhancements to FWA-related processes identified during the recent DHCS audit. Current efforts remain focused on strengthening verification of services procedures to promote clearer documentation standards, improved consistency in application, and sustained alignment with regulatory expectations.
  - As these process improvements continue to be implemented, the SIU has maintained steady progress in advancing active investigations toward resolution. In May 2026, one (1) investigation was completed and closed.
  - The structured case-management review framework, supported by ongoing collaboration across cross-functional teams, remains fully operational and continues to strengthen risk-based prioritization of investigations. These efforts support ongoing monitoring of emerging trends, with a continued focus on areas of higher potential financial exposure, program integrity risk, and regulatory sensitivity.

Enterprise Risk Management (ERM) and Operational Oversight Updates

- The Compliance Committee approved the ERM framework and risk taxonomy. The ERM team continues to work with organizational leaders to calibrate identified risks against the proposed risk assessment methodology.

- The Compliance Committee approved the Internal Audit Plan. Internal Audit has also initiated enterprise audits, including work related to the Business Continuity Plan.
- ERM-IA has scheduled upcoming office hours covering key topics, including common audit process gaps and proactive mitigation strategies, root cause analysis techniques, effective internal controls, and ERM fundamentals (risk taxonomy and COSO alignment). This effort supports enhanced organizational understanding of the ERM framework and the evolution of Internal Audit.
- The Compliance Committee approved both the ERM framework and risk taxonomy, as well as the Internal Audit Plan, establishing key governance foundations for an integrated ERM-IA program. The ERM team continues to partner with business leaders to calibrate risks in alignment with the proposed risk assessment methodology, supporting consistent enterprise-wide application. Internal Audit has commenced enterprise audits, including work related to the Business Continuity Plan, advancing organizational readiness and resilience. In parallel, ERM-IA has launched a series of office hours focused on common audit process gaps, root cause analysis, effective internal controls, and ERM fundamentals, including risk taxonomy and COSO alignment. These efforts are designed to strengthen organizational capability, promote consistency in risk and control practices, and support the continued maturation of the ERM and Internal Audit functions.

Compliance

Supporting Documents

2026 All Plan Letter (APL) List						
#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
1	1/1/2026	DHCS	26-001	Initial Health Appointment	MEDI-CAL, D-SNP	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding the requirements of the Initial Health Appointment (IHA) beginning January 1, 2023. This APL supersedes APL 22-030. This APL update provides technical fixes only.
2	1/2/2026	DMHC	26-001	National Committee for Quality Assurance Accreditation Compliance Filing	GROUP CARE	The purpose of this All Plan Letter (APL) is to inform health plans of the filing requirements for submitting the NCQA Accreditation Compliance Form (Form) and documentation of National Committee for Quality Assurance (NCQA) accreditation to demonstrate compliance with Health and Safety Code section 1399.871(d). Health plans must submit the Form and supporting documentation to the Department of Managed Health Care (DMHC), pursuant to the instructions below, no later than February 2, 2026.
3	1/15/2026	DMHC	26-002	Delegation of Risk for COVID-19 Testing or Immunizations	GROUP CARE	Senate Bill 510 (Pan, 2021), codified in Health and Safety Code section 1342.2, requires health plans to cover, without prior authorization or utilization management, COVID-19 testing and immunizations. Section 1342.2 further provides that a health plan may not delegate the financial risk for COVID-19 testing or immunizations to a provider unless the “parties have negotiated and agreed upon a new provision of the parties’ contract pursuant to [Health and Safety Code] Section 1375.7."
4	1/29/2026	DMHC	26-003	Large Group Renewal Notice Requirements	GROUP CARE	This letter provides guidance to plans on the timing and content requirements for renewal notices to large group contractholders under HSC section 1374.21 and HSC section 1385.046.
5	1/30/2026	DMHC	26-004	Plan Year 2027 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department offers current and prospective Qualified Health and Dental Plans, Covered California for Small Business Issuers, and health plans offering nongrandfathered Individual and Small Group product(s) outside of the California Health Benefit Exchange (Covered California), guidance to assist in the preparation of Plan Year 2027 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq.
6	2/2/2026	DHCS	26-002	Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) for the provision or arrangement of clinically appropriate and covered Non-Specialty Mental Health Services (NSMHS) and the regulatory requirements for the Medicaid Mental Health Parity Final Rule (CMS-2333-F). This APL outlines MCP responsibilities for referring and coordinating with County Mental Health Plans (MHPs) for the delivery of Specialty Mental Health Services (SMHS), including providing a list of Department of Health Care Services (DHCS)-approved youth trauma screening tools for the purposes of determining access criteria for the SMHS delivery system. This APL supersedes APL 22-006.
7	3/13/2026	DHCS	26-003	Quality Measures For Encounter Data Update: Quality Measures For Encounter Data 2.0	MEDI-CAL	The purpose of this All Plan Letter (APL) is to notify Medi-Cal managed care plans (MCPs) about an update to the Department of Health Care Services’ (DHCS) Quality Measures for Encounter Data (QMED) requirements. This APL supersedes APL 14-020. MCPs are expected to comply with updated requirements as set forth in their Contracts and APL 25-007.
8	3/16/2026	DHCS	26-004	Medi-Cal Managed Care Plan Responsibilities For Behavioral Health Data-Sharing	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal Managed Care Plans (MCPs) with clarified guidance regarding their existing responsibilities for data sharing, including ensuring data privacy and security of Members’ behavioral health data with Medi-Cal Third-Party Entities in real time pursuant to Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021), Health and Safety Code (H&S) section 130290, the California Health and Human Services Data Exchange Framework (DxF) Policies and Procedures (P&Ps), MCP contract requirements, relevant APLs, and other state and federal statutes and guidance including Health the Insurance Portability and Accountability Act (HIPAA), recent updates to the 42 Code of Federal Regulations (CFR) Part 2 (Part 2) regulations, Information Blocking, Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access Final Rule (May 2020), and CMS Interoperability and Prior Authorization Final Rule (January 2024) (collectively, the Federal Interoperability Rules).
9	3/20/2026	DMHC	26-005	Compliance with Assembly Bill 904, Maternal and Infant Health Equity Program	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to inform health care service plans (plans) covering maternity services of the filing requirements necessary to demonstrate compliance with and implementation of Assembly Bill (AB) 904. The plan filings required by this APL will assist the DMHC in preparing a statutorily required report for the Legislature by January 1, 2027, that describes “the doula coverage and programs established” pursuant to the bill.
10	3/25/2026	DHCS	26-005	Maternity Services for Pregnant and Postpartum Medi-Cal Members	MEDI-CAL	The purpose of this All Plan Letter (APL) is to consolidate and update guidance for Medi-Cal managed care plans (MCPs) on the maternity benefits that MCPs are required to provide to pregnant and postpartum Members. This omnibus APL supersedes APLs 00-012 and 18-022 and Policy Letters (PLs) 98-006, 98-010, and 12-003. This omnibus APL also retires APL 01-003 and PLs 98-001 and 02-004.
11	3/30/2026	DHCS	26-006	Skilled Nursing Facility Workforce Quality Incentive Program	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with instructions on the payment and data sharing process required for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for Rating Periods between January 1, 2023, and December 31, 2025. The Calendar Year (CY) 2023 Rating Period is referred to as Program Year (PY) 1, CY 2024 Rating Period as PY 2, and so forth.
12	4/8/2026	DMHC	26-006	AB 118: Part 2 - Compliance with Individual and Small Group Standardized Evidence of Coverage/Disclosure Form	N/A	Assembly Bill (AB) 118 (Ting, Chapter 42, Statutes of 2023) added Health and Safety Code section 1363.3 and revised Sections 1352.1, 1363, 1367.041, and 1367.24, effective January 1, 2025. Part 2 of the standardized EOC/DF will include the following template components: (1) Exclusions and Limitations, (2) Members’ Rights and Responsibilities, and (3) Definitions, for use in health care service plan contracts in the individual and small group markets issued, amended, or renewed on or after January 1, 2027.
13	4/15/2026	DMHC	26-007	2026 Health Plan Annual Assessments	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide information to health care service plans (health plans) pertaining to the DMHC’s fiscal year (FY) 2026-27 annual assessment.

14	4/24/2026	DHCS	26-007	Medi-Cal Managed Care Plan Guidance on Network Provider Agreements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, the MCP Contract, state law, APLs, and similar instructions.
15	5/12/2026	DHCS	26-008	Interoperability Final Rules, Including Prior Authorization Requirements	MEDI-CAL	To provide information to all Medi-Cal managed care plans (MCPs) regarding the Centers for Medicare and Medicaid Services' (CMS) interoperability requirements. This All Plan Letter (APL) supersedes APL 22-026.
16	5/12/2026	DMHC	26-008	Premium Rate Filing Review: Small Group Geographic Rating Practice	N/A	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide additional information as part of premium rate review submission to health care service plans (health plans) pertaining to the small group geographic rating practices to comply with the requirements of 45 Code of Federal Regulations (CFR) § 147.102(a)(1)(ii)(B).
17	5/26/2026	DMHC	26-009	State of Emergency Due to Orange County Chemical Incident	N/A	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to remind health care service plans of the requirements of Health and Safety Code section 1368.7 and to provide related DMHC filing instructions.
18	5/26/2026	DMHC	26-010	Pharmacy Benefit Manager Licensure	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Licensee Letter (ALL) to inform pharmacy benefit managers (PBMs) of the requirements of Assembly Bill 116 (Committee on Budget, Ch. 21, Stats. 2025) and Senate Bill 41 (Wiener, Ch. 605, Stats. 2025). Specifically, this ALL addresses the licensure requirements of PBMs in Article 6.1, including the requirements that all PBMs be licensed by January 1, 2027.
19	6/1/2026	DMHC	26-011	Compliance with Senate Bill 306 (2025) - First Data Call	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide notice to health care service plans (health plans) of compliance requirements with Senate Bill (SB) 306 (Becker, 2025), which added section 1367.025 to the California Health and Safety Code.
20	6/1/2026	DHCS	26-009	Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age of 21	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify Medi-Cal managed care plan (MCP) obligations to provide case management services to Members under the age of 21 for whom Private Duty Nursing (PDN) services have been authorized pursuant to the federally mandated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) available under Medi-Cal.

COMPLIANCE DASHBOARD SUMMARY													
	Resource	Type										TOTAL	% Completed
			2018	2019	2020	2021	2022	2023	2024	2025	2026		
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	24	20	0		165	
		Total Self-Identified Issues	12	0	0	2	0	2	6	3	2	27	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**26**	**3**	**2**	**192**	
		Total In Progress	0	0	0	0	0	3	0	0	2	5	
		Total Completed	50	28	7	35	15	23	26	3		187	**97%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**26**	**3**	**2**	**192**	
	DMHC	Total State Audit Findings			5	6	8	3		16		38	
		Total Self-Identified Issues			3	0	0	0		6		9	
		Total Findings			**8**	**6**	**8**	**3**		**22**		**47**	
		Total In Progress			0	0	0	0		18		18	
		Total Completed			8	6	8	3		4		29	**62%**
		Total Findings	**NA**	**NA**	**8**	**6**	**8**	**3**	**NA**	**22**	**NA**	**47**	
	DMHC Financial Services	Total State Audit Findings		5			4			2		11	
		Total Self-Identified Issues		0			0			0		0	
		Total Findings		**5**			**4**			**2**		**11**	
		Total In Progress		0			0			1		1	
		Total Completed		5			4			1		10	**91%**
		Total Findings	**NA**	**5**	**NA**	**NA**	**4**	**NA**	**NA**	**2**	**NA**	**11**	
STATE AUDIT FINDINGS		In Progress	0	0	0	0	0	3	0	13		16	
		Completed	38	33	12	39	27	24	20	5		198	**93%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**27**	**20**	**18**		**214**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	0	6	2	8	
		Completed	12	0	3	2	0	2	6	3	0	28	**78%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**6**	**9**	**2**	**36**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**29**	**26**	**27**	**2**	**250**	**90%**

Compliance Dashboard Summary

COMPLIANCE DASHBOARD SUMMARY			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	214	86%
	Total Self-Identified Issues	36	14%
	Total Findings	**250**	
	Total In Progress	24	10%
	Total Completed	226	90%
	Total Findings	**250**	
STATE AUDIT FINDINGS	In Progress	16	7%
	Completed	198	93%
	Total Findings	**214**	
SELF-IDENTIFIED FINDINGS	In Progress	8	22%
	Completed	28	78%
	Total Findings	**36**	

2026 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	0	0%
	Total Self-Identified Issues	2	100%
	Total Findings	**2**	
	Total In Progress	0	0%
	Total Completed	0	0%
	Total Findings	**2**	

Compliance Dashboard Summary

2025 DMHC Fiscal Examination			
	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**	

2025 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	0	0%
	Total Self-Identified Issues	3	100%
	Total Findings	**3**	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	**3**	

2025 DMHC Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	16	73%
	Total Self-Identified Issues	6	27%
	Total Findings	**22**	
	Total In Progress	18	82%
	Total Completed	4	18%
	Total Findings	**22**	

Compliance Dashboard Summary

2024 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	20	77%
	Total Self-Identified Issues	6	23%
	Total Findings	**26**	
	Total In Progress	0	0%
	Total Completed	26	100%
	Total Findings	**26**	

2023 DMHC Follow-Up Review			
	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**	

Compliance Dashboard Summary

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	3	33%
	Total Completed	6	67%
	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**	

Compliance Dashboard Summary

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	0	0%
	Total Completed	2	100%
	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**	

Compliance Dashboard Summary

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**	

Compliance Dashboard Summary

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**	

Compliance Dashboard Summary

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**	

Compliance Dashboard Summary

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**	

Compliance Dashboard Summary

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**	

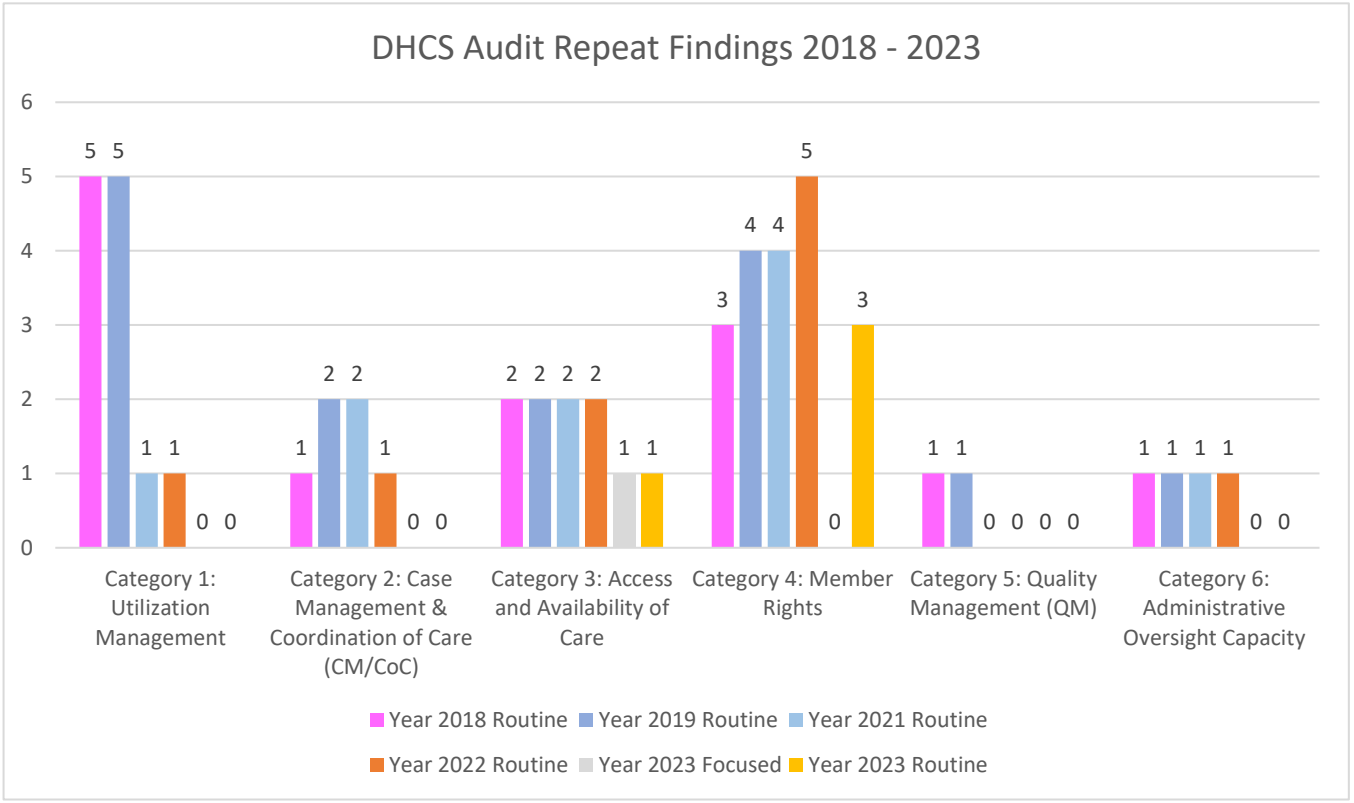
2018 DHCS Medical Services Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	38	76%
	Total Self-Identified Issues	12	24%
	Total Findings	**50**	
	Total In Progress	0	0%
	Total Completed	50	100%
	Total Findings	**50**	

Compliance Dashboard Summary

DHCS Audit Repeat Findings 2018 - 2023

Category	Year						TOTAL
	2018 Routine	2019 Routine	2021 Routine	2022 Routine	2023 Focused	2023 Routine	
Category 1: Utilization Management	5	5	1	1	0	0	12
Category 2: Case Management & Coordination of Care (CM/CoC)	1	2	2	1	0	0	6
Category 3: Access and Availability of Care	2	2	2	2	1	1	10
Category 4: Member Rights	3	4	4	5	0	3	19
Category 5: Quality Management (QM)	1	1	0	0	0	0	2
Category 6: Administrative Oversight Capacity	1	1	1	1	0	0	4
TOTAL	13	15	10	10	1	4	53

Compliance Dashboard Summary

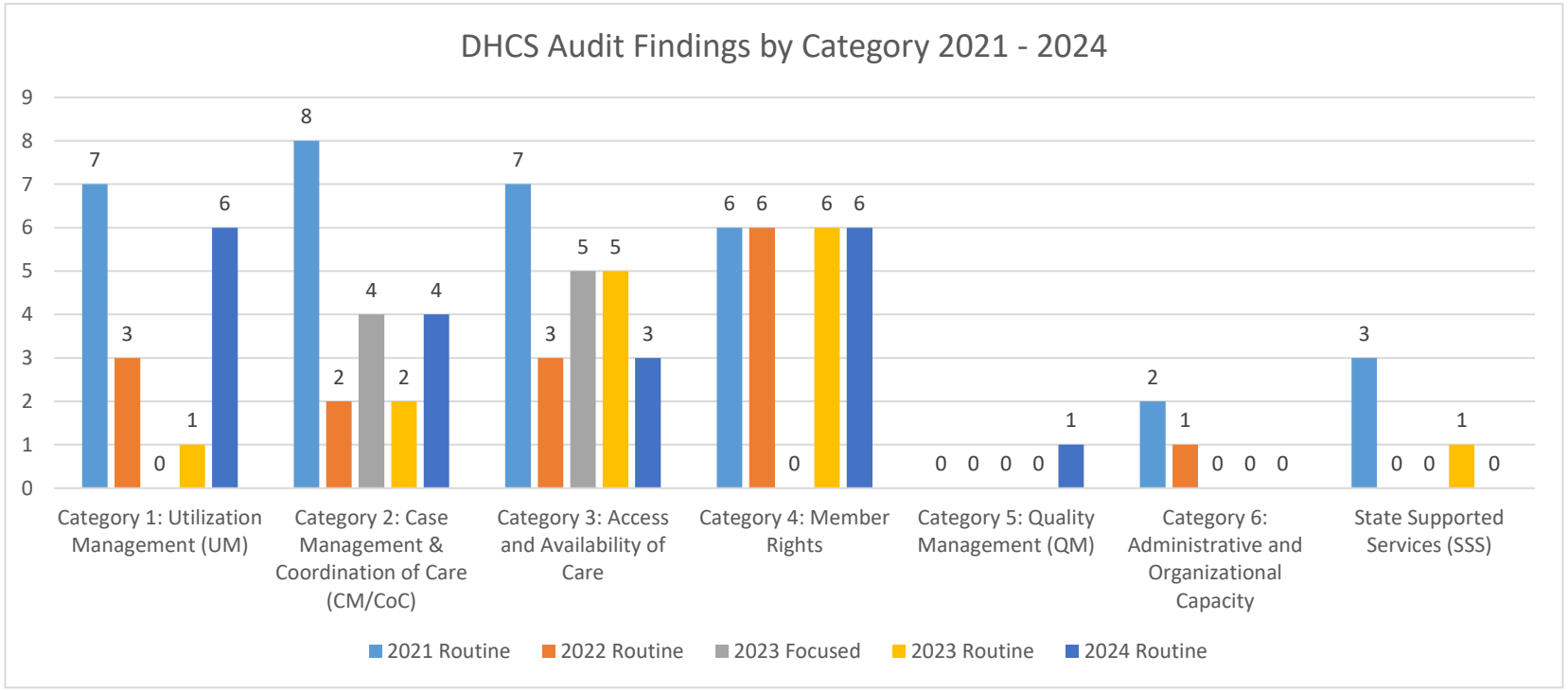


Compliance Dashboard Summary

DHCS Audit Findings by Category 2021 - 2024

	2021 Routine	2022 Routine	2023 Focused	2023 Routine	2024 Routine	TOTAL
Category 1: Utilization Management (UM)	7	3	0	1	6	17
Category 2: Case Management & Coordination of Care (CM/CoC)	8	2	4	2	4	20
Category 3: Access and Availability of Care	7	3	5	5	3	23
Category 4: Member Rights	6	6	0	6	6	24
Category 5: Quality Management (QM)	0	0	0	0	1	1
Category 6: Administrative and Organizational Capacity	2	1	0	0	0	3
State Supported Services (SSS)	3	0	0	1	0	4
TOTAL	33	15	9	15	20	92

Compliance Dashboard Summary



ALAMEDA ALLIANCE FOR HEALTH
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2026 DHCS Audit ***- Audit Review Period March 1, 2025 to December 31, 2025***
Virtual Audit Dates March 2, 2026 to March 13, 2026

#	Category	Plan Observations - DHCS Preliminary Findings expected June 2026	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
1	PHM & CoC (Enhanced Care Management)	The Plan's 2025 ECM Provider Directory did not show ECM providers for the months of January-February, and July - December.	The Alliance experienced a glitch in the provider directory data extraction process that caused the ECM providers to be excluded from the extraction. The Alliance has corrected the data template to ensure that required data elements are included in the reporting template and include ECM providers. In addition, on March 11, 2026, we also confirmed requirements with our vendor, KP, who uses the data extraction reports to create a PDF version of the directory. The new data extraction template will also be used going forward for subsequent Provider Directories. Recommend PS to develop an oversight element that addressed whether the directories are reviewed for accuracy and at what cadence so that the Plan may identify and correct errors timely. **5/5/2026 Update:** IT and C&O includes Provider Services when sending the Provider Directory files for ongoing oversight.	TBD	Pending	Provider Services
2	PHM & CoC (Pregnant & Postpartum Members)	Regarding CPSP reimbursement, the Plan does not have an oversight mechanism in place for CPSP providers.	CPSP approval is administered by the California Department of Public Health (CDPH) and is not reflected within Medi-Cal enrollment systems or Plan credentialing data sources. The Plan confirmed that there is no CPSP indicator available within the Medi-Cal enrollment portal or other DHCS-managed systems to validate CDPH CPSP approval status. Recommend to develop an oversight mechanism for CPSP claims monitoring and verification for CPSP approved providers.	TBD	Pending	Credentialing Provider Services Claims

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2025 DMHC Routine Fiscal Examination ***- Audit Review Period January 1, 2025 to March 31, 2025***
Audit Date August 4, 2025

#	Category	Deficiencies	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
1	Finance	The Department's examination disclosed that the Plan failed to pay interest on late claim payments related to Targeted Provider Rate Increases (TRI) issued after December 31, 2024. On June 20, 2024, The California Department of Health Care Services (DHCS) issued an All-Plan Letter (APL) 24-007 instructing Medi-Cal managed care plans to "achieve full compliance with this APL by December 31, 2024," including retroactive payment adjustments. Claim payments issued by the Plan after December 31, 2024, related to the TRI did not include interest on the late payments.	On September 10, 2025, prior to issuance of the Preliminary Report, the Plan paid the interest and penalties due on late claim payments resulting in additional payments of interest of $54,261 and penalties of $66,120 on 6,612 claims.	9/10/2025	**Complete**	Claims
2	Finance	The Department's examination disclosed that the Plan failed to follow up with its capitated providers on two claims forwarded by the Plan to the capitated providers. The Plan did not check the status of the forwarded claims with the capitated providers, nor did it keep any records to indicate whether these forwarded claims were received and processed by the capitated providers. The Department's examination also indicated that the Plan does not have written policies and procedures to ensure that claims forwarded to the Plan's capitated providers are processed in compliance with the requirements of Sections 1371, 1371.35, and Rule 1300.71.	The Plan currently forwards claims identified as the responsibility of delegates/capitated providers within regulatory timeframes per Cal. Code Regs. Tit. 28, § 1300.71(b)(2). 3/2/26 Update: To strengthen our oversight of misdirected claims, the Plan reviewed and enhance existing policies and procedures, as applicable, to clearly define the steps to audit forwarded claims and ensure compliance with Sections 1371, 1371.35, and Rule 1300.71. - CLM-009 P&P and CMP-403 Approved at AOC on 2/18/26; P&Ps were submitted to DMHC on 3/2/26. 4/3/26 Update: Compliance implemented the forwarded claims validation process to ensure oversight and compliance. 4/20/26 Update: DMHC confirmed that the CAP is completed and closed. 5/1/26 Update: Monthly forwarded claims validation is ongoing.	Ongoing	In Progress	Compliance - DO Claims

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2025 DMHC Audit - *Audit Review Period* 10/1/2022 - 9/30/2024
Audit Onsite Dates - March 3, 2025 to March 7, 2025

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
1	Quality Assurance	The Plan did not document that quality of care provided is reviewed, problems are identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.	The PQI CAP workflow was modified (orange) to include the following: 1) QI RN case owner to review response to each CAP question and reviewed by the MD, 2) for non-compliant/responsive providers, added that if noted by the MD, the QI RN case owner will be referred to the Peer Review Committee and/or report the quality issue to the appropriate regulatory bodies, 3) the provider or facility will be tracked on the Escalation Log maintained by Compliance. In addition, the MD will use a templated final note: "Medical Director CAP Review and Attestation" to ensure all CAP issues are addressed and follow up is planned where indicated. The PQI CAP template was revised to include a table with lines to ensure that each deficiency (problem) and corrective action(s) are addressed. **5/2026 Update**: Implementation is tied to the BOG meeting scheduled for 5/8/26 to allow formal inclusion in the CEO report and documentation in meeting minutes.	TBD	Quality Assurance
2	Grievance and Appeals	The Plan's governing body did not thoroughly document it periodically reviewed a written record of grievances.	The Plan revised its grievance governance reporting process to ensure that the written grievance report documentation the Board of Governors (BOG) periodically receives specifically includes aggregate grievance trends, categories, representative summaries, dispositions, and identification of systemic or recurring issues. The Plan implemented dedicating a duration of time for standardized grievance and appeals at BOG meetings and updated documentation requirements to ensure meeting minutes explicitly reflect the BOG's review of the written grievance record during each meeting, including reference to the report. **5/2026 Update:** Implementation is tied to the BOG meeting scheduled for 5/8/26. **06/03/26 Update:** Health Plan audit team is working with stakeholders to validate CAP implementation.	TBD	G&A
3	Grievance and Appeals	**(R)** The Plan did not consistently provide immediate notification to complainants of their right to contact the Department regarding an expedited grievance.Section 1368.01(b); Rule 1300.68.01(a)(1).	The Plan's Member Services Department conducted training on 12/19/2024 to reinforce the requirement to immediately notify members of their rights to contact DMHC when a case is logged as expedited. Additionally, Grievance and Appeals implemented a spot-check process to review all incoming expedited cases to ensure member rights are provided at intake. Monthly internal audits are conducted for expedited grievances and appeals. **06/03/26 Update:** Grievance resolution letter template coverage disputes updated. The Plan submitted its CAP and DMHC has reviewed, per DMHC final report, this deficiency has been corrected.	4/1/2026	G&A
4	Grievance and Appeals	The Plan's written response to expedited grievances involving a determination that the requested service was not a covered benefit did not include a notice that the enrollee should contact the Department if they believed a denial was based on lack of medical necessity. Rule 1300.68(d)(5).	**5/19/2026 - Corrected per DMHC.** The Plan will update its Grievance Resolution template letters to include language for when requested service are not a covered benefit, the enrollee should contact the Department if they believed the denial was based on lack of medical necessity. Once the templates are finalized, the Grievance and Appeals Department will provide training to staff of the new templates to utilize.	TBD	G&A
5	Access and Availability	The Plan did not monitor telephone triage service wait times to ensure the wait times did not exceed 30 minutes.	The Plan provided standard operating procedure file "CM_SOP_Nurse Line" detailing the monitoring workflow. Please also see included example file "Alameda Quarterly Telemetrics 2025 Q4" showing average wait times in seconds for all of 2025.	TBD	CM
6	Access and Availability	The Plan's notification to providers did not include the information required in Section 1367.27(l)(2)(A)-(C).	The Plan will update its Provider Demographic Form to include the information that providers may utilize the Plan's online interface through the Alliance Provider Portal to review the information in the directory (the Provider Demographic Attestation) and that failure to respond may result in a delay of payment or reimbursement of a claim pursuant to Section 1367.27 subdivision (p). In addition, the Plan will create a new provider notice that provides instructions on how providers can use the Alliance Provider Portal to review and attest to the Provider Directory information (the Provider Demographic Attestation) and work with our Provider Portal vendor to see if there are any available options to enhance the use of the Provider Demographic Attestation within the Alliance Provider Portal. **3/30/26 Update:** The Plan updated its provider communication document, Provider Demographic Attestation Form.	TBD	Provider Services
7	Access and Availability	The Plan did not have a process to monitor whether its provider networks experienced a 10 percent change.	**5/19/2026 - Corrected per DMHC.** Plan has updated its policy, PRV-003 Provider Network Capacity Standards, to include a process to monitor whether the network has experienced a 10 percent change. The policy was presented and reviewed in its Administrative Oversight Committee (AOC) Meeting on 1/21/2026 and anticipates it to be approved in the subsequent AOC meeting on 2/18/2026. In addition, the Plan has created a workflow that outlines the steps that will be taken to monitor (see DMHC Significant Network Filing Workflow). **2/18/26 Update:** PRV-003 P&P approved at AOC. **06/03/26 Update:** Health Plan audit team is working with stakeholders to validate CAP implementation.	TBD	Provider Services
8	UM	The Plan did not consistently notify the requesting provider within 24 hours of a decision to modify or deny a request. Section 1367.01(h)(3).	The Plan has initiated corrective actions to ensure notification timeliness fully Complies with DMHC regulatory requirements. Specifically, the Plan will conduct audits of the provider notification timeliness to address previously identified deficiencies. The Plan has updated policy UM-051 Timeliness of UM Decision Making and Notification to include the process for auditing the timeliness of member and provider notifications. The policy will be presented and reviewed at the next QIHEC meeting scheduled for 2/13/2026 and is anticipated to be presented for approval at the subsequent AOC meeting.	TBD	UM
9	UM	The Plan failed to demonstrate that in the case of concurrent review denials, care was not discontinued until the enrollee's treating provider was notified and agreed to an appropriate care plan. Section 1367.01(h)(3).	The Plan has updated its policy, UM 003 Concurrent Review, to clarify the steps for reaching an agreement with the Treating Provider. The Policy will be presented and reviewed at the next QIHEC meeting scheduled for 2/13/2026 and is anticipated to be presented for approval at the subsequent AOC meeting.	TBD	UM
10	UM	The Plan did not conduct adequate oversight of its delegates to ensure written communications to enrollees regarding decisions to deny or modify services were clear and concise. Section 1367.01(h)(4).	In regards to the Carelon/ Beacon findings, the plan has taken the proactive steps to de-delegate Carelon/ Beacon and bring the UM responsibilities for Behavioral and Mental Health in house with all functions performed by the Alliance effective April 2023. For the CFMG Delegate oversite, the plan has identified these same findings during the 2025 Annual Audit. The plan has a Corrective Action Plan (CAP) in place with CFMG that became effective on 11/14/2025. The CAP requires CFMG to provider evidence of efforts to monitor this requirement through internal audits. They must provide quarterly and annual internal audit results to the Alliance showing evidence of compliance/corrected deficiencies and submit documentation via the HICE reports for oversite and monitoring.	TBD	UM Compliance - DO

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2025 DMHC Audit - *Audit Review Period* 10/1/2022 - 9/30/2024
Audit Onsite Dates - March 3, 2025 to March 7, 2025

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
11	UM	The Plan did not conduct adequate oversight of its delegates to ensure delegates consistently provided the reviewer's required contact information. Section 1367.01(h)(4).	The Plan agrees with the findings. In regards to the Carelon/ Beacon findings, the Plan took proactive steps to de-delegate Carelon/ Beacon and transitioned all UM responsibilities for behavioral and mental health services in house, with all functions performed by the Alliance effective April 2023. With respect to CFMG Delegate oversite, the Plan identified the same findings during the 2025 Annual Audit and implemented a Corrective Action Plan (CAP) effective 11/14/2025. CFMG has corrected the deficiency to ensure that the peer-to-peer phone number listed on adverse decision letters connects directly to CFMG Medical Directors. CFMG completed re-recording of the peer-to-peer line with enhanced instructions in October 2025, and the updated number is now aligned with the adverse determination notices.	TBD	UM Compliance - DO
12	Pharmacy	The Plan did not consistently include a description of the criteria or guidelines used for the decision in formulary exception denial and modification letters. Section 1367.01(h)(4).	Contested: The Plan reviewed DMHC reports and confirmed their applicability to several identified criteria documents. The Plan prepared a narrative explaining how the Alliance develops clinical criteria and applies to them clearly, concisely, and on an individualized basis to member-specific circumstances.	TBD	Pharmacy
13	Pharmacy	**(R)** The Plan's published formulary did not meet regulatory requirements. Rule 1300.67.205(b), (c)(4)-(6), (d)(2), (4)-(7), (9)-(18).	The Plan has initiated corrective actions to ensure the online searchable formulary fully complies with DMHC regulatory requirements. Specifically, the Plan will update the formulary webpage to incorporate a direct link to the DMHC-approved Formulary Cover Page, thereby addressing previously identified deficiencies. This enhancement will ensure that members, providers, and regulators have immediate access to the approved formulary cover information, including all mandated disclosures.	TBD	Pharmacy
14	Behavioral Health	The Plan did not demonstrate that all staff who conducted utilization review of mental health and substance use disorder treatment services and benefits completed the formal education program for each nonprofit association criteria or guidelines utilized by the Plan. Section 1374.721(a), (b), and (e)(1)	Contested: The Plan documents in the Post-Audit file 145_NPA Guidelines Training that six (6) team members successfully completed training on ASAM, ECSII, LOCUS, and CALOCUS-CASII. Only Behavioral Health staff who have completed training on the Non-Profit Professional Association (NPA) guidelines are authorized to review Group Care mental health (MH) and substance use disorder (SUD) authorization requests (see documents 145_BH NPA Guidelines Training and 145_BH Training Certificates). The Plan further confirms that all utilization management (UM) staff who review transgender care authorizations have completed training on the World Professional Association for Transgender Health (WPATH) standards (see documents AAH WPATH Training Compliance Grid and WPATH Certificates of Completion). As documented in the APL 24-007 comment table (File Number: 20242576-7), the Plan does not conduct medical necessity reviews for applied behavior analysis (ABA) services for Group Care members and therefore does not utilize CASP guidelines. The comment table also documents the Plan's use of the American Psychiatric Association and American Psychological Association guidelines for the review of psychological testing, neuropsychological testing, transcranial magnetic stimulation (TMS), and electroconvulsive therapy (ECT) services.	TBD	Behavioral Health
15	Behavioral Health	The Plan did not conduct interrater reliability testing to ensure consistency in medical necessity decision making covering all aspects of mental health and substance use disorder utilization review. Section 1374.721(b), (e)(5) and (f)(3)(A).	**5/19/2026 - Corrected per DMHC.** Contested: The Plan develops Inter-Rater Reliability (IRR) testing to ensure consistency in authorization determinations and to confirm that appropriate clinical guidelines are applied throughout the review process. These IRRs are designed to validate that decision-making aligns with established standards for mental health and substance use disorder services. The urgency classification of an authorization request (routine, urgent, or retrospective) does not affect the application of medical necessity criteria; rather, it only determines the applicable turnaround timeframe for the authorization decision. The Plan believes that utilization management staff have been appropriately tested through IRR processes to ensure accurate and consistent application of medical necessity guidelines. **06/03/26 Update:** Health Plan audit team is working with stakeholders to validate CAP implementation.	TBD	Behavioral Health
16	Behavioral Health	The Plan did not ensure its delegate used only those criteria from nonprofit associations listed in the All Plan Letter 21-002 Attachment A, and alternative criteria approved by the Department, when making medical necessity determinations for requested mental health and substance use disorder services. Section 1367.01(j); Section 1374.721(a), (b) and (h).	**5/19/2026 - Corrected per DMHC.** Contested: The Plan documented in its APL 22-002 comment table (File Number: 20211181) that it confirmed with its delegate the required utilization management Non-Profit Professional Association (NPA) guidelines would be used to determine medical necessity for Group Care/IHSS members. At that time, the delegate submitted a written attestation and training logs as part of the DMHC comment table, which were accepted by the DMHC. The Plan also reviewed the delegate's policies requiring use of the applicable guidelines and completion of annual Inter-Rater Reliability (IRR) testing. In addition, the Plan audited a random sample of Notices of Action, which documented use of the appropriate guideline by service type and line of business. The Plan did not conduct a separate audit of this specific requirement because the delegate had provided written confirmation of compliance with SB 855, and this documentation was accepted by DMHC. The Plan subsequently insourced all behavioral health utilization review activities in April 2023. In August 2025, DMHC accepted the Plan's comment table (File Number: 20242576-7) documenting implementation of SB 855 and compliance with APL 24-007. **06/03/26 Update:** Health Plan audit team is working with stakeholders to validate CAP implementation.	TBD	Behavioral Health
A	Compliance	Corrective Action Plan (CAP) tracking, monitoring, and management.	The Plan's Compliance Team has enhanced its CAP form to facilitate a more efficient and streamlined review process. CAP items incorporated into meetings with delegates and subcontractors, ensuring thorough follow-up and reinforcing monitoring efforts. Additionally, the DO team oversees annual and ad hoc audit CAPs, reporting them to SDOC for review and closure, further strengthening compliance oversight. Finally, the DO team will conduct training for SMEs on CAP verification and monitoring, ensuring a timely and thorough review process. 06/03/26: Guidance provided at Internal kick-offs meeting and adhoc meetings.	Already in Place Already in Place Already in Place TBD	Compliance

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Audit Onsite Dates - March 3, 2025 to March 7, 2025

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
B	UM	Communication and notification process for decision letters, delay notices, and notification letters.	UM departments have P&Ps that detail our notification processes, including the required timeframes, content, and enclosures for all letters.	Already in Place	UM
C	UM	Utilization Management policy and procedures regarding 24 hour, seven day a week availability for urgent / emergent requests regarding members.	Currently, Plan contracted and non-contracted hospitals do have 24-hour access to the Alliance UM department to make authorization requests through on-call Plan RNs and MDs.	Already in Place	UM
D	Grievance and Appeals	Appeal process for terminally ill members	Grievance and Appeals has policy and procedure for accepting and resolving expedited appeals.	Already in Place	UM G&A
E	Access and Availability	Accuracy of provider network and directory information	Provider Services has in place a process to proactively outreach to providers to verify provider directory information as well as what steps to take when provider directory inaccuracies are reported.	Already in Place	Provider Services
F	Member Rights	Monitoring of calls and member services for expressions of dissatisfaction.	The Member Services Department has a process in place to monitor calls to ensure all expressions of dissatisfaction are appropriately identified.	Already in Place	Member Services G&A

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2024 DHCS Audit - *Audit Review Period* 6/1/2023 - 5/31/2024 *Audit Onsite Dates - June 17, 2024 - June 28, 2024*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self-Identified	Agency
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.	1. The Plan's Standard Operating Procedures (SOP) were updated to reflect the 72 hours MOT TAT and all UM staff were re-trained on 6/20/2024. 2. The UM team instituted a formal internal review process to ensure all operating procedures align with Policy & Procedures. A Standard Operating Procedures (SOP) was developed and staff were trained on the internal review process. 3. Policy & Procedure Tracker developed to ensure at least annual and ad-hoc updates to P&Ps are monitored and aligned with regulatory guidance. The Plan monitors MOT turnaround times via daily operational reports.	1/15/2025	Completed	UM		State	DHCS
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.	1. On 6/27/2024 The Plans Medical Directors were notified that Bone Marrow Transplant (BMT) and other regulatory Major Organ Transplants (MOT) are only managed in-network unless Continuity Of Care (COC) or related to urgent/emergent hospitalization. In addition, The Plan took the following actions: On 6/27/2024 the MOT workflows were updated to include Chief Medical Officer (CMO) Denial oversight. On 8/14/2024 The Plan conducted Delegate training for the new CHCN Medical Director and CHCN Utilization Management Director. On 8/1/2024 a copy of the current DHCS Centers Of Excellence list was distributed to staff. The Plan updated policy UM-071 and submitted to Utilization Management Committee on 8/30/2024. 2. The Plan updated Standard Operating Procedures to include DHCS Center Of Excellence requirements. 3. The UM team instituted a formal internal review process to ensure all operating procedures align with Policy & Procedures. A Standard Operating Procedures was developed, and staff were trained on the internal review process. Update 2/15/2025: Operation Major Organ Transplant reported created and being used to monitor the appropriate use of Medi-Cal COEs.	4/15/2025	Completed	UM		State	DHCS
3	UM	(1.3.1) Written Member Consent The Plan did not obtain members' written consent when providers requested appeals on behalf of members.	1. The Plan updated G&A-008 Adverse Benefit Determination Appeal Process to meet the requirements of Member Written Consent in accordance with The Plan's DHCS contract. The workflow was updated and staff training completed on 11/6/2024 2. Internal audits for requirement of written member consent started in January 2024 and will continue.	4/15/2025	Completed	G&A		State	DHCS
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.	1. CLS-003 Non-discrimination Language Assistance Services and Effective Communication for Individuals with Disabilities has been submitted and accepted by the MCOD. 2. The Your Rights Package was updated with the current Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT). The NDN and LAT were added to the Member Rights package and updated in the G&A system. 3. The G&A Department in conjunction with the Compliance Department will review all enclosures on an annual basis to ensure compliance. G&A is completing an Internal Audit SOP that outlines the self-monitoring / internal audit process. 5/9/2025: G&A completed an internal audit Standard Operating Procedure (SOP) the outlines the self-monitoring / internal audit process. In addition, a focused audit tool that identifies NDN and LAT information has been implemented for internal monitoring to ensure that the NDN and LAT information is correct.	4/15/2025	Completed	G&A	✓	State	DHCS

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self-Identified	Agency
5	UM	(1.5.1) Overutilization of Subacute Level of Facility Care The Plan did not ensure that its delegate 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.	1. The delegate reports over/under-utilization measures in their quarterly HICE report. The Plan has instituted a Standardized Operating Procedure that delineates roles and responsibilities for reviewing delegate reports, including a formal sign-off process, to be used in conjunction with P&P UM-060 Delegation Management and Oversight. 2. The Plan will request the delegate include post-acute cases in their annual UM audit universe and monthly internal UM audit reports. Update 1/15/2025: The Plan received the delegate's internal UM audit report submission on 12/27/2024 and completed a review of the delegate's audit results on 12/31/2024, and noted adequate strategies to address findings. 3. The Plan has requested the delegate include nursing facility utilization as part of their over/under utilization measures, reported in the Quarterly HICE report (auth volume by facility levels of care). The Q4 2024 HICE report is pending. Update 5/9/2025: The Q4 2024 HICE report has been submitted to the Plan for review that overutilization is being monitored. 4. The Plan shares all newly issued DHCS APLs and guidance, including billing instructions related to revenue codes, and collects attestations from delegates Update 7/11/2025: The Plan confirmed attestations for APLS 24-009 and 24-010 were received from the delegate and all revenue codes have been implemented	7/11/2025	Completed	UM		State	DHCS
6	UM	(1.5.2) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services The Plan did not ensure that its delegate provided medically necessary EPSDT services, care coordination, and appointment scheduling assistance to members under the age of 21.	1. The delegate created a new policy and procedure specific to EPSDT care coordination. This policy will be reviewed by the delegate's internal committee on 1/22/2025 and then the policy will be submitted to the Plan for review. 5/9/2025: The Policy for EPSDT Services has been finalized. 2. The Plan requested the delegate identify EPSDT cases in their monthly internal Case Management audit reports, as well as identifying EPSDT cases in their annual UM audit universe and monthly internal UM audit reports. The Plan will audit EPSDT cases to evaluate whether members are receiving appropriate EPSDT services, care coordination, and appointment scheduling as needed. Updated 1/15/2025: The Plan received confirmation that the delegate updated their internal audit tool to include the appropriate EPSDT elements. The Plan will review the delegate's next internal audit to verify use of the revised audit tool. Update 2/15/2025: The Plan received the delegate's internal audit tool and has confirmed it reflects the EPSDT elements were added appropriately. 3. The Plan will report the delegate's CM and UM audit outcomes at the UM Committee, upon receipt of reports. Update 7/11/2025: The delegate's audit tool was revised for EPSDT elements and an audit was completed by the delegate and reviewed by the Plan for March. The Plan will continue to monitor new EPSDT audit elements.	7/11/2025	Completed	UM		State	DHCS
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.	1. The Plan updated Policy QI-125 to include a requirement for providers to follow up on lab orders. Policy QI-125 will be approved in Quality Committee by 2/30/2025 and the Administrative Oversight Committee by 4/16/2025. 2. Funding for point-of-care testing units was provided in January 2024 to the delegate. These units aim to eliminate the need for members to make an additional visit to the lab. The Plan conducted member outreach and member incentives; members were offered a gift card to complete their services at the lab. 3. The Plan continues to monitor the HEDIS lead screening rates. Monitoring includes tracking of the documentation of lead level results by providers for ordered blood lead tests and any necessary follow-up activities and services for members, which is done through IHA audits and facility site reviews. 4. The Plan has conducted provider education through webinars, 1:1 meetings, CLPP training 1) Healthcare Services All-Staff meeting, 2) Provider webinar (live) and video (posted on Alliance website) and Measure Highlight tools. 5. The Plan previously conducted annual IHA audits to review provider charts for completion of preventive screenings. The frequency of these audits has now increased to twice a year. Additionally, during Facility Site Reviews (FSRs), charts are monitored for lead screening compliance. An audit is conducted for Blood Lead Screening, and charts are reviewed for evidence of discussion, orders/refusal and results. When evidence of lead screening is not found, the Plan sends education letters to providers indicating the discrepancy. Update 2/15/2025: The Plan conducted an IHA audit Q3 2024 for IHA period 10/1/2023-05/31/2024. 6. Lead screening rates and IHA results are revied at the Quality Improvement Health Equity Committee meetings. Update 5/9/2025: The IHA audit was completed for Q3 2025.	In Progress	Completed	QI		State	DHCS

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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*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self-Identified	Agency
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.	1. The Plan's existing policies support BHT services in accordance with BHT plans for members under the age of 21. The Plan insourced BHT services on 4/1/23 with the goal of increasing member access to care. The Plan has a dedicated team of care coordinators and BCBAs to support access to care. The Plan continues to explore opportunities to improve access to BHT care. This includes interventions to enhance the network and incentivize agencies to prioritize AAH members for services. The Plan continues to authorize out-of-network services whenever possible. 2. The Plan authorizes care within the required timeframes as requests are received. To monitor this issue, The Plan has established a metric to track the number of authorized hours to bill services. This functions as an indicator of the need for additional provider resources. This is a continuous process that started 5/10/2024. The Plan has ongoing efforts to onboard and contract additional BHT/ABA providers as additional resources are necessary. A monitoring and reporting process has been put in place to show the monthly authorized services for each member receiving BHT/ABA Treatment and for each QASP. The plan compares the # of authorized hours of BHT/ABA to the # of hours delivered based on claims data to monitor, track and report the % of authorized hours that are delivered. The plan reports these findings to the UM committee and identifies the QASPs with the lowest delivered services for outreach and intervention. Update 5/9/2025: Member utilization reports are being reviewed to measure utilization rates. The Plan works with providers who have low utilization to identify gaps or barriers preventing the fulfillment of authorized hours. Update 7/11/2025: Training for updated BHT-ABA Forms was completed on 4/30/2025 and BHT Utilization is being reported out at UM Committee. **Update 10/16/2025:** IA conducted an audit for this area beginning 08/26/25; the audit was closed on 10/16/25 with no CAPs. 3. The Plan has drafted parent advisement that is scripted and provided to each parent/guardian when BHT/ABA services are authorized that asks for parents/guardians to call the Alliance BHT/ABA case management team if they experience disruption or barriers in receiving the BHT/ABA services that have been authorized for their child.	7/11/2025	Completed	Behavioral Health	☑	State	DHCS
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.	1. The Plan established an EPSDT Policy & Procedure QI-135. The Plan established care coordination guidelines for staff providing care coordination with expectations. The Plan has a dedicated team of care coordinators and BCBAs to support access to care. The Plan has increased staffing to better support member' access to care. 2. BH Navigators are required to conduct monthly follow-up with parents or guardians to inform them of the status of Mental Health (MH), Behavioral Health Treatment (BHT), or Comprehensive Diagnostic Evaluation (CDE) referrals. This process ensures timely communication and continuity of care for families. 3. Mandatory training was provided to the BH Navigators with written standard work. 4. The Plan is developing a report that will be utilized in an ongoing manner to monitor compliance with current case management protocols and DHCS requirements. The implementation is scheduled for the end of the first quarter of 2025. Update 2/15/2025: Fields are undergoing validation to ensure accuracy with a goal to have a functional report ready by March 31, 2025 for monitoring and oversight. Update 5/9/2025: Draft Caregiver Update Report created that outlines criteria and dashboard. Update 7/11/2025: SOP created for monitoring and auditing process for timely caregiver updates. **Update 10/16/2025:** IA conducted an audit for this area beginning 08/26/25; the audit was closed on 10/16/25 with no CAPs. 5. BH will conduct biweekly reviews to confirm that follow-ups are performed consistently and on-schedule. Feedback loops will be established to address any barriers encountered during follow-ups and adjust the protocol accordingly. BH Navigators will undergo mandatory training to reinforce the importance of consistent monthly follow-ups, effective communication with parents, and accurate documentation. Update 5/9/2025: The standard operating procedure for the monitoring and auditing process for timely caregiver updates has been created. Update 7/11/2025: The monitoring and auditing report has been successfully deployed and is now utilized for monitoring and oversight. **Update 10/16/2025:** IA conducted an audit for this area beginning 08/26/25; the audit was closed on 10/16/25 with no CAPs.	7/11/2025	Completed	Behavioral Health	☑	State	DHCS
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.	1. Policy UM-054 Notice of Action supports the process to ensure NOAs contain clear explanations of denial reasons. SOPs were updated to reflect utilization of new CoC NOA in a single letter, Medical Directors were trained, and all impacted staff were notified on 8/14/2024. 2. The Plan will include CoC denial notices in the monthly operational NOA audits, reported quarterly at UMC. Update 5/9/2025: Two CoC audit tools have been created to monitor appropriate processing of the CoC requests, which includes a review of NOAs, and a more specific audit tool to look at each element of the NOA. Update 7/11/2025: Policies have been updated to correspond with the monthly audits, and regular monitoring and oversight are now in process.	7/11/2025	Completed	UM		State	DHCS

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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.	1. The Plan worked with the provider to close their panel in September, preventing additional wait listed members. (9/1/2024). The Plan met with the provider related to access in an On-going manner during Joint Operating Meetings (JOM) and Plan/provider Access Meetings. The provider actively outreached to members on the wait list. Progress reports were reviewed at Plan/provider Access meetings. In September 2024 the provider brought in two new providers to support with provider wait list. In review of grievances data, the number of grievances declined for timely access at this provider's location. The Plan has implemented QI initiatives to improve access to care, including pay for performance (P4P), extended office hours incentives and provider recruitment/retention incentives (AAH provider grant live as of 6/1/2024). 2. Provider access data shows outreach efforts have been effective in getting new members schedule for appointments and off the waitlist. The Plan is working on outreach reports from the provider to show continues self-monitoring as well as written procedures to support. Update 5/9/2025: Outreach reports have been obtained from the provider, and an analysis of grievance data for this provider show that timely access related grievances have declined.	4/15/2025	Completed	QI		State	DHCS
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.	1. The Plan added in-office wait times measure to CG-CAHPS survey for BH providers on 5/6/2024. The finalized report was presented at the Access & Availability Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025. The final report is expected to be completed by Q2, 6/30/2025 QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of in-office wait times for specialist and behavioral health providers.	4/15/2025	Completed	Behavioral Health		State	DHCS
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.	1. The Plan added telephone wait times measure to CG-CAHPS survey for BH providers. The finalized report was presented at the Access & Availability Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025. The final report is expected to be completed by Q2, 6/30/2025. QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of telephone wait times for specialist and behavioral health providers	4/15/2025	Completed	Behavioral Health		State	DHCS
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.	1. Policy G&A-003 Grievance and Appeals Receipt, Review, and Resolution was updated to require grievances with clinical issues, such as access or QOS grievances with clinical issues, to be resolved by the Medical Director. 2. The G&A Department will provide additional training to ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues. The Timeline will also need to be updated to include the contractual language. Update 5/9/2025: Training was completed in February 2025. 3. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for grievances involving clinical issues is being met. Update 5/9/2025: Internal audits were started in February 2025. Update 7/11/2025: Internal audits are now in progress and findings are shared with the G&A supervisor for retraining and coaching 4. The G&A Department will provide an Internal Audit Standard Operating Procedure that outlines our self-monitoring/internal auditing processes. Update 5/9/2025: The SOP for the self-monitoring process was completed.	7/11/2025	Completed	G&A		State	DHCS
15	Member Rights	(4.1.2) Resolution of Grievances The Plan did not completely resolve the members' grievances.	1. The QA Grievance Audit Tool was reviewed to outline the future monitoring process to ensure that all grievances are resolved prior to being closed. 2. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for resolution of grievances is being met. Update 5/9/2025: Internal audits started in February 2025 Update 7/11/2025: Audits are continuing monthly and findings are shared with the G&A supervisor for retraining and coaching if needed. Update 12/17/2025: Audit reports were presented during AOC meeting. **Update 10/21/2025:** IA conducted an audit of this area starting 04/04/2025; the audit was closed 07/09/2025. The CAPs were closed on 10/21/2025.	12/17/2025	Completed	G&A	☑	State	DHCS
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.	1. The QA Grievance Audit Tool was reviewed to outline the future monitoring process to ensure that all grievances have clear and concise resolution letters prior to being closed. The G&A Department will provide additional training to ensure that the Plan's written resolution contains a clear and concise explanation. Update 5/9/2025: Internal audit tools and SOP governing the internal review were created. 2. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for Clear and Concise Resolution Letters is being met Update 5/9/2025: Internal audits started in February 2025. Update 7/11/2025: Audits are continuing monthly and findings are shared with the G&A supervisor for retraining and coaching if needed. **Update 12/17/2025:** Audit reports were presented during AOC meeting. **Update 10/21/2025:** IA conducted an audit of this area starting 04/04/2025; the audit was closed 07/09/2025. The CAPs were closed on 10/21/2025.	12/17/2025	Completed	G&A		State	DHCS

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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.	1. Current LAT and NDN were added to the Member's Rights package and updated in the G&A system. 2. The G&A Department in conjunction with the Compliance Department will review all enclosures on an annual basis to ensure compliance. Update 5/9/2025: Internal audits started in February 2025. Update 7/11/2025: Audits are continuing monthly and findings are shared with the G&A supervisor for retraining and coaching if needed	8/1/2025	Completed	G&A	✓	State	DHCS
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.	1. The Plan has completed updates of Policy and Procedure (P&P) CLS-011-CLS Program Monitoring to include additional language on monitoring information collected and reporting. The Plan anticipates approval date of the updated draft by Alliance Administrative Oversight Committee (AOC) for 4/16/2025. Update 5/9/2025: The updated policy CLS-011 was approved by AOC on 4/16/2025. 2. The Plan anticipates that updates to vendor contracts to include reporting requirements for vendor interpreter qualifications and cadence will be implemented by 3/31/2025. Update 5/9/2025: Reporting amendments for the contracts were submitted for the vendors 3. The Plan anticipates the implementation of monthly vendor interpreter qualifications reporting by 1/31/2025. The Plan anticipates implementation of a monthly attestation of monthly vendor interpreter qualifications review by 1/31/2025. The Plan will review and address concerns with vendor interpreter qualifications at Quarterly Vendor Joint Operations Meeting (JOM) by 3/31/2025. The Plan will report and address concerns with vendor interpreter qualifications at Quarterly Cultural and Linguistic Services Subcommittee (CLSS) meeting by 4/30/2025. Update 5/9/2025: The monthly reporting and attestation process has been implemented, and discussions began at JOMs in April.	7/11/2025	Completed	Cultural and Linguistic Services		State	DHCS
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.	1. The Plan updated CMP-013 "HIPAA Privacy Reporting" in September 2024 to include verbiage addressing the gap that contributed to the audit finding: "Referrals must be made immediately upon discovery, and no later than 24 hours after." Additional updates included a Corrective Action section to address late referrals: "Corrective actions will be taken for delayed referrals, including but not limited to education, training, and / or Corrective Action Plans (CAP)." CMP-013 also states, "The Alliance will investigate the incident and submit an Initial Privacy Incident Report (PIR) to DHCS within 24 hours of discovery of a breach, suspected breach or security incident." Verbiage of Privacy Incident Investigation and Reporting Procedure updated to formalize education and corrective action for late referrals. 2. Implement new monitoring process to address the gap in referrals from G&A and internally within Compliance that contributed to the audit finding: "The Privacy Office will monitor the Compliance inbox, Compliance hotline, Privacy Compliance Inbox, and HealthSuite system for referral of any HIPAA Privacy reporting incidents. Each will be checked daily at minimum." 3. The Privacy Office is conducting weekly audits of HealthSuite referrals to ensure privacy concerns reported by members are appropriately categorized by the Member Services Department. Appropriate categorization will enable timely reporting of privacy incidents. Update 7/11/2025: Annual Plan wide training was completed, and ad hoc training and escalation is done in the case of late reporting. **Update 8/15/205**: IA conducted an audit of this area beginning 5/7/25; the final report was issued on 8/1/25. This audit was closed on 8/15/25. 4. The Plan will include review of the Internal Audit results at the Compliance Committee meetings.	7/11/2025	Completed	Compliance		State	DHCS
			1. The Plan will review and update the following impacted P&Ps as needed: PRV-005 & CRE-002. 3/14/2025: PRV-005 was reviewed and confirmed the information was present in the policy and no additional updates were identified. 2. The Plan will provide an advisory to delegates and/or providers that delegated for credentialing functions about timely reporting requirements. 3/14/2025: The Plan notified providers delegated for Credentialing functions about timely adverse termination reporting requirements by email and provided a PowerPoint Reminder Notice and a Adverse Reporting Template. In addition, the information was also shared with Teladoc during the Q1 2025 Joint Operations Meeting (JOM) on 02/04/2025. 3. The Plan conducts monthly review of the exclusion and suspension lists and this is an ongoing process that will support ongoing monitoring and the identification and reporting of adverse provider termination. This is ongoing. There are no changes to the Plan's provider notice templates and member notice templates. 4. The Plan's provider manual will be updated in Q1 2025. Update 5/9/2025: The provider manual was updated 5. The Plan will develop a log that will track Provider terminations, provider notification, and member notification including date of reports received and submitted to DHCS and date members were notified Update 5/9/2025: The		1.Completed 4/15/2025 2. Completed 4/15/2025 3.Completed 4/15/2025 4. Completed 4/15/2025				

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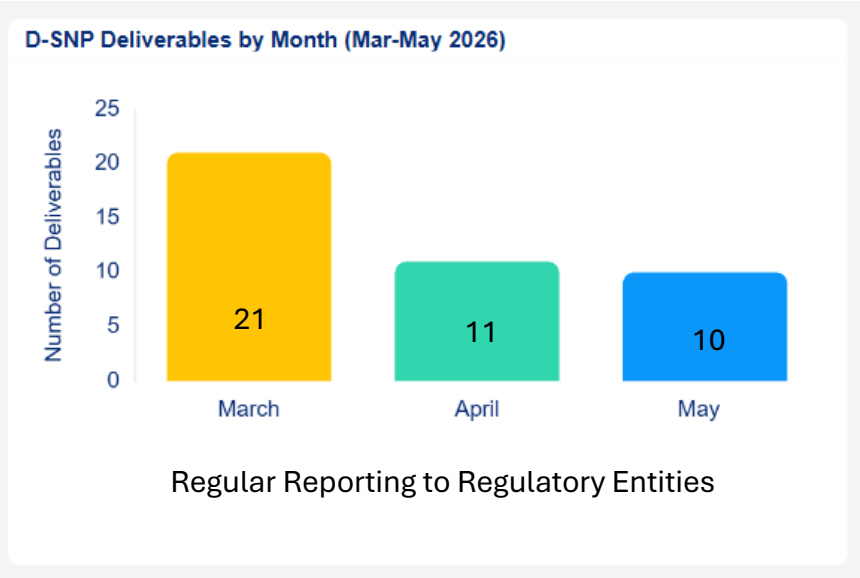
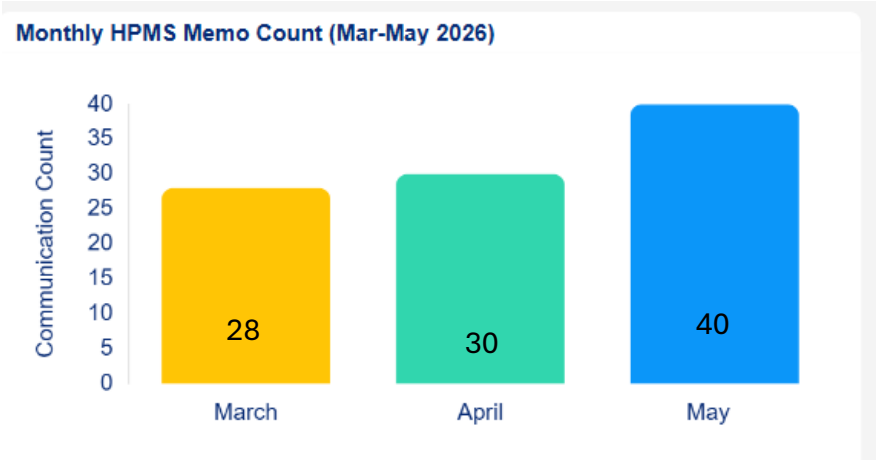
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self-Identified	Agency
20	Quality Management	(5.3.1) Notification of Provider Terminations The Plan did not meet DHCS reporting and member notification requirements for provider terminations.	log was completed. Update 7/11/2025: The Plan is now leveraging Potential Provider Terminations log and Adverse Event Report for tracking provider terminations 6. The Plan will develop a reporting template/instruction for Providers/Delegate/Subcontractor for reporting adverse terminations to the Plan. 2/15/2025: The Plan has developed a reporting template that includes instructions on how to complete for providers/delegates to use when reporting adverse terminations. The information was shared with providers delegated for Credentialing functions on 02/07/2025. 7. The Plan will review the quarterly HICE Credentialing report and confirm against the adverse termination log to determine if provider suspended/termed for quality of care has been reported during the month of termination. During this review, if providers are identified as having been suspended or terminated due to quality of care, the Plan will confirm submission of the 805 report to DHCS. **Update 06/03/26:** The Plan continues to monitor the quarterly credentialing report to ensure identified suspended or terminated providers due to QOC are appropriately reported to DHCS. 8. The Plan will include review of the reports/logs during Subcontractor Delegation Oversight Committee meetings. 9. The Plan will include review of the Internal Audit results at the Compliance Committee meetings. Update 2/27/2026: IA conducted an audit for this area beginning 6/20/25; the audit was closed on 2/27/26. CAPs are ongoing. The results for this audit will be presented to the AOC. **Update 06/03/26**: The CAP was closed on 05/29/26, and it will be reported at AOC this month.	In Progress	5.Completed 4/15/2025 6. Completed 4/15/2025 7. Completed 8. Completed 9. Completed	Operations		State	DHCS

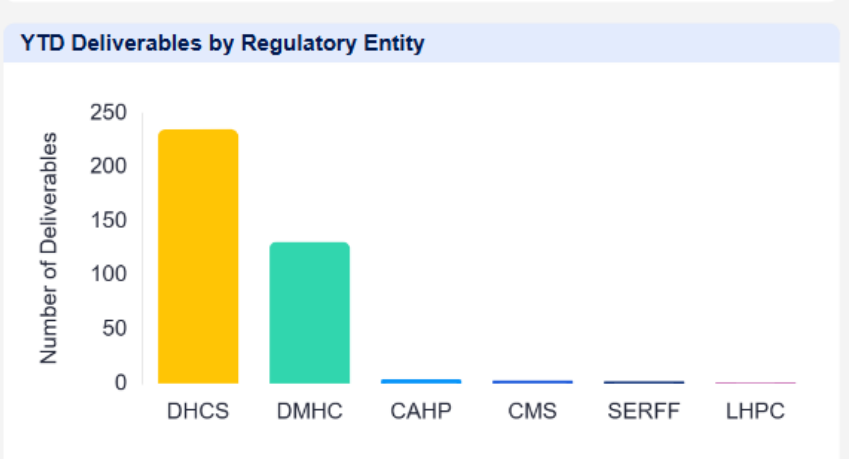
Regulatory Affairs and Compliance Dashboard



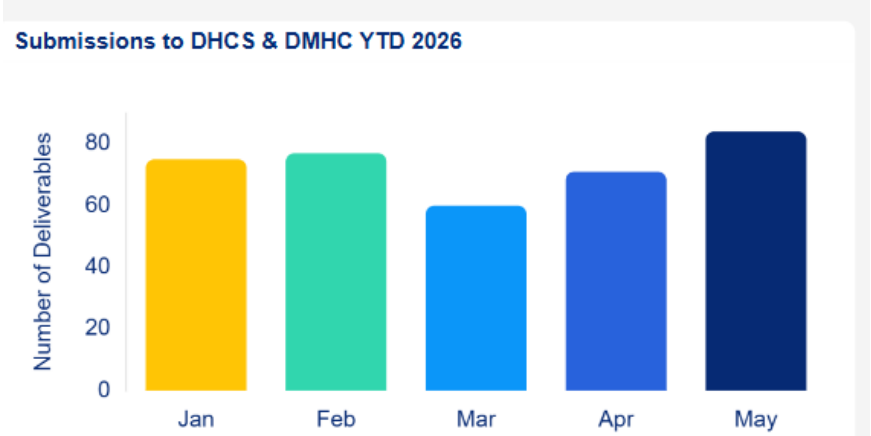
Regular Reporting to Regulatory Entities



HPMS memos are reviewed to confirm applicability to the Alliance and triaged based on intent and required response, including Information Only, Feedback Request, and Action/Implementation items.



Group Care & Medi-Cal related deliverables are predominantly driven by DHCS and DMHC, reflecting the volume of Group Care and Medi-Cal–related regulatory submissions by primary state regulators.



Submissions to DHCS and DMHC demonstrate a sustained and increasing volume of Group Care and Medi-Cal regulatory activity,

Compliance Committee Summary Report – Q2 2026

The Compliance Committee continued quarterly oversight of the Alliance's compliance program, including key issues, regulatory reporting, policy implementation, regulatory audits, privacy, fraud/waste/abuse (FWA), delegated oversight, and operational committee activities, and reported no sanctions for the period.

Enterprise-wide participation was reflected through presentations and input from key functional areas, including but not limited to:

- Executive/CEO–BOG
- IT Security
- Various Issue owners – Discussed key compliance and operational issues, including:
  - Standard grievance 30-day turnaround time (TAT) performance below target
  - BCBA PAVE enrollment requirements,
  - Claims 30-calendar-day TAT, on track to close by June.

The Committee reviewed and approved the annual Compliance Program Plan update, some of which include:

- Enhanced integration of Compliance, Enterprise Risk Management (ERM), and Internal Audit,
- Strengthened
  - Oversight of delegated entities,
  - Audit/monitoring processes, and
  - Training effectiveness.

Anne Beech, Senior Director, Enterprise Risk Management & Operational Oversight, presented and the Committee approved foundational ERM governance components, including:

- Adoption of the COSO ERM Framework
- Enterprise Risk Taxonomy
- Risk-based Internal Audit Plan

Compliance staff presented the Compliance Program Survey results, which assessed program effectiveness across knowledge, communication, training, and culture:

- Overall results were favorable, with strong scores in knowledge and leadership commitment
- Opportunities for improvement were identified in:
  - Communication & reporting
  - Training & resources
- Leadership identified these areas as priorities for targeted program enhancements going forward.

Health Care Services

Donna Carey, MD

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

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

Date: **June 12th, 2026**

Subject: **Health Care Services (HCS) Report**

Credentialing Committee

- At the Peer Review and Credentialing (PRCC) meetings held on May 19, 2026, there were one hundred and seventy-five (175) initial network providers approved; three (3) primary care providers, nine (9) specialists, seventeen (17) ancillary providers, eleven (11) midlevel providers, and one hundred and thirty-five (135) behavioral health providers.

- Additionally, ninety-five (95) providers were re-credentialed at this meeting; eight (8) primary care providers, twenty-one (21) specialists, five (5) ancillary providers, nineteen (19) midlevel providers, and forty-two (42) behavioral health providers.

- The report shows 431 facilities that are currently credentialed.

Utilization Management: Outpatient

- The prior authorization and benefits grid revision was completed and the searchable code tool is now posted on the external website. The goal was to create a more provider-friendly reference document to delineate code-specific authorization rules.
- OP processed a total of 3,481 authorizations for the month of May. We also processed 414 CCS referrals, of which 92 cases were submitted to our regional CCS office for review (35 approved, 21 denied, 36 pending). CBAS 2 New CEDT, 1 Discharge, 4 ERS, 54 renewals.
- Overall OP Turnaround times exceeded the threshold of 95% for the month of May 2026. The OP UM team, in collaboration with the MDs, continue to explore process improvements to streamline efficiency and reduce missed TATs. The D-SNP LOB missed TAT on 1 of the 36 authorizations in May, however missing 1 of the 16 in March caused the score to be below the 95% threshold in March and missed 1 of the 23 in April; therefore, benchmark was not met and the trend will continue to be monitored.
- The top 5 categories remain unchanged TQ, Radiology, Home Health, outpatient Rehab and Outpatient Facility. These 5 categories represent ~75% of this volume.

- The Home Health pilot launched in July continues to be effective, reducing the number of manual reviews for selected HH services and diagnoses. There has been a slow increase in providers now using the portal (now up to 9 providers from 7). The pilot is being monitored and will be expanded in the future.
- The number of D-SNP authorizations created continue to rise as April was the first month that the 90-day Continuity of Care provisions were lifted for the original D-SNP members. There were 23 Outpatient D-SNP Authorizations created April 2026 and 36 in May.

Total Outpatient Authorization Volume			
Authorization Status	**March 2026**	**April 2026**	**May 2026**
Approvals	3,176	3,396	3,054
Partial Approvals	0	0	0
Denials	431	554	427
Total	**3,608**	**3,950**	**3,481**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**March2026**	**April2026**	**May 2026***
Denial Rate Excluding Partial Denials	3.8%	4.3%	2.7%
Partial Denial Rate	0.1%	0.1%	0.3%
Overall Denial Rate	3.9%	4.4%	3.0%

***Source**: #01292 All Auth Denial Rate – data only available through March 2026*

Outpatient Turn Around Time Compliance *(benchmark: 95%)*			
Line of Business	**March 2026**	**April 2026**	**May 2026**
Overall	98.3%	99.6%	98.5%
Medi-Cal	98.3%	99.6%	99.7%
IHSS	99.3%	100%	98.6%
D-SNP	93.8%	95.7%	97.2%

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- Total inpatient auth volume (including all IP authorization types processed by department: Acute, LTACH, Skilled SNF, and OP auths related to discharge) decreased from 3,869 in April 2026 to 3,411 in May 2026.

- Inpatient overall average LOS decreased from 5.5 in March to 5.2 in April Admits per thousand increased from 52.1 in March to 53.5 in April. As did days per thousand - decreased from 284.2 in March to 276.3 in April.

- IP overall denial rate decreased from 3.2% in April to 2.0% in May.

- IP Auth TAT –99% overall- surpassed 95% benchmark across all lines of business in May 2026.

- IP UM successfully launched DSNP workflows and is actively processing requests on behalf of DSNP members, in compliance with TAT, in alignment with Medicare guidelines and established processes. There were 21 D-SNP Authorization lines reviewed by the Inpatient Team in April.

- External hospital rounds are ongoing with UCSF, Stanford, Alameda Health System, Kindred LTACH, Kentfield LTACH, Washington, Eden, Alta Bates, and Summit, to review members' current active admissions discuss UM issues, address discharge barriers, offer other opportunities for supporting throughput and appropriate discharge.

- Alameda Alliance IP UM RN onsite nurse pilot program completed its 4th month at Washington Hospital. Data shows readmission rates from quarter 1 in 2025 were 23.6% compared to quarter 1 in 2026 19.7%. Preliminary data suggests decreases in readmissions and length of stay. Report out next month, with confirmed data after 3-month claims lag. The IP UM Onsite RN meets with members in the ED and on the inpatient floors, interacting with hospital care management staff to ensure appropriate care coordination, follow ups, and discharge authorizations are in place.

Total Inpatient Authorization Volume			
Authorization Status	**March 2026**	**April 2026**	**May 2026**
Approvals	3,424	3,869	3,411
Partial Approvals	0	0	0
Denials	53	59	73
Total	**3,477**	**3,928**	**3,484**

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**February 2026**	**March 2026**	**April 2026**
Authorized LOS	5.4	5.5	5.2
Admits/1,000	48.3	52.1	53.5
Days/1,000	261.7	284.2	276.3

Source: #01034_AuthUtilizationStatistics – *data only available through April 2026

Inpatient Authorization Denial Rates			
Denial Rate Type	**March 2026**	**April 2026**	**May 2026**
Full Denials Rate	1.3%	1.4%	0.8%
Partial Denials	2.6%	1.8%	1.2%
All Types of Denials	3.9%	3.2%	2.0%

Source: #01292_AllAuthDenialsRate

Inpatient Turn Around Time Compliance *(benchmark: 95%)*			
Line of Business	**February 2026**	**March 2026**	**April 2026**
Overall	99%	99%	99%
Medi-Cal	99%	99%	99%
IHSS	100%	100%	100%
D-SNP	100%	100%	100%

Utilization Management: Long-Term Care

- LTC census during May 2026 was 2203 members. This is a decrease of -0.27% (6 members) from April 2026.

- Month to Month, the admissions and length of stays seem to decrease from February 2026 - April 2026 of 52%, 68%, 59% respectively. Some of this could be due to a lag in claims data being available.

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Totals	February 2026	March 2026	April 2026
Admissions	132	141	63
Days	904	1017	291
Readmissions	22	37	9

Source: #14236_LTC_Dashboard

- LTC Staff continue to participate in SNF collaboratives around the county to ensure that our facility partners are updated with processes and program enhancements.
- Having virtual rounds with AHS, San Leandro, Kyakameena, Elmwood, Jones Convalescent and Eden LTC facilities to coordinate on complex cases

- LTC Team continues to meet individually with multiple facilities to discuss collaboration with discharge planning and submitting proper documentation for requests.
- Quarterly rounds with Regional Center of Easy Bay to discuss any ICF/DD members.
- 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 a 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.
- The LTC Manager position is vacant effective 03/29/26.
- The LTC Director position is vacant effective 05/01/26.
- Authorization processing turn-around time (TAT) has remained at 99%, which is exceeding the threshold of 95%.

Total LTC Authorization Volume			
Authorization Status	**March 2026**	**April 2026**	**May2026**
Approvals	890	1040	830
Partial Approvals	0	0	0
Denials	54	58	41
Total	**944**	**1098**	**871**

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 *(benchmark: 95%)*			
Line of Business	**March 2026**	**April 2026**	**May2026**
Medi-Cal	99%	98%	99%

Source: #02569_AuthTAT_Summary

Behavioral Health

- In May, the Behavioral Health Department processed 719 authorizations, 620 Care Coordination referrals, and 225 mental health screenings and transition of care tools.

BH Authorization Volume			
	26-Mar	**26-Apr**	**26-May**
Approvals	702	748	712
Partial Approval	0	0	0
Denials	30	9	7
Total	732	757	719

Source: 14939_BH_AuthTAT

MH TAT			
**Goal ≥95%*	**26-Mar**	**26-Apr**	**26-May**
Determination TAT%	94%	100%	98%
Notification TAT%	92%	98%	98%

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
**Goal ≥95%*	**26-Mar**	**26-Apr**	**26-May**
Determination TAT%	99%	100%	98%
Notification TAT%	99%	100%	95%

Behavioral Health Denial Rates

**Goal ≤ 5%*	BH Denial Rates	
26-Mar	**26-Apr**	**26-May**
<1%	<1%	<1%

Mental Health Care Coordination

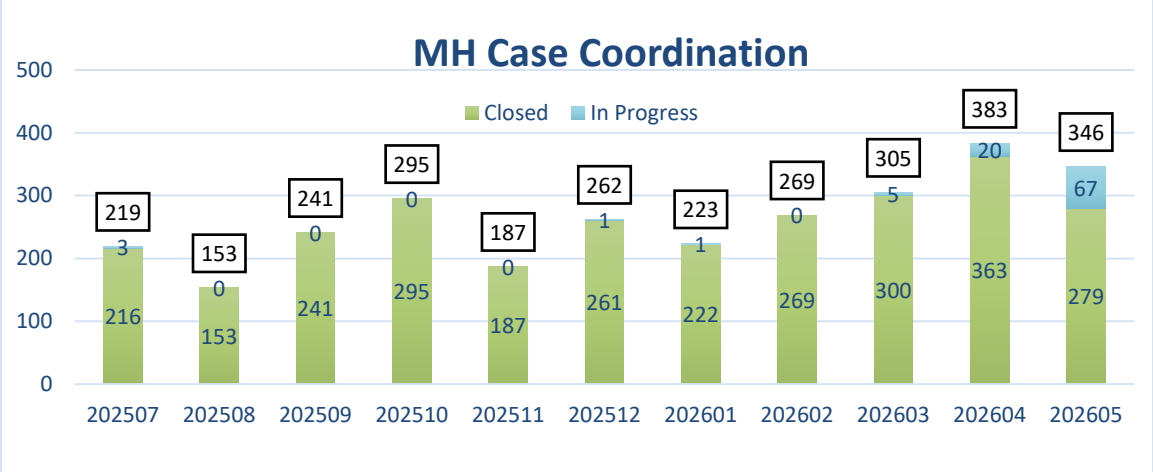
- In compliance with the No Wrong Door policy, the Alliance completes the DHCS-required screening tools when members are seeking to start new mental health services. The screening tools determine if members meet the criteria to be referred to ACBHD for Specialty Mental Health Services.

Total # Medi-Cal Screenings & TOC Tools			
	26-Mar	**26-Apr**	**26-May**
Youth Screenings	70	62	75
Adult Screenings	160	122	149
Incoming ACBH Referrals	102	159	91
Outgoing Referrals to ACBH	47	32	43
Transition of Care Tools to ACBH	1	1	1

Source:16015_MH_Assessments, 16093_BH Referral Report

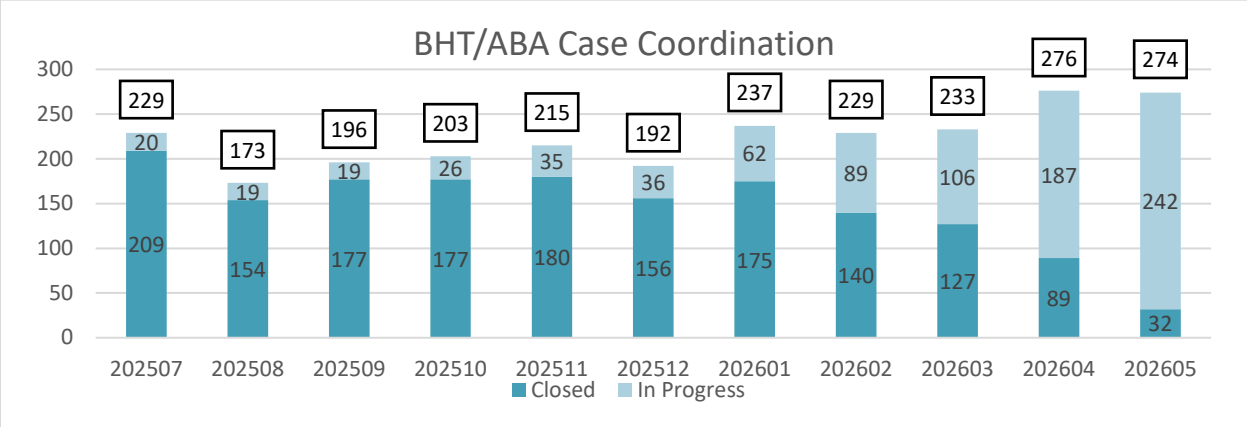
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.

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 needed. The Alliance manages each child's unique needs and follows up with parents and caregivers to resolve barriers to care.

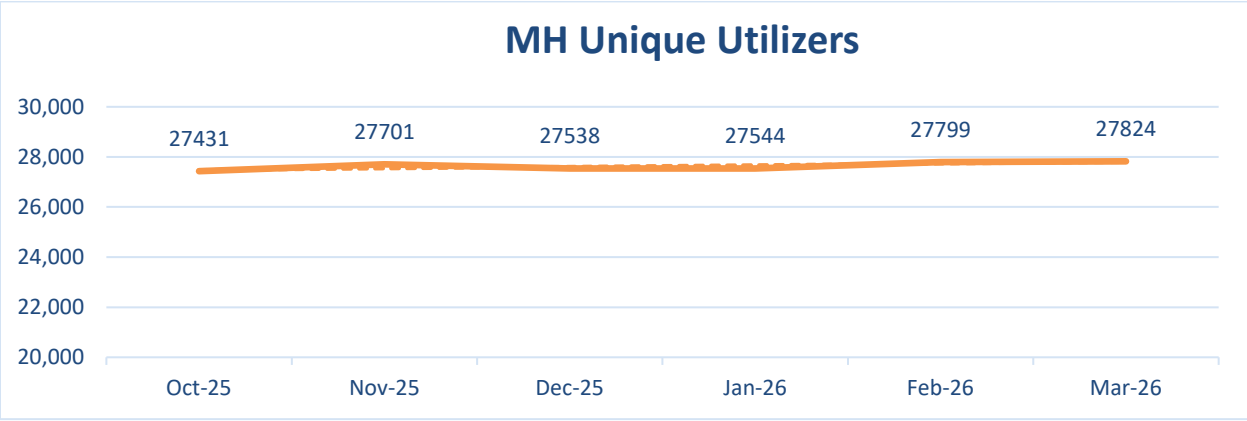


Source: 14665_BH_Cases

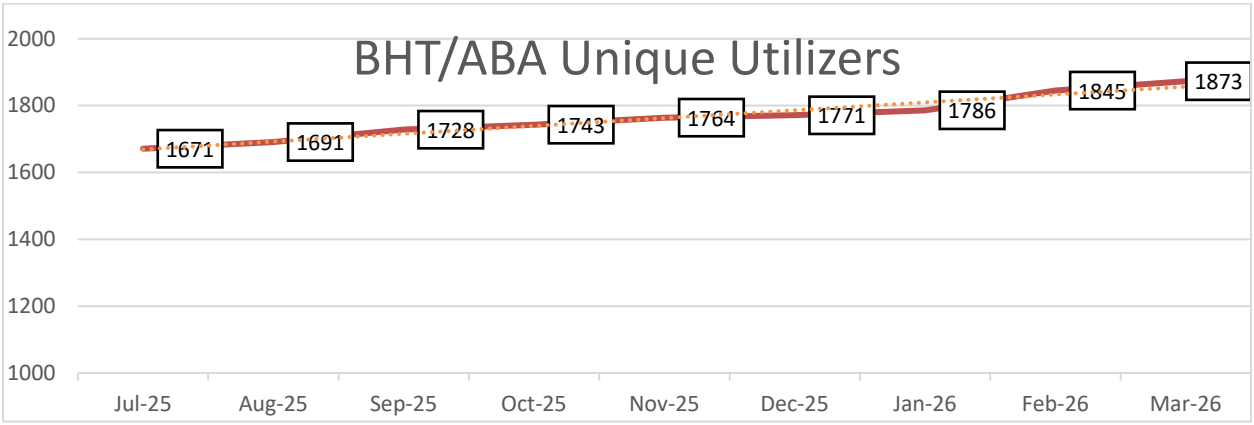
Behavioral Health Unique Utilizers

- 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.

Mental Health Unique Utilizers:



***BHT/ABA Unique* Utilizers:**



Source: PBI 14621 BHT Utilization Report

Pharmacy

- Pharmacy Services process outpatient pharmacy claims, and pharmacy prior authorization (PA) has met turn-around time compliance for GroupCare and DSNP line of business (LOB) for May, 2026:

LOB	Number of Outpatient PAs Processed	Turn Around Rate Compliance (%)
Group Care	165	100%
DSNP	20	100%

Decisions	GroupCare PAs Processed May 2026	DSNP PAs Processed May 2026
Approved	57	9
Denied	89	10
Closed	19	1
Total	**165**	**20**

- Group Care Medications for weight loss and diabetes are in the top categories for denials.

May Ranking	Drug Name	Common Use
1	WEGOVY Soln Auto-inj 0.25MG/0.5ML	Weight loss
2	LIDOCAINE Patch 5%	Topical pain relief
3	WEGOVY Tablet 4MG	Weight loss
4	WEGOVY Soln Auto-inj 0.5MG/0.5ML	Weight loss
5	VEMLIDY Tablet 25MG	Hepatitis B
6	TRETINOIN Cream 0.025%	Acne
7	ESTRING Ring 7.5MCG/24HR	Hormone replacement
8	JARDIANCE Tablet 10MG	Diabetes
9	WEGOVY Soln Auto-inj 1MG/0.5ML	Weight loss
10	JARDIANCE Tablet 25MG	Diabetes

- DSNP Medications for diabetes are in the top categories for denials

May Ranking	Drug Name	Common Use
1	LIDOCAINE Patch 5%	Topical pain relief
2	ZEPBOUND Soln Auto-inj 5MG/0.5ML	Weight loss
3	OZEMPIC (1 MG/DOSE) Soln Pen-inj 4MG/3ML	Diabetes
4	OZEMPIC (0.25 OR 0.5 MG/DOSE) Soln Pen-inj 2MG/3ML	Diabetes
5	CYCLOBENZAPRINE HCL Tablet 10MG	Muscle relaxer
6	VITAMIN D3 Capsule 50 MCG(2000 UT)	Vitamin deficiency
7	HUMIRA (2 PEN) Auto-inj Kit 40MG/0.8ML	Autoimmune disorders
8	BELBUCA Film 75MCG	Pain management
9	ADMELOG Solution 100UNIT/ML	Diabetes

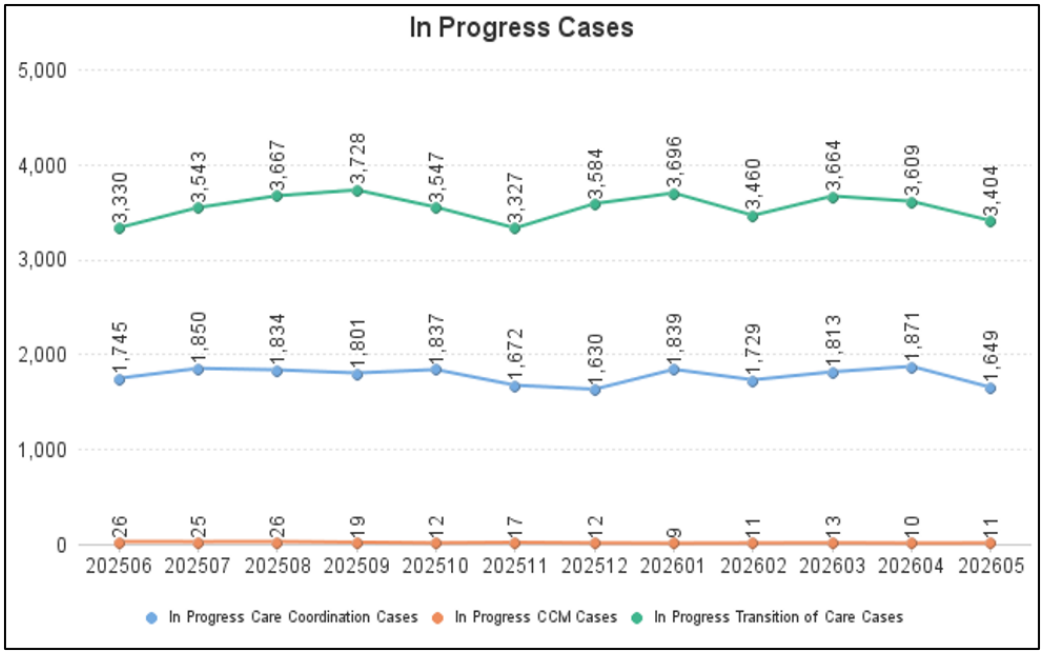
Turnaround Time and Determinations By Line of Business[1]

LOB	Determination	January 2026	February 2026	March 2026
IHSS	Approved	54	55	52
	Denied/Partials	95	76	86
	TAT	100%	100%	100%
DSNP	Approved			11
	Denied/Partials			9
	TAT			100%

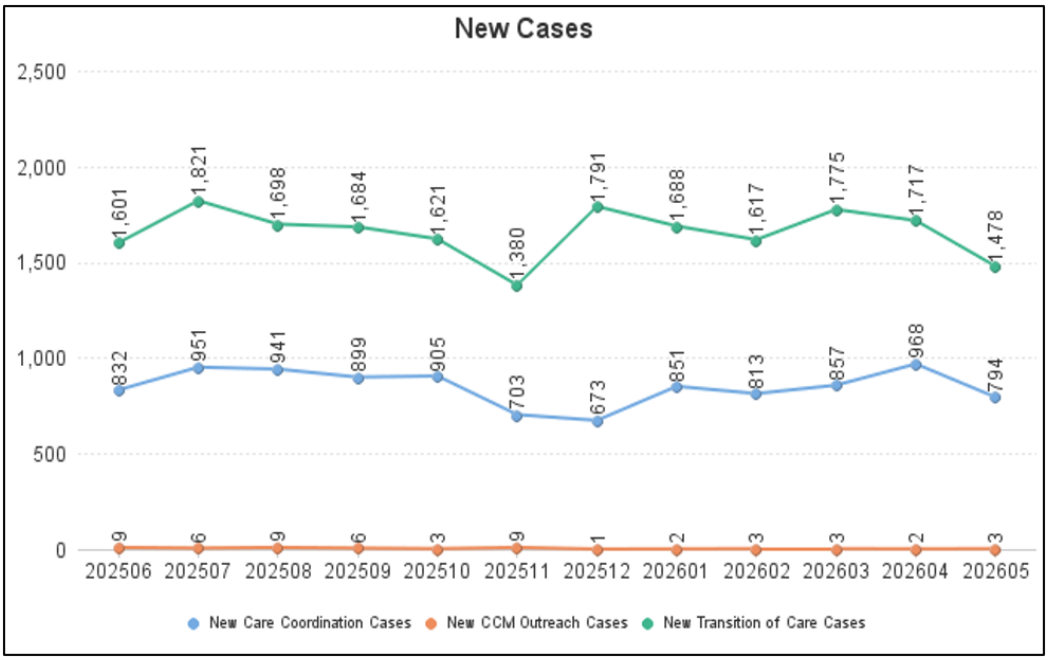
[1] Only includes authorizations that have been determined excluding closed authorizations.

Case and Disease Management

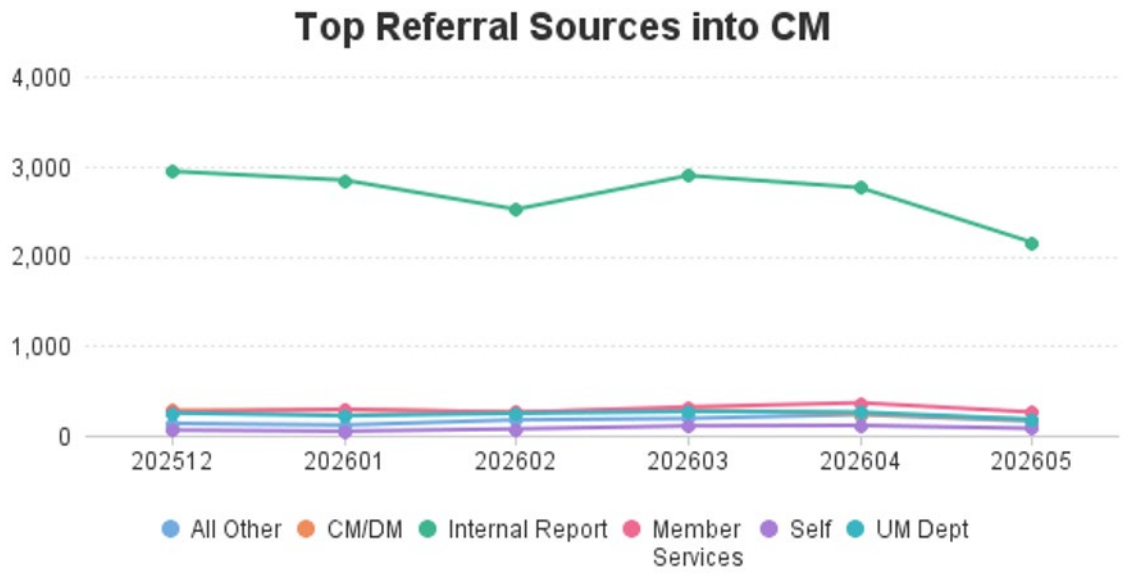
- D-SNP case management is live. The Case Management (CM) team is engaging D-SNP members in completing HRA assessments and building care plans.
- The CM team continues to assist the high volume of members needing Transitional Care Services (TCS) as they transition from one level of care to another. This includes outreaching members who are still hospitalized and following up post-discharge to help meet the members' needs. The CM team is partnering with an in-person provider for the adult TCS population beginning 6/1/2026.
- The TCS work also includes collaboration 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 working closely with UM and LTC teams 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. The transportation liaison has also increased oversight of ModivCare's facility transportation services, including making onsite visits with hospitals to address transportation concerns.



Source: #03342 TruCare Caseload

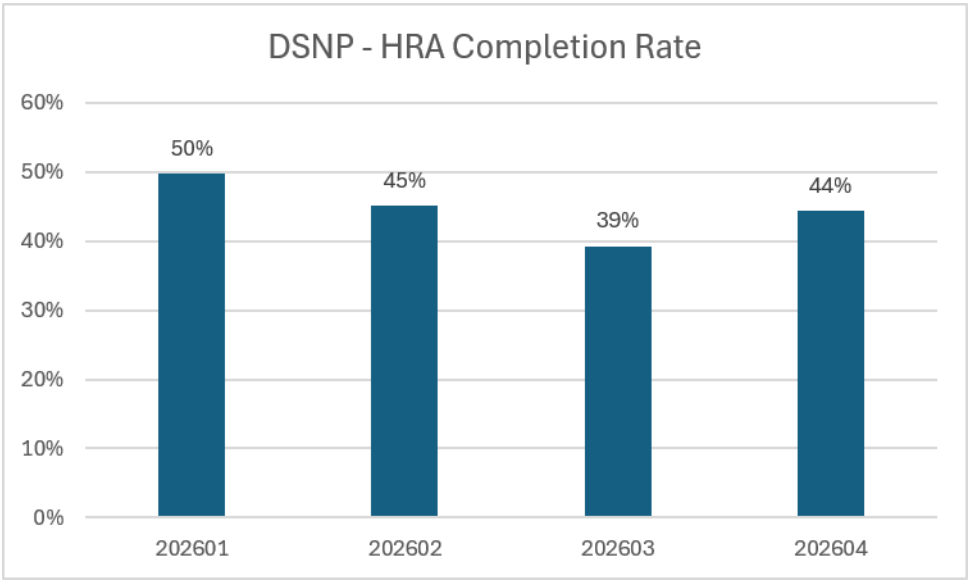


Source: #03342 TruCare Caseload



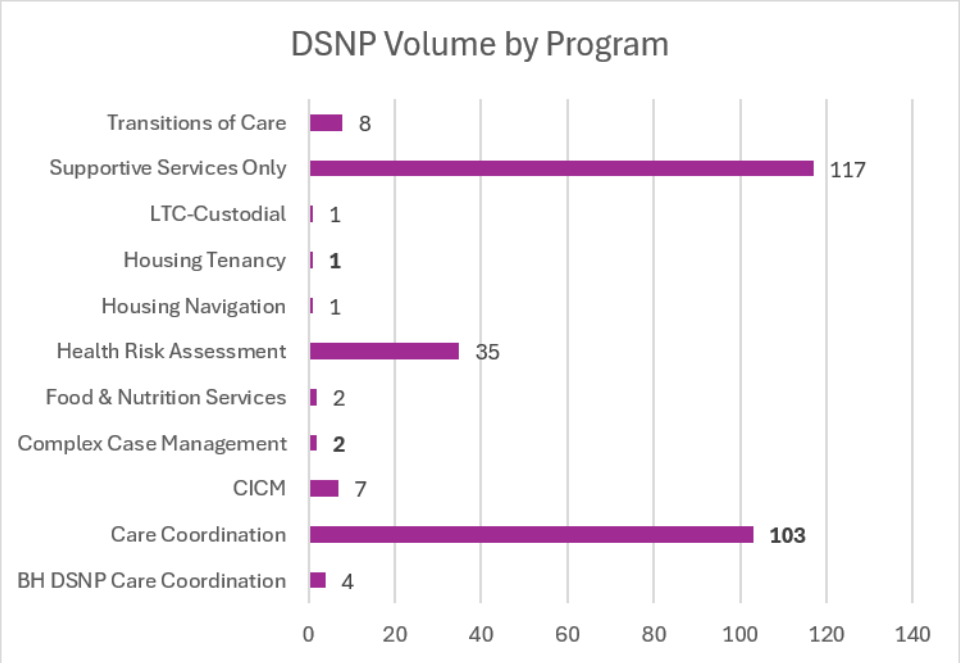
*Internal Report represents Transitional Care Services (TCS) data for recently admitted patients via Admissions Discharges Transfers (ADT) feed from hospital / skilled nursing facility partners

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



***Source*: #00835 HRA Dashboard**

DSNP CM Volume by Program Type



Source: #17175 CM DSNP Aging

Definitions:

- All programs linked to single DSNP Case/Care Coordination Program - Engaged members, custom care plan
- Health Risk Assessment Program – Still being outreached to complete HRA
- Supportive Services Only – Unengaged members receiving generic care plan
- BH DSNP (supplemental program) – Member engaged with both Physical Health and Behavioral Health CM teams
- Complex Case Management – Member with Complex CM needs, higher level of CM
- Palliative Care (supplemental program) - Member enrolled in palliative care
- Transitions of Care (supplemental program) - Member who experienced a transition of care such as hospital discharge

CalAIM

Enhanced Case Management

- All Populations of Focus are live:
    - Homeless children/youth and adults
    - High Utilizer children/youth and adults
    - SMI/SUD children/youth and adults
    - Children/Youth Transitioning from a Youth Correction Facility
    - Adults Transitioning from Incarceration
    - Adults Living in the Community and At Risk for Long-Term Care Institutionalization
    - Children/Youth Enrolled in CCS with Additional Needs Beyond the CCS Condition
    - Children/Youth Involved in Child Welfare
    - Children/Youth and Adults Who are Pregnant or Postpartum

- With DSNP live, the ECM team is working closely with the ECM providers to assist with Continuity of Care for these members and confirm the Alliance is meeting the new requirements associated with DSNP requirements for California Integrated Care Management (CICM).

- The ECM team is collaborating with IT and IPD to automate creation of authorization shells, provide auto authorizations where possible, and centralize ECM referrals. This will improve referral processing and authorization determination decisions with improved turnaround times. Additionally, this will free up ECM staff to work on other areas of ECM (i.e. graduating or assisting with stepping members down to a lower level of care, clinical audits, additional support to Provider frontline staff to improve effectiveness of care plan outcomes and, further advance the growth of ECM especially in key POF areas that are underdeveloped like Birth Equity).

- Efforts to expand the ECM provider network have resumed. The screening panel reviews provider applications based on capacity to serve targeted Populations of Focus, demonstrated operational excellence in programming, and quality benchmarks.

- The ECM team continues to build rapport with the ECM providers, meeting to discuss specific cases and work with the ECM providers to assist with moving members through the ECM program by addressing care plan barriers and offering support and services ECM providers may not be aware of. This has led to more collaboration and community referrals to additional resources. Additional meetings are scheduled with ECM providers for individual case conferences as needed. Clinical Operations meetings that support ECM provider leadership and processes have begun. These meetings further support the relationship between the ECM provider and AAH, to better understand the ECM providers barriers to moving members through the ECM care continuum appropriately and with a high level of quality of care.

- ECM and CS teams have begun a collaborative meeting to confirm communication is occurring between Community Supports providers and ECM lead care managers. The collaboration further enhances coordination of care, ensuring non-duplicative services and members receive appropriate services to meet their needs. One new area where collaboration is happening is in preparing for Transitional Rent, ensuring smooth transitions into ECM as necessary.

- The ECM team is wrapping up the Spring Audit of the ECM providers. The ECM team has met with Compliance to begin to address findings and develop best practices in consistent communication with the providers to monitor improvements.

- The ECM team continues the ECM Training Academy. The trainings began in April and occur monthly throughout the year. Topics will include ECM referrals and documentation for reauthorizations, nonjudgemental language and care, Dementia Care Aware and more.

	February 2026		March 2026		April 2026	
ECM Providers	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**
ACBH	-	13	-	13	-	13
Alameda Health System (AHS)	22	221	6	219	-	228
Bay Area Community Services (BACS)	39	201	42	238	29	245
California Cardiovascular Consultants	-	134	-	132	-	131
California Children's Services (CCS)	7	54	9	57	11	60
CHCN	57	1,302	148	1,341	202	1,396
East Bay Innovations (EBI)	21	159	14	164	14	167
Full Circle	-	153	1	148	-	149
Institute on Aging	141	255	175	251	180	265
La Familia	44	33	46	35	47	30
MedZed	267	1,338	1,404	1,483	650	1,556
Roots Community Health Center (includes Street Medicine)	-	603	1	594	-	504
Seneca Family Services	11	49	10	58	-	53
Pair Team	-	2,296	-	2,141	-	1,958
Titanium Health Care	314	1,788	529	1,826	648	1,920
Tiburcio Vasquez Health Center (Street Medicine)	-	114	-	113	-	112
BACH (Street Medicine)	-	78	-	76	-	71
Lifelong (Street Medicine)	-	441	1	421	1	401

Source: #13360 ECM Dashboard – data available through March 2026

Community Supports (CS)

- 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)
  - Assisted Living Facility Transition
  - Community or Home Transition Services
  - Transitional Rent

- The Alliance is working to identify gaps in current service capacity and member access to Community Supports; this will inform future targeted efforts for CS network expansion.

- 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. AAH is also working with CS providers, in coordination with DHCS, to clarify any policy or operational questions that may inform potential refinement of processes.

- LTSS Director position vacant as of 5/1/26.

- Oversight of Community Supports providers continues through the provider audit process.

Community Supports	Services Authorized in March 2026	Services Authorized in April 2026	Services Authorized in May2026
Housing Navigation	1209	1138	1022
Housing Deposits	383	363	321
Housing Tenancy	1789	1882	1867
Asthma Remediation	139	136	121
Meals	1208	1299	1194
Medical Respite	59	54	49
Transition to Home	6	6	2
Nursing Facility	2	1	1
Home Modifications	13	15	15
Homemaker Services	20	32	29
Caregiver Respite	2	1	1
Transitional Rent	13	28	31
Total	**4,843**	**4955**	**4653**

Source: #13581 Community Supports Auth Dashboard – data only available through May 2026

- There has been an decrease in the amount of authorization requests by 4% from March 2026 to May 2026.

Total CS Authorization Volume			
Authorization Status	**March 2026**	**April 2026**	**May 2026**
Approvals	966	943	905
Partial Approvals	0	0	0
Denials	123	68	76
Total	**1089**	**1011**	**981**

Source: #02569_AuthTAT_Summary

- Authorization processing turn-around time (TAT) has remained at between 99%, which is exceeding the threshold of 95%.

CS Turn Around Time Compliance *(benchmark: 95%)*			
Line of Business	**March 2026**	**April 2026**	**May 2026**
Medi-Cal	99%	99%	99%

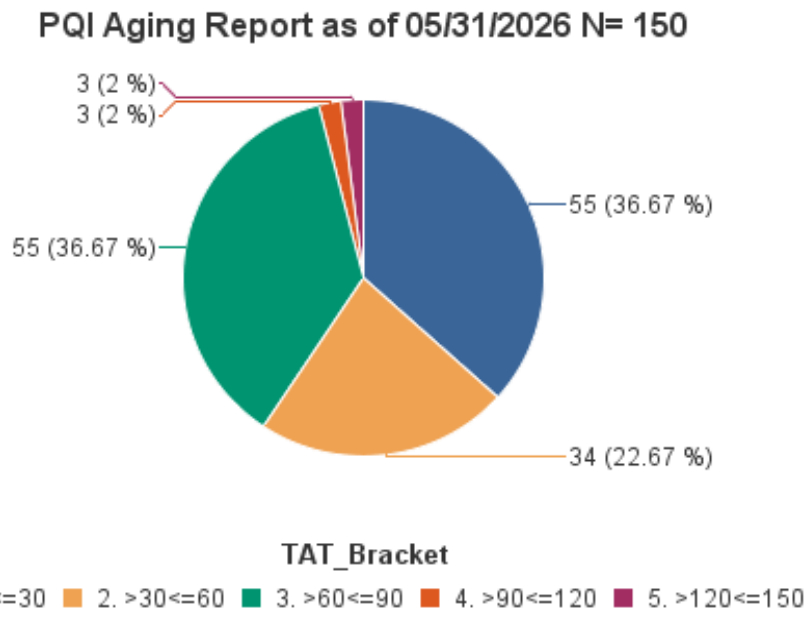
Source: #02569_AuthTAT_Summary

Quality

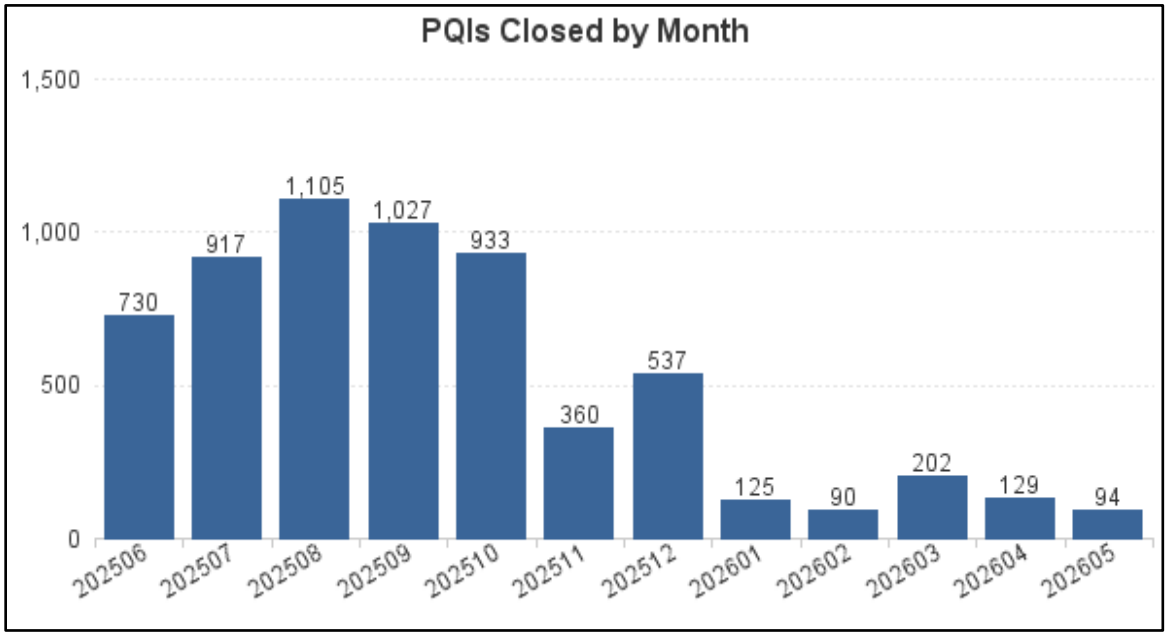
- As of May 31, 2026, the turnaround time (TAT) for Potential Quality Issues (PQI) is 100% closed within 150 days which exceeded the standard of 95% case closure rate. The majority of the cases were closed within 900 days (96%). The TAT at which PQI cases are being leveled and closed with final MD recommendations was met for the last 3 consecutive months.

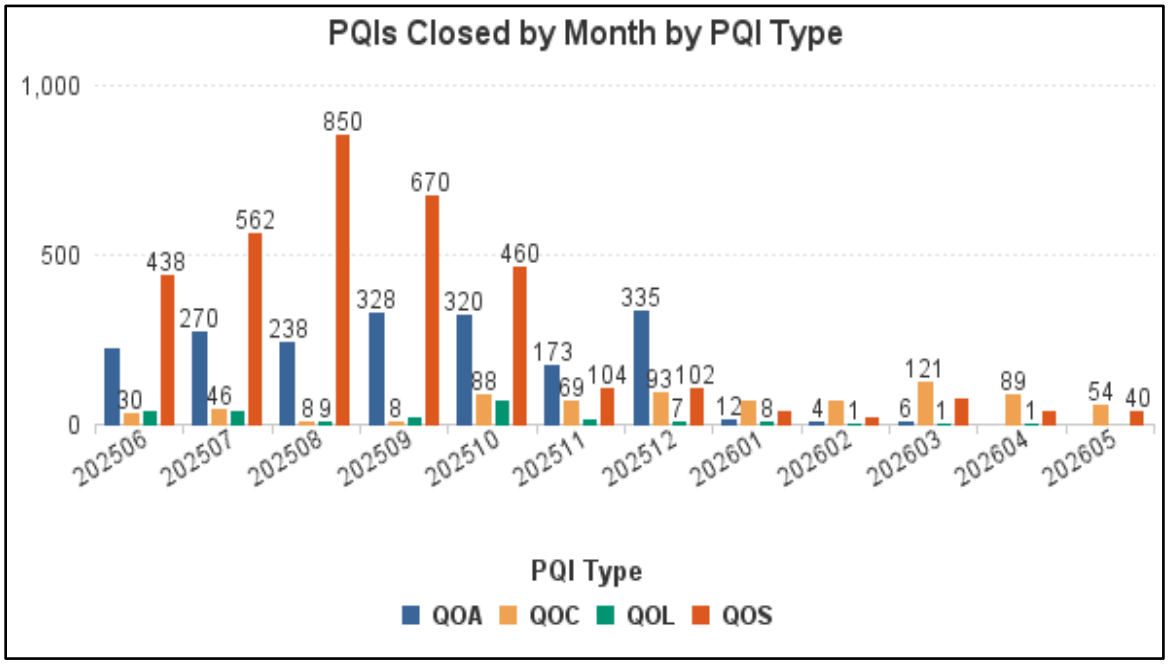
- The PQI volumes have decreased following implementation to streamline processes. There are on-going efficiencies implemented by the QI Medical Director on the overall review process.

- In response to the Department of Managed Health Care (DMHC) audit, the team has strengthened the PQI workflow for the corrective action plan process. This included refinement of the escalation process and options to address non-compliant, non-responsive, and ineffective or insufficient corrective action plan received from providers.



Note: PQI closed by month is lagged due to 150-day TAT





Provider Satisfaction Survey:

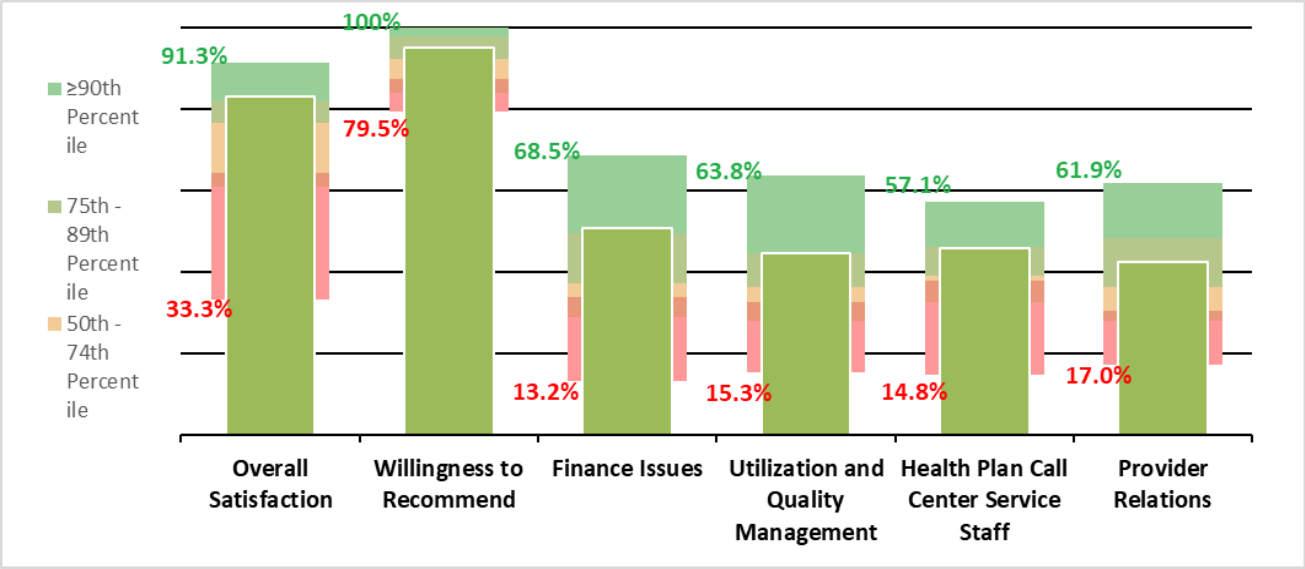
- Survey Objective: The Provider Satisfaction Survey targets providers to measure their satisfaction with Alameda Alliance for Health. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Provider Satisfaction Survey typically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

Provider Satisfaction Composite Scores

Composite	MY 2025 Result	Variance Compared to Previous Year	Variance Compared to PG Commercial Benchmark BoB	MY 2024 Result	MY 2023 Result
Overall Satisfaction	**83.1%**	Higher	Significantly Higher	80.7%	78.4%
All Other Plans (Comparative Rating)	**62.9%**	Lower	Significantly Higher	64.1%	55.3%
Finance Issues (Claims)	**50.6%**	Lower	Significantly Higher	56.3%	49.0%
Utilization and Quality Management	**44.7%**	Lower	Significantly Higher	50.4%	47.5%
Network/Coordination of Care	**33.5%**	Higher	N/A	27.0%	41.7%
Pharmacy	**33.7%**	Lower	N/A	35.6%	38.1%
Health Plan Call Center Service Staff	**45.7%**	Lower	Significantly Higher	50.9%	49.2%
Provider Relations	**42.3%**	Lower	Significantly Higher	52.6%	61.8%

- The Alliance identified higher composite scores in 2 of 8 measures compared to MY 2024 scores.
- Six (6) of the 8 composites scores are significantly higher than the vendor (PG) commercial BoB scores.

Comparison Relative to PG Book of Business



Green bar = AAH performing at or above the 75th percentile

Red bar = AAH performing below the 25th percentile

- The graph above shows how Alameda Alliance for Health scores compared to the distribution of scores in the 2024 PG Commercial BoB. All measures are performed above the 75th percentile.

Key Drivers of Overall Satisfaction with Health Plan

Power: Promote and leverage Strengths (Top 5 Listed)

- The health plan's facilitation/support of appropriate clinical care for patients
- Timeliness of plan decisions on urgent prior authorization requests
- Timeliness of obtaining pre-certification/referral/authorization information
- Procedures for obtaining pre-certification/referral/authorization information
- Accuracy of claims processing

Opportunities: Focus resources on improving processes

- Ability to speak with plan medical director about prior authorization decisions

Subject: Community Health Strategy (CHS) – May 2026

- The Community Health Worker (CHW) Benefit aims to mitigate health disparities and improve outcomes for Alliance members by bridging health and housing systems of care. CHWs support overall wellness through preventative services that positively impact members' social determinants of health.

Staffing Updates:

- No updates at this time.

May Program Summary:

- May represented a significant period of strategic advancement for Alameda Alliance's Community Health Strategy Department (CHS) as efforts increasingly focused on integrating Community Health Worker interventions into the organization's broader quality, population health, and health equity infrastructure.

- As healthcare systems continue evolving toward whole-person care models under CalAIM, CHS has expanded beyond traditional benefit administration and provider network development. The department is increasingly serving as a bridge between clinical, non-clinical care, community-based services, and quality improvement efforts designed to address the social and structural factors that influence health outcomes.

- Throughout the month, CHS advanced several initiatives aimed at strengthening community-based care delivery, improving member engagement, reducing barriers to care, and supporting populations experiencing disproportionate health disparities. These efforts reflect Alameda Alliance's continued commitment to integrating community-centered strategies into enterprise-wide approaches that improve quality performance, member experience, and health outcomes.

- A continued area of advancement has been the evolving integration of Community Health Strategy within Alameda Alliance's broader HealthCare Services and Quality infrastructure. This work reflects the visionary leadership of Chief Medical Officer Dr. Donna Carey, whose strategic perspective continues to shape enterprise-wide transformation, as well as the partnership of Senior Director of Quality Michelle Stott and Medical Director, Dr. Stephanie Brown, whose collaboration is helping operationalize this vision across CHS and related areas. This cross-functional alignment is creating the conditions for innovation in the CHW space, an area that remains relatively underdeveloped within the broader DHCS framework. Through this cross-functional redesign, CHS is strengthening its role in advancing community-based interventions that complement traditional clinical care and support improved outcomes for members with complex health and social needs.

Quality In the Community: Community Health Worker-Led Interventions

- Community Health Workers represent a critical component of Alameda Alliance's strategy to improve quality outcomes beyond traditional clinical settings. While many healthcare interventions occur within physician offices, hospitals, and clinics, barriers affecting member outcomes often occur within homes, neighborhoods, and community environments. CHWs help bridge this gap by addressing social and environmental factors that influence health, supporting members in navigating complex systems, and strengthening connections to preventive and ongoing care.

- During May, CHS continued advancing a diverse portfolio of CHW-led interventions addressing chronic disease management, maternal and child health, hospital-based care transitions, medication adherence, asthma education, food insecurity, housing stability, healthy aging, and other priority population health initiatives. The CHW-Led Intervention Pilot Portfolio currently includes twelve strategic initiatives across Alameda Alliance's HealthCare Services division. Together, these initiatives reflect a coordinated approach to addressing diverse population health needs through community-based, outcomes-oriented interventions.

- These interventions are designed to advance organizational goals related to preventive care utilization, care coordination, quality performance, health equity, and the reduction of avoidable utilization. Collectively, they demonstrate how community-based strategies can complement traditional clinical care and strengthen Alameda Alliance's member-centered service delivery.

- These pilots function as Alameda Alliance's community-based innovation laboratory, allowing the organization to test, evaluate, and refine intervention models before broader implementation. Through structured evaluation and cross-functional collaboration, CHS is identifying scalable approaches capable of advancing quality performance, strengthening member engagement, and improving long-term population health outcomes.

- In addition, CHS has continued identifying and implementing training oversight, monitoring processes, and quality assurance activities designed to support program integrity, provider accountability, and sustainable program growth.

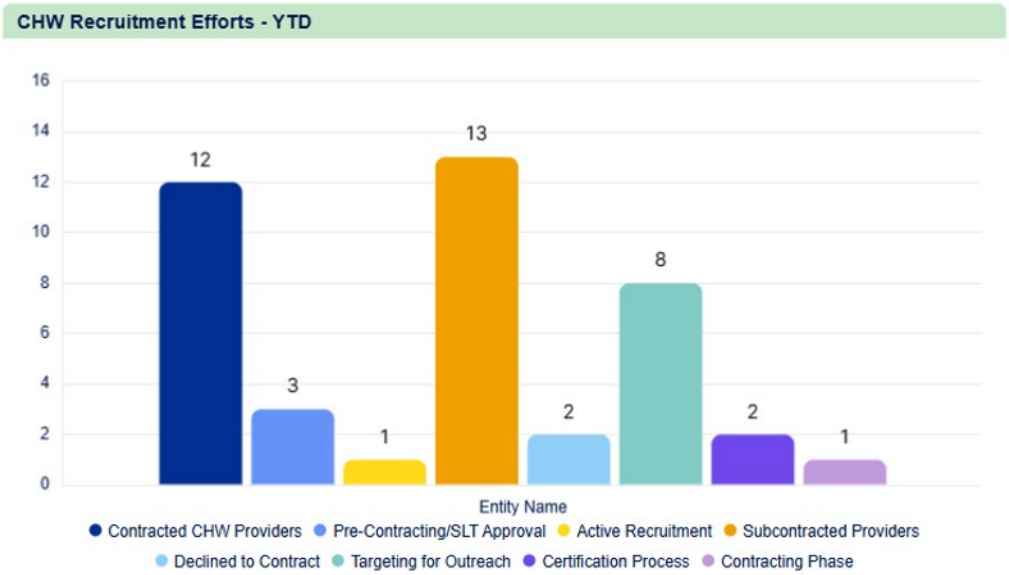
Provider Recruitment and Community Partnership Development

- Provider partnerships remain foundational to Alameda Alliance's ability to translate strategy into meaningful member impact. Recruitment efforts continue to focus on expanding organizational capacity to deliver culturally responsive, community-based interventions for members with complex health and social needs.

- During May, CHS advanced several partnership opportunities, including Zocalo Health, HomeBridge, Love Never Fails, and Ascension Health. These organizations are currently engaged in scope development, readiness assessment, and pilot planning activities designed to strengthen access to health education, care navigation, supportive services, and community-based interventions.

- Collectively, these efforts support Alameda Alliance's strategic priorities related to reducing health inequities, strengthening access to care, improving member engagement, and enhancing outcomes for populations experiencing disproportionate disparities.

Provider Recruitment Snapshot

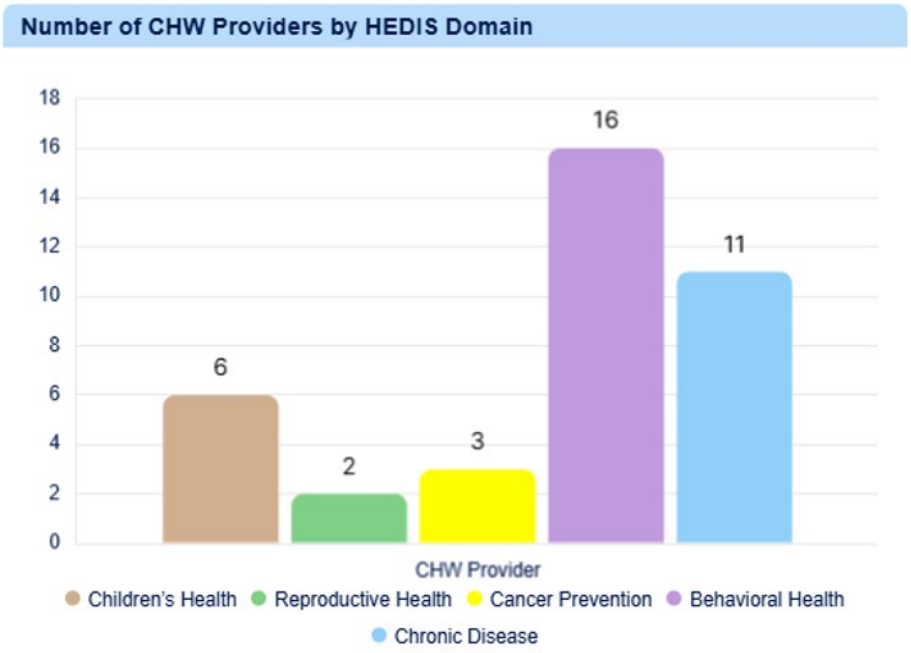


- As of May 2026, the CHS provider network includes twenty-three (23) contracted providers, consisting of twelve (12) directly contracted organizations and thirteen (13) subcontracted entities.

- Additional recruitment pipeline activity includes:
    - One (1) organization actively assessing readiness to pursue certification and contracting.
    - Two (2) organizations are currently engaged in the CHW certification process.
    - Three (3) organizations are in pre-contracting review pending Senior Leadership Team approval.
    - One (1) organization is currently onboarding.
    - Two (2) organizations deemed ineligible or electing not to proceed year-to-date.

- These efforts reflect a continued focus on sustainable network growth while maintaining alignment with program standards, quality expectations, and member needs.

CHW Provider Alignment across HEDIS Domains



- The chart demonstrates how the CHW provider network aligns with key HEDIS domains and quality priorities. The strongest area of alignment is Behavioral Health with sixteen (16) CHW providers supporting this domain. This reflects the CHS network's continued focus on behavioral health outreach, trauma-informed support, care coordination, and hospital-based interventions for members with complex needs.

- The second strongest domain is chronic disease with eleven (11) CHW providers supporting activities related to chronic disease prevention, health education, care coordination, and member navigation. This demonstrates the CHS network's role in supporting population health priorities such as hypertension, diabetes, asthma, and other chronic condition management efforts.

- Additional provider alignment is present across children's health with six (6) providers, cancer prevention with three (3) providers, and reproductive health with two (2) providers. These areas represent targeted opportunities for continued network development and CHW integration into quality improvement initiatives, particularly around pediatric preventive care, colorectal cancer screenings, pregnancy/postpartum support, and reproductive health education.

- Looking ahead, Community Health Strategy will continue focusing on:
    - Expanding integration of CHW interventions into Quality and Population Health initiatives.
    - Strengthening hospital-based CHW partnerships and care transition models.
    - Advancing evaluation and scalability of community-based pilot interventions.
    - Enhancing provider readiness, compliance monitoring, and quality oversight infrastructure.
    - Supporting enterprise-wide efforts to improve quality outcomes, reduce health disparities, and advance whole-person care.

Interpreter Services

Interpreter Services Annual Overview

- In 2025, over 124,000 interpreter services (in-person, telephonic, and video) were provided across 127 languages.

- Top 10 languages requested in 2025 included threshold languages, American Sign Language, Mam, and other languages. See table 1 below.

Table 1. Top 10 Languages Requested by Modality, 2025

2025 Top 10 Languages		
In-Person	**Telephonic**	**Video**
Spanish	Spanish	Spanish
Cantonese	Cantonese	Vietnamese
Vietnamese	Vietnamese	Cantonese
Mandarin	Mandarin	Mandarin
Mam	Mam	Khmer
Arabic	Arabic	Korean
Dari	Dari	Arabic
American Sign Language	Farsi	American Sign Language
Farsi	Punjabi	Amharic
Hindi	Khmer	Mam

- 2026 Q1, we saw an 18% increase over 2025 Q1, with a 99% fulfillment rate for Medi-Cal and Group Care and 100% fulfillment rate for Alliance Wellness/D-SNP, exceeding our 95% target.

- 78% of interpreter services utilized in 2026 Q1 were on-demand (Phone 96%, Video 4%); 22% were prescheduled (In-person 88%, Video 10%, and Phone 2%).

- See table 2 below for the top 10 languages requested in 2026 Q1 by line of business (LOB).

Table 2. Top 10 Languages Requests, 2026 Q1

Alliance Wellness/ D-SNP	Medi-Cal and Group Care
Spanish	Spanish
Chinese Cantonese	Chinese Cantonese
Chinese Mandarin	Vietnamese
Vietnamese	Chinese Mandarin
Tagalog	Mam
Arabic	Arabic
Hindi	Dari
Punjabi	Farsi
French	Punjabi
Turkish	Hindi

- The Alliance is currently working on implementing efficiency/enhancement interpreter services projects aimed at the following focus areas:
    - Addressing rising costs
    - Improving efficiency
    - Reducing non-attendance

<u>Member Satisfaction with Language Services- Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)</u>

- Adult scores improved throughout 2025, while child scores remained strong for favorable responses to the Member Satisfaction Survey, CG-CAHPS question: *"Were you able to communicate with your doctor and clinic staff in your preferred language?"*

- There is an opportunity to further increase awareness and use of qualified interpreter services, while recognizing member cultural and personal preferences.
- Overall, we met or exceeded our workplan goal: 81% of Adult members and 92% of Child members who needed interpreter services reported receiving a qualified non-family interpreter.

Table 3. Favorable Responses, CG-CAHPS, 2025
2025 Workplan Goal: 81% of Adult members and 92% of Child members who needed interpreter services reported receiving a qualified non-family interpreter.

Favorable Response Rate	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Total Avg.
Adult	83.7%	85.8%	88.1%	88.2%	**86.5%**
Child	91.9%	92.3%	93.4%	91.1%	**92.2%%**

Health Equity

Lao Paul Vang

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

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

Date: **June 12th, 2026**

Subject: **Health Equity Report**

Internal Collaboration

- **Ongoing 1x1 meetings and check-ins with Division Chiefs Update**
  - The CHEO meets with the Alliance division chiefs on a 1x1 basis each month to provide updates on Health Equity (HE) and Diversity, Equity, and Inclusion (DEI) activities.

- **NCQA Health Equity Related Issues**
  - The Health Equity Team, in collaboration with NCQA and IPD teams, will lead in the development of Policies and Procedures for the 5 domains as required under the new NCQA accreditation, namely: Race/Ethnicity, Language, Geographical Data, Sexual Orientation, and Disability status.

- **PHM Workgroup**
  - The Health Equity team continues to collaborate with the PHM team and participates in the weekly PHM workgroup, including reviewing new PHM strategies for the upcoming year.

- **QI Workgroups**
  - The Health Equity team continues to participate in the monthly QI workgroups, namely Chronic Disease, Well-Child Quality Workshops, and Cancer Prevention

- **Over/Under Utilization Workgroup**
  - The Health Equity team continues to meet with the Healthcare Service workgroup to discuss and share best practices for overcoming over- and underutilization.

External Collaboration

- **CIN Collaborative Project: Cross-Sector Strategies to Sustain Care for Undocumented Californians**
  - Funded by the California Healthcare Foundation, the new convening of selected MCPs and CBOs began in April 2026, with the goal of developing cross-sector strategies to sustain care for undocumented Californians.

- **Successful facilitation of partnership between local CBO and Faith-based organization:**
    - The Health Equity team successfully facilitated a partnership between **Health & Human Resource Education Center** (HHREC) and **Glad Tidings** church as of May 14, 2026.
    - HHREC provides a series of free outreach classes, “Health through the Arts,” to the seniors of the church.

- **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**
    - The DHCS CHEO and MCPs CHEOs meet to collaborate on Health Equity and DEI initiatives.
    - The meeting included updates from DHCS and CHEO.

- **Local Initiatives DEI Training Monthly Collaborative Meeting**
    - Local MCPs continue to meet to update, share, and collaborate on the DEI Training Program. The monthly collaborative allows MCPs to ask questions, update each other on curriculum information, discuss potential risks, and assist with moving the DEI Training forward**.** Many FQHC agencies expressed concerns about complying with the DEI training requirement because it may impact their federal funding.

<u>Alliance Health Equity Strategic Roadmap Update</u>

- The Health Equity Team identified two milestone priorities for FY25-26, namely, Community Engagement and SDOH Mitigation Measures. As milestones are implemented, updates will be provided to reflect all activities and achievements.

- **Health Equity Initiatives:**

    A. <u>California Improvement Network funded workgroup on Sustaining Care for Undocumented Californians</u>
    - The Health Equity Team join the CIN-funded workgroup to design a resource toolkit for all healthcare providers to sustain and strengthen care access to undocumented Californians.
    - The estimated 9-month (April to Dec 2026) workgroup consists of top leadership representatives from MCPs and CBOs

B. <u>California Healthcare Foundation (CHCF) grant-funded program to address HEDIS measures through the lens of Health Equity</u>

- As a member of California Improvement Network (CIN), the Health Equity division successfully applied for a grant of $20k on August 11, 2025.
- The goal of the grant is to advance health equity and close health disparity gaps among targeted vulnerable Medi-Cal members.
- The Health Equity Division partnered with Dr Simms-Mackey, the chair of Pediatrics at Alameda Health System, to kick-start an innovative health equity-focused intervention specifically for post-natal Black/African American mothers. The grant spans 10 months, from October 2025 to August 2026.

- Rationale of the grant:
  a. The Well-Child Care (WCC) visits and child immunization have been persistently lower among the Black/African American population compared to other ethnic groups in Alameda County.
  b. One of the barriers or Social Determinants of Health (SDOH) is the lack of culturally appropriate postnatal care that is customized for Black/African American families. Unfortunately, this has been an unmet need among our Medi-Cal members.

- Goals:
  - To implement the **Beloved Black Babies (BBB) Initiative** to meet the unmet SDOH, which is a culturally appropriate and racially concordant post-natal group provided by Black/African American medical providers for Black/African American mothers and babies to improve the WCC and other social-emotional well-being among the Black/African American mothers.

- The CIN grant, therefore, addresses two major gaps in health disparities.
  a. WCC among the Black/African American members of the Alliance has consistently not met MPL. WCC is an HEDIS measure and part of the DHCS Bold Goals.
  b. Lack of culturally appropriate care is a major SDOH among the Black/African American community.

C. <u>Food-is-Medicine as the SDOH Mitigation Measure</u>

- Statistically, the non-white ethnic minorities suffer 2 to 3 times more food insecurity than the White community in Alameda County.
- Food insecurity is significantly associated with chronic diseases, and our membership data indicates that chronic diseases, such as diabetes and hypertension, disproportionately affect our ethnic minorities. Food insecurity is thus not only a healthcare urgency but also a major health inequity.
- Food-is-Medicine, or providing access to healthy food to our patients identified as our priority SDOH Mitigation Measure for FY 2026-2027.
- A pilot FIM project with a selected healthcare provider is expected

to be launched by July 2026. The 12-week program is based on a well-established evidence-based FIM intervention model and will be tested for operational sustainability and effectiveness on selected clinical and non-clinical outcomes.

D. <u>Grant-funded California Improvement Network (CIN) Membership</u>.

- The Alliance became one of the 25 lead agency partners to CIN in the 2025-2027 grant cycle.
- The $4500 grant provides the Health Equity team with networking opportunities, education, and resource-sharing with other MCPs and CBOs, with the goal of stimulating health equity innovation to help close health disparities.
- The Health Equity director presented at the CIN affinity group meeting our vision and initiatives on 7/9/2025.

E. <u>SDOH Mitigation Exploration with Direct Engagement with Providers</u>.

- Beginning September 2025, Health Equity, in partnership with the QI team, began direct engagement with providers in the bimonthly quality meeting series, with the goal to explore potential partnerships for SDOH Mitigation Measures (Milestone #6), specifically food-is-medicine.

    a) Tiburcio Vasquez: initiated 9/11/2025
    b) La-Clinica San Antonio Health Center: initiated 9/12/2025
    c) Axis: initiated 9/24/2025
    d) La-Clinica San Antonio Health Center: initiated 10/21/2025 (in-person visit)
    e) Bay Well Health: initiated 1/25/2025

F. <u>Community Connect:</u>

- A new bi-monthly virtual meeting series launched in January 2026, designed specifically for our network providers and community-based organizations that serve our members directly and indirectly.
- The goals are to facilitate peer learning, resource sharing, communication, and promising practices that lead to better services for our members.
- Average attendance: 35.

Health Equity Roadmap Milestone Trackers:

- Below are the up-to-date achievements for the six milestones.

Health Equity Milestone	Goals
1. Organization Transformation	a) CHEO collaborates with SLT to facilitate a system-wide organizational transformation that supports the long-term vision of health equity for the Alliance.
2. Data-Driven	a) Collaboration with UM, PHM, QI, and Analytics. b) Utilize grant-funded health equity projects to gather data that will augment the Alliance's claim data depository to formulate a comprehensive understanding of the SDOHs that perpetuate the health disparities faced by our Medi-CAL members.
3. Education	a) Lead in the development of DEI Training APL 24-016 (APL 23-025) and APL 24-017 (SB 923) TGI training. b) Collaboration with Culture and Linguistics, PHM, QI, and other stakeholders to ensure all our policies, services, and programs are rooted in the core foundation of health equity. c) Participation in various Functional Area Delegate (FAD) workgroups to ensure the Alliance work supports the health equity vision and mission.
4. Communication	a) Collaboration with the Community and Outreach to develop effective communications for all aspects of health equity activities to ensure that staff and members are fully informed.
5. Community Engagement	a) **Mongolian Americans in Alameda**: HE helped the community to apply for a mini-grant to conduct a health needs assessment in May 2026. b) Launched the inaugural Community Connect meeting series on 1/22/2026. c) The Faith-Based Community Engagement workgroup was established in December 2024 and recently renamed the Community Engagement Workgroup to reflect more accurately our broader mission.

	d) Facilitation of local CBO with Glad Tidings church to provide education classes to the seniors. e) Direct Engagement with Provider's meetings, in partnership with the QI team. f) Initiated potential providers' partnership in Food-Is-Medicine initiatives. g) CIN membership (2025-2027).
6. SDOH Mitigation Measures	a) Initiated a partnership with AHS to implement the **Beloved Black Babies** pilot program to address HEDIS measures, specifically Well-Child Visits. b) Exploration of potential collaboration with selected providers to initiate **Food-is-Medicine** services. c) Collaborate with QI and PHM to identify high-value clinical partners who would co-develop a relevant intervention to address specific SDOH. d) Collaborate with CMO and HCS team to assess and analyze non-utilization data aimed at identifying health disparities.

DHCS-DMCS APL Update

- **DEI Training APL 23-025 Update**
  - We received DHCS approval for the DEI training curriculum.
  - Updated Timeline:
    - ✓ May 2025: DEI Provider Training Pilot with California Cardiovascular Consultants (CCC)
    - ✓ May – June 2025: pilot training completed.
    - ✓ July to Dec 2025: training given to subcontractors, downstream subcontractors, and network providers.

- **APL 24-018: TGI-SB 923 Update**
  - The Transgender, Gender Diverse, and Intersex (TGI) Cultural Competency Training was provided to all the Alliance staff.
  - We provided training to our member-facing vendors, contractors, and downstream subcontractors, followed by training our providers. However, at this time, due to federal regulations and the uncertain future of TGI training, the Alliance SLT decided on 12/15/2025 to temporarily pause the TGI training project.
  - We are currently waiting for the revised APL from DHCS.
    - ✓ Jan 2026: The IPD team closed the TGI training, but it may be provided upon request by any of our network contracted health providers.

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

DEIB Committee Update

- The DEIB Committee meeting on May 1st was canceled due to no agenda items.

VIA Committee Update

- The VIA Committee met on May 12th to discuss logistics for the upcoming 30th Anniversary Event. Also, the committee asked that the 30th Anniversary video be added to the upcoming All Staff Meeting.

Calendar of Community Engagements

CBO/FBO/Providers		Services	Status
1	California Improvement Network	A learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading innovative ideas, and implementing improvements.	➢ June 11, 2026: in-person meeting in LA. ➢ Feb 5, 2026: in-person meeting in Oakland. ➢ July 9, 2025: Presented health equity best practices at the Affinity group virtual meeting. ➢ May 8, 2025: in-person meeting in Oakland.
2	Crisis Support Services of Alameda County: Healing Hearts WALK/RUN/MOVE! For Suicide Prevention	Crisis Support Services of Alameda County's 16th Annual 5k is rooted in community care, connection, and healing.	➢ May 30, 2026: Walked in the 5k race and participated in the activities from 8:30AM-11:30AM. ➢ This was in support and collaboration with our Behavioral Health Department. CCS is contracted with the Alliance to support after-hours crisis calls.
3	Coffee & Conversations: A Community Chat with Alliance + CAC	Joining the Alliance + CAC for a welcoming, in-person community conversation at our provider partner, Roots Community Health Center, Armstead Hall, 10:30AM - 11:30AM.	➢ April 11, 2026: Attended to support the Alliance and our Community Advisory Committee (CAC).
4	Black Resilience, Kenyan Experience Event, HHREC	A powerful day celebrating Black culture, history, creativity,	➢ March 18, 2026, in collaboration with our community partner, HHREC CHW, to build

		wellness, and community.	community, celebrate culture, and mental health wellness.
5	Black Joy Parade	The 9th Annual Black Joy Parade, with the theme: "Black is the Blueprint".	➢ Feb 22, 2026, attended the 9th Annual Black Joy Parade as a multi-departmental collaboration. ➢ This year's community event observed the centennial celebration of Black History Month with over 100+ vendors, community partners, live performances, and featured artists.
6	Asian Health System	Monthly food distribution.	➢ Feb 4, 2026: Participated with the C&O team to support our provider partners' monthly food distribution. ➢ Approximately 300 participants received food bags and educational resources.
7	Bay Area Mongolian Community Association BAMCA	Non-profit organization that promotes the well-being of the small and underserved community of 1500 Mongolian residents living in the Bay Area.	➢ Feb 4, 2026: Visited with the president of BAMCA in person. ➢ Jan 2026: Initiated collaborative discussions with the president of BAMCA in Jan 2026. ➢ Goal to co-develop a community health assessment for the Mongolian community in Alameda.
8	Health & Human Resource Education Center (HHREC)	Provider of education and training in health and wellness.	➢ Feb 9, 2026: Visited with the CEO and her team at the office. ➢ Initiated discussions for a strategic partnership to augment our outreach services to our faith-based organizations and other CBOs who are serving our medical members.
9	Black Men's Brain Health Initiative: 2026 Black Men's Brain Health Conference	The fifth annual conference advocates focus is on brain health, Alzheimer's disease, mental wellness, and reducing health disparities among Black men.	➢ Feb 3, 2026: Attended the fifth annual conference focused on Black men's brain health, which aims to empower communities, especially the Black community, through education, prevention, and access to trusted health information and resources. Continuing to partner and collaborate with our CHS department.

10	Glad Tidings International Church of God	Established in 1978, the church serves over 1,000 members and is well known in the Hayward community.	➢ Dec 3, 2025: visited with the church bishop and the executive director of the community outreach. ➢ Oct 21, 2025: Visited the church food distribution. ➢ July 24, 2025: Initiated meeting. ➢ *Potential collaboration:* Promoting resources in health education, e.g., Doula services, diabetes, and other chronic diseases.
11	Youth ALIVE, "Free Your Mind: An Imaginative Evening Benefiting Youth ALIVE!"	Youth Alive is a community-based violence prevention, intervention, and healing organization based in Oakland since 1991, whose mission is to break the cycle of violence.	➢ Nov 13, 2025: Attended their benefit and informational on in collaboration with our Community Health Strategy Department. ➢ Will continue building a relationship with one of our CHWs to help address one of Alameda County's CHIP Priorities: "Promoting Peaceful Families and Communities."
12	Alameda Health System	One of the pediatricians works predominantly with Black mothers and children.	➢ Oct 21, 2025: BBB grant-funded Partnership project kicked off. ➢ Successful grant application of $20K to implement a 10-month Beloved Black Babies Initiative (BBB): a culturally appropriate program designed to improve Well-Child measures and post-partum depression.
13	La-Clinica St Antonia Health Center	One of Alliance's contracted providers that serves our members.	➢ Oct 21, 2025: Visited the on-site food pantry and reviewed the food-is-medicine services. ➢ Sept 12, 2025: Initiated partnership meeting. ➢ Potential collaboration: data-driven food-is-medicine targeting chronic diseases.
14	Oakland Black Cowboy Assoc., City of Oakland, Black Cowboy Parade & Heritage Festival	Local organization is celebrating its 51st annual parade & festival in the community.	➢ Oct 4-2025: Hosted an information booth from 10-6 PM. ➢ Bring visibility to the Alliance within the community. ➢ Collaborator: C&O
15	School-based Health Center in	One of the eight school-based health centers	➢ July 8th, 2025: Visited the school clinic.

	Madison Park Academy, Oakland	operated by Native Americans.	➢ *Potential collaboration:* promote child health. ➢ Collaborator: QI
16	Native American Health Center	Native Americans and other PCP services, WIC, and dental.	➢ July 6th, 2025: Table at the annual Indigenous Red Market event. ➢ December 2024: Visited the health center.
17	Allen Temple Baptist Church	A predominantly African American church established in 1919. They serve approximately 3,000 members and the broader community.	➢ June 2025: Initiated collaborative meetings. ➢ *Potential collaboration:* Co-design community survey with the church to identify needs and SDOHs; support health education outreach to the congregation and community at large.
18	True Vine Ministries Church	Serves predominantly African Americans in the West Oakland area.	➢ June 2025: submitted RWJF Grant application of $250K for a program to advance mental health healing through the arts. The grant application was unsuccessful.
19	Oakland Unified School District (OUSD)	The largest school district in Alameda County, serving about 33,000 students in about 75 schools, K-12.	➢ April 2025: Collaborative meetings initiated. ➢ *Potential collaboration*: Co-design Parent Survey with OUSD to study food insecurity and SDOHs.
20	Black Women's Health Forum	Annual event to raise awareness about healthy living resources available to Black women in the Bay Area.	➢ April 8th, 2025: Table event to support and build relationships. ➢ Collaborator: C&O
21	Oakland Catholic Workers	Provides transitional housing and resettlement resources to Central American refugees and immigrants.	➢ March 2025: initiated collaborative meetings. ➢ Resource sharing. ➢ Collaborator: PHM

Information Technology

Sasikumar Karaiyan

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

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

Date: **June 12th, 2026**

Subject: **Information Technology Report**

Encounter Data

- In the month of May 2026, the Alliance submitted 166 encounter files to the Department of Health Care Services (DHCS) with a total of 755,406 encounters.
    - Lag time results for professional claims lower than thresholds due to submission of older encounters with zero-dollar lines as part of new functionality to submit these to DHCS.
- In the month of May 2026, the Alliance submitted 1,522 encounters to the Centers for Medicare Services (CMS) for D-SNP members.

Enrollment

- HEALTHsuite successfully received and imported the May 2026 Medi-Cal enrollment file and shared them with our delegated on-time. The June monthly files from DHCS and IHSS were processed as scheduled. In addition, 21 daily DHCS files were completed, and 17 new D-SNP applications were processed, reflecting continued timely execution of core enrollment and eligibility operations.

Workflow Automation

- Alliance completed the AI-powered compliance platform to automate regulatory adherence by linking internal documents with requirements. Phase 1 of the work is complete, which includes:
    - Access to Readily platform has been provided to all business resources in Compliance, Regulatory affairs, audit Teams.
    - Single Sign On (SSO) integration is complete. Users can access the platform with one click from the Alliance Internal portal.
    - Training completed for all modules.

  Our next 3 months plan is to complete automation of PolicyTech documents workflow from AAH to Readily platform.

- The AI Governance Framework Policies and Procedures (PnP) have been presented in our Administrative Oversight Committee (AOC) and approved.

- Alliance has kicked off AI-driven automation to transform software development by enhancing developer productivity, improving code quality, and accelerating delivery across the full software development lifecycle (SDLC) from design and development to deployment, quality assurance, and maintenance. This initiative includes capabilities such as automated code generation, DevOps and Continuous Integration/Delivery (CI/CD) automation, as well as code reviews and testing. The AI transformation is planned as a 12-month level of effort.

- Alliance developed a high-accuracy (Optical Character Recognition) OCR using OpenAI, automating image interpretation and text extraction from faxes and user prompts, now integrated into key workflows.
    - Automated Phase 2 of Prior Authorization, Health Home, and Pre-Service Authorization in April 2026.

    - CM end-to-end process redesign is underway.

    - Completed Community Support Referral Forms for DSNP & MediCal in the month of April 2026.

    - 10+ Health Care Services workflow processes are in the pipeline for automation in CY2026 which includes Health Ed Wellness, Behavioral Health care - Autism evaluation form etc.

- The enterprise-wide implementation of Speech to Text capabilities has been initiated. Following a comprehensive product assessment, Alliance has selected Nuance Dragon as the preferred solution. The procurement of the product took additional timeline due to vendor licensing error. As of now, the procurement is complete and has started implementation to the pilot users.

- To enhance Claim TAT, our IT Configuration team has pinpointed three main areas for process improvement that could potentially increase our claims auto-adjudication rate from 85% to 92%. As part of the implementation, we have engaged Optum AI to do a pilot program to automate some of the claims manual processing. At the same time, team is design solutioning to automate COB claim workflows.

Claims – HEALTHsuite Application

- High level dashboard of cases for the month of May 2026:

    - The Alliance received 468,352 claims in the month of May 2026.

- For both the MediCal and Group Care lines of business, a total of 368,652 claims finalized, out of which 323,766 claims auto adjudicated, setting the auto-adjudication rate at 87.7%.

- The D-SNP line handled 916 finalized claims during the period, out of which 491 were auto adjudicated, resulting in a 53.6% auto-adjudication rate.

- HEALTHsuite Upgrade estimated to go-live in June 2026. Key system enhancements and bug fixes will become available with the upgrade.

- Actively exploring AI-led solutions to boost claims auto-adjudication percentages and improve processing accuracy.

Quality Suite Application

- High level dashboard of cases for the month of May 2026:

  This initiative will improve the application with faster turnaround and better-quality metrics by implementing three high-impact automations.

  - G&A cases received in the month were 2393.

  - Exempt Grievances received in the month were1939.

  - PQI cases received in the month were 97.

  - PDR cases received in the month were 2142.

TruCare

- A total of 21,030 authorizations were received and processed in the TruCare application.

- TruCare Application Uptime – 99.875%.

- The Alliance has successfully completed the upgrade of TruCare version 24.1.1 to 25.2.1. This upgrade introduces enhancements to case management, program engagement, and split-screen functionality within the assessment module, enabling users to simultaneously view clinical data and complete documentation.

Data Integration

- D-SNP Program Enablement: Delivered key enrollment capabilities (Member ID creation, welcome communications) and progressed core

data integrations supporting eligibility, ID card generation and TruCare network enhancements (60–70%).

- Platform Data Enhancements: Advanced provider data standardization and onboarding to support TruCare upgrade and vendor integrations.

- Operational Data Modernization: Enabled Community Support data integration into DAAS and improved DWH performance through parallel processing optimization.

- Strategic Integrations: Progressed AOR and ECM data integrations to support TruCare and HealthX (60%).

Application Development

- Delivered EREx upgrades and supported TruCare platform modernization.

- Advanced Behavioral Health digital forms and care coordination capabilities; go-live planned next month.

- Enhanced encounter processing through Edifecs improvements increasing reliability and throughput.

- Strengthened QualitySuite workflows, improving member communication (Preferred Name alerts) and maintaining operational stability.

IT Service Desk

- In May 2026, 1,410 Service Desk tickets were opened—a 1.47% decrease from April (1,431) and 9.73% above the previous four-month average (1,285), showing continued growth in ticket volume.

- 1,305 Service Desk tickets were closed, down 8.23% from April (1,422) and 0.56% above the prior 4-month average of 1,297.75, maintaining a strong closure trend despite increased demand.

IT Security Program

- As part of the broader IT Security Program execution (4-year roadmap), Security efforts to improve posture continue through various means – P&P, frameworks, operational streamlining, projects, and compliance.

- Operational progress includes (1) blocking unsanctioned AI use (2) staging final phase of email authentication hardening (3) progress in annual Security Risk Assessment and Penetration Test findings (4)

remediation of Cisco Secure Endpoint events (5)

- Prioritizing *Authentication Pattern* initiative to reduce service downtime related to authentication activities. IT Glue will become the source of truth. As of June, 2026 – data collection from IT is underway.

- Network Micro-segmentation project is now in the non-production stage starting with HealthSuite and TruCare.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of May 2026”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of May 2026”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal, Wellness and Group Care Member enrolment in the month of May 2026

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated	Alliance Wellness
May	374,595	3,203	5,814	6,312	130	113	245

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 May 2026

Auto-Assignments	Member Count
Auto-assignments MC	2,024
Auto-assignments Expansion	2,146
Auto-assignments GC	78
Auto-assignment AW	3
PCP Changes (PCP Change Tool) Total	4,251

TruCare Application

- See Table 2-1 “Summary of Intake Authorizations for the month of May 2026”.
- There were 22,044 intake authorizations for the Month of May 2026.
- TruCare Application Uptime – 99.9%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of Intake Authorizations for the Month of May 2026

Transaction Type	Total Auths Received
Provider Portal Requests (mPulse)	5,675
EDI (CHCN)	6,881
ADT	1,250
Behavioral Health COC Update - Online	58
Behavioral initial evaluation - Online	63
Manual Entry	3,418
OCR	3,685
Total	21,030

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)

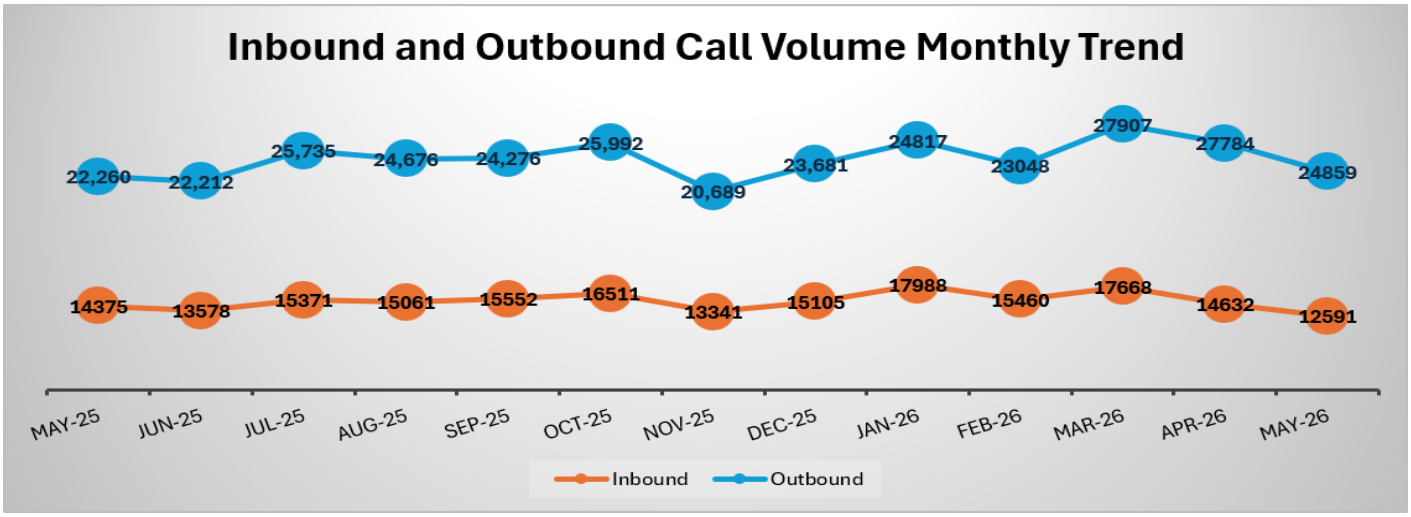
Table 3-1 Web Portal Usage for the Month of April 2026

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	13,477	6,974	630,280	788
MCAL	141,096	3,774	9,109	991
IHSS	4,391	74	778	32
Total	158,964	10,822	640,167	1,811

Table 3-2 Top Pages Viewed for the Month of April 2026

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	2,006,389
Provider – Claims	Claim Status	241,762
Directory Config	Provider Directory	11,225
Provider – authorizations	Auth Search	11,140
Provider – authorizations	Auth Submit	7,981
Provider – Claims	Submit professional claims	6,621
Member My Care	Member Eligibility	3,173
Provider - eligibility/claim	Member Roster	2,698
Member Help Resources	Find a Doctor or Hospital	2,667
Member Help Resources	ID Card	2,525
Member My Care	My Benefits	2,220
Provider – Home	Behavior Health Forms SSO	1,837
Member Help Resources	Select or Change Your PCP	1,569
Member My Care	My Claims Services	1,371
Member Home	MC ID Card	1365
Provider – Home	Long Term Care Forms SSO	1,086
Provider - Provider Directory	Provider Directory 2019	952
Provider – Reports	Reports	821
Member My Care	Authorization	690
Provider – Home	Forms	553
Member My Care	VSP SSO	464
Member My Care	My Pharmacy Medication Benefits	392
Member Help Resources	Forms Resources	358

Call Center – Call Volume Overview:



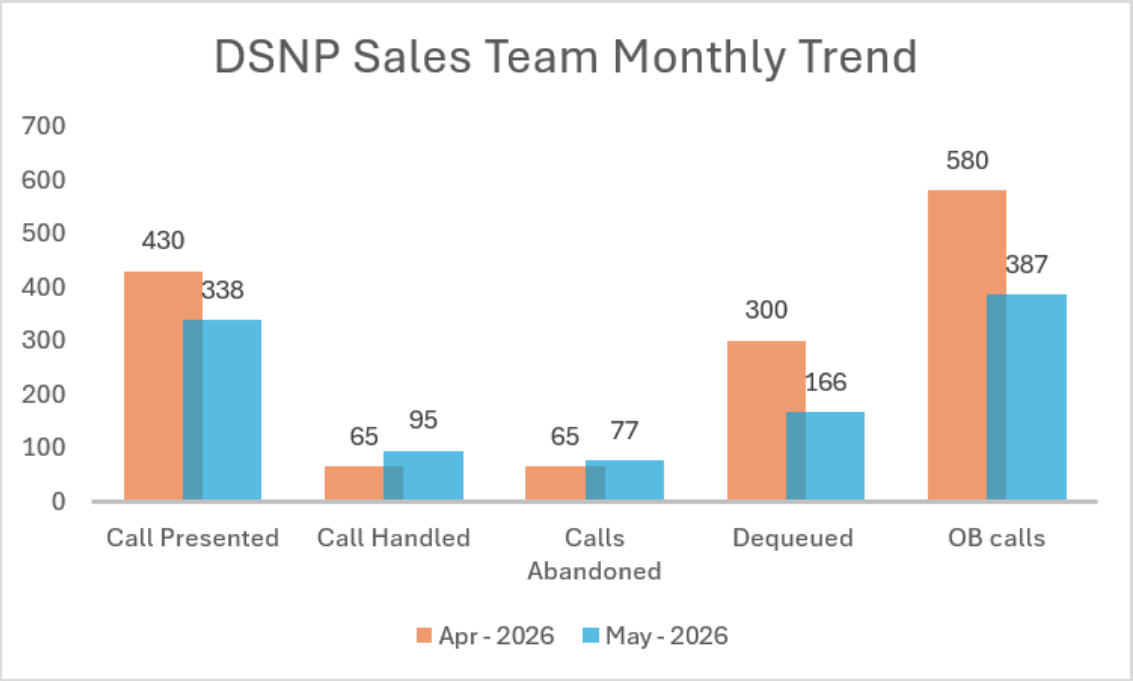
Members - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
December	13436	11549	594
January	15727	12696	731
February	13250	11092	592
March	15280	12079	782
April	14265	11108	721
May	12435	10655	554

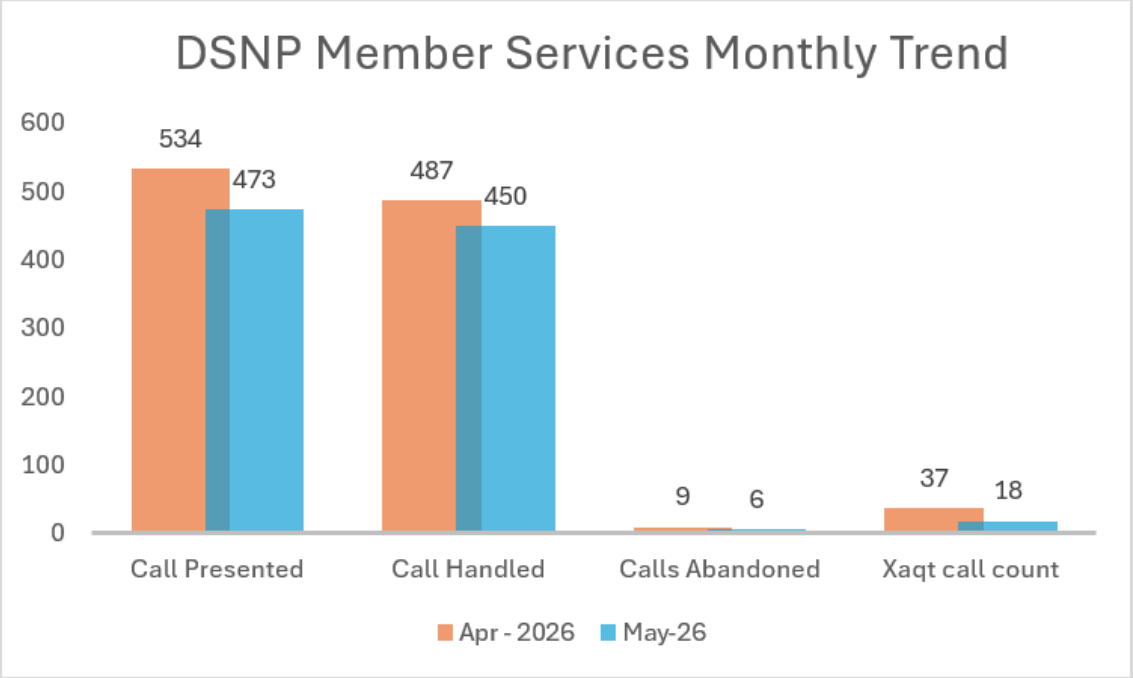
Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
December	10851	7853	2251
January	13333	8809	3495
February	10591	8020	1942
March	10195	8332	1356
April	11135	7919	2439
May	8351	6869	1095

- Calls Presented: Total number of calls received.
- Calls Handled: Total number of calls answered.
- Calls Abandoned: Calls abandoned before being completely answered.

Note: It is important to note that there is a slight discrepancy between the number of calls presented, handled, and abandoned. This discrepancy is due to calls being rerouted to the XAQT vendor, which are not included in the calls handled or abandoned statistics. This rerouting can account for some of the differences observed in the totals.

Call Center – DSNP Sales and Member Services:



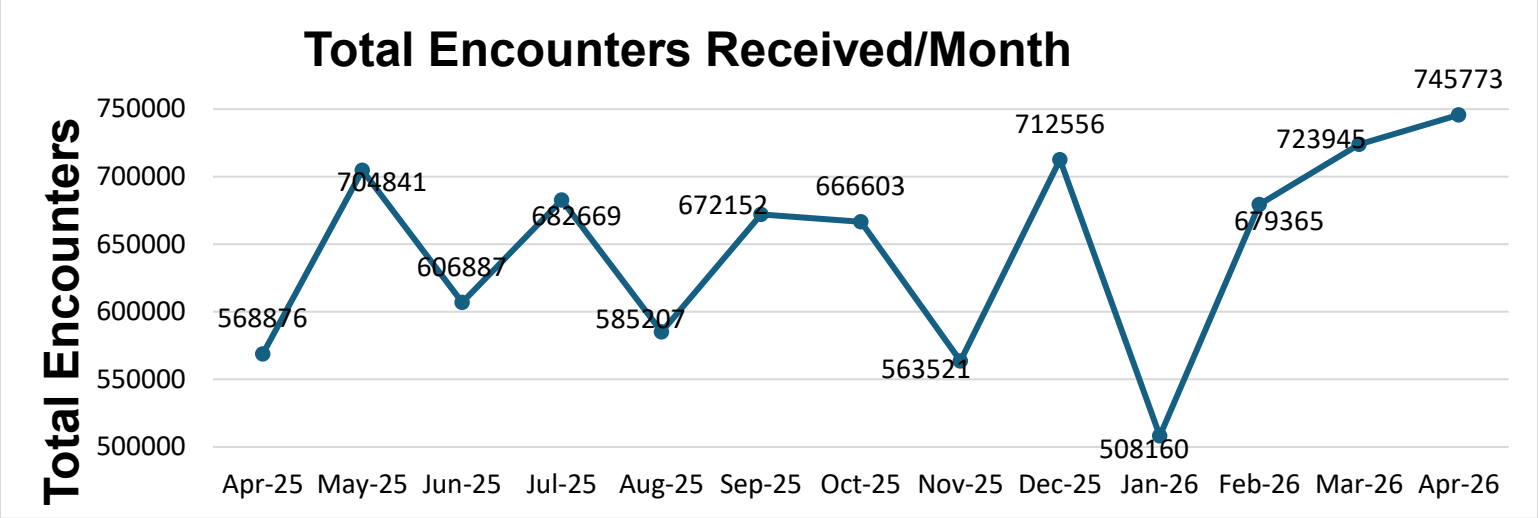


Encounter Data from Trading Partners 2026

- **AHS**: May monthly files (9,261 records) were received on time.
- **BACH**: May monthly files (0 records) were received on time.
- **BACS**: May monthly files (248 records) were received on time.
- **CHCN**: May monthly files (147,494 records) were received on time.
- **CHME**: May monthly files (7,571 records) were received on time.
- **CLAIMSNET**: May monthly files (18,591 records) were received on time.
- **Docustream**: May monthly files (164 records) were received on time.
- **EBI**: May monthly files (1,881 records) were received on time.
- **FULLCIR**: May monthly files (1,641 records) were received on time.
- **HCSA**: May monthly files (5,710 records) were received on time.
- **IOA**: May monthly files (1,570 records) were received on time.
- **LAFAM**: May monthly files (86 records) were received on time.
- **LIFE**: May monthly files (293 records) were received on time.
- **Logisticare**: May monthly files (40,646 records) were received on time.
- **Magellan**: May monthly files (560,692 records) were received on time.
- **March Vision**: May monthly files (1,197 records) were received on time.
- **MED**: May monthly files (5,381 records) were received on time.
- **PAIRTEAM**: May monthly files (6,195 records) were received on time.
- **Quest**: May monthly files (22,501 records) were received on time.
- **SENECA**: May monthly files (407 records) were received on time.
- **SERENE**: May monthly files (0 records) were received on time.
- **TITANIUM**: May monthly files (4,824 records) were received on time.
- **TVHC**: May monthly files (0 records) were received on time.
- **VSP**: May monthly files (15,956 records) were received on time.

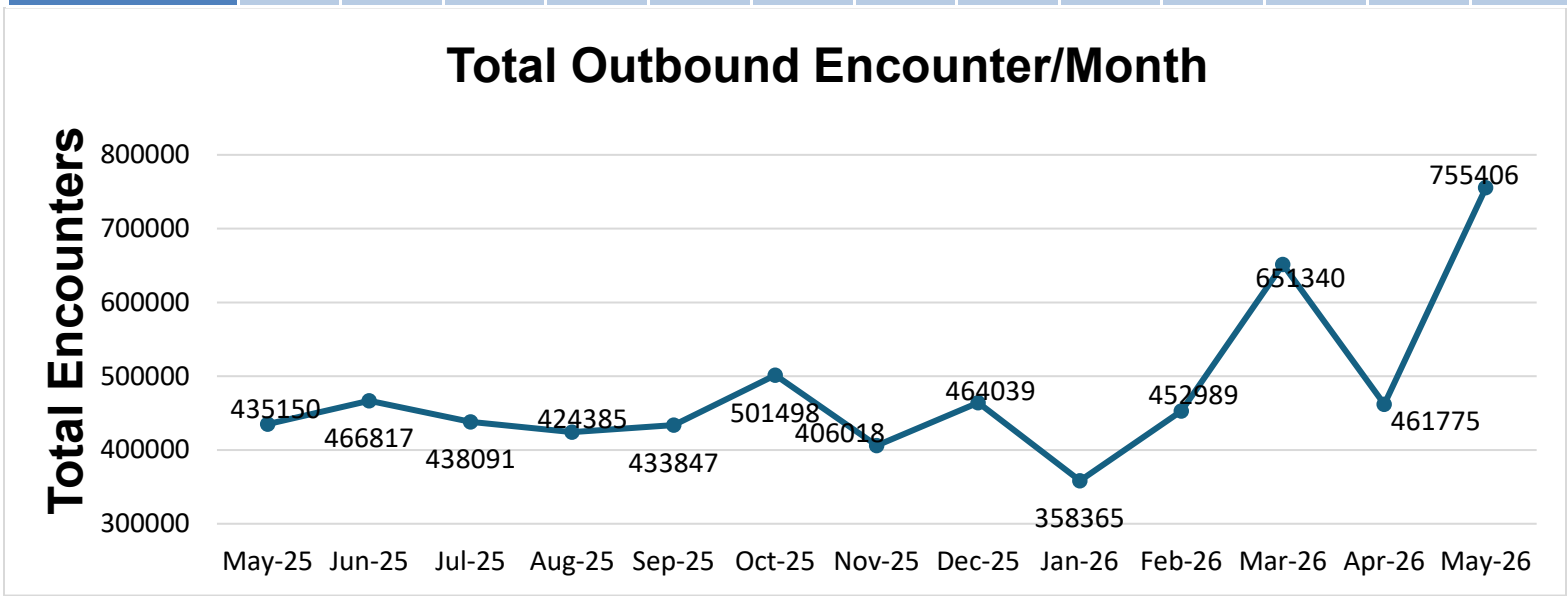
Trading Partner Encounter Inbound Submission History

Trading PartnerName	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
AHS	15875	7712	7880	10257	8455	9267	11333	8671	8345	10599	9835	8399	9261
BACH	0	296	172	172	180	181	0	0	0	0	0	0	0
BACS	88	128	81	82	100	102	114	109	196	140	359	409	248
CHCN	151416	170810	125697	132885	170744	152102	138524	153899	104101	193474	177607	178392	147494
CHME	9045	8638	8115	8368	8228	7938	9119	7579	8492	8597	7129	6348	7571
CLAIMSNET	21443	15710	13266	13336	20280	15705	20083	16647	10692	22313	17563	13461	18591
Docustream	1068	1052	1215	704	423	829	322	0	1568	852	1292	420	164
EBI	1457	1381	2946	1940	1800	1823	1922	1683	1856	1690	1910	1825	1881
FULLCIR	1479	1441	3266	3972	5006	2176	168	1358	462	3150	2698	1077	1641
HCSA	2628	2467	2671	2453	2930	172	2481	2876	2532	3008	3496	4888	5710
Health Suite	416295	339917	429170	326681	348267	415000	296716	413349	291556	381019	396918	452452	381229
IOA	2068	3083	1851	635	1377	1683	0	3095	1697	1672	1660	1485	1570
LAFAM	101	81	85	83	74	87	247	84	87	85	72	78	86
LIFE	1274	412	388	541	245	290	330	361	250	229	255	281	293
Logisticare	35875	15025	38834	34040	62760	15649	36206	59563	34215	16237	62637	38508	40646
March Vision	7929	8100	6914	7877	8374	9295	9338	7336	10116	2845	2702	2040	1197
MED	1581	958	2722	1246	1172	1468	1299	2894	1443	1434	912	5462	5381
PAIRTEAM	9244	7724	15956	14426	9446	9972	7871	10633	7419	5779	14368	8550	6195
Quest	22501	18000	18000	22500	18001	18001	22500	18004	18001	22499	18000	18002	22501
SENECA	109	160	76	0	188	66	0	123	360	206	932	395	407
SERENE	0	0	581	0	0	0	0	0	0	0	0	0	0
TITANIUM	2970	3792	2782	3010	4102	4796	4950	4244	4746	3536	3558	3300	4824
TVHC	395	0	0	0	0	0	0	49	26	0	43	0	0
VSP	0	0	0	0	0	0	0	0	0	0	0	0	15956
TOTAL	704841	606887	682668	585208	672152	666602	563523	712557	508160	679364	723946	745772	672846



Trading Partner Outbound Encounter Submission

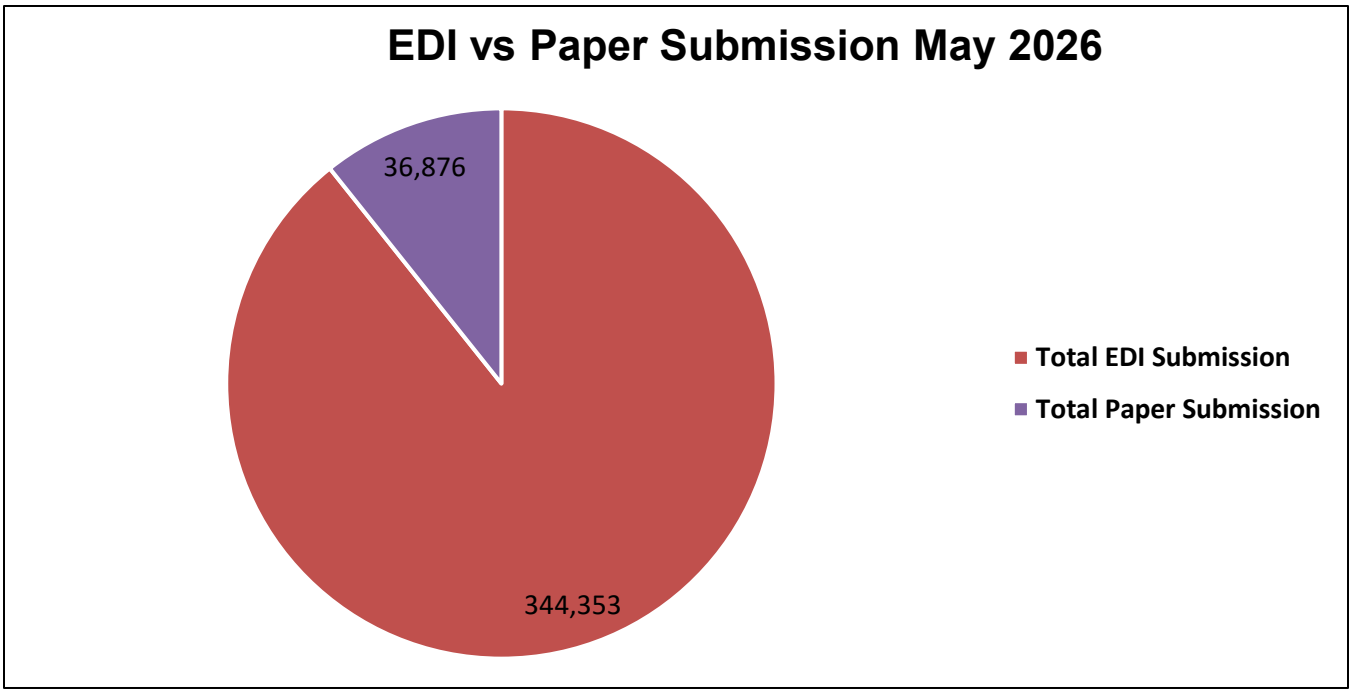
Trading PartnerName	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
AHS	9326	14010	7038	10166	8358	9125	11095	8218	8090	10555	9316	8363	9211
BACH	0	270	138	0	147	139	0	0	0	0	0	0	0
BACS	51	59	60	52	82	77	86	79	96	112	178	332	186
CHCN	106733	98329	106648	92163	89837	133350	93935	101887	69962	121092	119747	127177	98429
CHME	8914	8471	7991	8232	8090	7822	8407	7470	7697	8191	6682	6170	7386
CLAIMSNET	12430	13853	9238	9252	10764	11978	11518	13611	7425	13874	17300	10228	12177
Docustream	540	385	381	192	131	247	99	0	338	307	496	148	69
EBI	1346	1328	1885	1745	1634	1718	1834	1600	1770	1610	1869	1777	1827
FULLCIR	1155	1236	2889	3407	2713	1748	89	1081	165	2479	2226	634	1121
HCSA	2603	2448	2637	2430	2871	149	2462	2840	2505	2979	3451	4832	5661
Health Suite	226401	274828	222783	228707	236163	253075	207026	228028	188845	245896	390092	230072	534368
IOA	48	1836	1732	551	1176	1304	0	2911	1617	1474	1108	1338	1178
LAFAM	90	67	80	76	69	84	93	83	87	82	64	73	75
LIFE	93	202	122	142	152	111	222	175	140	119	144	157	188
Logisticare	35829	15010	38763	33974	36968	41267	36150	59480	34166	16213	62539	38458	40564
March Vision	4591	4657	3888	4183	4724	5103	4847	3696	6051	1272	518	312	119
MED	595	553	2471	1124	974	1103	1160	1547	1360	1344	65	5010	1482
PAIRTEAM	4670	4549	9364	8386	8229	7901	5824	6500	6777	5157	11205	6835	4360
Quest	16853	21031	16774	16903	16855	20951	16810	20937	16905	16777	20859	16724	16798
SENECA	98	139	63	0	164	19	0	109	319	190	174	168	92
SERENE	0	0	569	0	0	0	0	0	0	0	0	0	0
TITANIUM	2714	3556	2577	2700	3746	4227	4361	3772	4039	3266	3293	2967	4242
TVHC	70	0	0	0	0	0	0	15	11	0	14	0	0
VSP	0	0	0	0	0	0	0	0	0	0	0	0	15873
TOTAL	435150	466817	438091	424385	433847	501498	406018	464039	358365	452989	651340	461775	755406



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
26-May	344,353	36,876	381,229

Key: EDI – Electronic Data Interchange

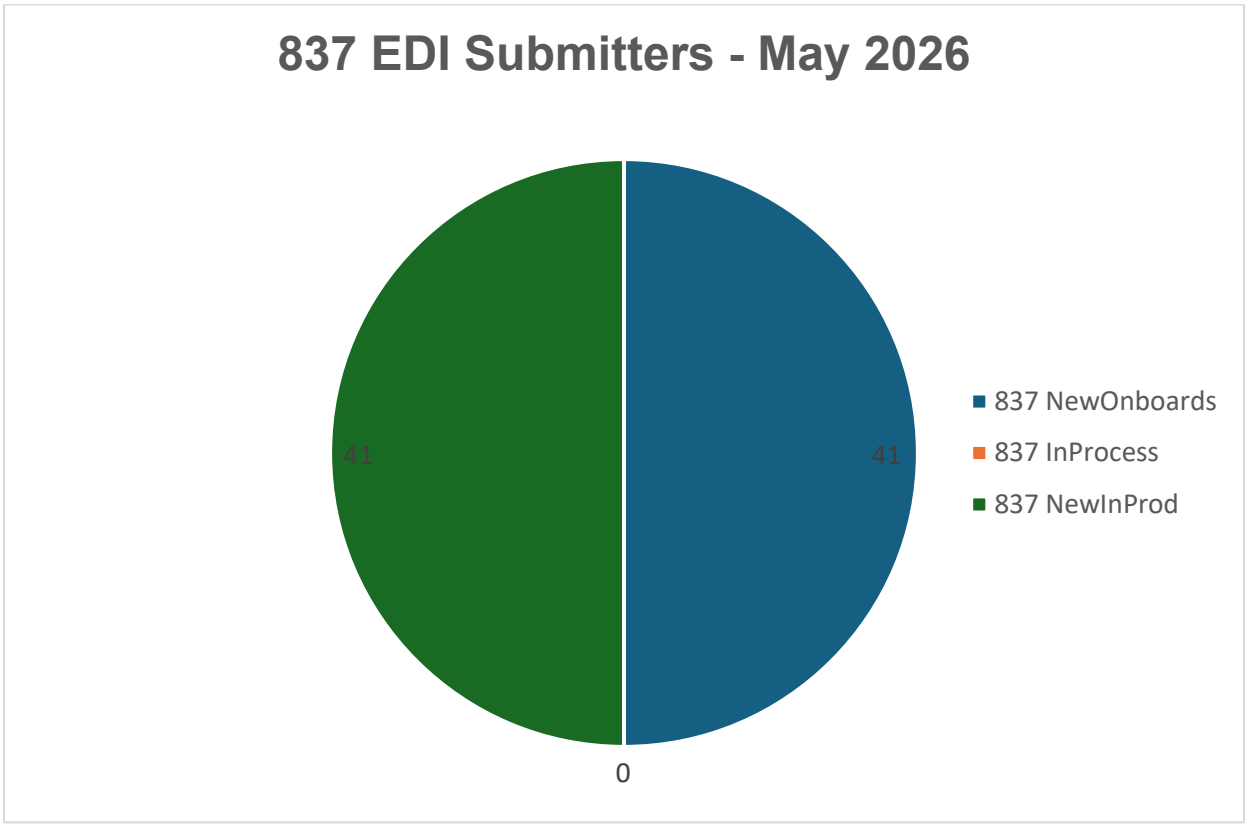


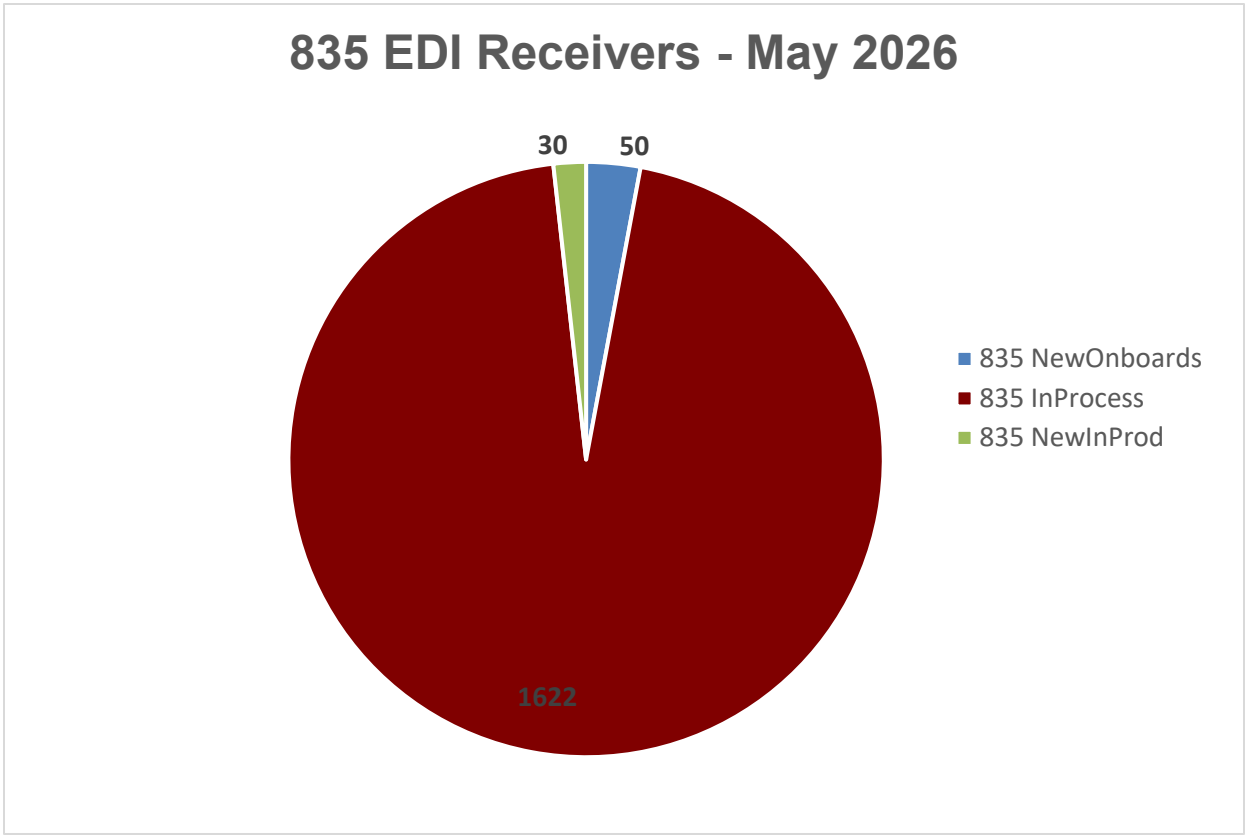
Onboarding EDI Providers – Updates

- May 2026 EDI Claims:
  - A total of 3590 new EDI submitters has been added since October 2015, with 41 added in May 2026.
  - The total number of EDI submitters is 4,330 providers.

- May 2026 EDI Remittances (ERA):
  - A total of 1,671 new ERA receivers has been added since October 2015, with 30 added in May 2026.
  - The total number of ERA receivers is 1687 providers.

YearMonth	837 NewOnboards	837 InProcess	837 NewInProd	837 TotalInProd	835 NewOnboards	835 InProcess	835 NewInProd	835 TotalInProd
Mar-25	46	3	43	3697	74	1328	32	1339
Apr-25	38	14	24	3721	63	1370	26	1365
May-25	47	3	44	3765	77	1402	45	1410
Jun-25	52	25	27	3792	62	1445	19	1429
Jul-25	52	0	52	3844	60	1487	18	1447
Aug-25	35	19	16	3860	37	1502	22	1469
Sep-25	92	6	86	3946	65	1516	51	1520
Oct-25	76	11	65	4011	42	1528	30	1550
Nov-25	41	7	34	4045	26	1536	18	1568
Dec-25	50	0	50	4045	32	1549	19	1587
Jan-26	48	0	48	4143	32	1555	26	1613
Feb-26	35	8	27	4170	18	1563	10	1623
Mar-26	53	0	53	4223	18	1581	5	1628
Apr-26	67	1	66	4289	50	1602	29	1657
May-26	41	0	41	4330	50	1622	30	1687


837 EDI Submitters - May 2026
41
41
0
837 NewOnboards
837 InProcess
837 NewInProd


835 EDI Receivers - May 2026
30
50
1622
835 NewOnboards
835 InProcess
835 NewInProd

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 **May** 2026.

File Type	TOTAL COUNT	YEAR MONTH
837 I Files	29	May-26
837 P Files	137	May-26
Total Files	**166**	

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	LagPercent	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	86%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	99%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	64%	65%
Timeliness-% Within Lag Time - Professional 0-180 days	77%	80%

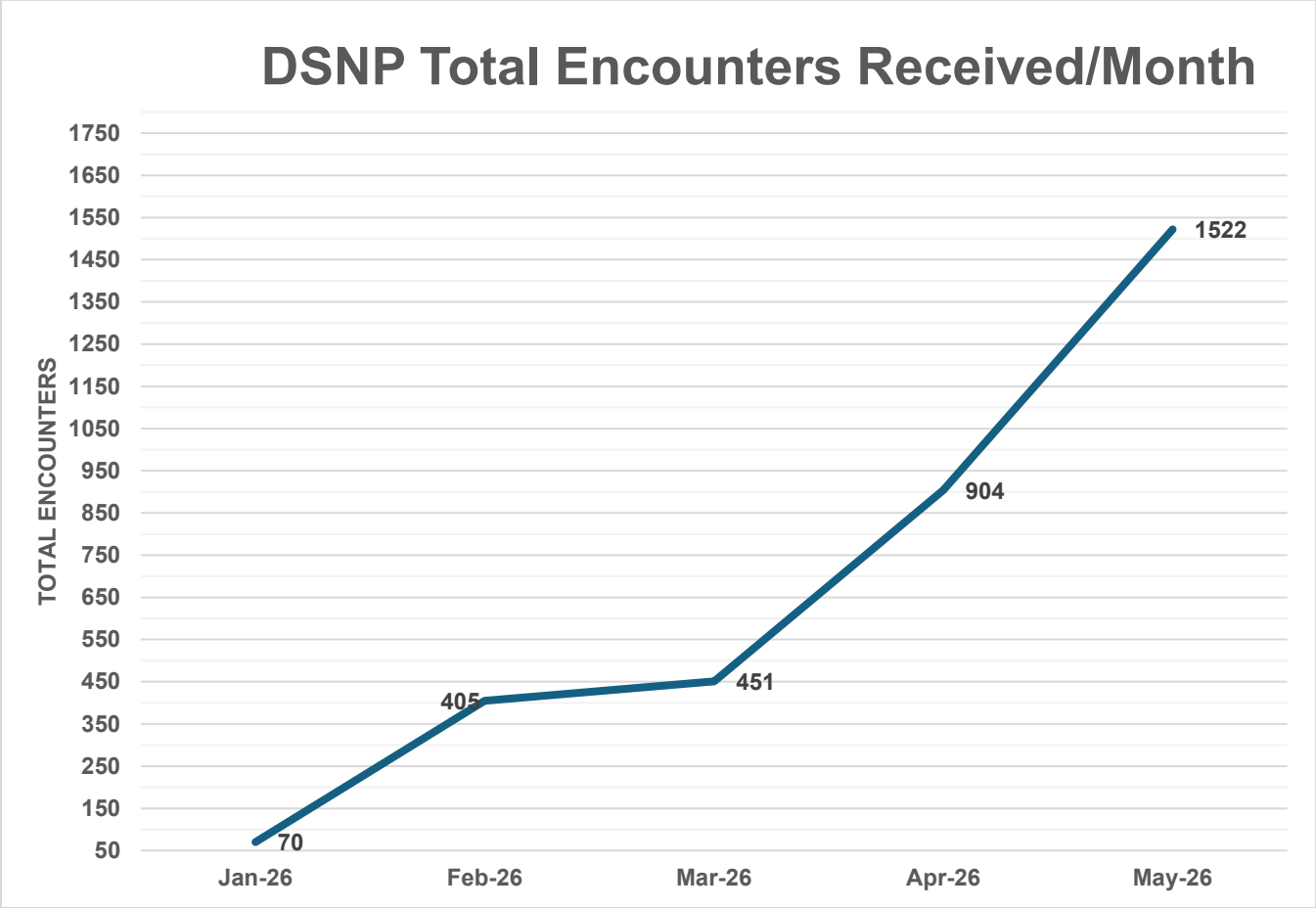
*Note, the Number of Encounters comes from: Total at bottom of this chart: **Outbound Encounter Submission**

DSNP Encounter Data from Trading Partners

- CHME: May monthly files (31 records) were received on time.
- Nations Flex Card: May monthly files (542 records) were received on time.
- Nations Hearing: May monthly files (3 records) were received on time.
- VSP: May monthly files (28 records) were received on time.

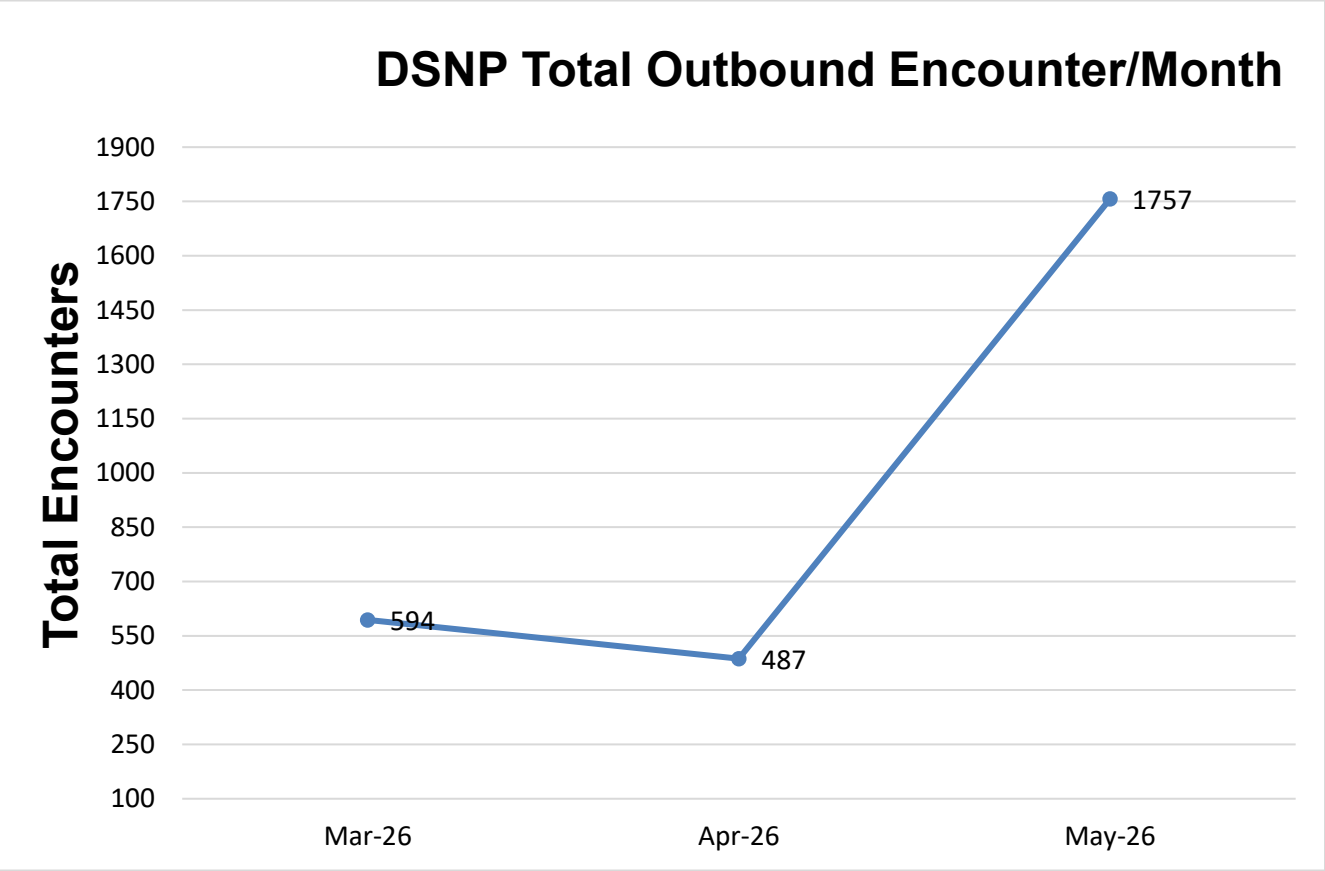
DSNP Trading Partner Encounter Inbound Submission History

TradingPartnerName	Jan-26	Feb-26	Mar-26	Apr-26	May-26
CHME		10	11	29	31
HealthSuite	70	395	440	875	918
Nations Benefits					545
Vision Service Plan					28
TOTAL	70	405	451	904	1522



DSNP Trading Partner Encounter Outbound Submission History

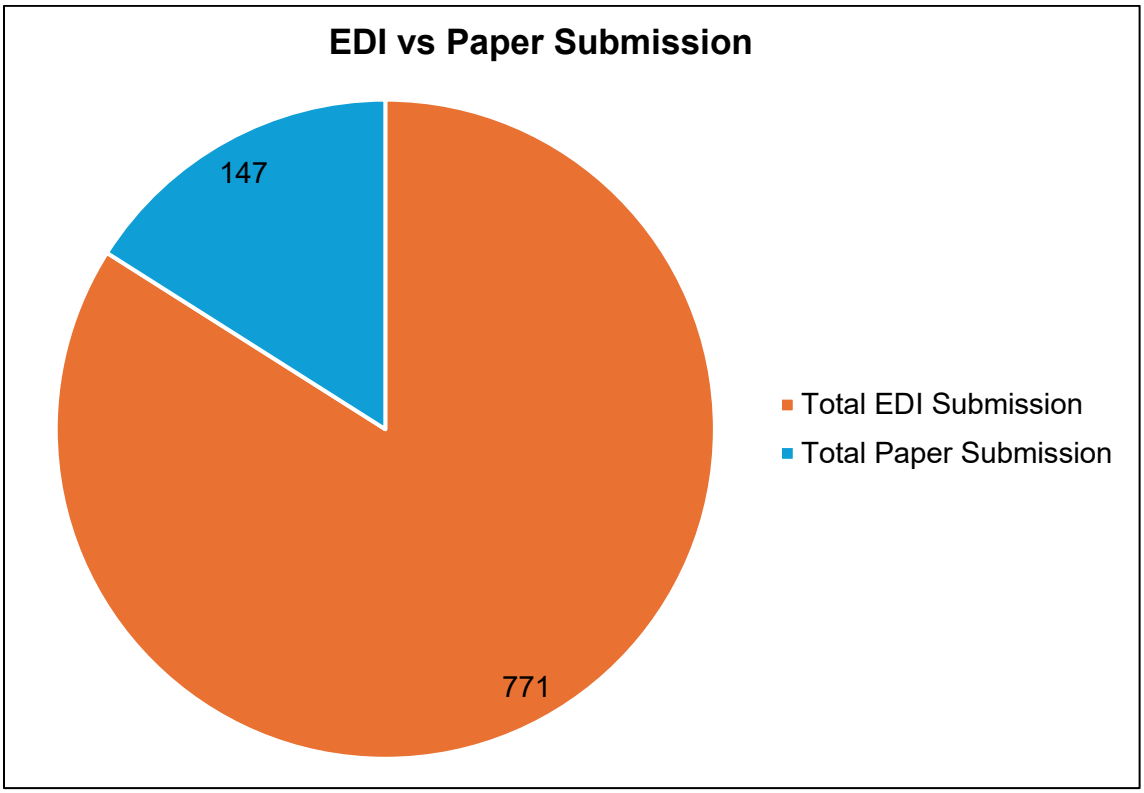
TradingPartnerName	Mar-26	Apr-26	May-26
CHME	20	29	29
HealthSuite	574	458	1155
Nations Flex Card			542
Nations Hearing			3
Vision Service Plan			28
TOTAL	594	487	1757



DSNP HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
26-MAY	771	147	918

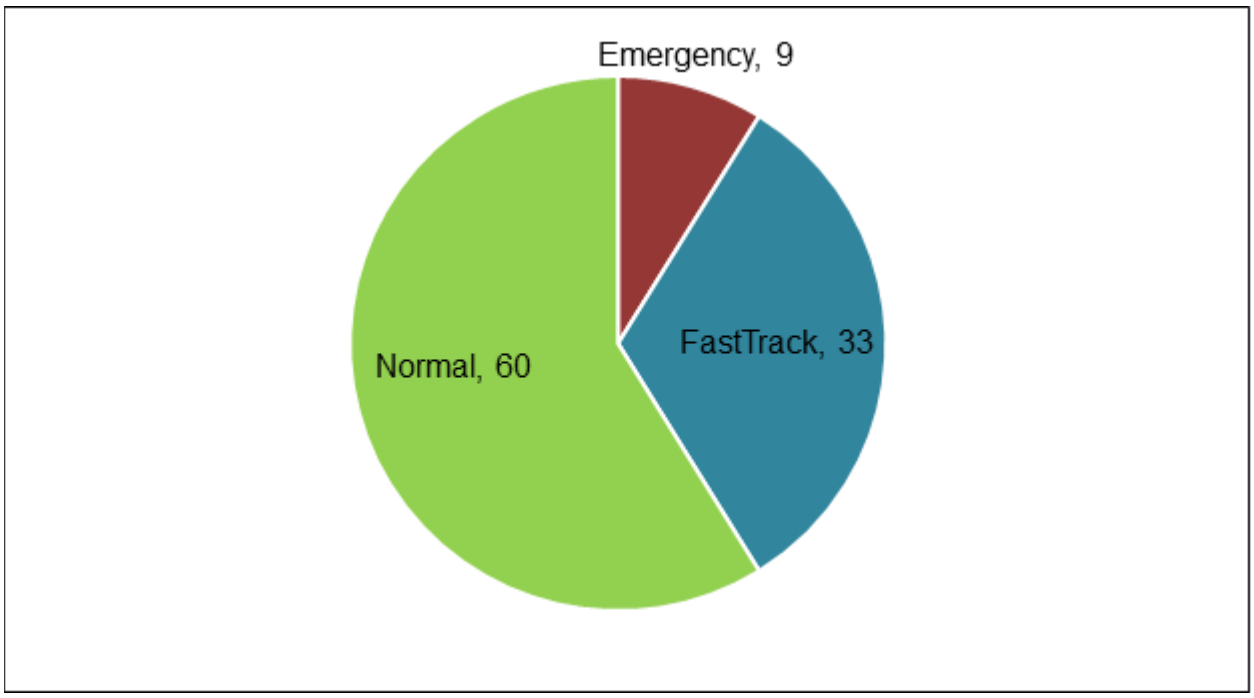
Key: EDI – Electronic Data Interchange



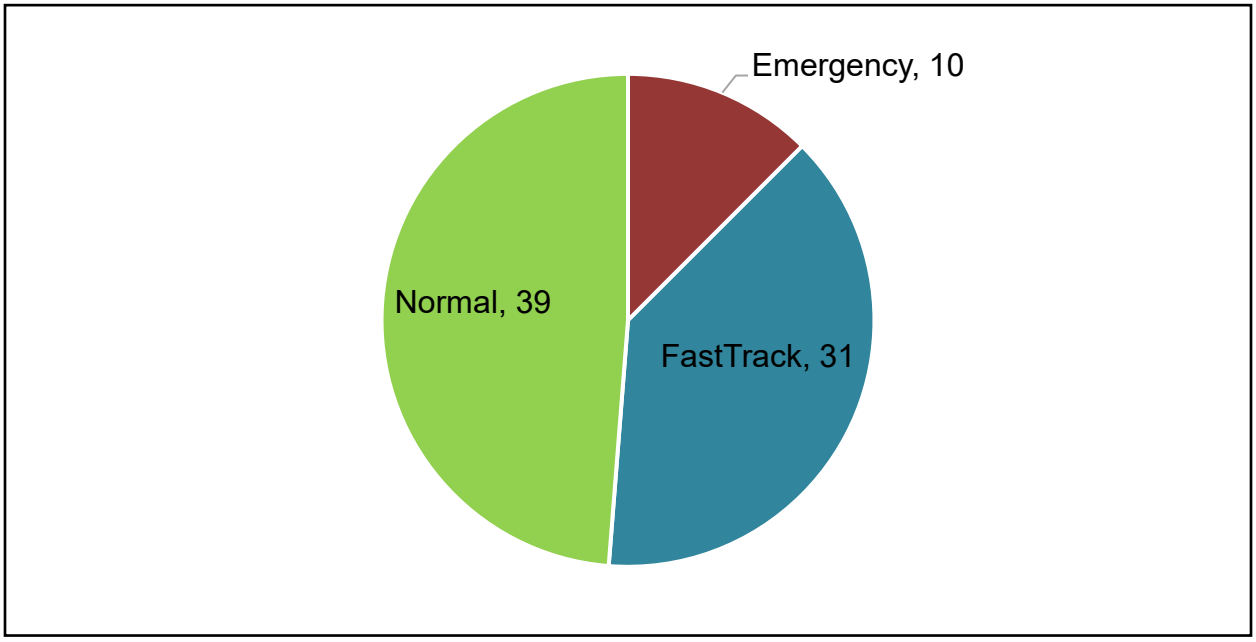
Change Management Key Performance Indicator (KPI)

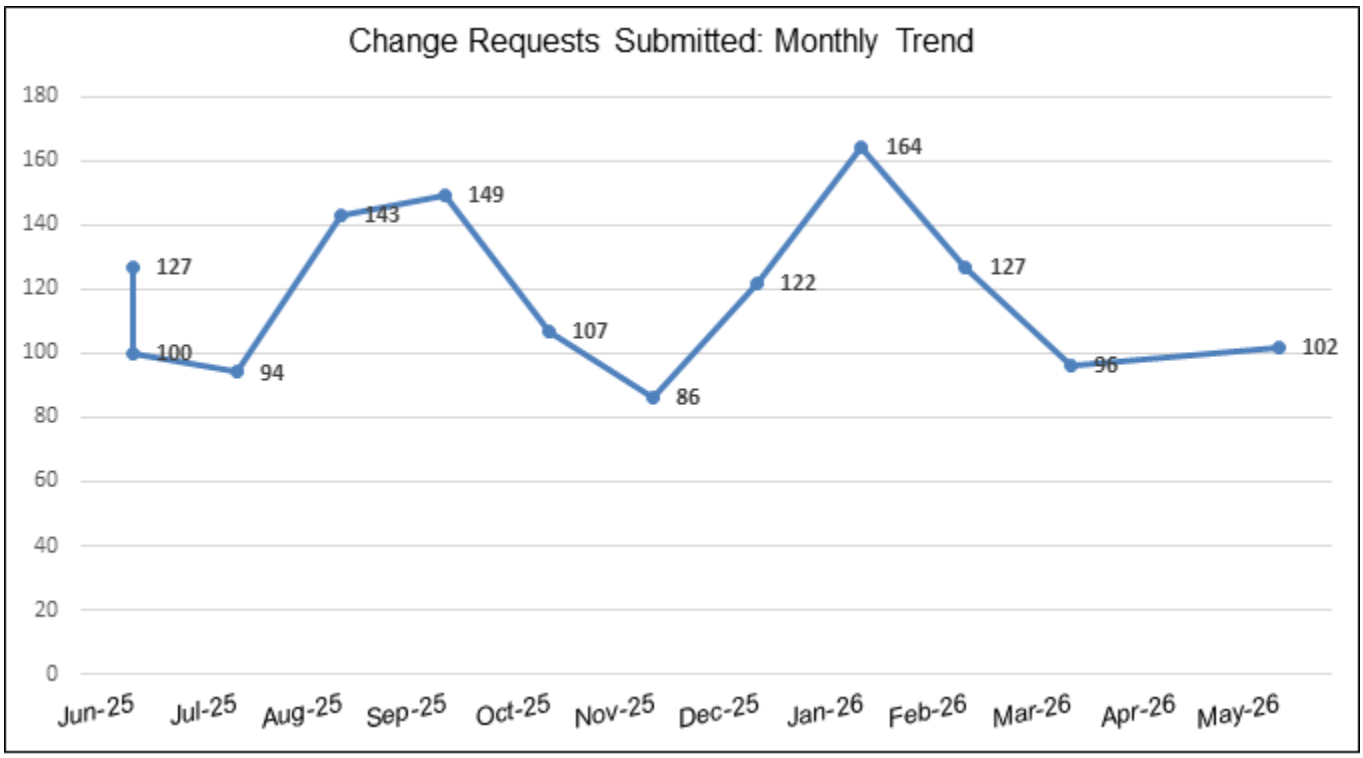
- Change Request Overall Summary in the month of May 2026 KPI:
  - 102 Changes Submitted.
  - 80 Changes Completed and Closed.
  - 135 Active Change Requests in pipeline.
  - 5 Change Requests Cancelled or Rejected.

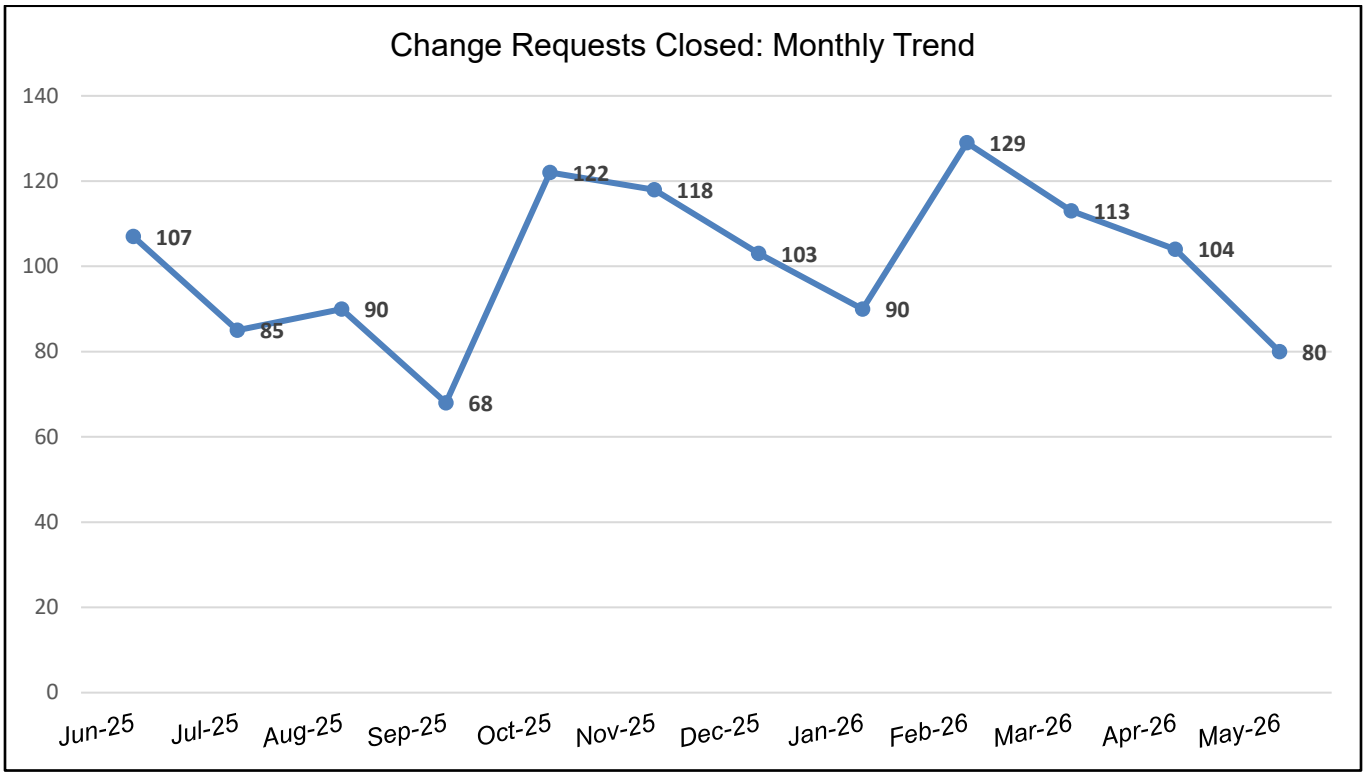
- 96 Change Requests Submitted in the month of May 2026



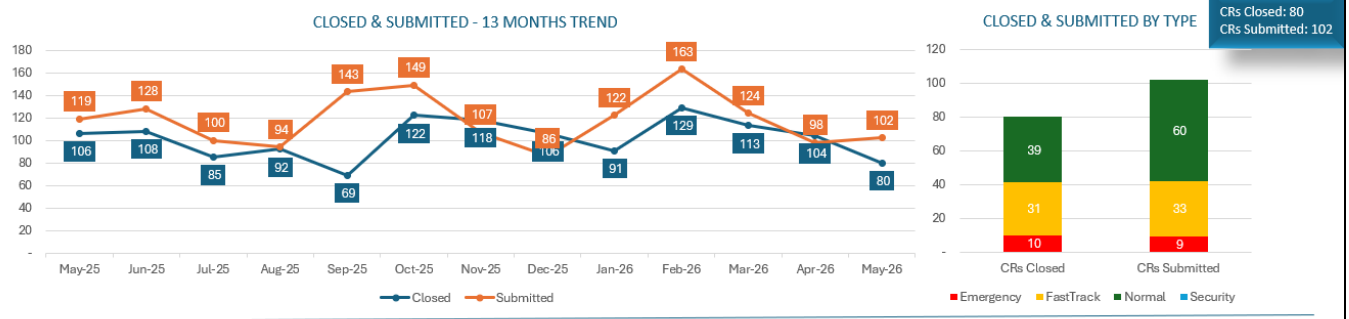
- 80 Change Requests Closed in the month of May 2026

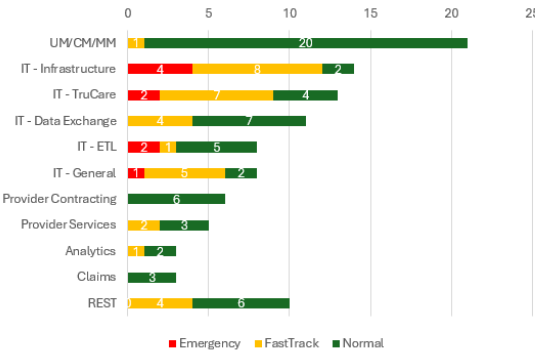


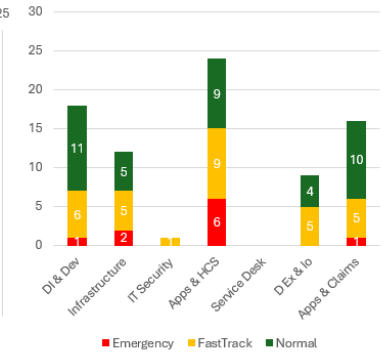

Change Requests Submitted: Monthly Trend
180
160
140
120
100
80
60
40
20
0
127
100
94
143
149
107
86
122
164
127
96
102
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Apr-26
May-26

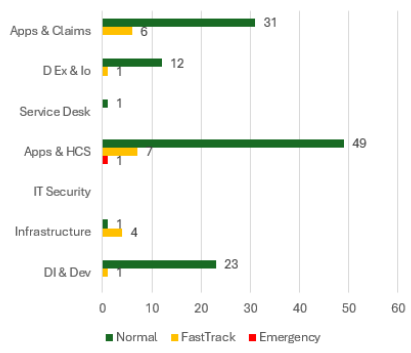

Change Requests Closed: Monthly Trend
140
120
100
80
60
40
20
0
107
85
90
68
122
118
103
90
129
113
104
80
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Apr-26
May-26

Change Management Dashboard – MAY 2026



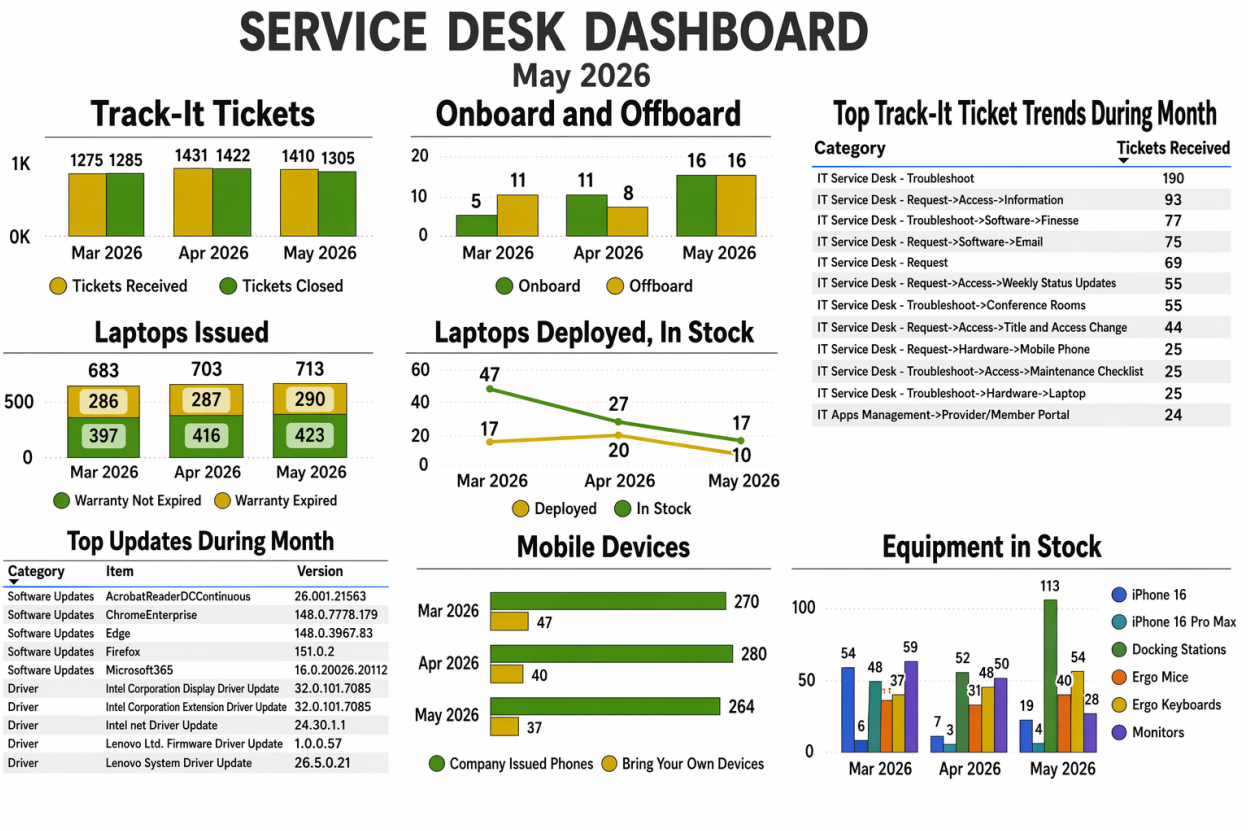






Active CRs - 137 CRs Open > 30 days - 71 CRs Open > 60 days - 43 CRs Open > 90 days - 32 CRs Open > 1 year - 3

IT Stats: Service Desk



- 1,410 Service Desk tickets were opened in May 2026, which is 1.47% lower than the previous month (April: 1431) and 9.73% higher than the previous 4-month average of 1285 (January–April).

- 1,305 Service Desk tickets were closed in May 2026, which is 8.23% lower than the previous month (April: 1422) and 0.56% higher than the previous 4-month average of 1297.75 (January–April).

IT Security & Compliance (No outstanding issues to report)

Risk Register

Risk	Likelihood	Impact	Residual (after controls)	Risk Trend	Owner	Status
Penetration test (2025)	Low	High	Low	↓	Various	WIP
Security Risk Assessment (2025)	Medium	Medium	Low	↓	Various	WIP
Certificate - process/renewal/enrollment/revamp	Medium	High	Low	↑	Various	WIP
Network / Firewall - audit/access (part of SRA)	Medium	High	Low	→	Aman	WIP - will coordinate with Gobi
AI	Medium	High	Low	↓	ITSec	WIP – blocking started
Access & Permissions (RBAC) – new employees / lateral post changes, etc.	High	Medium	Low	↓	Juan	Completed
NEW Endpoint – vuln data	Medium	High	Low	→	Service Desk	Assign to SD as project
Endpoint – malware events	Medium	Medium	Low	→	Service Desk	Assign to SD as a daily task

Projects / Annuals

Activity	Due	Lead	% Complete	Status	Level of Effort (LoE)
Network Micro-Segmentation	July '26	Dan + Arwyn	50%	On track	High
M365 + Copilot Security Assessment	June '26	Juan + Jose	25%	On track	Medium
Keeper (password vault)	June '26	Juan	Pending	TBD	Medium
Security Risk Assessment (2025)	July '26	Dan	23 of 63 left	On track	High
Penetration Test (2025)	July '26	Dan	2 of 9 left	On track	High
Authentication (certificate)	July '26	Eddy	33%	On track	High
Audit - CFMG	May '26	Eddy	-	On track	Medium
Audit - SRA Remediation / Compliance Committee Presentation	May '26	Eddy	-	Completed	Medium

P&P

Activity	Due	Lead	Status	Notes
IT-013 (Sys Dev. & Maintenance)	May '26	Eddy	WIP	Drafted, review, socializing, alignment
Cert Mgmt	June '26	Eddy	WIP	Drafted, information gathering, alignment
Patching RASC Matrix	June '26	Eddy	WIP	Drafted, review, socializing, alignment
SSO Onboarding & Provisioning	May '26	Jose	WIP	Drafted, review, socializing, alignment

…continued

Activity (Juan)	Due	Weekly	MTTD (Mean Time To Detect)	MTTR (Mean Time To Remediate)	Level of Effort (LoE)
SecureLink - 119 consultants across 30 vendors	“”	1	Immediate	15 mins	Medium
KnowBe4 - various	“”	15	Daily	5 mins	Low
Cisco DUO – administrative events	“”	3	Immediate	5 mins	Low

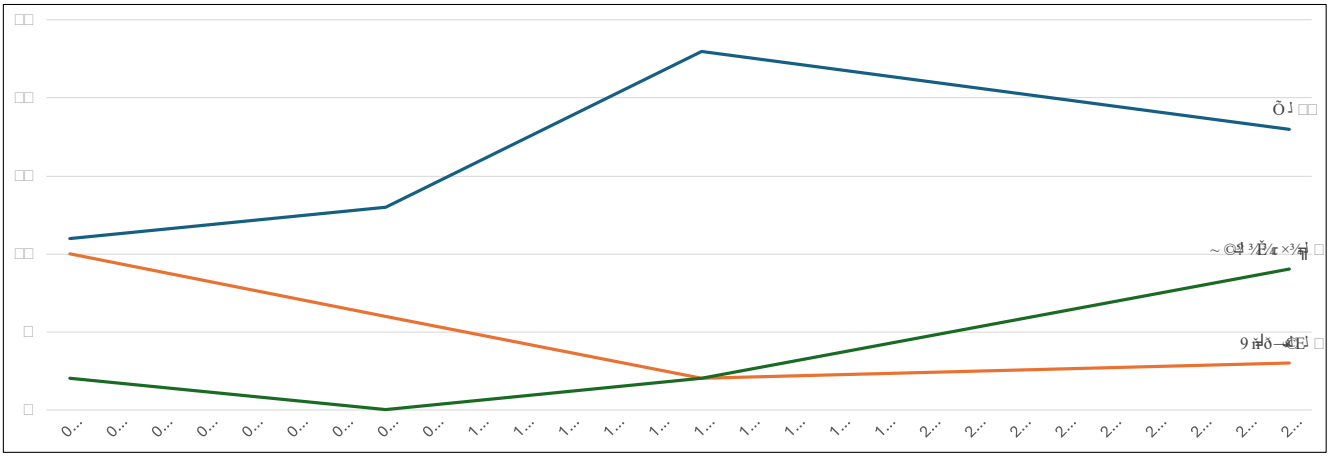
Other Operations

Activity	Due	Lead	% Complete	Status	Level of Effort (LoE)
TLS -1.0 / 1.1 Deprecation	May ‘26	Vinay	92%	Delayed	Medium
AI block	May ’26	Dan	75%	On track	Medium
Linux – PnP / patching / scanning	June ’26	Vish	50%	On track	Medium

Resources
JIRA workloads (Project: IT Security and Compliance)

Threat & Incident Activity (7d) – 1 of 2

Activity	Timeframe	Weekly Count	MTTD (Mean Time To Detect)	MTTR (Mean Time To Remediate)	Level of Effort (LoE)
Arctic Wolf – investigations	5/29	18	Immediate	20 mins	Medium
Cisco Secure Endpoint – investigations	“”	3	Daily	30 mins	Medium
MS Defender – investigations	“”	9	Immediate	60 mins	High



Analytics

Tiffany Cheang

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

From: **Tiffany Cheang, Chief Analytics Officer**

Date: **June 12th, 2026**

Subject: **Performance & Analytics Report**

Member Cost Analysis

The Member Cost Analysis below is based on the following 12 month rolling periods:

Current reporting period: Mar 2025 – Feb 2026 dates of service
Prior reporting period: Mar 2024 – Feb 2025 dates of service
(Note: Data excludes Kaiser membership data.)

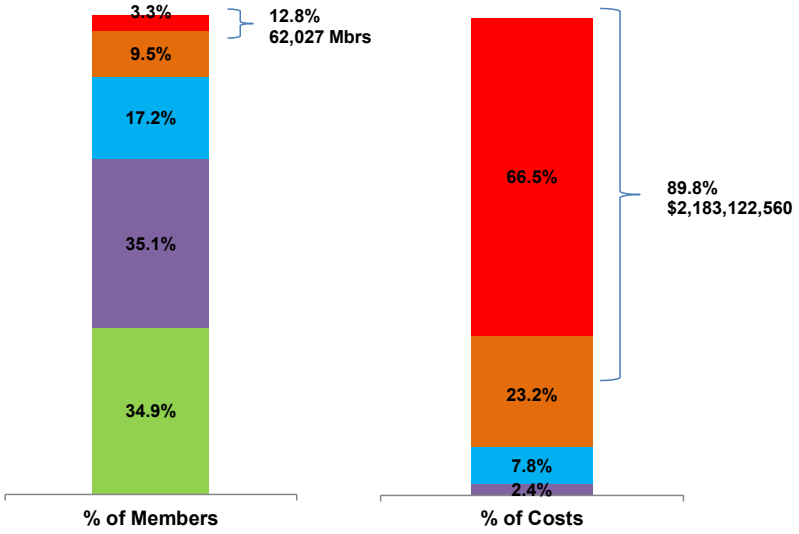
- For the Current reporting period, the top 12.8% of members account for 89.8% of total costs.
- In comparison, the Prior reporting period was lower at 11.5% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
- The SPD/LTC (non duals) and ACA OE categories of aid slightly decreased to account for 53.6% of the members, with SPD/LTCs accounting for 17.7% and ACA OE's at 35.9%.
- The percent of members with costs >= $30K slightly increased from 3.0% to 3.3%.
- Of those members with costs >= $100K, the percentage of total members remained consistent at 1.0%.
    - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 29.9%.
- 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 12.8% is more concentrated in the 45-66 year old category (33.4%) compared to the overall population (20.6%).

Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Mar 2025 - Feb 2026
Note: Data incomplete due to claims lag
Run Date: 05/28/2026

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	15,839	3.3%	$ 1,617,752,156	66.5%
$5K - $30K	46,188	9.5%	$ 565,370,404	23.2%
$1K - $5K	83,733	17.2%	$ 190,767,556	7.8%
< $1K	170,280	35.1%	$ 58,137,805	2.4%
$0	169,471	34.9%	$ -	0.0%
Totals	**485,511**	**100.0%**	**$ 2,432,027,922**	**100.0%**

Top 12.8% of Members = 89.8% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	5,067	1.0%	$ 1,044,256,083	42.9%
$75K to $100K	1,856	0.4%	$ 161,602,971	6.6%
$50K to $75K	3,038	0.6%	$ 185,265,516	7.6%
$40K to $50K	2,294	0.5%	$ 102,484,241	4.2%
$30K to $40K	3,584	0.7%	$ 124,143,345	5.1%
SubTotal	***15,839***	***3.3%***	***$ 1,617,752,156***	***66.5%***
$20K to $30K	6,479	1.3%	$ 157,615,440	6.5%
$10K to $20K	17,865	3.7%	$ 252,485,548	10.4%
$5K to $10K	21,844	4.5%	$ 155,269,416	6.4%
SubTotal	***46,188***	***9.5%***	***$ 565,370,404***	***23.2%***
Total	**62,027**	***12.8%***	**$ 2,183,122,560**	***89.8%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Feb 2026	392,314	$ 2,200,324,351
Dis-Enrolled During Year	93,197	$ 231,703,571
Totals	**485,511**	**$ 2,432,027,922**

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
12.8% of Members = 89.8% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Mar 2025 - Feb 2026
Note: Data incomplete due to claims lag
Run Date: 05/28/2026

12.8% of Members = 89.8% of Costs
17.7% of members are SPD/LTCs and account for 24.1% of costs.
35.9% of members are ACA OE and account for 34.0% of costs.
8.5% of members disenrolled as of Feb 2026 and account for 9.6% of costs.

Highest Cost Members: Cost Per Member >= $100K
25.6% of members are SPD/LTCs and account for 28.5% of costs.
28.2% of members are ACA OE and account for 32.1% of costs.
8.8% of members disenrolled as of Feb 2026 and account for 9.4% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	229	1,007	1,236	2.0%
MCAL	MCAL - ADULT	1,383	8,356	9,739	15.7%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	834	4,120	4,954	8.0%
	MCAL - ACA OE	5,231	17,037	22,268	35.9%
	MCAL - DUALS	-	-	-	0.0%
	MCAL - SPD-LTC	3,868	7,114	10,982	17.7%
	MCAL - SPD-LTC/Full Dual	2,641	4,881	7,522	12.1%
D-SNP	DSNP	11	30	41	0.1%
Not Eligible	Not Eligible	1,642	3,643	5,285	8.5%
Total		**15,839**	**46,188**	**62,027**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	53	1.0%
MCAL	MCAL - ADULT	310	6.1%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	88	1.7%
	MCAL - ACA OE	1,427	28.2%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,297	25.6%
	MCAL - SPD-LTC/Full Dual	1,443	28.5%
D-SNP	DSNP	2	0.0%
Not Eligible	Not Eligible	447	8.8%
Total		**5,067**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 21,702,882	$ 11,928,267	$ 33,631,149	1.5%
MCAL	MCAL - ADULT	$ 125,640,021	$ 102,921,059	$ 228,561,080	10.5%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 60,945,535	$ 46,558,402	$ 107,503,937	4.9%
	MCAL - ACA OE	$ 532,124,116	$ 209,440,857	$ 741,564,974	34.0%
	MCAL - DUALS	$ -	$ -	$ -	0.0%
	MCAL - SPD-LTC	$ 434,540,082	$ 92,620,324	$ 527,160,406	24.1%
	MCAL - SPD-LTC/Full Dual	$ 276,469,981	$ 57,652,160	$ 334,122,141	15.3%
D-SNP	DSNP	$ 1,038,116	$ 359,097	$ 1,397,213	0.1%
Not Eligible	Not Eligible	$ 165,291,422	$ 43,890,238	$ 209,181,660	9.6%
Total		**$ 1,617,752,156**	**$ 565,370,404**	**$ 2,183,122,560**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 12,704,370	1.2%
MCAL	MCAL - ADULT	$ 71,952,288	6.9%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 25,431,675	2.4%
	MCAL - ACA OE	$ 335,384,532	32.1%
	MCAL - DUALS	$ -	0.0%
	MCAL - SPD-LTC	$ 297,310,153	28.5%
	MCAL - SPD-LTC/Full Dual	$ 202,562,862	19.4%
D-SNP	DSNP	$ 567,891	0.1%
Not Eligible	Not Eligible	$ 98,342,313	9.4%
Total		**$ 1,044,256,083**	**100.0%**

% of Total Costs By Service Type

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs
$100K+	4%	0%	1%
$75K to $100K	4%	0%	1%
$50K to $75K	4%	0%	2%
$40K to $50K	5%	0%	2%
$30K to $40K	6%	0%	3%
$20K to $30K	2%	1%	6%
$10K to $20K	0%	0%	10%
$5K to $10K	0%	0%	4%
Total	**3%**	**0%**	**3%**

Breakout by Service Type/Location

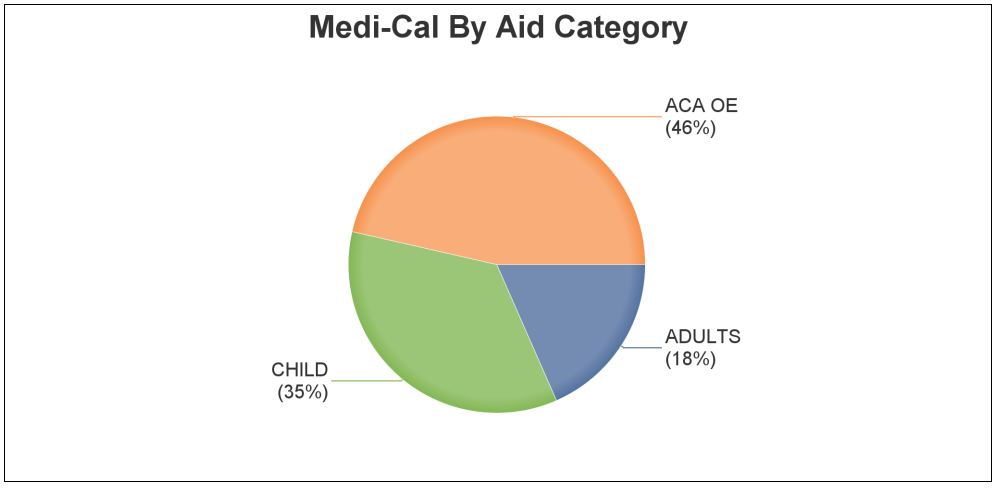
Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
15%	35%	1%	10%	3%	2%	34%
22%	23%	3%	6%	5%	4%	37%
28%	26%	5%	7%	7%	3%	24%
33%	22%	8%	6%	9%	1%	21%
33%	20%	11%	7%	9%	1%	19%
36%	21%	6%	9%	9%	1%	18%
38%	20%	6%	9%	10%	1%	16%
31%	10%	11%	13%	15%	1%	19%
24%	**27%**	**4%**	**9%**	**6%**	**2%**	**28%**

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

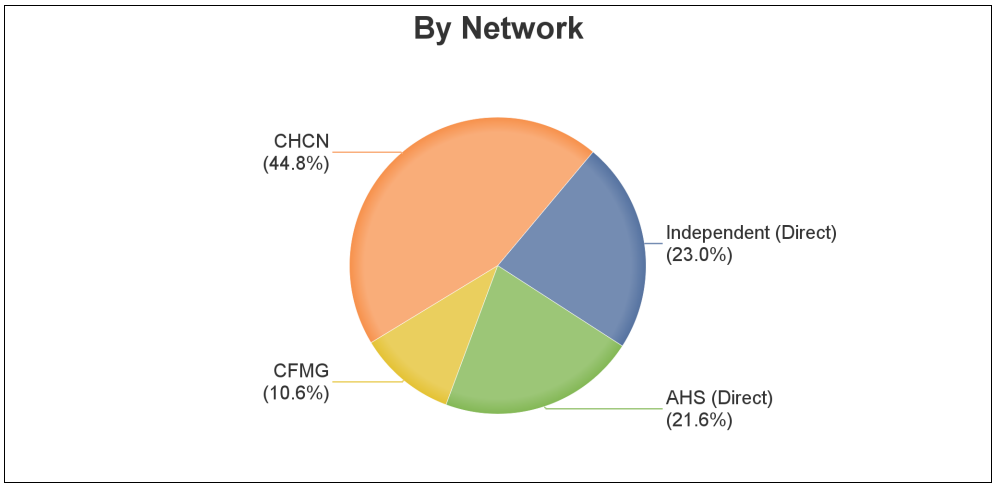
Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Apr 2026	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	54,867	15%	11,181	13,286	0	30,400
CHILD	104,710	28%	9,404	13,686	37,508	44,112
SPD	0	0%	0	0	0	0
ACA OE	138,309	37%	25,571	45,292	1,445	66,001
DUALS	0	0%	0	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	27,944	7%	8,043	5,076	1,500	13,325
SPD-LTC/Full Dual	48,039	13%	30,968	3,441	0	13,630
Other	0		0	0	0	0
Medi-Cal	373,869		85,167	80,781	40,453	167,468
Group Care	6,291		2,270	1,191	0	2,830
D-SNP	231		68	27	0	136
Total	**380,391**	**100%**	**87,505**	**81,999**	**40,453**	**170,434**
Other %	0.0%		0.0%	0.0%	0.0%	0.0%
Medi-Cal %	98.3%		97.3%	98.5%	100.0%	98.3%
Group Care %	1.7%		2.6%	1.5%	0.0%	1.7%
D-SNP %	0.1%		0.1%	0.0%	0.0%	0.1%
	Network Distribution		**23.0%**	**21.6%**	**10.6%**	**44.8%**
			% Direct:	**45%**	**% Delegated:**	**55%**



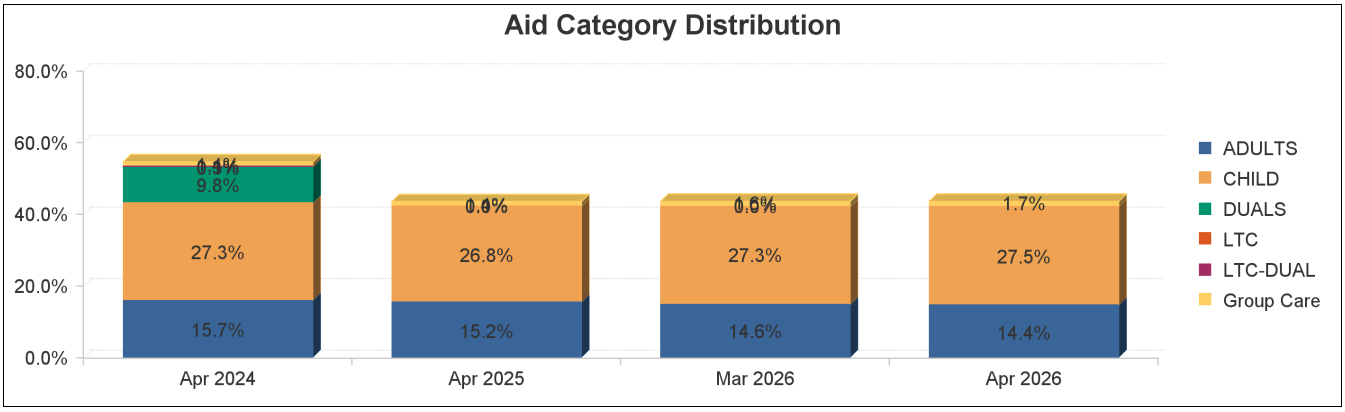
Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

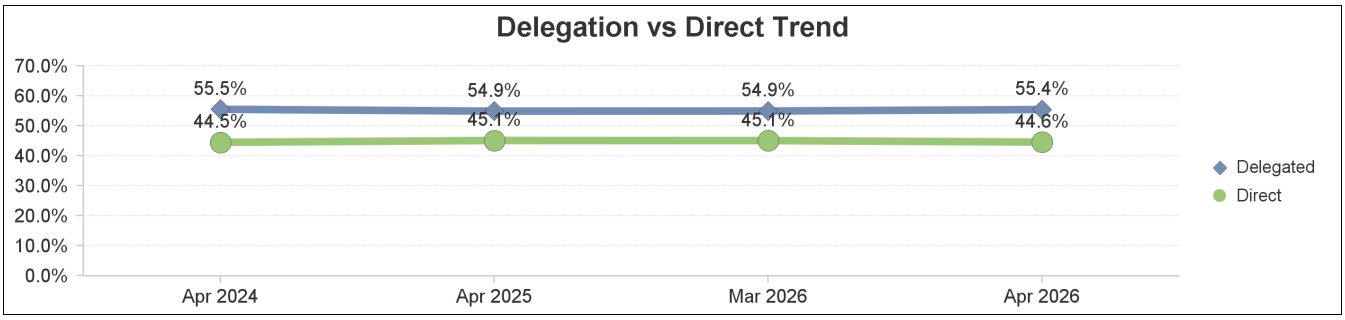
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
ADULTS	63,551	62,532	56,388	**54,867**	15.7%	15.2%	14.6%	14.4%	-1.6%	-14.0%	-2.8%
CHILD	110,566	110,211	105,604	**104,710**	27.3%	26.8%	27.3%	27.5%	-0.3%	-5.3%	-0.9%
SPD	34,887	0	0	**0**	8.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ACA OE	149,154	154,154	141,335	**138,309**	36.8%	37.5%	36.6%	36.4%	3.2%	-11.5%	-2.2%
DUALS	39,912	1	85	**0**	9.8%	0.0%	0.0%	0.0%	##########	0.0%	0.0%
LTC	223	0	0	**0**	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LTC-DUAL	1,291	0	0	**0**	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SPD-LTC	0	29,316	28,477	**27,944**	0.0%	7.1%	7.4%	7.3%	100.0%	-4.9%	-1.9%
SPD-LTC/ Full Dual	0	48,733	48,300	**48,039**	0.0%	11.9%	12.5%	12.6%	100.0%	-1.4%	-0.5%
Other	0	0	0	**0**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medi-Cal	399,584	404,947	380,189	**373,869**	98.6%	98.6%	98.3%	98.3%	1.3%	-8.3%	-1.7%
Group Care	5,643	5,896	6,240	**6,291**	1.4%	1.4%	1.6%	1.7%	4.3%	6.3%	0.8%
D-SNP	0	0	212	**231**	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
Total	**405,227**	**410,843**	**386,641**	**380,391**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**1.4%**	**-8.1%**	**-1.6%**



Delegation vs Direct Trend

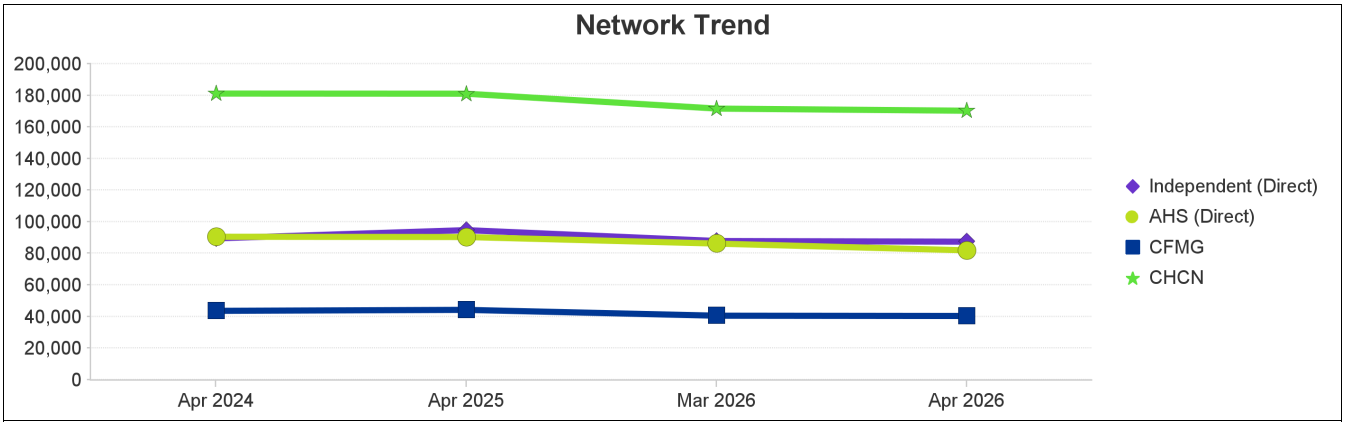
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
Delegated	225,002	225,555	212,420	**210,887**	55.5%	54.9%	54.9%	55.4%	0.2%	-7.0%	-0.7%
Direct	180,225	185,288	174,221	**169,504**	44.5%	45.1%	45.1%	44.6%	2.7%	-9.4%	-2.8%
Total	**405,227**	**410,843**	**386,641**	**380,391**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**1.4%**	**-8.1%**	**-1.6%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Network Trend

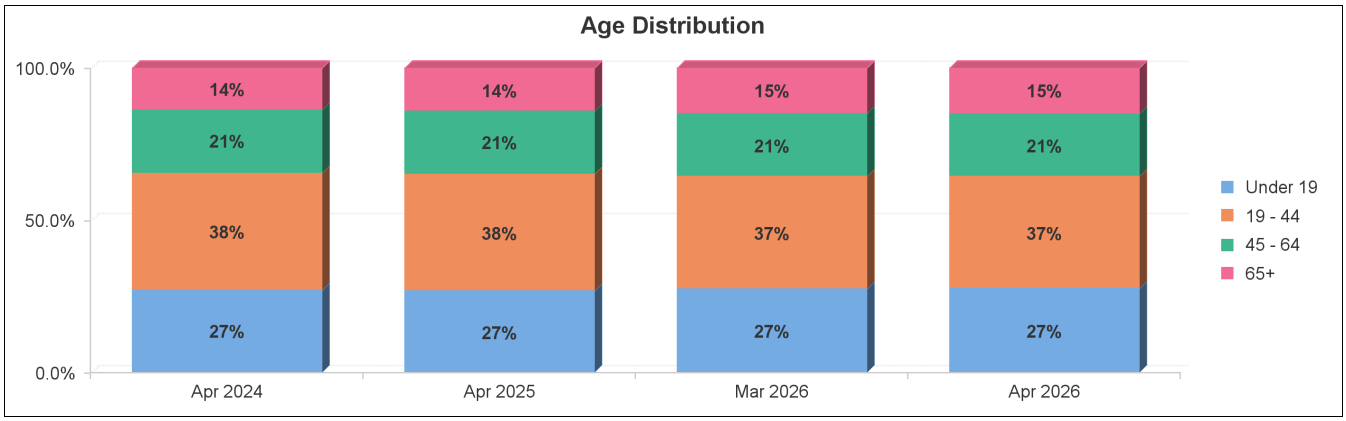
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
Independent (Direct)	89,595	94,829	87,920	**87,505**	22.1%	23.1%	22.7%	23.0%	5.5%	-8.5%	-0.5%
AHS (Direct)	90,630	90,459	86,301	**81,999**	22.4%	22.0%	22.3%	21.6%	-0.2%	-10.4%	-5.3%
CFMG	43,702	44,330	40,627	**40,453**	10.8%	10.8%	10.5%	10.6%	1.4%	-9.6%	-0.4%
CHCN	181,300	181,225	171,793	**170,434**	44.7%	44.1%	44.4%	44.8%	0.0%	-6.4%	-0.8%
KAISER	0	0	0	**0**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**405,227**	**410,843**	**386,641**	**380,391**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**1.4%**	**-8.1%**	**-1.6%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

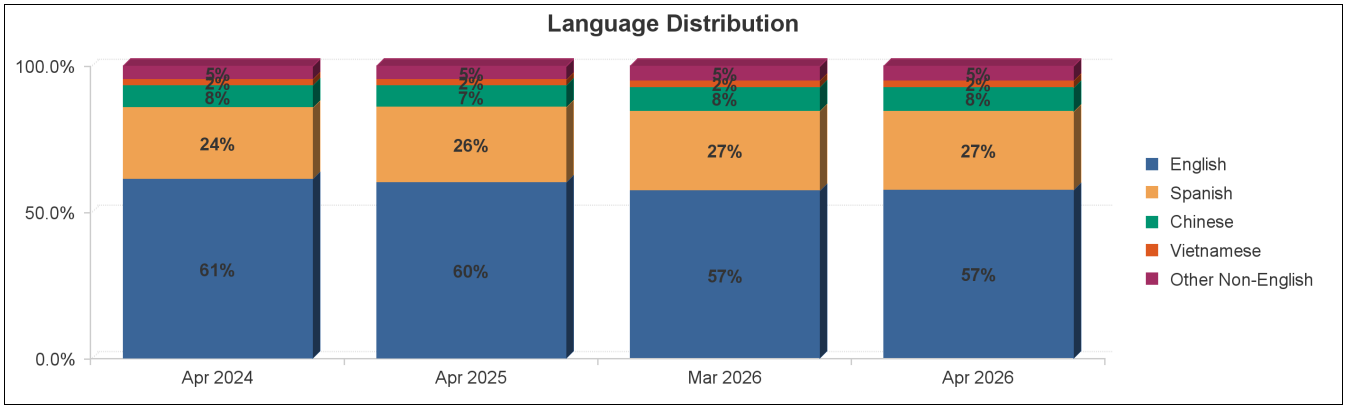
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
Under 19	108,917	109,618	105,461	**104,534**	27%	27%	27%	27%	1%	-5%	-1%
19 - 44	156,001	157,592	143,052	**139,860**	38%	38%	37%	37%	1%	-13%	-2%
45 - 64	84,128	84,775	79,641	**78,293**	21%	21%	21%	21%	1%	-8%	-2%
65+	56,181	58,858	58,275	**57,473**	14%	14%	15%	15%	5%	-2%	-1%
Total	**405,227**	**410,843**	**386,429**	**380,160**	**100%**	**100%**	**100%**	**100%**	**1%**	**-8%**	**-2%**



Language Trend

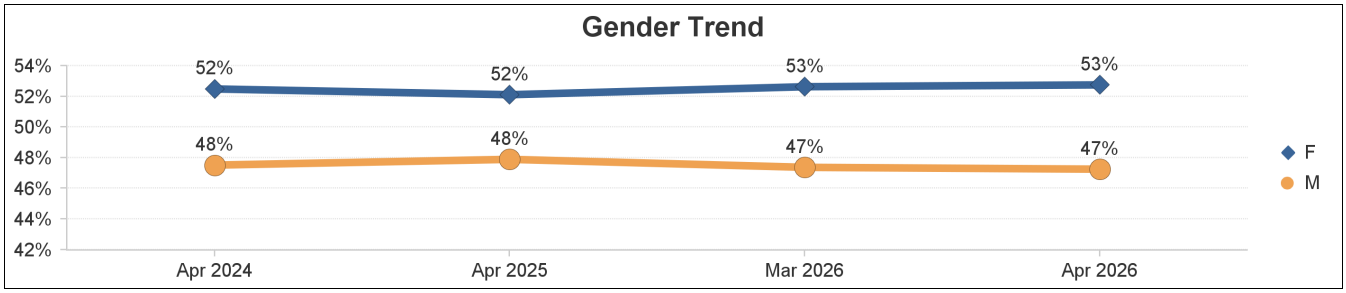
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Apr 2024	Apr 2025	Mar 2026	Apr 2026	pr 2024	pr 2025	Mar 2026	pr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
English	247,927	246,716	221,048	**218,138**	61%	60%	57%	57%	0%	-13%	-1%
Spanish	98,970	105,652	105,190	**102,453**	24%	26%	27%	27%	6%	-3%	-3%
Chinese	30,725	30,517	31,146	**30,854**	8%	7%	8%	8%	-1%	1%	-1%
Vietnamese	8,548	8,174	8,804	**8,730**	2%	2%	2%	2%	-5%	6%	-1%
Other Non-English	19,057	19,784	20,241	**19,985**	5%	5%	5%	5%	4%	1%	-1%
Total	**405,227**	**410,843**	**386,429**	**380,160**	**100%**	**100%**	**100%**	**100%**	**1%**	**-8%**	**-2%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

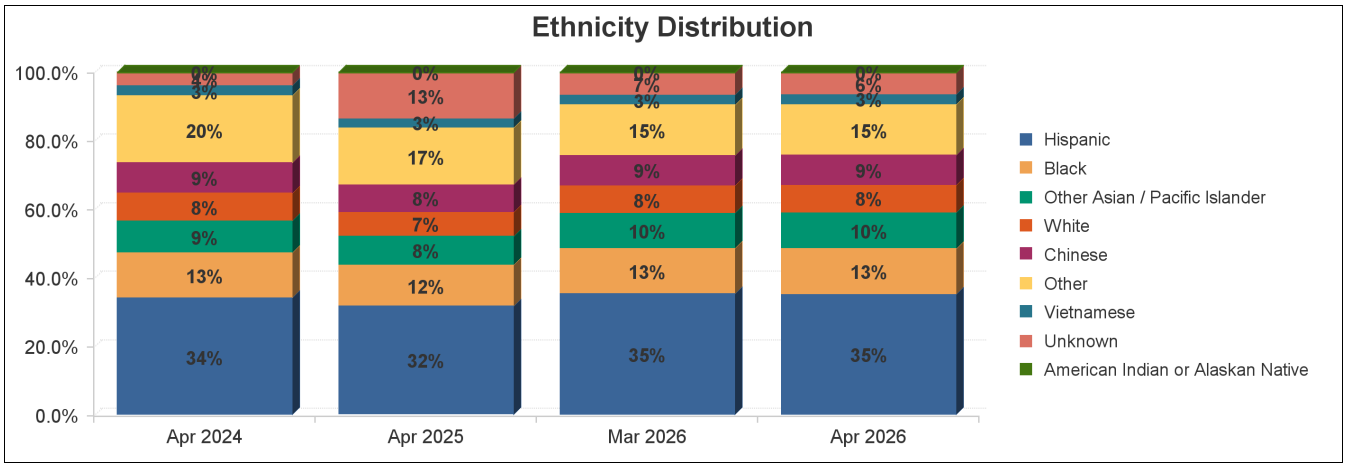
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
F	212,693	214,090	203,499	**200,666**	52%	52%	53%	53%	1%	-7%	-1%
M	192,534	196,753	183,142	**179,725**	48%	48%	47%	47%	2%	-10%	-2%
Total	**405,227**	**410,843**	**386,641**	**380,391**	**100%**	**100%**	**100%**	**100%**	**1%**	**-8%**	**-2%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024	Apr 2025	Mar 2026	Apr 2026	Apr 2024 to Apr 2025	Apr 2025 to Apr 2026	Mar 2026 to Apr 2026
Hispanic	138,080	130,033	136,346	**133,496**	34%	32%	35%	35%	-6%	3%	-2%
Black	53,580	49,313	51,132	**50,764**	13%	12%	13%	13%	-9%	3%	-1%
Other Asian / Pacific Islander	37,409	34,386	39,844	**39,738**	9%	8%	10%	10%	-9%	13%	0%
White	32,949	28,815	31,056	**30,622**	8%	7%	8%	8%	-14%	6%	-1%
Chinese	35,847	33,056	33,831	**33,486**	9%	8%	9%	9%	-8%	1%	-1%
Other	79,277	68,358	57,391	**56,149**	20%	17%	15%	15%	-16%	-22%	-2%
Vietnamese	12,050	10,834	10,991	**10,863**	3%	3%	3%	3%	-11%	0%	-1%
Unknown	15,231	55,315	25,308	**24,531**	4%	13%	7%	6%	72%	-126%	-3%
American Indian or Alaskan Native	804	733	742	**742**	0%	0%	0%	0%	-10%	1%	0%
Total	**405,227**	**410,843**	**386,641**	**380,391**	**100%**	**100%**	**100%**	**100%**	**1%**	**-8%**	**-2%**



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

Medi-Cal By City

City	Apr 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	148,472	40%	22,100	38,834	15,912	71,626
HAYWARD	48,202	13%	11,297	13,035	5,327	18,543
FREMONT	35,800	10%	15,116	5,862	1,953	12,869
SAN LEANDRO	23,526	6%	6,332	3,806	2,922	10,466
UNION CITY	13,499	4%	5,463	2,305	749	4,982
ALAMEDA	12,894	3%	3,174	2,393	1,987	5,340
BERKELEY	15,425	4%	3,309	2,555	1,664	7,897
LIVERMORE	12,279	3%	1,981	365	1,963	7,970
NEWARK	8,524	2%	2,661	3,405	444	2,014
CASTRO VALLEY	10,481	3%	3,077	1,586	1,642	4,176
SAN LORENZO	5,672	2%	1,202	1,289	661	2,520
PLEASANTON	7,540	2%	2,212	274	807	4,247
DUBLIN	7,394	2%	2,468	285	867	3,774
EMERYVILLE	2,925	1%	555	654	512	1,204
ALBANY	2,446	1%	471	283	556	1,136
PIEDMONT	425	0%	89	162	64	110
SUNOL	88	0%	30	9	7	42
ANTIOCH	25	0%	8	8	3	6
Other	18,252	5%	3,622	3,671	2,413	8,546
Total	373,869	100%	**85,167**	**80,781**	**40,453**	**167,468**

Group Care By City

City	Apr 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,887	30%	338	444	0	1,105
HAYWARD	711	11%	328	196	0	187
FREMONT	716	11%	450	89	0	177
SAN LEANDRO	698	11%	281	112	0	305
UNION CITY	297	5%	179	53	0	65
ALAMEDA	326	5%	95	40	0	191
BERKELEY	161	3%	39	16	0	106
LIVERMORE	99	2%	28	0	0	71
NEWARK	152	2%	88	39	0	25
CASTRO VALLEY	225	4%	91	36	0	98
SAN LORENZO	178	3%	55	42	0	81
PLEASANTON	81	1%	33	4	0	44
DUBLIN	135	2%	49	8	0	78
EMERYVILLE	43	1%	9	8	0	26
ALBANY	24	0%	11	2	0	11
PIEDMONT	5	0%	0	2	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	26	0%	8	5	0	13
Other	526	8%	187	95	0	244
Total	**6,291**	**100%**	**2,270**	**1,191**	**0**	**2,830**

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

D-SNP By City

City	Apr 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	89	39%	17	9	0	63
HAYWARD	27	12%	10	3	0	14
FREMONT	17	7%	9	1	0	7
SAN LEANDRO	16	7%	6	4	0	6
UNION CITY	2	1%	1	0	0	1
ALAMEDA	16	7%	2	5	0	9
BERKELEY	14	6%	0	1	0	13
LIVERMORE	13	6%	2	1	0	10
NEWARK	6	3%	6	0	0	0
CASTRO VALLEY	3	1%	2	1	0	0
SAN LORENZO	3	1%	3	0	0	0
PLEASANTON	5	2%	3	0	0	2
DUBLIN	4	2%	0	0	0	4
EMERYVILLE	2	1%	1	0	0	1
ALBANY	0	0%	0	0	0	0
PIEDMONT	0	0%	0	0	0	0
SUNOL	0	0%	0	0	0	0
ANTIOCH	0	0%	0	0	0	0
Other	14	6%	6	2	0	6
Sum:			**2,270**	**1,191**	**0**	**2,830**

Total By City

City	Apr 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	150,359	40%	22,438	39,278	15,912	72,731
HAYWARD	48,913	13%	11,625	13,231	5,327	18,730
FREMONT	36,516	10%	15,566	5,951	1,953	13,046
SAN LEANDRO	24,224	6%	6,613	3,918	2,922	10,771
UNION CITY	13,796	4%	5,642	2,358	749	5,047
ALAMEDA	13,220	3%	3,269	2,433	1,987	5,531
BERKELEY	15,586	4%	3,348	2,571	1,664	8,003
LIVERMORE	12,378	3%	2,009	365	1,963	8,041
NEWARK	8,676	2%	2,749	3,444	444	2,039
CASTRO VALLEY	10,706	3%	3,168	1,622	1,642	4,274
SAN LORENZO	5,850	2%	1,257	1,331	661	2,601
PLEASANTON	7,621	2%	2,245	278	807	4,291
DUBLIN	7,529	2%	2,517	293	867	3,852
EMERYVILLE	2,968	1%	564	662	512	1,230
ALBANY	2,470	1%	482	285	556	1,147
PIEDMONT	430	0%	89	164	64	113
SUNOL	89	0%	31	9	7	42

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

ANTIOCH	51	0%	16	13	3	19
Other	18,778	5%	3,809	3,766	2,413	8,790
Total	380,160	100%	**87,437**	**81,972**	**40,453**	**170,298**

Human Resources

Anastacia Swift

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

From: **Anastacia Swift, Chief Human Resources Officer**

Date: **June 12th, 2026**

Subject: **Human Resources Report**

Staffing

- As of June 1st, 2026, the Alliance had 669 full time employees and 1 part time employee.
- On June 1st, 2026, the Alliance had 24 open positions in which 4 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 24 positions open to date. The Alliance is actively recruiting for the remaining 24 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by division:

Division	Open Position June 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	6	1	5
Operations	12	3	9
Healthcare Analytics	1	0	1
Information Technology	1	0	1
Finance	0	0	0
Compliance	1	0	1
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	24	4	20

- Our current recruitment rate is 4%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in May 2026 included:

  5 years:
  - Asha A (Healthcare Analytics)

  6 years:
  - Cassie V (Utilization Management)
  - Fiona Q (Quality Management)

  7 years:
  - Pedro L (Information Technology)
  - Reya B (Case/Disease Management)
  - Carla H (Utilization Management)

  8 years:
  - Randy S (Quality Analytics)
  - Jessica J (Quality Management)
  - Leticia A (Provider Services)
  - Aman A (IT Quality & Process Improvement)

  9 years:
  - Rahel N (Pharmacy Services)
  - Kwan P (IT Data Exchange)

  10 years:
  - Ria H (Claims)
  - Aracely M (Claims)

  11 years:
  - Jeremy A (IT Ops and Quality Apps Mgt)

  13 years:
  - Michelle L (Marketing & Communications)
  - Alicia G (Utilization Management)

  14 years:
  - Linda A (Quality Management)

  18 years:
  - Ceci G (Provider Services)

  23 years:
  - Nancy K (Case/Disease Management)