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Board of Governors PACKET

APRIL 10th, 2026



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EXECUTIVE SUMMARY APPENDIX

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SUPPORTING MATERIALS APPENDIX

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CEO Update

Matthew Woodruff

To: Alameda Alliance for Health Board of Governors
From: Matthew Woodruff, Chief Executive Officer
Date: April 10th, 2026
Subject: CEO Report

- **Financials:**

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

	<u>February</u>	<u>YTD</u>
Medi-Cal	\$23.5M	\$62.5M
Group Care	(\$886K)	(\$1.6K)
Medicare	(\$890K)	(\$7.4K)
Total	\$21.8M	\$53.5M

- **Revenue was \$191.1 million in February and \$1.5 billion Year-to-Date (YTD).**
 - Medical expenses were \$160.3 million in February and \$1.4 billion for the fiscal year-to-date; the medical loss ratio is 83.9% for the month and 92.3% for the fiscal year-to-date.
 - Administrative expenses were \$10.7 million in February and \$81.9 million for the fiscal year-to-date; the administrative loss ratio is 5.6% of net revenue for the month and 5.4% of net revenue year-to-date.
- **Tangible Net Equity (TNE):** Financial reserves are 284% of the required DMHC minimum, representing \$144.4 million in excess TNE.
- **Total enrollment in February was 391,433**, decreased by 3,828 Medi-Cal members compared to January 2026.

- **Key Performance Indicators:**

- **Regulatory Metrics:**
 - Member grievances scored 89% processing time, which is below the 95% compliance mark.
- **Non-Regulatory Metrics:**
 - All non-regulatory metrics were met for January.

- **Legislative Updates:**

- State And Federal Updates

- Legislative update attached.
- **IT Workflow Automation - Quarterly Updates – Next Update June 2026**
- **Alliance in the Community – Quarterly Updates**
 - Community Engagement: Participated in 45 of 57 events that Alliance was invited to attend, including major Bay Area and countywide activities such as the Oakland Chinatown Chamber of Commerce (OCCC) 34th Lunar New Year Bazaar, Laney College Welcome Back Week Resource Fair, Oakland Unified School District (OUSD) Special Education Resource Fair, 4th Annual Heart Health Weekend and Hypertension Sunday, McClymonds High School Black Health Fair, State of the District Resource Fair (SD-10), Black Joy Parade, and the 4Cs of Alameda County and Asian Health Services Wilma Chan Park monthly food distributions.
 - Community Relations Reinvestment Sponsorships: Sponsored the OCCC Chinatown Lunar New Year event (\$5,000) and the Black Joy Parade (\$6,000), reaching more than 20,000 and 120,000 participants, respectively. The Alliance also participated in the Black Joy Parade for the first time, walking in the parade in recognition of Black History Month and 30 years of service to the community. In addition, supported high-profile community relations events across the Bay Area, including the Sinkler Miller Medical Association (SMMA) 42nd Annual Scholarship Gala, Physicians Medical Forum, Native American Health Center Annual Gala, Abode Journey Home Breakfast, Alameda County Women's Hall of Fame Luncheon, LifeLong's 50th Anniversary Gala, and La Familia's 50th Anniversary Gala.
 - Looking Ahead: Approximately 40 community engagement events and 18 community relations events are planned through June 2026, with major upcoming activities including Coffee & Conversations: A Community Chat with the Alliance + CAC (Community Advisory Committee), the Downtown Livermore Street Fair, the Alameda County Fair, Oakland Pride, and community relations events such as the Alameda Health System Foundation Soul of Spring 2026, St. Mary's Center Annual Celebration, the 3rd Annual Black Women's Health Forum, and the Family Bridges Annual Gala.

- **Medicare Overview**

- Medicare D-SNP product (Alameda Alliance Wellness) launched successfully on January 1st, 2026, which aligns with the Alliance's 30th anniversary.
- Continued collaborations with the Medicare supplemental benefit vendors – Liberty Dental, VSP, and NationsBenefits - on operational excellence and process improvements.
- 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.
- 2027 Medicare Bid Submission:
 - Weekly meetings with key stakeholders and external Actuarial team to discuss the approach to the 2027 plan design and to provide deliverables needed to meet bid submission requirements.
- Bay Area Community Health (BACH) from Community Health Center Network (CHCN) has joined the Medicare D-SNP pilot as an active participating health center.
 - The Alliance is scheduling an onsite roadshow in Q2 2026.
- Medicare Marketing has identified a set of qualified vendors for marketing/brand awareness and is currently in the interview process. The goal is to select a preferred vendor and begin onboarding to ensure readiness for July implementation.
- CHCN Marketing Blitz: Completed three (3) waves of postcard marketing blitz to CHCN leads, which drove up sales and brand awareness.

- **Medi-Cal Incentive Programs**

- **Overview**

- The Medi-Cal incentive programs were funded by the State of California/DHCS and authorized through the American Rescue Plan Act, Home and Community-Based Services, State general funds, and other waivers.
 - Participation in the incentive programs was voluntary, and the incentive funding paid by the DHCS could be recouped if performance outcomes and measures were not met.
 - Funding was allocated to build capacity in local health systems and was intended to establish sustainable operations to continue functioning after the incentive programs were completed. Alameda Alliance also applied incentive funds to expand current infrastructure, and to develop more resources for members, providers, and community-based organizations.
 - Leveraging the available guidance from State agencies, the managed care health plans were responsible for developing an evaluation, selection, and payment process.
 - Incentive payments were aligned with the payment tranches from the State of California. Periodically, required performance reports were assessed by DHCS and were used to calculate the awarded amounts. DHCS assessed the program's performance by examining the actual outcomes and changes in quality metrics.
 - Alameda Alliance developed additional incentive/grant programs outside of DHCS-sponsored programs.
 - The Incentives & Reporting (I&R) department is responsible for managing the programs, enterprise reporting of outcomes (quality, performance), generating reports, and coordinating directly with program participants. I&R transitioned from the Operations Division to the Analytics Division on March 30th.

Section 2. Incentive Program Summary (2022 – 2026)

<i>Incentive Program</i>	<i>Duration</i>	<i>Maximum</i>	<i>Awarded</i>	<i>Paid Out</i>
1) Behavioral Health Integration*	2021-2022	\$3.2M	\$3.2M	\$3.0M
2) COVID-19 Vaccine*	2021-2022	\$8.4M	\$3.0M	\$1.4M
3) CalAIM IPP*	2022-2024	\$29.9M	\$19.4M	\$17.0M
4) Student Behavioral Health*	2022-2024	\$9.7M	\$9.7M	\$9.1M
5) Housing and Homelessness*	2022-2023	\$44.3M	\$38.0M	\$26.9M
6) Provider Recruitment Initiative	2024-2025	\$2.0M	\$1.9M	\$710k
7) Doula Scholarship Program	2024-2025	\$20k	\$20k	\$14k
8) Provider Recruitment Initiative	2025-2026	\$2.0M	\$1.9M	\$206k
9) Doula Scholarship Program	2025-2026	\$40k**	\$19k	\$13k
Totals		\$99.5M*	\$77.1M	\$58.5M

*DHCS incentive program

**\$8,500 earmarked for outstanding deliverables from the FY 2024-25 program



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Demographics

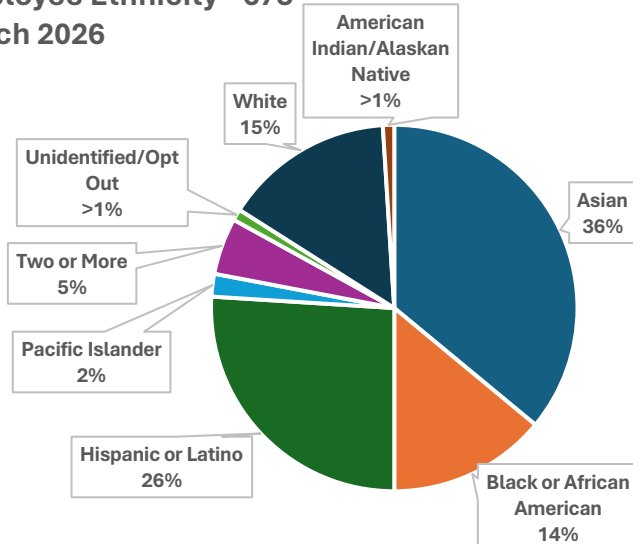
This report provides a comparative analysis of the demographic composition of Alameda Alliance for Health’s workforce in relation to the population profile of Alameda County. The evaluation focuses on key demographic indicators, including race/ethnicity, gender, and age distribution. The objective is 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 2025. Additionally, demographic data for Alameda Alliance for Health was last updated March 2026 and is collected and maintained internally, monthly, by the Human Resources Department.

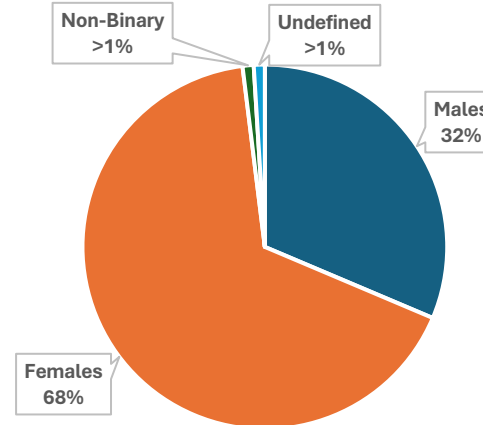
Category	Alameda Alliance for Health (Workforce information last updated March 2026)	Alameda County (Population Information last updated in May 2025)
Population/Total Employees	675	1,626,575
Race & Ethnicity		
Asian	36%	35.39%
Hispanic	26%	23.94%
White	15%	28.26%
Black/African American	14%	9.15%
Native Hawaiian/Pacific Islander	2%	0.82%
American Indian/Alaskan Native	>1%	1.18%
Two or More Races	5%	11.62%
Unidentified/Opt Out	>1%	-
Gender		
Male	32%	49.67%
Female	68%	50.33%
Non-Binary	>1%	-
Undefined	>1%	-
Age Distribution		
Under 25	>1%	8.33%
25-34	20%	13.92%
35-44	36%	16.13%
45-54	27%	13.59%
55-Older	17%	29.03%

AAH Employee Demographics Data Report March 2026

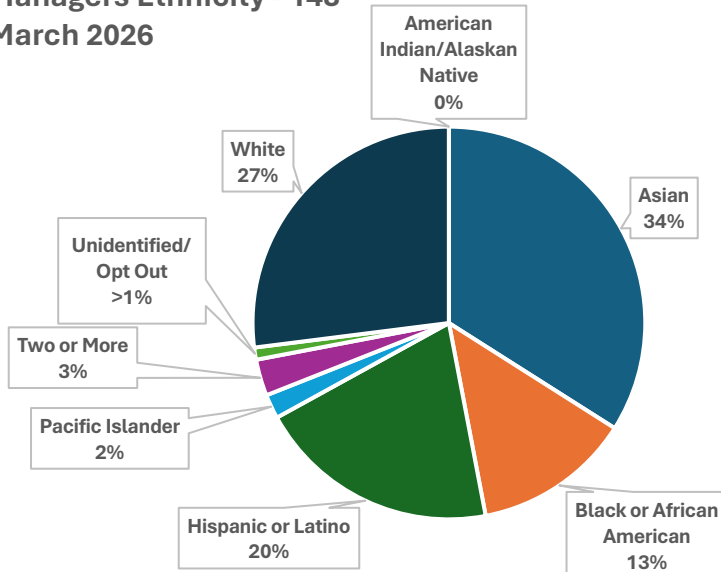
Employee Ethnicity - 675
March 2026



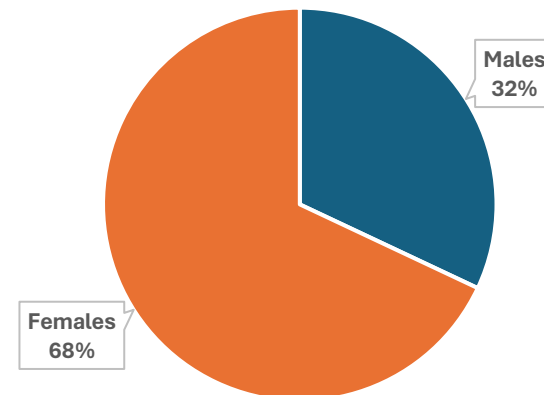
Employee Gender - 675
March 2026



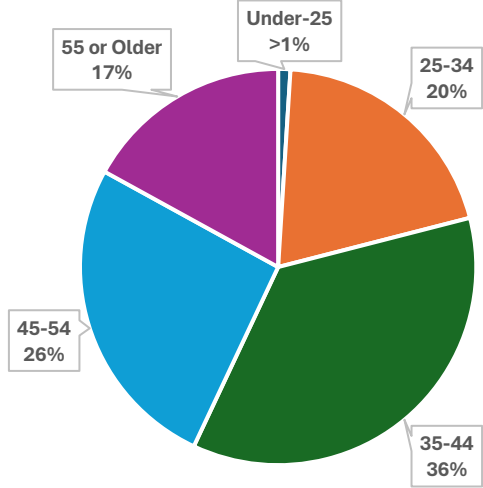
Managers Ethnicity - 148
March 2026



Managers Gender - 148
March 2026



Employee Age Demographics - 675
March 2026





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Legislative Tracking



April 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

Fraud, Waste and Abuse (FWA) within the Medicaid program continues to be a focus for the Federal Government. Along with various FWA letters received by the state from the Energy & Commerce Committee and CMS, the President announced the Task Force to Eliminate Fraud. As part of these efforts the Vice President was tasked with a new role as fraud czar which will primarily focus on Democratic-led states. CMS also recently released a Request for Information (RFI) related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH).

On March 16, the U.S. District Court for Massachusetts ruled that the CDC's vaccine advisory committee cannot move forward with its changes to childhood vaccine recommendations. The lawsuit was filed by the American Academy of Pediatrics (AAP) and other health organizations to prevent the CDC's proposed changes to vaccine recommendations that they claimed would jeopardize children's health.

The Alliance continues to participate in coordinated multi-agency efforts to address changes to the Medi-Cal program due to H.R. 1 and the state budget. Our work is focused on minimizing harm to our members, providers and partners across the county. Since November 2025, over 2000,000 'Keep Your Coverage' postcards have been sent to Alliance members.

State Legislative Update

The Alliance Legislative Affairs and Media Relations team has been attending several state Senate and Assembly hearings around the 2026-27 state budget and proposed legislative bills. Most of the recent hearings are primarily focused on the impact of H.R. 1 on California's safety net system.

On March 10, the Senate and Assembly Joint Committees on Health held an informational hearing on health coverage, access, and affordability. Panelists including the California Health Care Foundation and the UC Berkeley Labor Center highlighted how healthcare costs have grown in recent years and with ongoing federal uncertainty, it is likely that more Californians will skip or delay necessary care due to cost.

On March 19, and March 26, the Senate Budget and Fiscal Review Committee on Health and Human Services held two separate hearings on H.R. 1 repercussions. DHCS testified how California is pursuing the maximum amount of work and community engagement exemptions to



ensure that as many people as possible remain on CalFresh and Medi-Cal. DHCS estimates that approximately 1.4 million individuals, or 30 percent of the entire ACA expansion population, will be disenrolled due to failure to submit verification records or because of non-compliance with community engagement requirements.

DHCS assumes approximately 840,000 individuals will be subject to CalFresh work requirements and of that, 660,000 will likely not meet work requirements or exemption qualifications. Individuals that are unable to comply or submit verification of compliance will lose CalFresh benefits after three months. Notably, around 92 percent of CalFresh enrollees receive Medi-Cal and about 34 percent of Medi-Cal enrollees receive CalFresh.

As DHCS emphasized in the Assembly Budget Joint Health and Human Services hearing on March 25, the state will continue to actively engage in outreach campaigns with Members, Medi-Cal applicants, community-based organizations, counties, and MCPs to ensure that all partners are kept abreast of any new federal regulatory policies. Based on the hearing testimony, DHCS remains committed to reduce the number of individuals impacted by community engagement requirements, and is working closely with federal partners to minimize harm to the most vulnerable Californians.

Our team will continue to attend relevant stakeholder meetings to ensure alignment with pending legislative and/or regulatory changes. Additional information from the federal government on H.R. 1 implementation is expected in the upcoming months, and a clearer picture of California's 2026-27 state budget revenue should emerge by May 2026.

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.

AB 1126	Patterson	Medi-Cal Managed Care Plans: Enrollees with Other Health Care Coverage	This bill requires DHCS implement several changes to help Medi-Cal managed care enrollees who have other health coverage (OHC) and for whom Medi-Cal is a payer of last resort to maintain their providers. AB 1126 requires DHCS limit administrative and contracting requirements for providers when billing Medi-Cal managed care plans for services provided, prohibits DHCS from requiring a provider that is enrolled as a Medi-Cal fee-for-service provider to also enroll as a Medi-Cal managed care provider to bill a managed care plan for

			covered services, and allows a Medi-Cal managed care plan to require a letter of agreement with a non-contracting provider, under specified circumstances.
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: Additional Compensation	This bill would require that a provider be paid additional compensation when a patient's physical, behavioral, developmental, or emotional condition requires significant extra time, attention, or personnel to safely deliver dental care. The bill would limit this additional payment to 3 times in a 12-month period.
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	Existing law requires the department to pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods. Existing law requires the department to develop and pay capitation rates to entities contracted pursuant to the PACE program, using actuarial methods consistent with those provisions, with specified exceptions. Existing law requires the department to consult with those contracted entities in developing a rate methodology. This bill would delete the consultation-related requirement. Under the bill, and consistent with the requirements under federal law, capitation rates would be negotiated between the department and each contracting PACE organization. The bill would require the department, as part of this negotiation before submission for federal approval, to respond in writing to any comments made by a contracting PACE organization concerning prospective rates, provide the rationale for any assumptions or calculations concerning rates upon request, and 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 requires the Medi-Cal program, a health care service plan (health plan), and a health insurer reimburse an advanced practice pharmacist (APP) for medication therapy management (MTM) services. AB 1366 also requires DHCS seek federal approval of a state plan amendment to recognize pharmacists as health care providers at federally qualified health centers (FQHCs) for reimbursement under the Medi-Cal program and mandates DHCS implement an MTM reimbursement methodology for covered pharmacist services related to the use of qualified specialty drugs.
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	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. The bill would require that the rate be adjusted to a minimum of \$120 per patient per date of service, with subsequent readjustments every 2 years to account for inflation and provider cost data. The bill would require the department, every 2 years, to report to the Legislature about the impact of the rate adjustments on access, utilization, and

			reductions in emergency department visits for dental conditions. The bill would condition implementation of these provisions on an appropriation, receipt of any necessary federal approvals, and the availability of federal financial participation.
AB 1773	Blanca Rubio	Pharmacy Benefit Managers	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 nonprofit integrated health care service plan regulated by the department to annually disclose its material investment holdings to the department on or before July 1 of each year, unless otherwise specified by regulation, beginning on July 1, 2027. The bill would require the department to prominently display, and make

			accessible to the public, those disclosures on the department's internet website. If a nonprofit integrated health care service plan fails to comply with the disclosure requirements, the bill would require the department to assess a civil penalty against the plan, as specified. The bill would require the 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 the benefit is not subject to utilization controls, except as specified.
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 <i>a serious mental illness or substance use disorder, as those terms are defined</i> . 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 prohibit a health facility, clinic, physician's office, or office or a group practice from using or deploying a tool, system, or device that includes artificial intelligence for any activity requiring the use of professional judgment by a licensed health care professional, as specified, and would prohibit the use of artificial intelligence to direct, guide, supervise, or instruct unlicensed personnel in performing any function that requires a professional license. 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.
AB 2036	Patel	Medi-Cal: Federally Qualified Health Centers and Rural Health Clinics	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. 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 the 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 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.

<u>AB 2161</u>	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 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.
<u>AB 2123</u>	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 authorize the authority 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 authorize the authority to adopt, amend, or repeal regulations to establish criteria for the operation and administration of the program, and would require the authority to consider specified factors in developing its ranking and priority criteria.

<u>AB 2138</u>	Krell	Medi-Cal: Enhanced Care Management: Peer Support Specialists	This bill would require the department to require, as a condition of providing ECM, that each ECM provider maintain an interdisciplinary care team that includes at least one peer support specialist 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 for ECM purposes. The bill would authorize 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 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.
<u>AB 2201</u>	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.
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: Specialty Care	Under this bill, private duty nursing services, provided to a child under 21 years of age by a home health agency, would be considered specialty care for purposes of Medi-Cal reimbursement under the provisions of the Medi-Cal Act. The bill would not apply this designation for purposes of Medi-Cal reimbursement under the provisions of the Protect Access to Health Care Act of 2024, an initiative measure enacted by Proposition 35, as approved by the voters at the November 5, 2024, statewide general election.

<u>AB 2268</u>	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.
<u>AB 2278</u>	Ávila Farías	In-Home Supportive Services: County of Contra Costa: Innovative Technologies	This bill would require the department to develop and make available a 5-year pilot project for the County of Contra Costa, to be implemented at the election of the county, for the purpose of improving IHSS eligibility and processing times through the use of innovative technologies. Under the bill, the project would be designed with a focus on decreasing IHSS application processing times for recipients participating in the CFCO program. The bill would require the county to post annual reports on project progress and outcomes. This bill would make legislative findings and declarations as to the necessity of a special statute for the County of Contra Costa.
<u>AB 2327</u>	Lowenthal	Medi-Cal: Subcontractors: Rates	This bill would require the department, for rates effective on or after January 1, 2027, to require that a Medi-Cal managed care plan operating as a downstream fully or partially delegated subcontractor, as defined, be paid actuarially sound rates developed in accordance with generally accepted actuarial rate development principles and practices. Under the bill, failure to pay the subcontractor in a manner consistent with these provisions would be deemed a violation, constituting an unlawful and unfair business practice, as specified. The bill would afford the contractor the opportunity to enforce these requirements by filing a notice of dispute with the department.

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 that provides 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 2415	Tangipa	Air Ambulance Services	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. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2020, to provide, among other things, that if an enrollee, insured, or subscriber receives covered services from a noncontracting air ambulance provider, the individual will pay no more than the same cost sharing that the individual would pay for the same covered services received from a contracting air

			ambulance provider, referred to as the in-network cost-sharing amount. This bill would make a technical, non-substantive change to those provisions.
AB 2431	Patel	Downcoding Medical Claims	This bill would prohibit a health care service plan or an insurer issuing group or individual policies of health insurance from using an automated process, system, or tool 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. 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.
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	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. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. This bill would express the intent of the Legislature to enact legislation to require health care service plans and health insurers to survey and publicly report the percentage of enrollees or insureds going in network or out of network for behavioral

			health care, among other things. The bill would also make related findings and declarations.
AB 2565	Wallis	Medi-Cal: Pharmacist Services: Reporting	This bill would require the department to require each Medi-Cal managed care plan to submit an annual report to the department containing information about pharmacist services that are within the jurisdiction of managed care plans and not within the jurisdiction of the FFS delivery system under the Medi-Cal Rx program. The bill would require the department to compile the information and to submit an annual consolidated report to the appropriate policy and fiscal committees of the Legislature, as specified. The bill would require the consolidated report to contain certain information relating to, among other things, implementation, compliance, service access, claims processing, oversight, and fiscal and public health impact. If the department determines that a managed care plan has failed to comply with the pharmacist services-related provisions, the bill will require the department to take appropriate corrective action, including enforcement action and the imposition of sanctions, if a pattern of noncompliance is identified.
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 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 an advanced practice pharmacist enrolled as a provider with the plan or insurer. The bill would authorize payment or reimbursement if the coverage otherwise provides reimbursement for similar services performed by other licensed health care providers, among other requirements.
<u>AB 2575</u>	Ortega	Health Care Services: Artificial Intelligence	This bill requires a health facility, clinic, physician's office, or office of a group practice that uses or deploys a covered tool, as defined, for patient care to disclose required information to any licensed health care professional or other person using a covered tool or viewing outputs from a covered tool. The bill would require, among other things, the disclosure to include a notice that a worker providing direct patient care is permitted to override the output of a covered tool if, in the judgment of the worker acting in their scope of practice, an override is appropriate for the patient, or as necessary to comply with applicable law, including civil rights 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	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. Existing law requires a health care service plan to meet specified requirements, including notice requirements, and requires a health care service plan contract to provide to subscribers and enrollees specified basic health care services. This bill would state the intent of the Legislature to enact legislation to require health care service plans to provide clear notice to consumers about their health care coverage.
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 Penalty: Contribution	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, 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 state the intent of the Legislature to enact legislation that would require employers that employ individuals who are enrolled in the Medi-Cal program to pay a penalty as a contribution to a Medi-Cal fund.
SB 490	Umberg	Alcohol and Drug Programs	Existing law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal) and authorizes the department to enter a Drug Medi-Cal contract with each county for the provision of alcohol and drug use services within the county service area. This bill would require the department, if it determines whether it has authority 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 authority, 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.

<u>SB 874</u>	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 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 professionals, as specified. The bill would require the department, on or before April 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.
<u>SB 912</u>	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 would, among other things, require DHCS to develop training on administering comprehensive perinatal services, require all perinatal providers providing perinatal care to Medi-Cal members to attend the training, and require all Medi-Cal managed care plans to ensure providers receive the training.

<u>SB 944</u>	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.
<u>SB 950</u>	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. 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. The bill would require a health care service plan or health insurer that, as a medical benefit, covers nonself-administered treatments approved by the FDA for the treatment of Alzheimer's disease or other medical conditions affecting memory to also include those nonself-administered treatments as an outpatient prescription drug benefit.

<u>SB 964</u>	Smallwood-Cuevas	Prescription Drug Coverage: Dose Adjustments	This bill would authorize a licensed health care professional to request, and would require that they be granted, the authority to adjust the dose or frequency of a drug to meet the specific medical needs of the enrollee or insured without prior authorization if specified conditions are met. Under the bill, if the enrollee or insured has been continuously using a prescription drug selected by their prescribing provider for the medical condition under consideration while covered by their current or previous health coverage, the health care service plan or health insurance policy would be prohibited from limiting or excluding coverage of that prescription.
<u>SB 1023</u>	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.

SB 1089	Richardson	Preventive Treatment Health Care Act	This bill, the Preventive Treatment Health Care Act, would require the above-described partnerships to also include the acquisition of brand name prescription drugs and the acquisition or production of pens, vial injections, pills, and patches of glucagon-like peptide-1 (GLP-1) semaglutide, GLP-1 receptor agonist (GLP-1RA), glucose-dependent insulintropic polypeptide plus GLP-1 (GIP+GLP-1) tirzepatide, and future chronic weight disease products made available at production and dispensing costs and to consider guaranteeing priority access to GLP-1 semaglutide, GLP-1RA, GIP+GLP-1 tirzepatide, and future chronic weight disease products supply for the state.
SB 1037	Weber Pierson	Health Care Coverage: Rate Review	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. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires that health care service plans and health insurers 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 requires the Department of Managed Health Care and the Department of Insurance, in collaboration with the Office of Health Care Affordability, to each conduct an enhanced rate review to determine if health care premiums are affordable for individual and group purchasers.
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, due process rights, and resources, and to meet certain cultural and linguistic appropriateness standards.
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 proceedings, 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 Compensation Disclosure Act	This bill would require a covered service provider, defined to mean a broker, agent, consultant, or advisor that meets specified criteria, to disclose to a public <i>agency, defined to only include local entities</i> , 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.
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.
SB 1221	Stern	Lanterman-Petris-Short Act: Conservatorships	Existing law, the Lanterman-Petris-Short (LPS) Act, authorizes the involuntary commitment and treatment of a person, when the person, because of a mental health disorder, is a danger to themselves or others, or is gravely disabled. This bill would require this definition of “gravely disabled” to be evaluated based upon a person’s ability to provide for those basic personal needs outside of an incarcerated setting, as specified. This bill would require the condition of whether the person represents a substantial danger of physical harm to be evaluated based upon the person’s ability to be nonviolent outside of an incarcerated setting, as specified.
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 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.

<u>SB 1280</u>	Valladares	Health Care Service Plan Requirements	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. Existing law requires a health care service plan to meet specified requirements, and requires a health care service plan contract to provide to subscribers and enrollees specified basic health care services. This bill would make technical, non-substantive changes to those provisions.
<u>SB 1284</u>	Smallwood-Cuevas	Medi-Cal Benefits: Employer Reports	This bill would require the California Health and Human Services Agency, after obtaining specified information from the Employment Development Department, to prepare a report that includes information regarding employers in California that employ 50 or more employees and have any employees who receive benefits from the Medi-Cal program, including, among other things, the annual cost to the Medi-Cal program provided to each identified employer's employees and their dependents enrolled in the Medi-Cal program, and submit that report to the Legislature no later than July 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 California Health and Human Services Agency and the Employment Development Department to enter into data-sharing agreements, as provided. The bill would also repeal an obsolete reporting requirement.

<u>SB 1309</u>	Rubio	Health Care Coverage: Lung Cancer	This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, that provides coverage for hospital, medical, or surgical expenses 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. 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.
<u>SB 1377</u>	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.
<u>SB 1422</u>	Durazo	Medi-Cal: Eligibility: Immigration Status	The federal Medicaid program prohibits payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Existing state law extends Medi-Cal eligibility for the full scope of Medi-Cal benefits to individuals who do not have satisfactory immigration status if they are otherwise eligible for those benefits, except for specified dental benefits for individuals who are 19 years of age or older. Existing law makes an individual who is 19 years of age or older, who

does not have satisfactory immigration status, and who applies for Medi-Cal on or after January 1, 2026, or loses eligibility for eligibility for full-scope Medi-Cal on or after January 1, 2026, eligible only for pregnancy-related services and emergency medical treatment. Existing law, beginning no sooner than July 1, 2027, as specified, requires individuals who do not have satisfactory immigration status, who are not pregnant, and who are 19 to 59 years of age, inclusive, to pay a monthly premium of \$30, subject to certain exceptions.

This bill would instead make 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.



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

Executive Dashboard

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Financials

Income & Expenses

FEBRUARY 2026

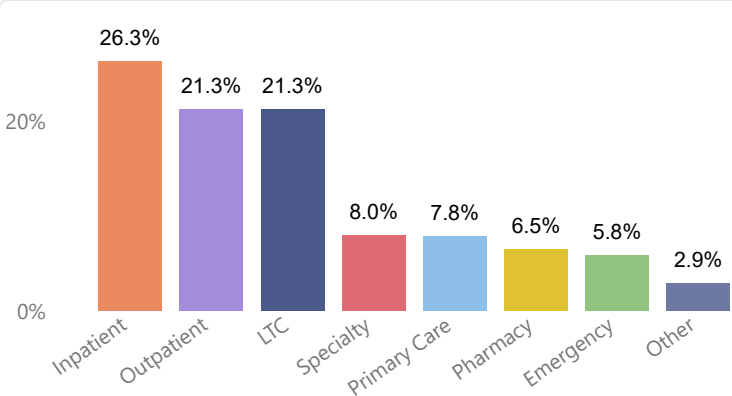
FISCAL YTD

REVENUE	\$ 256.1 M	\$ 2.0 B
MEDICAL EXPENSE	\$ (160.3) M	\$ (1.4) B
ADMIN EXPENSE	\$ (10.7) M	\$ (81.9) M
OTHER/TAX	\$ (63.4) M	\$ (500.9) M
NET INCOME	\$ 21.8 M	\$ 53.5 M

Medical Loss % (Fiscal YTD)

92.3%

Medical Expenses



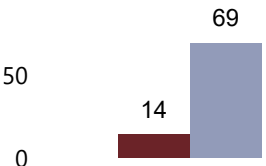
Liquid Reserves

Reinsurance Cases

TNE %
284.3%

TNE \$
\$222.8M

New Submitted

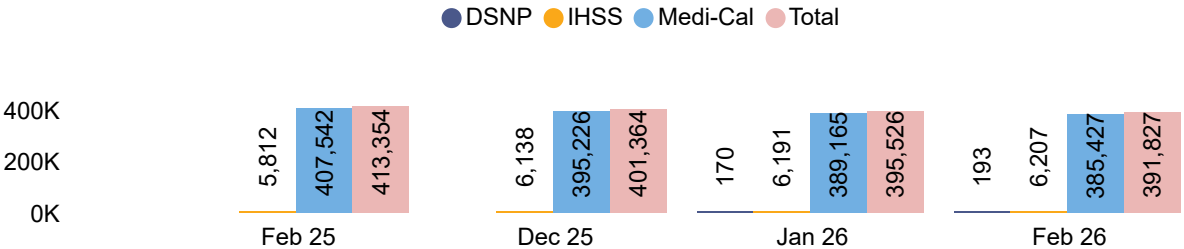


Balance Sheet

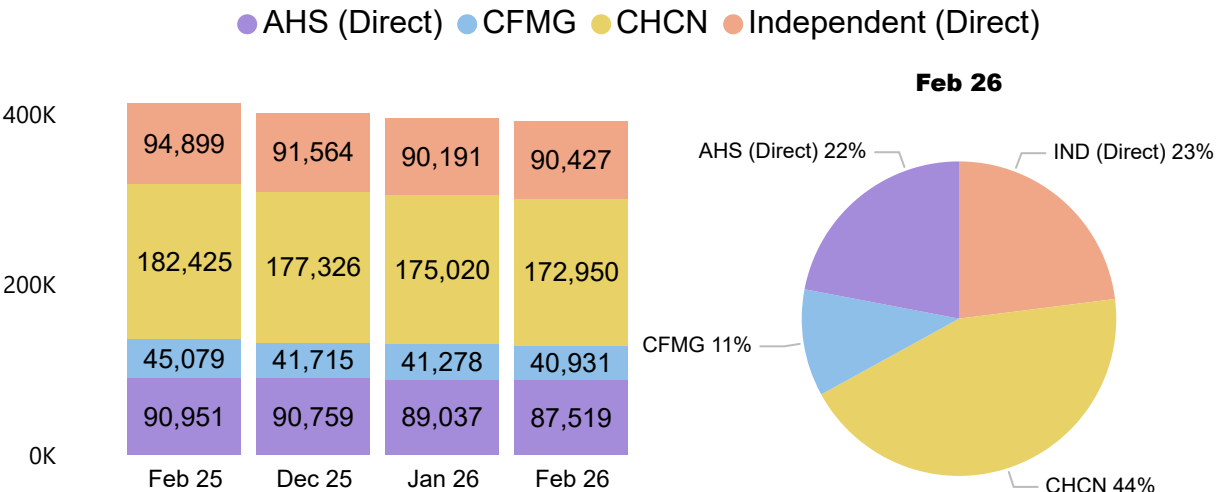
Cash Equivalents	\$644.5M	Current Ratio 1.16
Pass-Through Liabilities	\$375.6M	
Uncommitted Cash	\$268.9M	
Working Capital	\$173.1M	

Membership

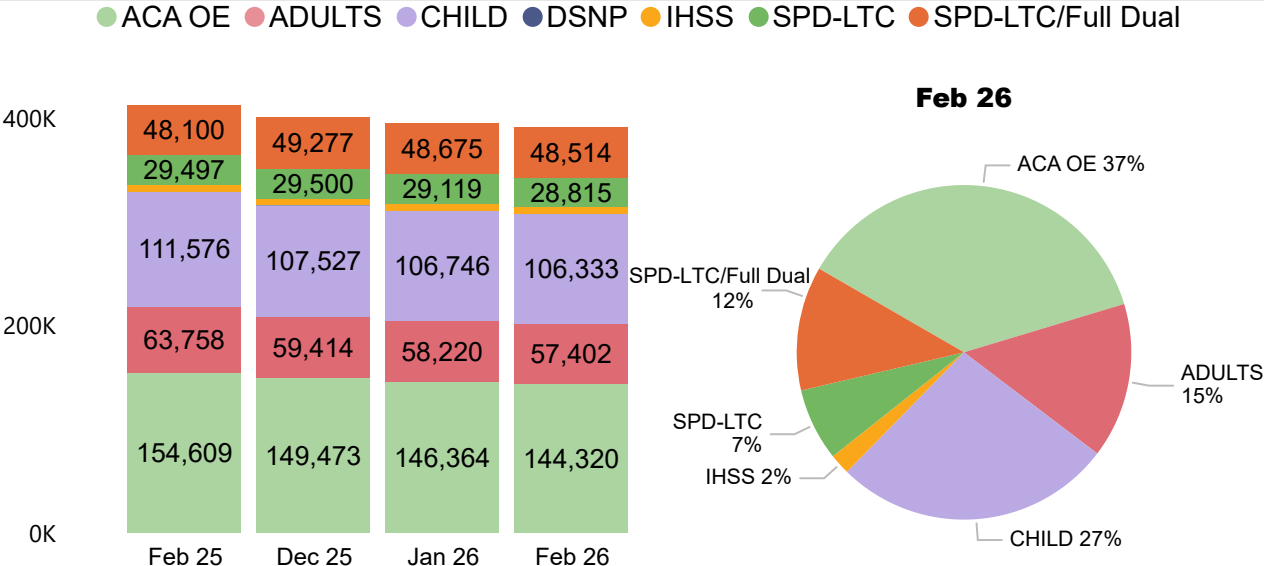
By Plan



By Network

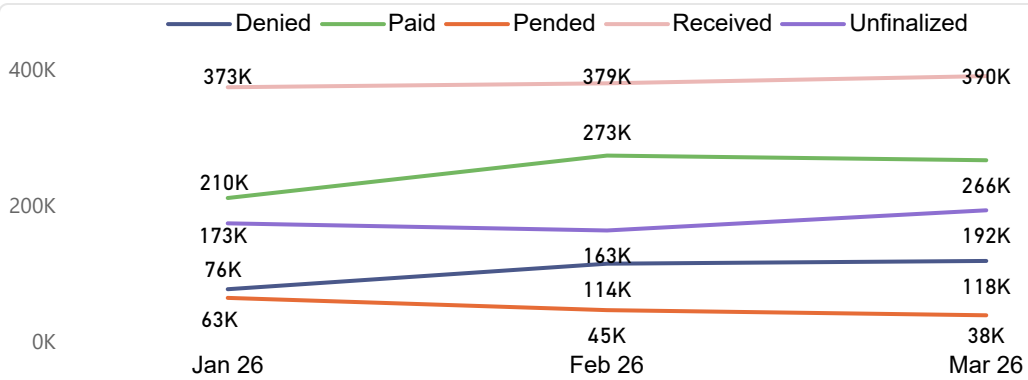


By Category

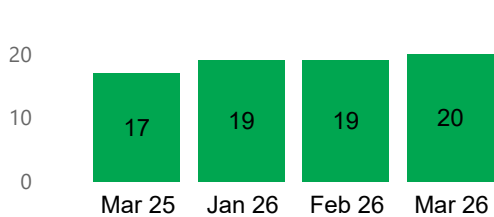


Claims

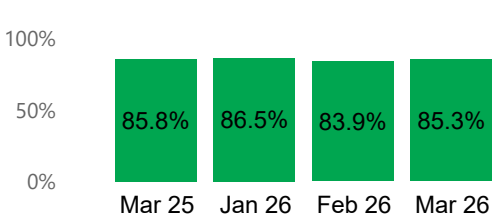
Claims Processing



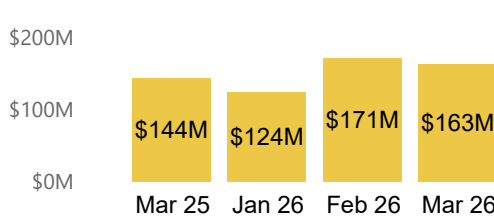
Average Payment TAT (Days)



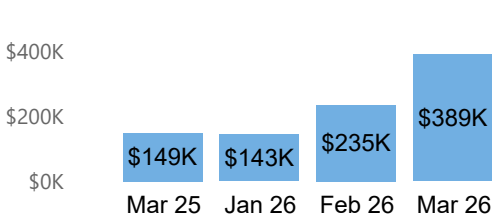
Auto Adjudication Rate (%)



Claims Paid (\$)

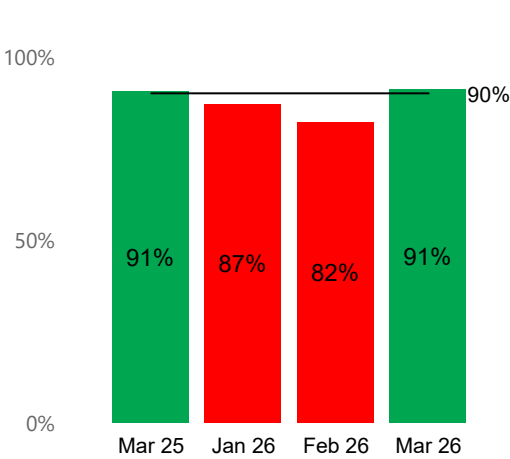


Interest Paid (\$)

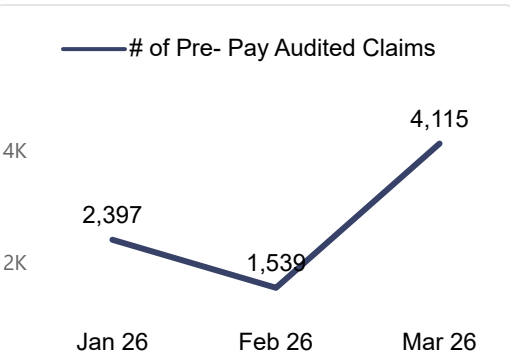


Claims Compliance

Processed 30 Cal Days (%)

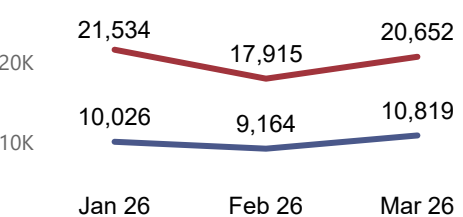


Claims Auditing

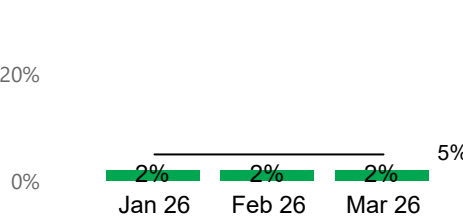


Member Services

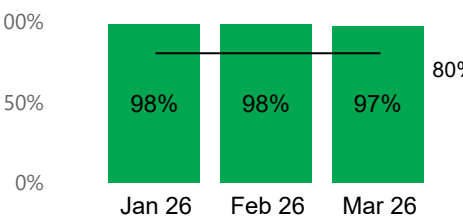
Inbound Calls Outbound Calls



Abandoned Call Rate (%)



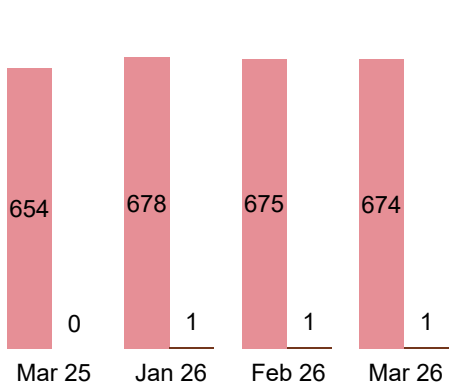
Calls Answered in 30 Seconds (%)



Average Call Times	Jan 26	Feb 26	Mar 26
Wait Time	00:07	00:07	00:02
Call Duration	07:02	07:08	07:20

Human Resources

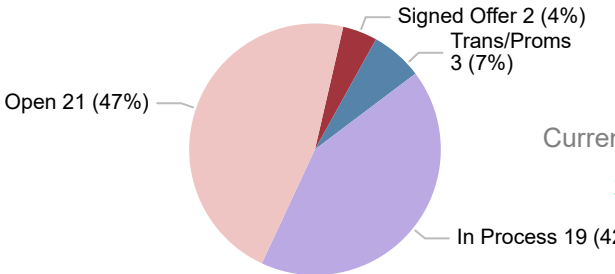
Full Time Part Time



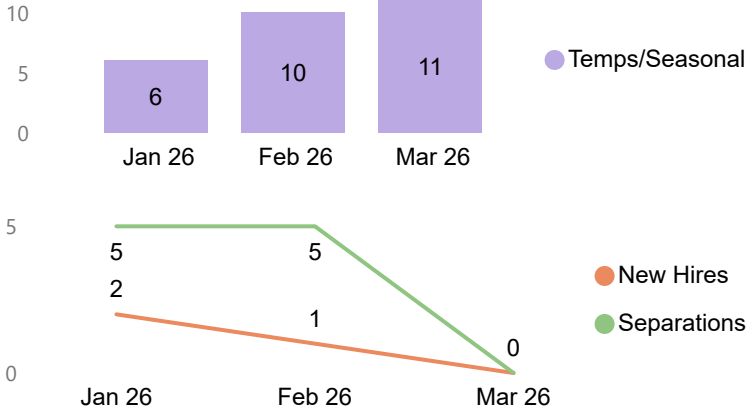
Recruiting Status

Mar 26

Signed Offer Trans/Proms In Process Open



Current Vacancy
3%



Provider Services

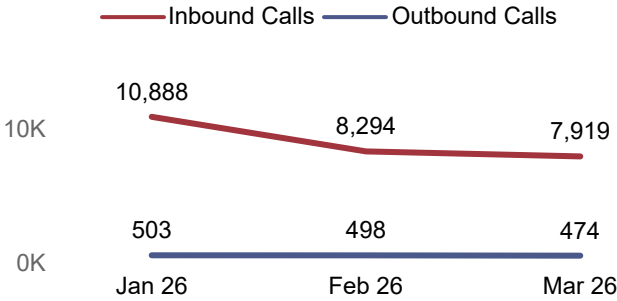
Provider Network

Hospital	17
Specialist	11,912
Primary Care Physician	712
Skilled Nursing Facility	108
Urgent Care	17
Health Centers (FQHCs and Non-FQHCs)	87
TOTAL	12,853

Provider Credentialing

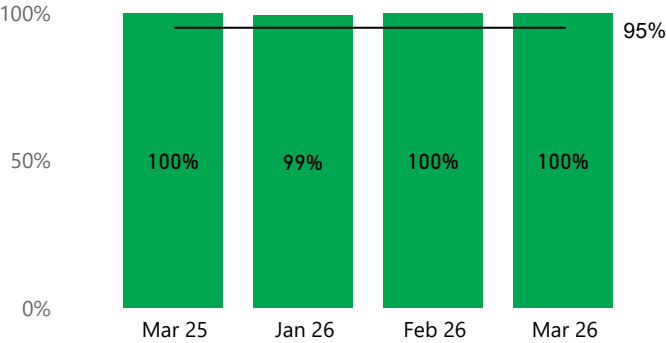
5,826

Provider Call Center



Provider Disputes & Resolutions

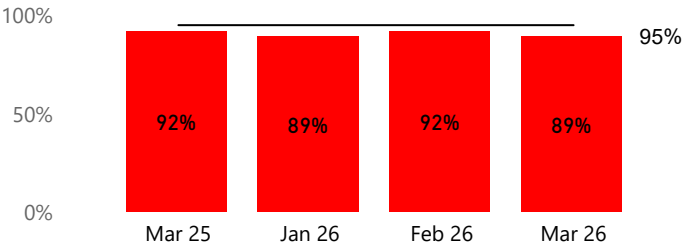
Turnaround Compliance (45 business days)



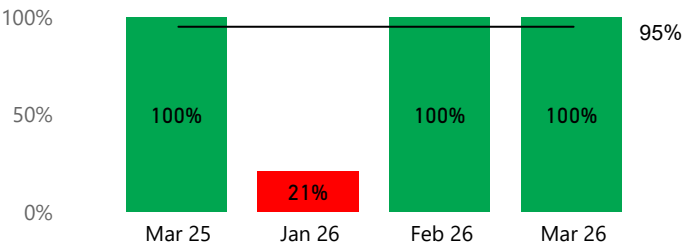
Compliance

Member Grievances

Standard (30 calendar days)

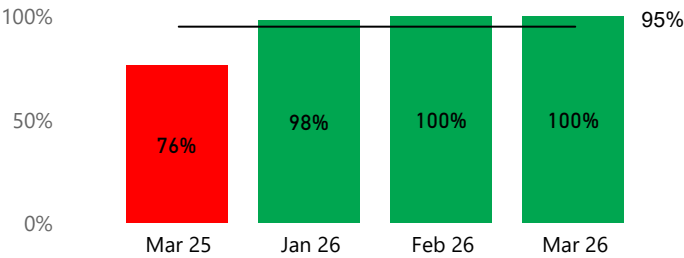


Expedited (3 calendar days)

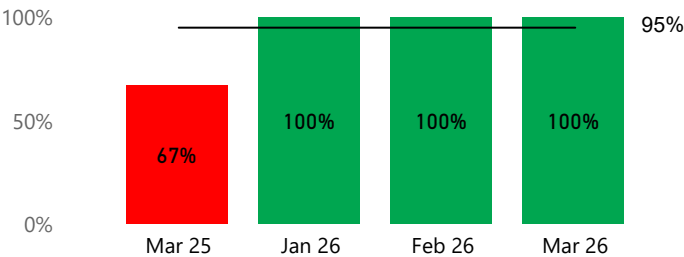


Member Appeals

Standard (30 calendar days)

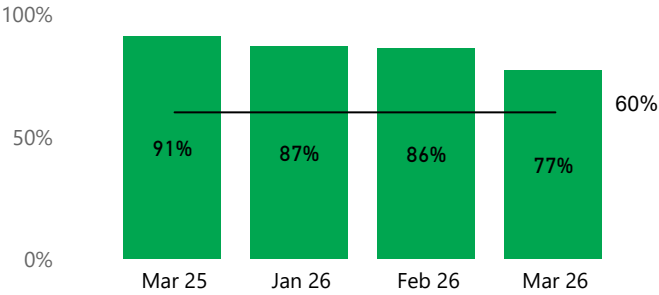


Expedited (3 calendar days)

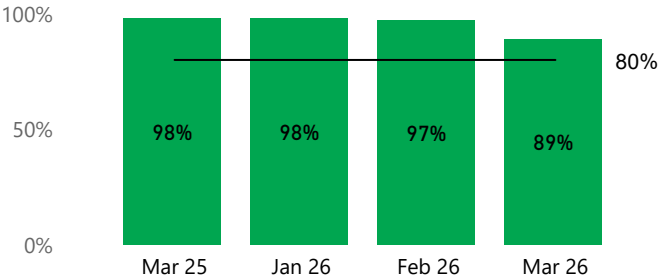


Encounter Data

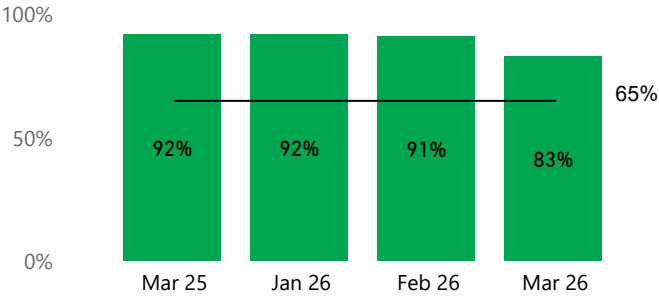
Institutional 0-90 days



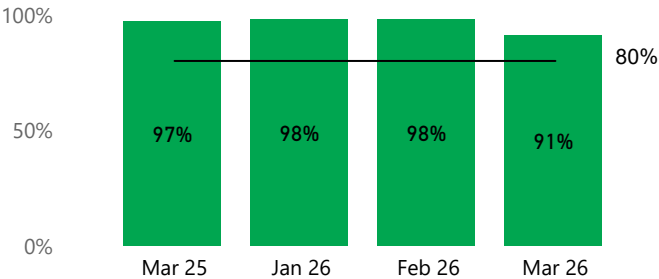
Institutional 0-180 days



Professional 0-90 days



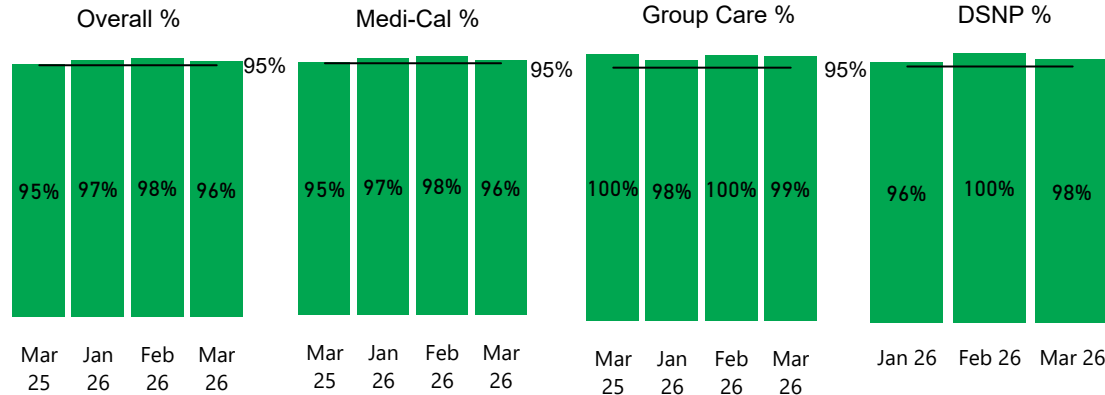
Professional 0-180 days



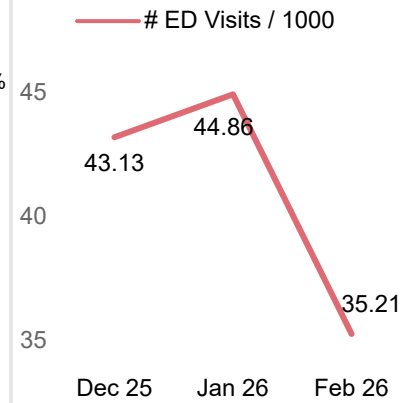
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Health Care Services

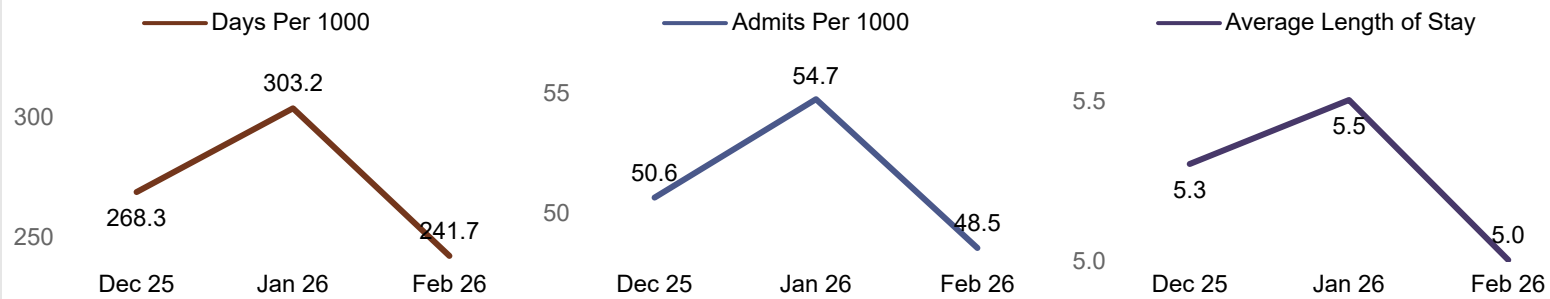
Authorization Turnaround



ED Utilization



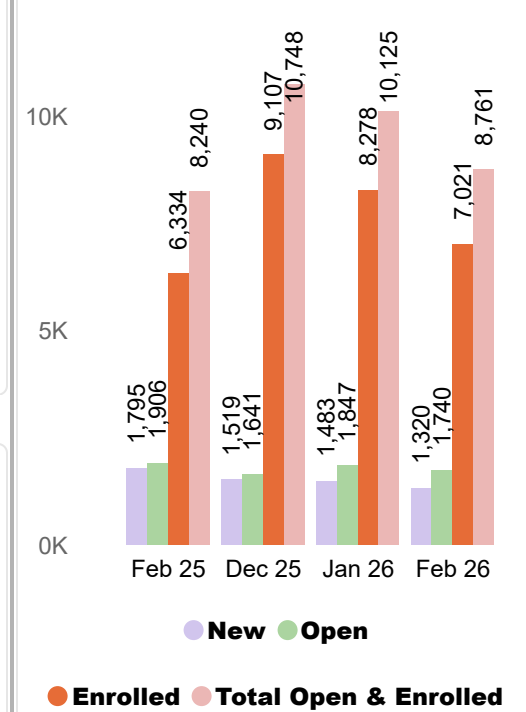
Inpatient Utilization



Case Management

Total Cases^

^ ECM Metrics since 2022

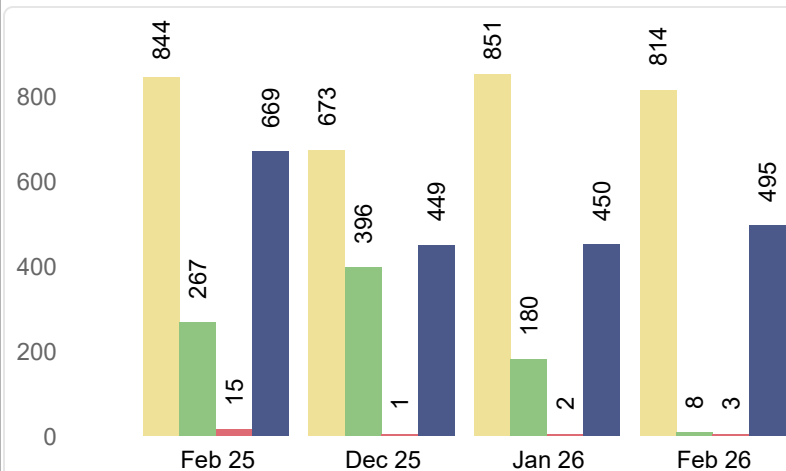


Case Management^

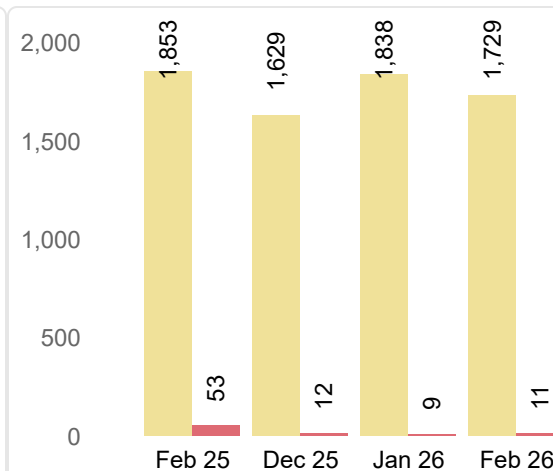
● Care Coordination ● Community Supports ● Complex Cases ● Enhanced Case Management

^ ECM Metrics since 2022

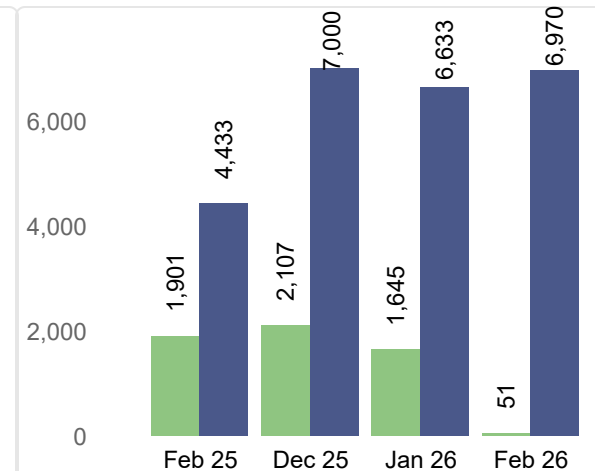
New Cases



Open Cases



Enrolled Cases



Technology (Business Availability)

Applications ▲	Mar 25	Jan 26	Feb 26	Mar 26
HEALTHsuite System	100.0%	99.9%	99.9%	99.9%
Other Applications	100.0%	99.9%	99.9%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Mar 25	Jan 26	Feb 26	Mar 26
Denial Rate Excluding Partial Denials (%)	5.0%	4.9%	4.4%	3.7%
Overall Denial Rate (%)	5.5%	5.1%	4.6%	4.1%
Partial Denial Rate (%)	0.5%	0.2%	0.2%	0.4%

* IHSS and Medi-Cal Line Of Business

Pharmacy Authorizations

Authorizations ▲	Mar 25	Jan 26	Feb 26	Mar 26
Approved Prior Authorizations	43	54	55	52
Closed Prior Authorizations	27	15	17	29
Denied Prior Authorizations	83	95	76	86
Total Prior Authorizations	153	164	148	167



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

Finance

Gil Riojas

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

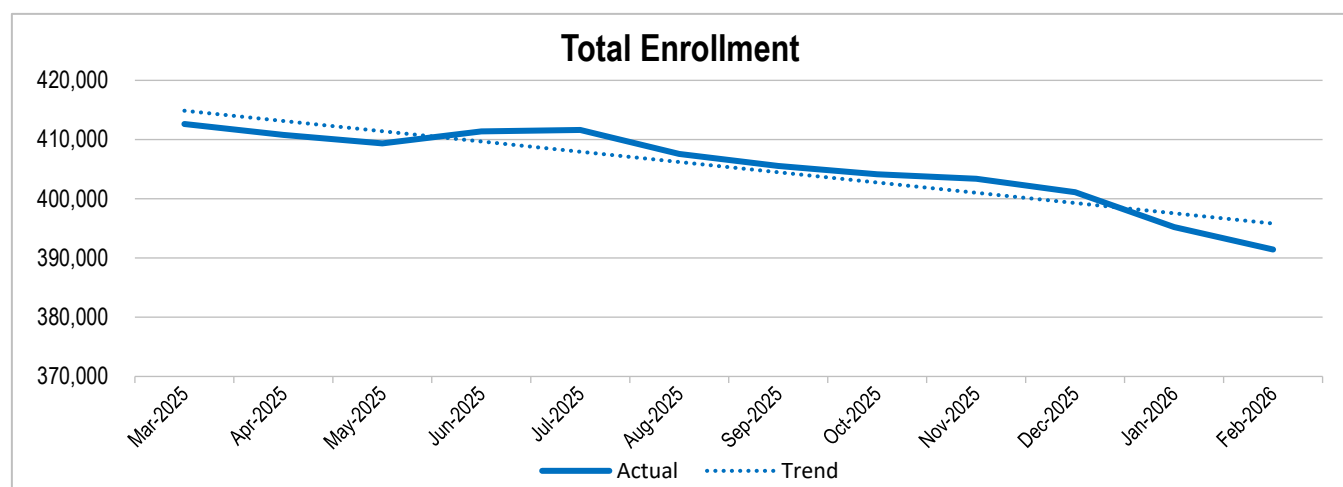
Date: April 10th, 2026

Subject: Finance Report – February 2026 Financials

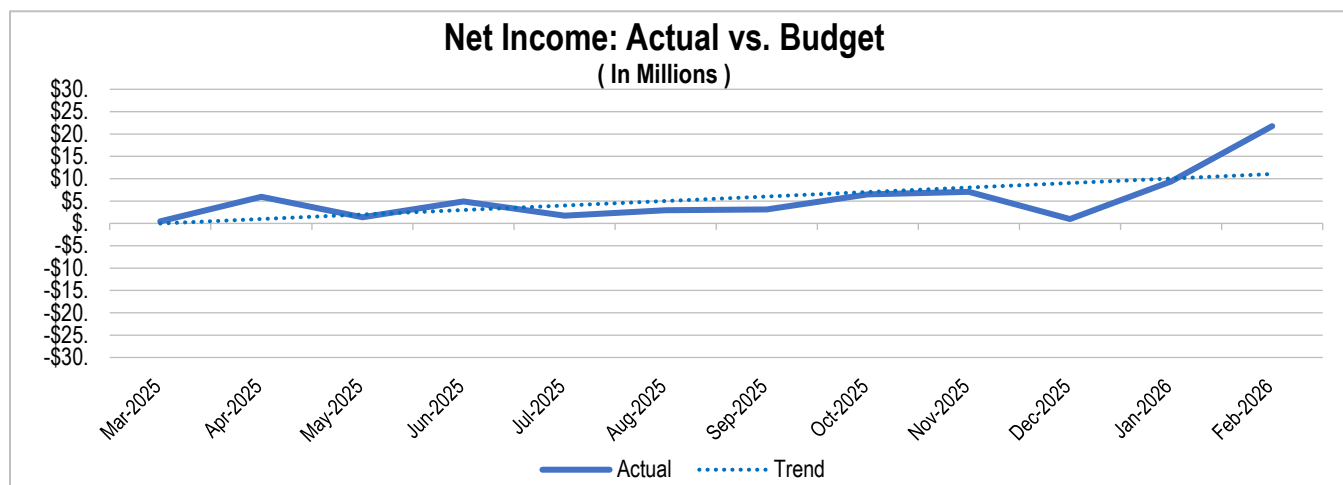
Executive Summary

For the month of February, the Alliance decreased in enrollment, down to 391,433 members. Net Income of \$21.8 million was reported, and the Plan's Medical Expenses represented 83.9% of Premium Revenue. Alliance reserves increased to 284% of required and continue to remain above minimum requirements.

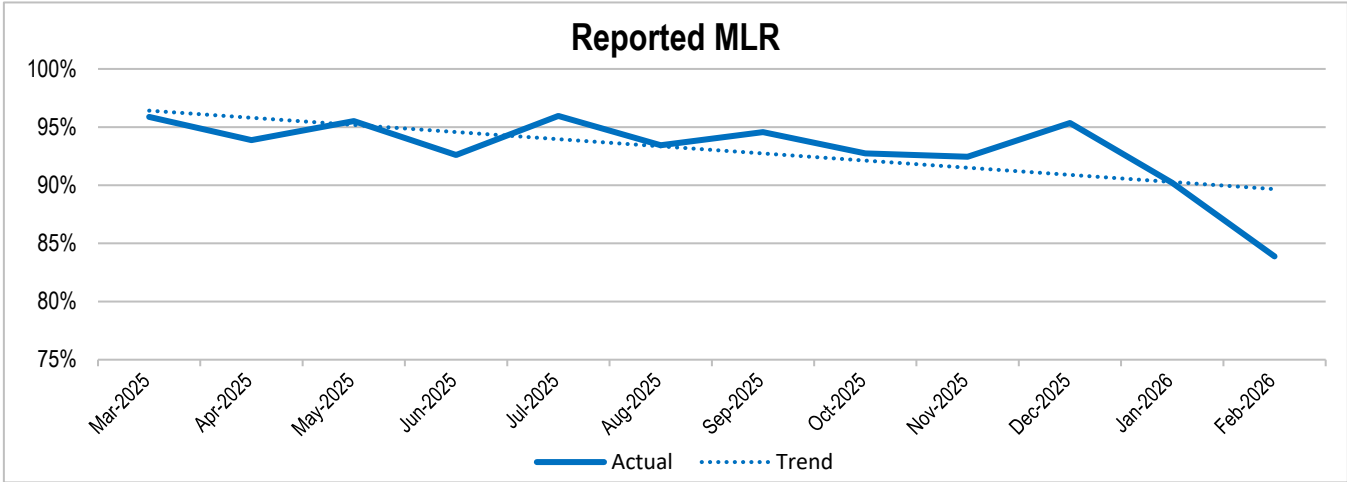
Enrollment – In February, Enrollment decreased by 3,787 members.



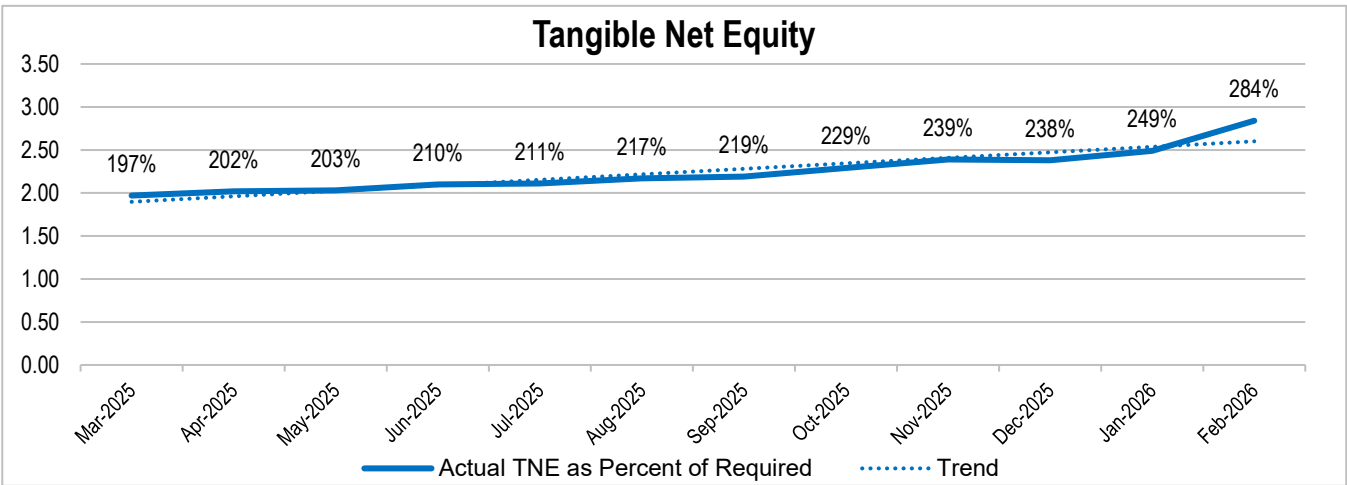
Net Income – For the month ended February, actual Net Income was \$21.8 million vs. budgeted Net Income of \$8.3 million. For the fiscal YTD, actual Net Income was \$53.5 million vs. budgeted Net Income of \$22.1 million. For the month, Premium Revenue was favorable to budget, actual Revenue was \$191.1 million vs. budgeted Revenue of \$186.3 million. Premium Revenue favorable variance of \$4.8 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 83.9% for the month, and 92.3% for fiscal YTD.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required \$78.4 million in reserves, we reported \$222.8 million. Our overall TNE remains above DMHC requirements at 284%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, investments show a gain of \$18.3 million and capital assets acquired are \$36,000.

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: April 10th, 2026

Subject: Finance Report – February 2026 Financials

Executive Summary

- For the month ended February 28th, 2026, the Alliance had enrollment of 391,433 members, a Net Income of \$21.8 million and 284% of required Tangible Net Equity (TNE).

<u>Overall Results: (in Thousands)</u>		
	Month	YTD
Revenue	\$256,115	\$2,043,033
Medical Expense	160,314	1,406,686
Admin. Expense	10,665	81,939
MCO Tax Expense	64,994	519,185
Other Inc. / (Exp.)	1,615	18,257
Net Income	\$21,758	\$53,480

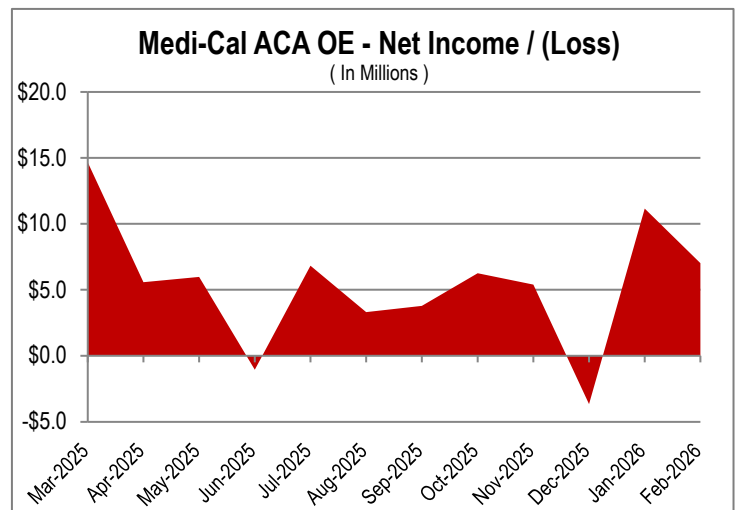
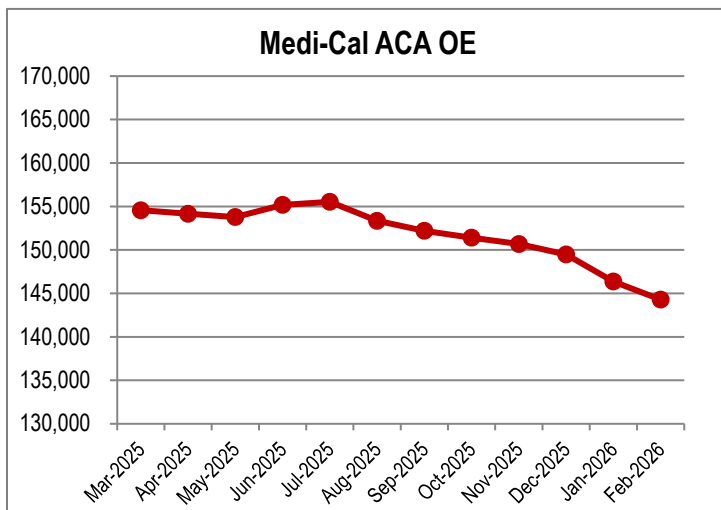
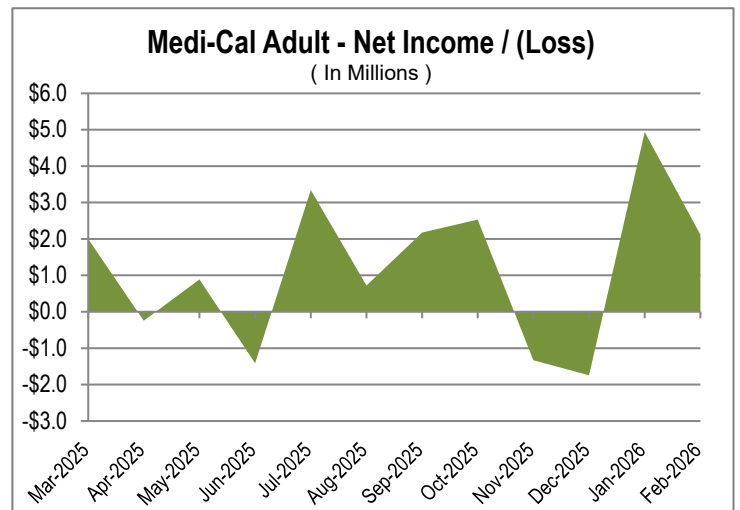
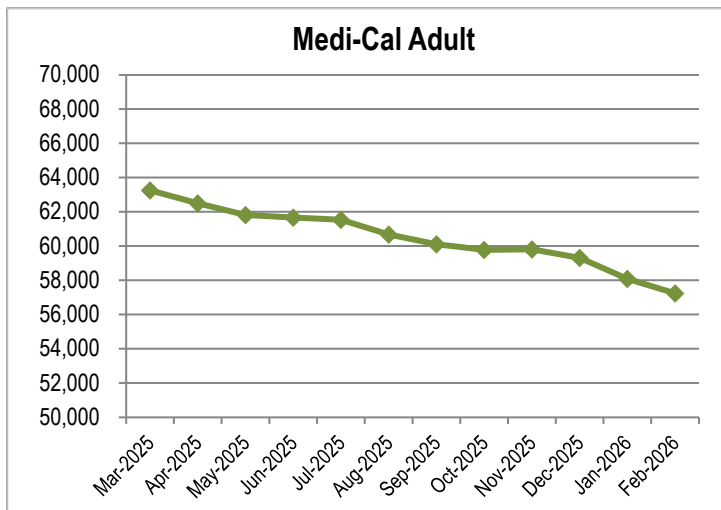
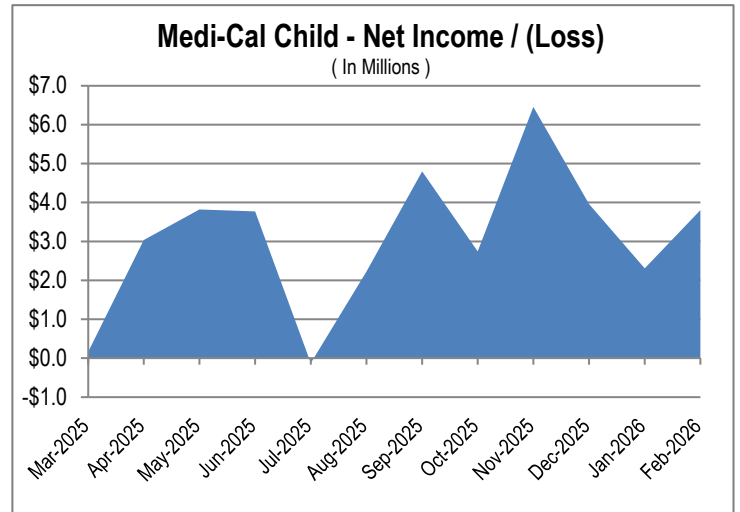
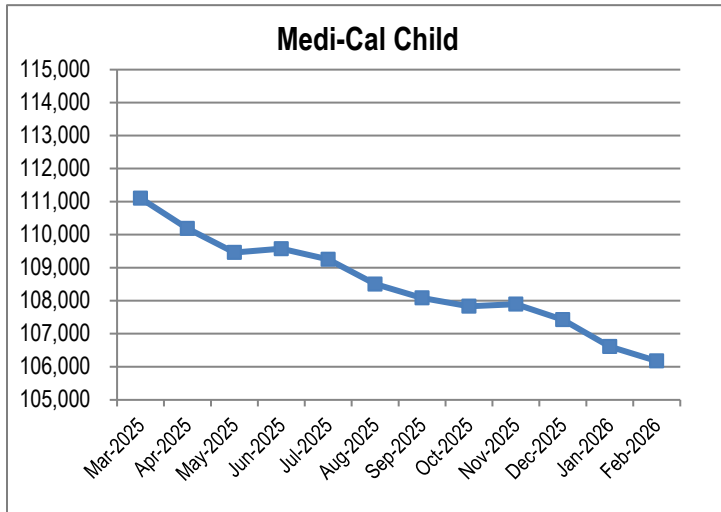
<u>Net Income by Program: (in Thousands)</u>		
	Month	YTD
Medi-Cal	\$23,534	\$62,514
Group Care	(886)	(1,645)
Medicare	(890)	(7,390)
	\$21,758	\$53,480

Enrollment

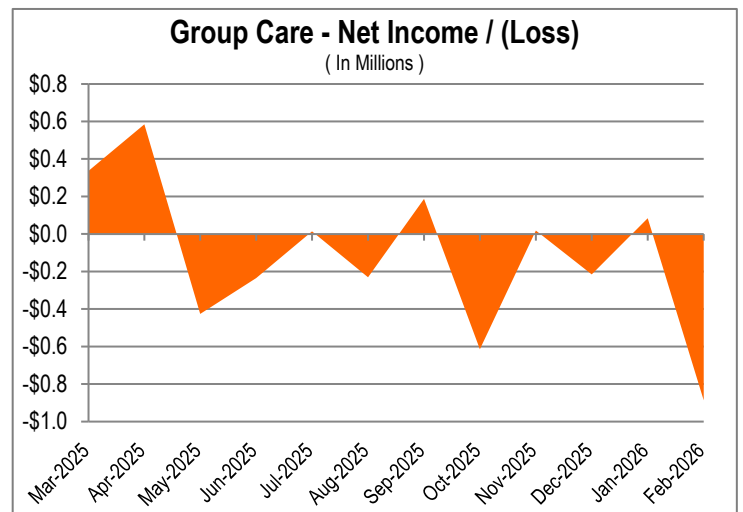
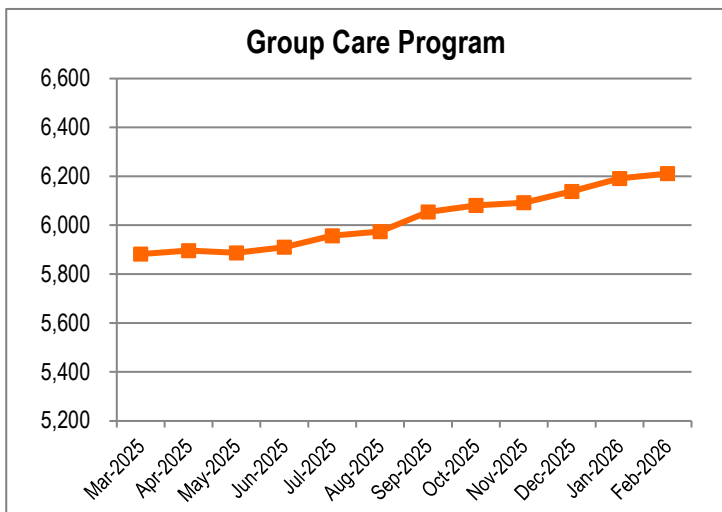
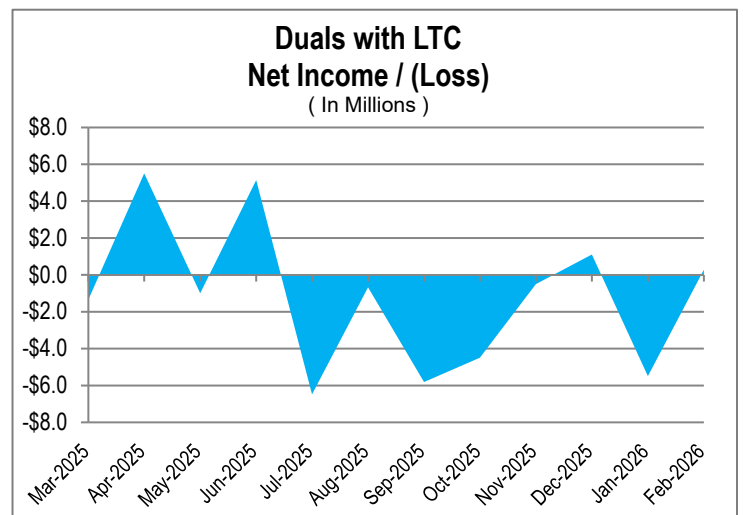
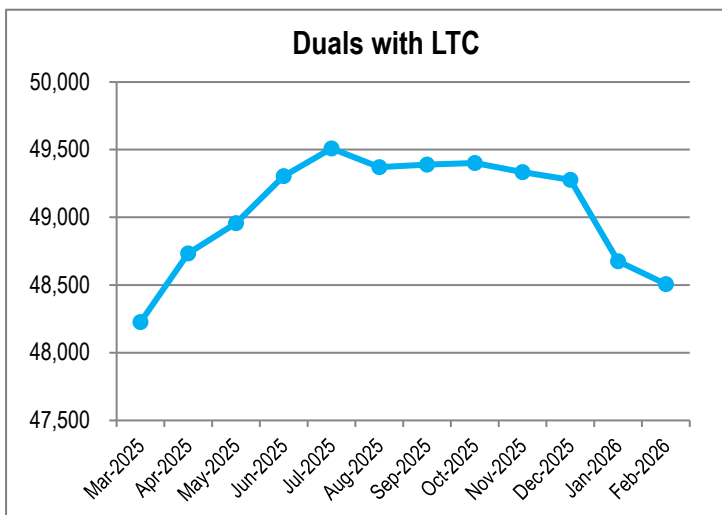
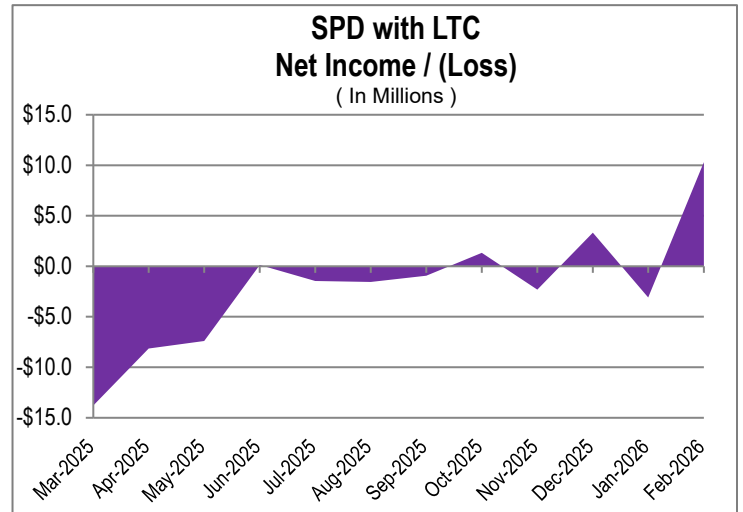
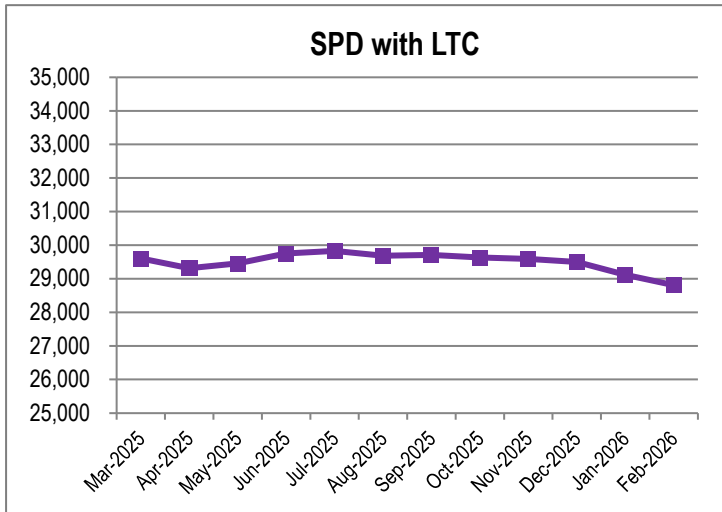
- Total enrollment decreased by 3,787 members since January 2026.
- Total enrollment decreased by 19,950 members since June 2025.

Monthly Membership and YTD Member Months									
Actual vs. Budget									
Enrollment				Medi-Cal:	Member Months				
Current Month					Year-to-Date				
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %	
106,175	105,806	369	0.3%		Child	861,772	860,519	1,253	0.1%
57,240	57,197	43	0.1%		Adult	476,549	475,359	1,190	0.3%
144,297	142,205	2,092	1.5%	ACA OE	1,203,292	1,200,421	2,871	0.2%	
28,813	21,666	7,147	33.0%	SPD with LTC	235,880	221,365	14,515	6.6%	
48,506	56,344	(7,838)	(13.9%)	Duals with LTC	393,463	408,751	(15,288)	(3.7%)	
385,031	383,218	1,813	0.5%	Medi-Cal Total	3,170,956	3,166,415	4,541	0.1%	
6,211	6,085	126	2.1%	Group Care	48,698	48,394	304	0.6%	
191	370	(179)	(48.4%)	Medicare	361	636	(275)	(43.2%)	
391,433	389,673	1,760	0.5%	Total	3,220,015	3,215,445	4,570	0.1%	

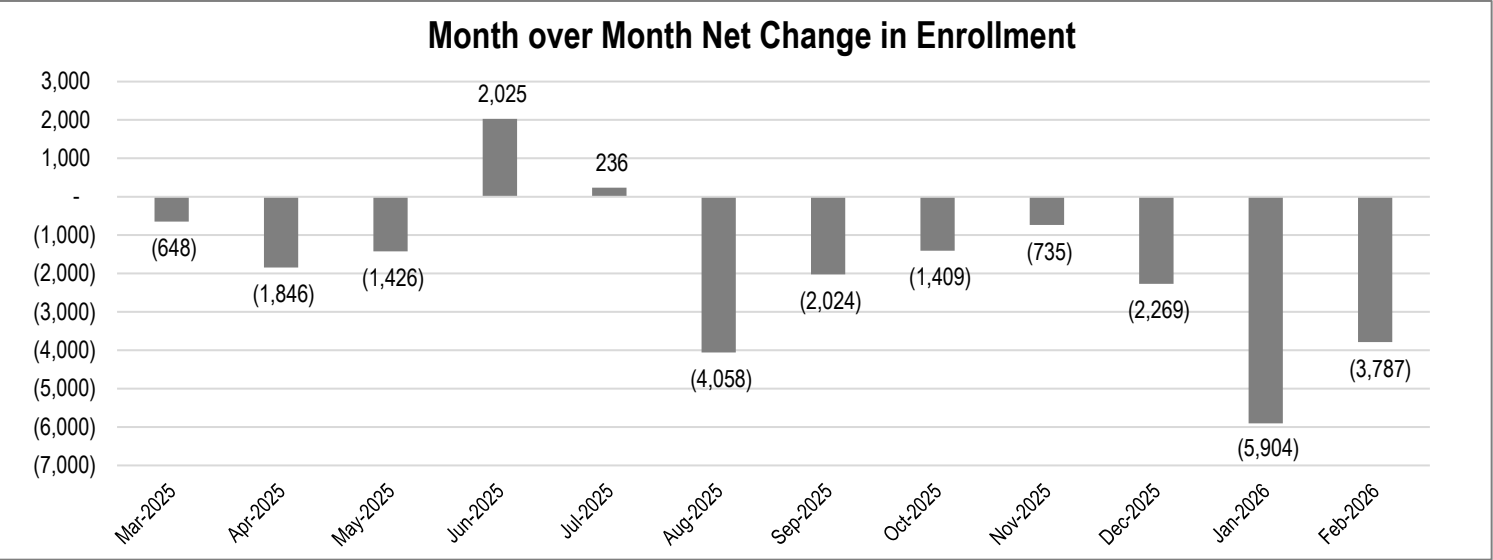
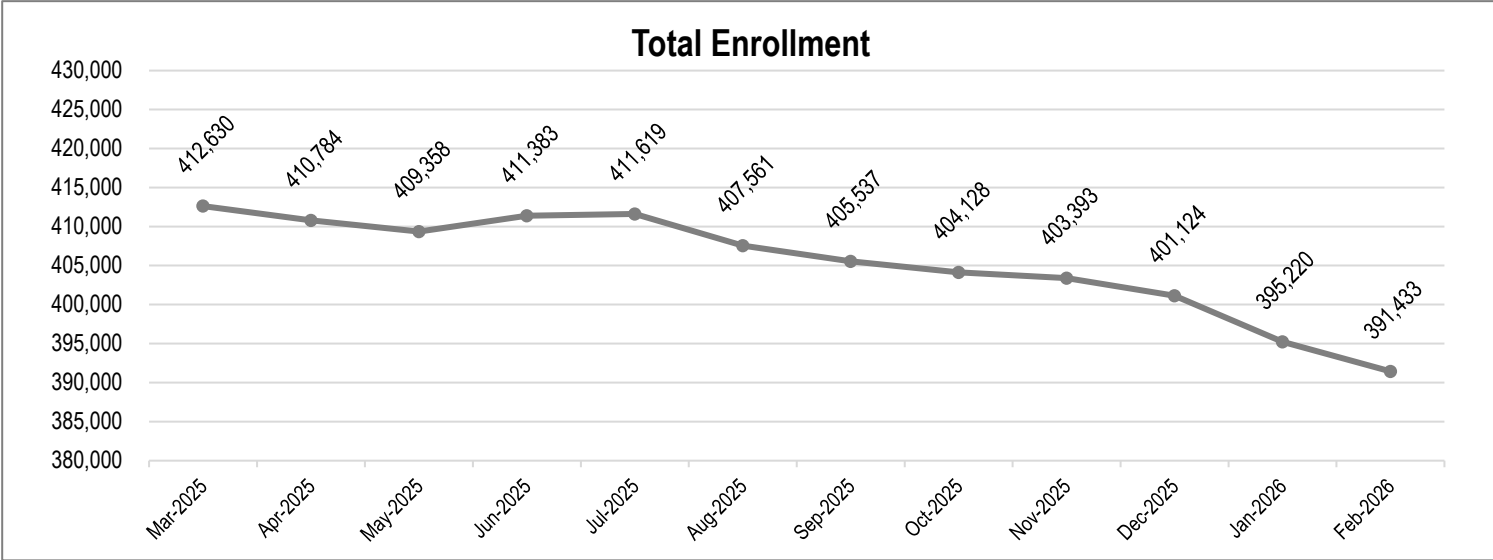
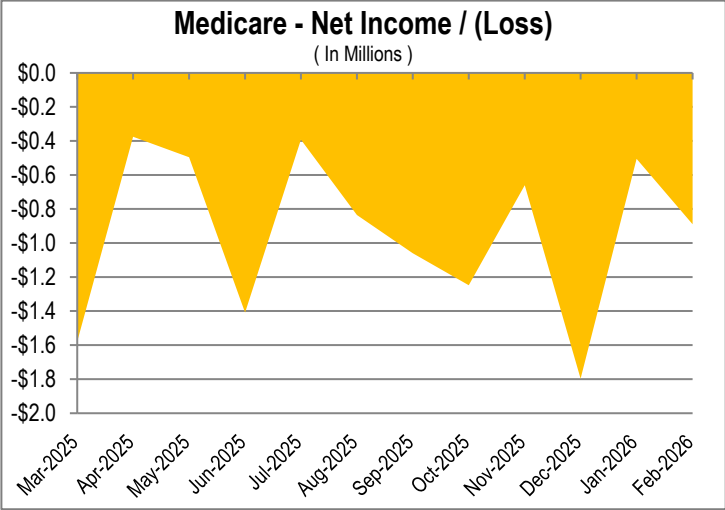
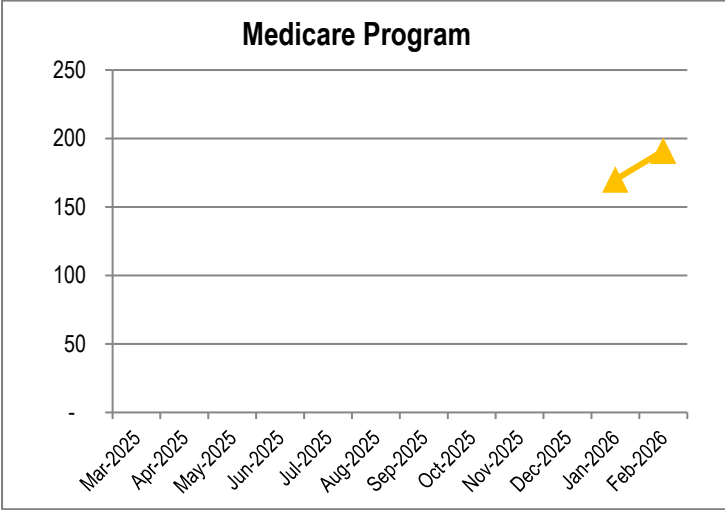
Enrollment and Profitability by Program and Category of Aid



Enrollment and Profitability by Program and Category of Aid

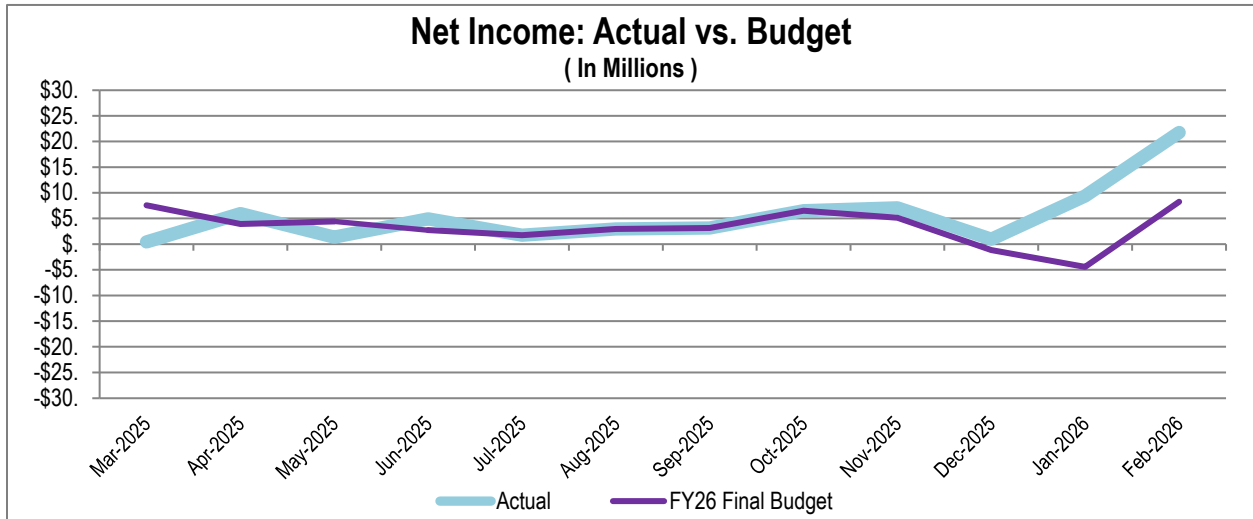


Enrollment and Profitability by Program and Category of Aid



Net Income

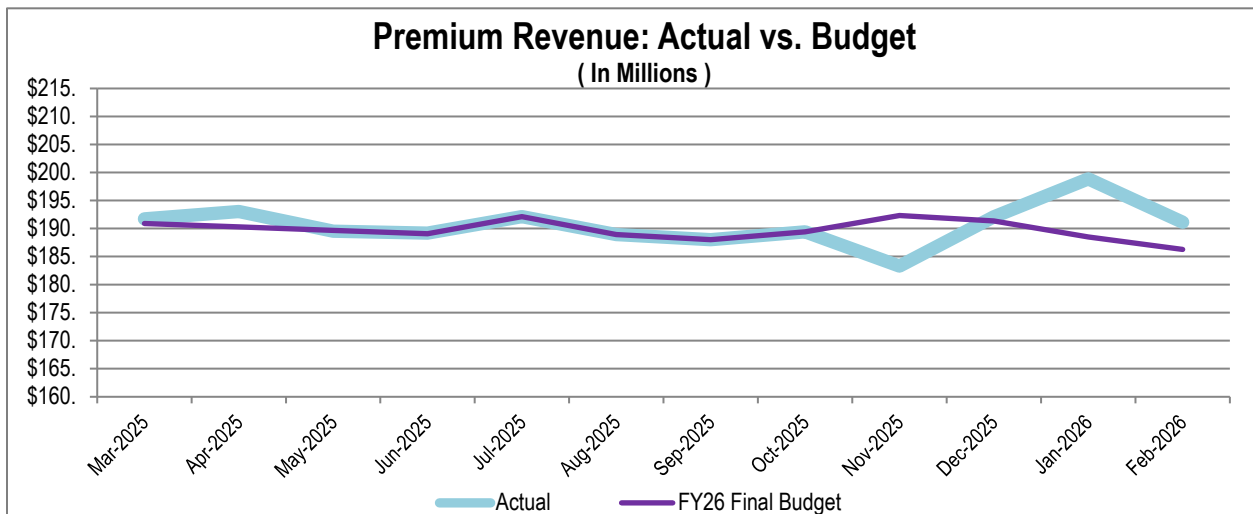
- For the month ended February 28th, 2026:
 - Actual Net Income: \$21.8 million.
 - Budgeted Net Income: \$8.3 million.
- For the fiscal YTD ended February 28th, 2026:
 - Actual Net Income \$53.5 million.
 - Budgeted Net Income \$22.1 million.



- The favorable variance of \$13.5 million in the current month is primarily due to:
- Favorable \$9.5 million lower than anticipated Medical Expense
 - Favorable \$4.8 million higher than anticipated Premium Revenue.
 - Unfavorable \$1.1 million lower than anticipated Other Income/Expense.

Premium Revenue

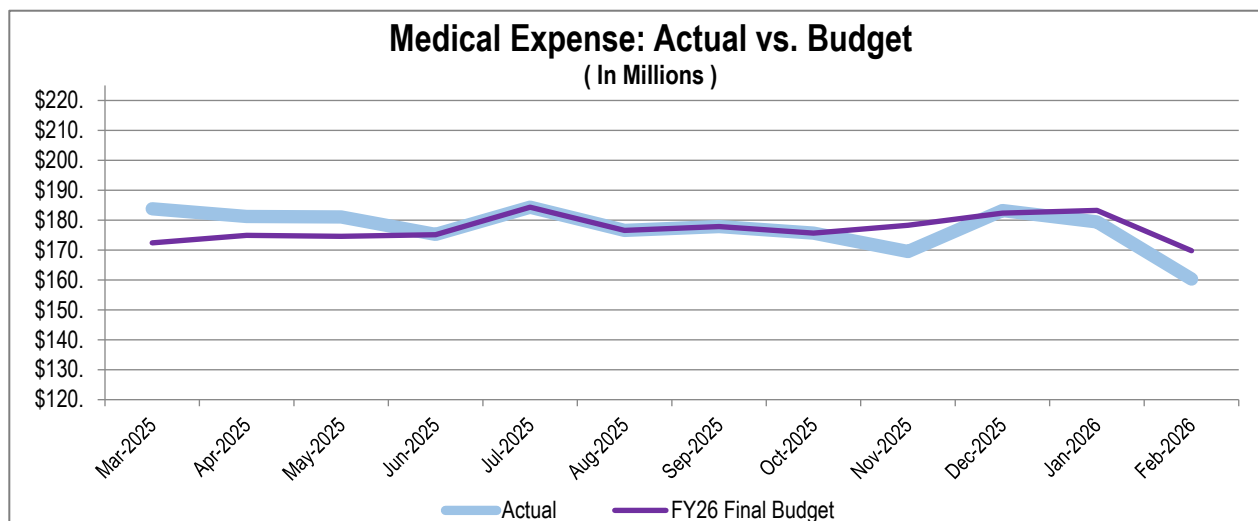
- For the month YTD ended February 28th, 2026:
 - Actual Revenue: \$191.1 million.
 - Budgeted Revenue: \$186.3 million.
- For the fiscal YTD ended February 28th, 2026:
 - Actual Revenue: \$1.5 billion.
 - Budgeted Revenue: \$1.5 billion.



- For the month ended February 28th, 2026, the favorable Premium Revenue variance of \$4.8 million is primarily due to favorable \$6.2 million budgeted Medicare Part A “buy-in” for February 2026 that did not occur and favorable \$1.4 million retroactive membership for January 2025 through December 2025. This was partially offset by an unfavorable \$1.8 million CY26 Acuity adjustment and unfavorable \$1.2 million Supplemental Maternity Revenue variance.

Medical Expense

- For the month ended February 28th, 2026:
 - Actual Medical Expense: \$160.3 million.
 - Budgeted Medical Expense: \$169.8 million.
- For the fiscal YTD ended February 28th, 2026:
 - Actual Medical Expense: \$1.4 billion.
 - Budgeted Medical Expense: \$1.4 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 February, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by \$11.2 million. Year to date, the estimate for prior years decreased by \$8.3 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)						
Adjusted to Eliminate the Impact of Prior Period IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical Expense	\$145,297,013	\$0	\$145,297,013	\$144,225,586	(\$1,071,426)	(0.7%)
Primary Care FFS	\$25,303,852	\$9,932,994	\$35,236,846	\$40,201,646	\$14,897,794	37.1%
Specialty Care FFS	\$65,857,414	\$1,353,761	\$67,211,175	\$69,387,167	\$3,529,753	5.1%
Outpatient FFS	\$104,146,479	(\$112,602)	\$104,033,877	\$107,475,067	\$3,328,588	3.1%
Ancillary FFS	\$167,982,382	\$1,940,201	\$169,922,583	\$161,327,939	(\$6,654,443)	(4.1%)
Pharmacy FFS	\$98,451,573	(\$6,649,468)	\$91,802,105	\$85,622,273	(\$12,829,300)	(15.0%)
ER Services FFS	\$82,073,492	\$175,714	\$82,249,206	\$82,831,863	\$758,371	0.9%
Inpatient Hospital FFS	\$380,840,906	(\$10,533,613)	\$370,307,293	\$388,234,391	\$7,393,485	1.9%
Long Term Care & SNF FFS	\$303,556,717	(\$4,377,510)	\$299,179,207	\$304,745,968	\$1,189,251	0.4%
Other Benefits & Services	\$30,856,071	\$0	\$30,856,071	\$35,491,782	\$4,635,711	13.1%
Net Reinsurance	\$851,736	\$0	\$851,736	\$1,637,503	\$785,767	48.0%
Provider Incentive	\$9,739,099	\$0	\$9,739,099	\$6,699,099	(\$3,040,000)	(45.4%)
	\$1,414,956,733	(\$8,270,523)	\$1,406,686,209	\$1,427,880,283	\$12,923,550	0.90%

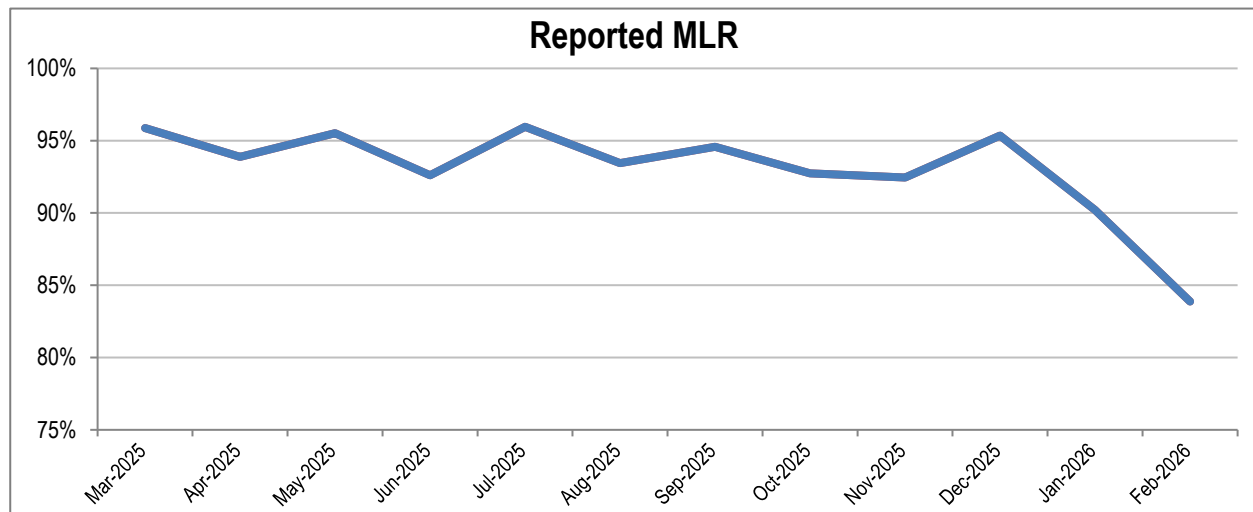
Medical Expense - Actual vs. Budget (Per Member Per Month)						
Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical Expense	\$45.13	\$0.00	\$45.13	\$44.86	(\$0.27)	(0.6%)
Primary Care FFS	\$7.86	\$3.09	\$10.94	\$12.51	\$4.65	37.2%
Specialty Care FFS	\$20.45	\$0.42	\$20.88	\$21.58	\$1.13	5.2%
Outpatient FFS	\$32.35	(\$0.03)	\$32.31	\$33.43	\$1.08	3.2%
Ancillary FFS	\$52.17	\$0.60	\$52.78	\$50.18	(\$1.99)	(4.0%)
Pharmacy FFS	\$30.58	(\$2.07)	\$28.51	\$26.63	(\$3.94)	(14.8%)
ER Services FFS	\$25.49	\$0.05	\$25.55	\$25.77	\$0.27	1.1%
Inpatient Hospital & SNF FFS	\$118.29	(\$3.27)	\$115.01	\$120.76	\$2.48	2.1%
Long Term Care & SNF FFS	\$94.28	(\$1.36)	\$92.92	\$94.79	\$0.51	0.5%
Other Benefits & Services	\$9.58	\$0.00	\$9.58	\$11.04	\$1.46	13.2%
Net Reinsurance	\$0.26	\$0.00	\$0.26	\$0.51	\$0.24	48.1%
Provider Incentive	\$3.02	\$0.00	\$3.02	\$2.08	(\$0.94)	(45.2%)
	\$439.47	(\$2.57)	\$436.91	\$444.16	\$4.68	1.1%

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is \$12.9 million favorable to budget. On a PMPM basis, medical expense is 1.1% 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 Group Care.

- Specialty Care Expense is under budget, driven by lower unit cost and utilization.
- Outpatient Expense is under budget due to lower utilization of Facility Other services and dialysis.
- Ancillary Expense is over budget due to higher utilization, partially offset by lower unit cost in the SPD with LTC, 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 under budget, driven by lower unit cost in the ACA OE and Child aid code categories.
- Inpatient Expense is under budget, driven by lower unit cost and utilization across all populations.
- Long Term Care Expense is over budget, driven by unit cost 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, subscriptions, insurance and fees expense.
- Net Reinsurance is under budget because more recoveries were received than expected.
- Provider Incentive was over budget, due to timing and accruals.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported Medical Expense divided by Premium Revenue) was 83.9% for the month and 92.3% for the fiscal year-to-date.



Administrative Expense

- For the month ended February 28th, 2026:
 - Actual Administrative Expense: \$10.7 million.
 - Budgeted Administrative Expense: \$11.0 million.
- For the fiscal YTD ended February 28th, 2026:
 - Actual Administrative Expense: \$81.9 million.
 - Budgeted Administrative Expense: \$88.4 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 %	
\$6,502,376	\$6,355,851	(\$146,526)	(2.3%)		Personnel Expense	\$51,445,817	\$54,169,585	\$2,723,768	5.0%
(9,216)	92,659	101,875	109.9%		Medical Benefits Admin Expense	414,699	761,434	346,735	45.5%
2,438,306	2,484,890	46,584	1.9%		Purchased & Professional Services	16,603,947	18,992,301	2,388,354	12.6%
1,733,059	2,023,826	290,767	14.4%		Other Admin Expense	13,474,715	14,452,369	977,654	6.8%
\$10,664,525	\$10,957,226	\$292,701	2.7%	Total Administrative Expense	\$81,939,178	\$88,375,689	\$6,436,512	7.3%	

The year-to-date variances include:

- Employee Expense ran favorably overall, driven by favorable Salary and Benefits resulted from hiring restrictions.
- Favorable in Purchased & Professional Services, primarily due to Consultant and Purchased Services, Provider Credentialing, and Hardware Purchases.
- Favorable Licenses, Insurance & Fees primarily due to favorable Licenses and Subscriptions.
- Favorable Supplies and Other expenses primarily due to favorable Community Reinvestment expense and settlement costs.
- Favorable Benefit Administration Expense, primarily for the decreases in Behavioral Health Admin Fees, M3P fees, and Pharmacy Admin Fees.
- Partially offset by unfavorable Printing/Postage/Promotions, result of booking of a debit to clear a budgeted credit that was booked in October.
- Partially offset by unfavorable Building Occupancy costs due to SBITA Amortization.

The Administrative Loss Ratio (ALR) is 5.6% of net revenue for the month and 5.4% 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 \$1.5 million.

Other Income / (Expense)

Other Income & Expense is comprised primarily of investment income. Fiscal year-to-date net investments show a gain of \$18.3 million.

Managed Care Organization (MCO) Provider Tax

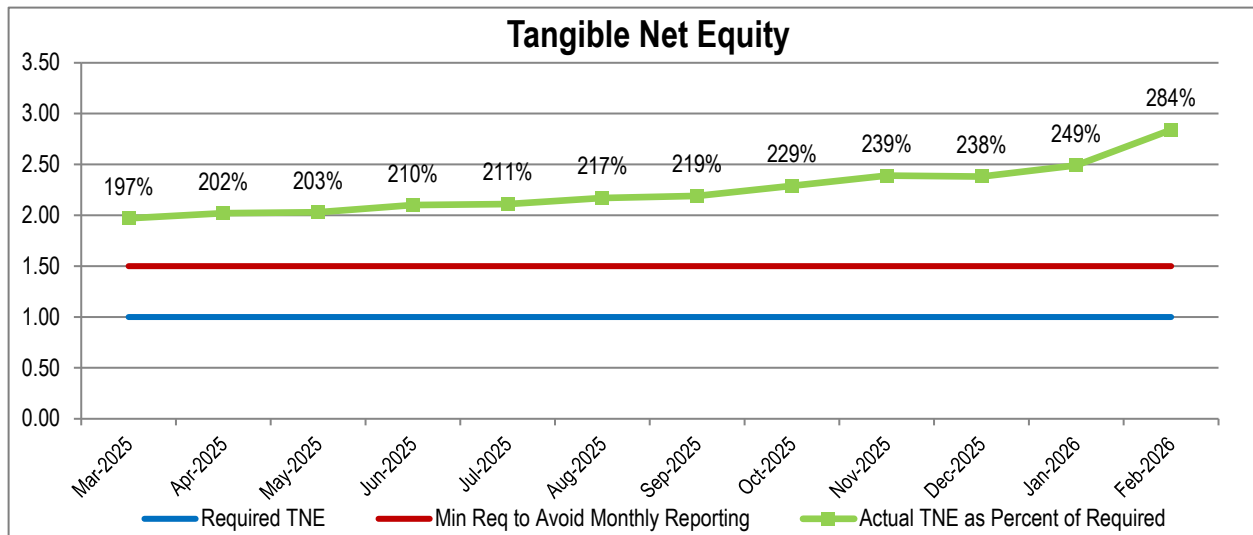
- Revenue:
 - For the month ended February 28th, 2026:
 - Actual: \$65.0 million.
 - Budgeted: \$61.9 million.
 - For the fiscal YTD ended February 28th, 2026:
 - Actual: \$519.2 million.
 - Budgeted: \$512.1 million.
- Expense:
 - For the month ended February 28th, 2026:
 - Actual: \$65.0 million.
 - Budgeted: \$61.9 million.

- For the fiscal YTD ended February 28th, 2026:
 - Actual: \$519.2 million.
 - Budgeted: \$512.1 million.

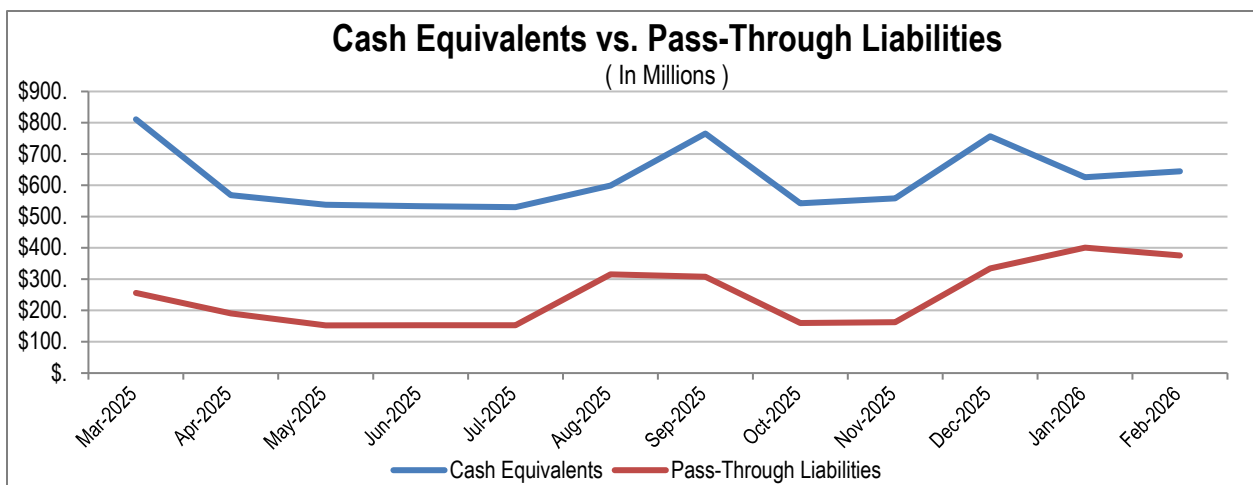
Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus total liabilities divided by a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.

- Required TNE \$78.4 million
- Actual TNE \$222.8 million
- Excess TNE \$144.4 million
- TNE % of Required TNE 284%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
 - Cash & Cash Equivalents \$644.5 million
 - Pass-Through Liabilities \$375.6 million



○ Uncommitted Cash	\$268.9 million
○ Working Capital	\$173.1 million
○ Current Ratio	1.16 (regulatory minimum is 1.00)

Capital Investment

- Fiscal year-to-date capital assets acquired: \$36,000.
- 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 28 FEBRUARY, 2026

CURRENT MONTH					FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance	% Variance	Account Description	Actual	Budget	\$ Variance	% Variance	
		(Unfavorable)	(Unfavorable)				(Unfavorable)	(Unfavorable)	
MEMBERSHIP									
385,031	383,218	1,813	0.5%	1. Medi-Cal	3,170,956	3,166,415	4,541	0.1%	
6,211	6,085	126	2.1%	2. GroupCare	48,698	48,394	304	0.6%	
191	370	(179)	(48.4%)	3. Medicare SNP	361	636	(275)	(43.2%)	
391,433	389,673	1,760	0.5%	3. TOTAL MEMBER MONTHS	3,220,015	3,215,445	4,570	0.1%	
REVENUE									
\$191,121,346	\$186,275,048	\$4,846,298	2.6%	4. Premium Revenue	\$1,523,847,782	\$1,516,897,092	\$6,950,690	0.5%	
\$64,994,094	\$61,912,700	\$3,081,394	5.0%	5. MCO Tax Revenue AB119	\$519,184,732	\$512,093,814	\$7,090,918	1.4%	
\$256,115,440	\$248,187,748	\$7,927,692	3.2%	6. TOTAL REVENUE	\$2,043,032,515	\$2,028,990,906	\$14,041,608	0.7%	
MEDICAL EXPENSES									
Capitated Medical Expenses									
\$16,443,638	\$15,923,351	(\$520,286)	(3.3%)	7. Capitated Medical Expense	\$145,297,013	\$144,225,586	(\$1,071,426)	(0.7%)	
Fee for Service Medical Expenses									
\$42,783,524	\$46,522,355	\$3,738,831	8.0%	8. Inpatient Hospital Expense	\$370,307,293	\$388,234,391	\$17,927,098	4.6%	
\$3,313,765	\$4,222,079	\$908,313	21.5%	9. Primary Care Physician Expense	\$35,236,846	\$40,201,646	\$4,964,800	12.3%	
\$6,547,660	\$7,635,275	\$1,087,615	14.2%	10. Specialty Care Physician Expense	\$67,211,175	\$69,387,167	\$2,175,992	3.1%	
\$21,629,138	\$19,398,977	(\$2,230,161)	(11.5%)	11. Ancillary Medical Expense	\$169,922,583	\$161,327,939	(\$8,594,644)	(5.3%)	
\$9,801,305	\$11,237,945	\$1,436,640	12.8%	12. Outpatient Medical Expense	\$104,033,877	\$107,475,067	\$3,441,190	3.2%	
\$9,849,289	\$9,669,807	(\$179,482)	(1.9%)	13. Emergency Expense	\$82,249,206	\$82,831,863	\$582,657	0.7%	
\$13,992,176	\$11,506,340	(\$2,485,836)	(21.6%)	14. Pharmacy Expense	\$91,802,105	\$85,622,273	(\$6,179,832)	(7.2%)	
\$29,373,122	\$36,614,693	\$7,241,571	19.8%	15. Long Term Care Expense	\$299,179,207	\$304,745,968	\$5,566,760	1.8%	
\$137,289,978	\$146,807,471	\$9,517,493	6.5%	16. Total Fee for Service Expense	\$1,219,942,291	\$1,239,826,313	\$19,884,022	1.6%	
\$4,478,917	\$4,445,485	(\$33,432)	(0.8%)	17. Other Benefits & Services	\$30,856,071	\$35,491,782	\$4,635,711	13.1%	
\$61,885	\$554,638	\$492,753	88.8%	18. Reinsurance Expense	\$851,736	\$1,637,503	\$785,767	48.0%	
\$2,040,000	\$2,040,000	\$0	0.0%	19. Risk Pool Distribution	\$9,739,099	\$6,699,099	(\$3,040,000)	(45.4%)	
\$160,314,418	\$169,770,945	\$9,456,527	5.6%	20. TOTAL MEDICAL EXPENSES	\$1,406,686,209	\$1,427,880,283	\$21,194,074	1.5%	
\$95,801,022	\$78,416,803	\$17,384,219	22.2%	21. GROSS MARGIN	\$636,346,305	\$601,110,623	\$35,235,682	5.9%	
ADMINISTRATIVE EXPENSES									
\$6,502,376	\$6,355,851	(\$146,526)	(2.3%)	22. Personnel Expense	\$51,445,817	\$54,169,585	\$2,723,768	5.0%	
(\$9,216)	\$92,659	\$101,875	109.9%	23. Benefits Administration Expense	\$414,699	\$761,434	\$346,735	45.5%	
\$2,438,306	\$2,484,890	\$46,584	1.9%	24. Purchased & Professional Services	\$16,603,947	\$18,992,301	\$2,388,355	12.6%	
\$1,733,059	\$2,023,826	\$290,767	14.4%	25. Other Administrative Expense	\$13,474,715	\$14,452,369	\$977,654	6.8%	
\$10,664,525	\$10,957,226	\$292,701	2.7%	26. TOTAL ADMINISTRATIVE EXPENSES	\$81,939,178	\$88,375,689	\$6,436,512	7.3%	
\$64,994,094	\$61,912,700	(\$3,081,394)	(5.0%)	27. MCO TAX EXPENSES	\$519,184,732	\$512,093,814	(\$7,090,918)	(1.4%)	
\$20,142,403	\$5,546,877	\$14,595,526	263.1%	28. NET OPERATING INCOME / (LOSS)	\$35,222,395	\$641,120	\$34,581,275	5,393.9%	
OTHER INCOME / EXPENSES									
\$1,615,130	\$2,710,433	(\$1,095,304)	(40.4%)	29. TOTAL OTHER INCOME / (EXPENSES)	\$18,257,419	\$21,486,228	(\$3,228,809)	(15.0%)	
\$21,757,533	\$8,257,310	\$13,500,222	163.5%	30. NET SURPLUS (DEFICIT)	\$53,479,813	\$22,127,348	\$31,352,466	141.7%	
83.9%	91.1%	7.2%	7.9%	31. Medical Loss Ratio	92.3%	94.1%	1.8%	1.9%	
5.6%	5.9%	0.3%	5.1%	32. Administrative Expense Ratio	5.4%	5.8%	0.4%	6.9%	
8.5%	3.3%	5.2%	157.6%	33. Net Surplus (Deficit) Ratio	2.6%	1.1%	1.5%	136.4%	

**ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED 28 FEBRUARY, 2026**

	2/28/2026	1/31/2026	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	\$18,237,861	\$24,400,385	(\$6,162,524)	(25.3%)
CNB Short-Term Investment	626,271,302	601,118,853	25,152,449	4.2%
Interest Receivable	2,481,111	3,413,091	(931,980)	(27.3%)
Premium Receivables	601,680,490	591,462,702	10,217,788	1.7%
Reinsurance Recovery Receivable	14,174,761	14,059,446	115,315	0.8%
Other Receivables	1,786,777	2,369,971	(583,194)	(24.6%)
Prepaid Expenses	1,088,552	998,418	90,134	9.0%
TOTAL CURRENT ASSETS	1,265,720,854	1,237,822,865	27,897,989	2.3%
OTHER ASSETS				
CNB Long-Term Investment	33,283,044	36,025,008	(2,741,965)	(7.6%)
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	361,892	360,866	1,025	0.3%
GASB 87-Lease Assets (Net)	52,400	55,675	(3,275)	(5.9%)
GASB 96-SBITA Assets (Net)	7,939,369	6,772,912	1,166,458	17.2%
TOTAL OTHER ASSETS	50,442,685	52,020,442	(1,577,756)	(3.0%)
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,878,278	9,867,101	11,177	0.1%
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	39,005,035	38,993,858	11,177	0.0%
Less: Accumulated Depreciation	(33,889,485)	(33,827,040)	(62,445)	0.2%
PROPERTY AND EQUIPMENT (NET)	5,115,550	5,166,818	(51,268)	(1.0%)
TOTAL ASSETS	1,321,279,089	1,295,010,125	26,268,964	2.0%
CURRENT LIABILITIES				
Trade Accounts Payable	11,965,917	11,940,489	25,428	0.2%
Incurred But Not Reported Claims	367,386,373	410,915,970	(43,529,597)	(10.6%)
Other Medical Liabilities	145,392,072	138,633,439	6,758,633	4.9%
Pass-Through Liabilities	375,614,750	400,943,325	(25,328,575)	(6.3%)
MCO Tax Liabilities	179,853,380	114,859,286	64,994,094	56.6%
GASB 87 and 96 ST Liabilities	2,685,571	1,730,313	955,258	55.2%
Payroll Liabilities	9,342,995	9,319,935	23,061	0.2%
Deferred Revenues	405,514	358,999	46,515	13.0%
TOTAL CURRENT LIABILITIES	1,092,646,573	1,088,701,757	3,944,817	0.4%
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	2,633,036	2,066,421	566,615	27.4%
Deferred Inflow	3,240,306	3,240,306	0	0.0%
TOTAL LONG TERM LIABILITIES	5,873,341	5,306,726	566,615	10.7%
TOTAL LIABILITIES	1,098,519,915	1,094,008,483	4,511,432	0.4%
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)	53,479,813	31,722,281	21,757,533	68.6%
TOTAL NET WORTH	222,759,174	201,001,642	21,757,533	10.8%
TOTAL LIABILITIES AND NET WORTH	1,321,279,089	1,295,010,125	26,268,964	2.0%
Additional Information				
Cash Equivalents	644,509,163	625,519,237	18,989,925	3.0%
Pass-Through	375,614,750	400,943,325	(25,328,575)	(6.3%)
Uncommitted Cash	268,894,413	224,575,912	44,318,501	19.7%
Working Capital	173,074,281	149,121,108	23,953,172	16.1%
Current Ratio	115.8%	113.7%	2.1%	1.8%

**ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED**

February 28, 2026

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	\$3,371,893	\$10,118,171	\$20,077,405	\$26,595,709
GroupCare Receivable	(608)	(7,259)	(6,670)	(9,368)
Total	3,371,285	10,110,912	20,070,735	26,586,341
Medicare Premiums				
Medicare Premiums	418,847	782,900	782,900	782,899
Deferred Premium Revenue	46,515	405,514	405,514	405,514
Medicare Receivable	-	-	-	-
Total	465,362	1,188,414	1,188,414	1,188,413
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	252,324,701	766,365,869	1,575,437,642	2,015,653,904
Premium Receivable	(10,217,181)	(47,991,625)	(145,756,801)	(103,398,450)
Total	242,107,520	718,374,244	1,429,680,841	1,912,255,454
Investment & Other Income Cash Flows				
Other Revenues	267,628	874,738	499,931	853,287
Interest Income	1,366,716	5,388,768	12,535,654	17,473,150
Interest Receivable	931,980	1,582,305	1,432,749	1,105,847
Total	2,566,324	7,845,811	14,468,334	19,432,284
Medical & Hospital Cash Flows				
Total Medical Expenses	(160,314,421)	(522,870,652)	(1,045,813,047)	(1,406,686,215)
Other Health Care Receivables	466,040	489,173	10,028,061	(5,769,913)
Capitation Payable	-	-	-	-
IBNP Payable	(43,529,597)	(17,082,586)	(36,342,593)	(44,730,922)
Other Medical Payable	(18,609,942)	226,052,958	86,238,364	250,324,113
Risk Share Payable	40,000	80,000	80,000	280,000
New Health Program Payable	-	-	-	-
Total	(221,947,920)	(313,331,107)	(985,809,215)	(1,206,582,937)
Administrative Cash Flows				
Total Administrative Expenses	(10,683,740)	(33,370,107)	(61,246,176)	(82,008,196)
Prepaid Expenses	(90,134)	35,610	(398,257)	(370,741)
Other Receivables	1,839	(2,635)	132,192	(10,500)
CalPERS Pension	-	-	-	-
Trade Accounts Payable	25,427	1,201,873	714,966	448,994
Payroll Liabilities	23,060	1,530,576	(208,310)	(20,919)
GASB Assets and Liabilities	358,690	(1,000,508)	(994,710)	(601,012)
Depreciation Expense	62,445	186,963	373,189	496,892
Total	(10,302,413)	(31,418,228)	(61,627,106)	(82,065,482)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(64,994,094)	(195,175,872)	(453,472,794)	(519,184,732)
MCO Tax Liabilities	64,994,094	(118,782,462)	76,698,038	(45,965,023)
Total	0	(313,958,334)	(376,774,756)	(565,149,755)
Net Cash Flows from Operating Activities	16,260,158	78,811,712	41,197,247	105,664,318

**ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED**

February 28, 2026

	MONTH	3 MONTHS	6 MONTHS	YTD
<u>CASH FLOWS FROM INVESTING ACTIVITIES</u>				
Investment Cash Flows				
Long Term Investments	2,741,970	7,527,106	4,179,201	5,872,329
Total	2,741,970	7,527,106	4,179,201	5,872,329
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(1,025)	(3,035)	(6,044)	(8,026)
Total	(1,025)	(3,035)	(6,044)	(8,026)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	(11,177)	(11,177)	(35,630)	(35,630)
Depreciation expense				
Change in A/D				
Purchases of Property and Equipment	(11,177)	(11,177)	(35,630)	(35,630)
Net Cash Flows from Investing Activities	2,729,768	7,512,894	4,137,527	5,828,673
Financing Cash Flows				
Subordinated Debt Proceeds	-	-	-	-
Net Change in Cash	18,989,926	86,324,606	45,334,774	111,492,991
Rounding	-	-	-	-
Cash @ Beginning of Period	625,519,238	558,184,558	599,174,390	533,016,173
Cash @ End of Period	\$644,509,164	\$644,509,164	\$644,509,164	\$644,509,164
Variance	-	-	-	-

**ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED**

February 28, 2026

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	\$21,757,530	\$32,113,815	\$48,801,514	\$53,479,806
Add back: Depreciation & Amortization	62,445	186,963	373,189	496,892
Receivables				
Premiums Receivable	(10,217,181)	(47,991,625)	(145,756,801)	(103,398,450)
Interest Receivable	931,980	1,582,305	1,432,749	1,105,847
Other Health Care Receivables	466,040	489,173	10,028,061	(5,769,913)
Other Receivables	1,839	(2,635)	132,192	(10,500)
GroupCare Receivable	(608)	(7,259)	(6,670)	(9,368)
Total	(8,817,930)	(45,930,041)	(134,170,469)	(108,082,384)
Prepaid Expenses	(90,134)	35,610	(398,257)	(370,741)
Trade Payables	25,427	1,201,873	714,966	448,994
Claims Payable and Shared Risk Pool				
IBNP Payable	(43,529,597)	(17,082,586)	(36,342,593)	(44,730,922)
Capitation Payable & Other Medical Payable	(18,609,942)	226,052,958	86,238,364	250,324,113
Risk Share Payable	40,000.00	80,000.00	80,000	280,000
Claims Payable				
Total	(62,099,539)	209,050,372	49,975,771	205,873,191
Unearned Revenue				
Deferred Premium Revenue				
Deferred Revenue - IHSS				
Deferred Revenue - Medicare (DSNP)	46,515	405,514	405,514	405,514
Total	46,515.00	405,514.00	405,514.00	405,514.00
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	23,060	1,530,576	(208,309)	(20,919)
GASB Assets and Liabilities	358,690	(1,000,508)	(994,710)	(601,012)
New Health Program	-	-	-	-
MCO Tax Liabilities	64,994,094	(118,782,462)	76,698,038	(45,965,023)
Total	65,375,844	(118,252,394)	75,495,019	(46,586,954)
Rounding	-	-	-	-
Cash Flows from Operating Activities	16,260,158	78,811,712	41,197,247	105,664,318
Variance	-	-	-	-

**ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED**

February 28, 2026

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	\$242,107,520	\$718,374,244	\$1,429,680,841	\$1,912,255,454
Medicare Revenue	\$465,362	\$1,188,414	\$1,188,414	\$1,188,413
GroupCare Premium Revenue	3,371,285	10,110,912	20,070,735	26,586,341
Other Income	267,628	874,738	499,931	853,287
Interest Income	2,298,696	6,971,073	13,968,403	18,578,997
Less Cash Paid				
Medical Expenses	(221,947,920)	(313,331,107)	(985,809,215)	(1,206,582,937)
Vendor & Employee Expenses	(10,302,413)	(31,418,228)	(61,627,106)	(82,065,482)
MCO Tax Expense AB119	0	(313,958,334)	(376,774,756)	(565,149,755)
Net Cash Flows from Operating Activities	16,260,158	78,811,712	41,197,247	105,664,318
Cash Flows from Investing Activities:				
Long Term Investments	2,741,970	7,527,106	4,179,201	5,872,329
Restricted Assets-Treasury Account	(1,025)	(3,035)	(6,044)	(8,026)
Purchases of Property and Equipment	(11,177)	(11,177)	(35,630)	(35,630)
Net Cash Flows from Investing Activities	2,729,768	7,512,894	4,137,527	5,828,673
Net Change in Cash	18,989,926	86,324,606	45,334,774	111,492,991
Rounding	-	-	-	-
Cash @ Beginning of Period	625,519,238	558,184,558	599,174,390	533,016,173
Cash @ End of Period	\$644,509,164	\$644,509,164	\$644,509,164	\$644,509,164
Variance	\$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	\$21,757,530	\$32,113,816	\$48,801,513	\$53,479,806
Add Back: Depreciation	62,445	186,963	373,189	496,892
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(8,817,930)	(45,930,041)	(134,170,469)	(108,082,384)
Prepaid Expenses	(90,134)	35,609	(398,256)	(370,741)
Trade Payables	25,427	1,201,873	714,966	448,994
Claims Payable, IBNP and Risk Sharing	(62,099,539)	209,050,372	49,975,771	205,873,191
Deferred Revenue- Medicare (DSNP)	46,515	405,514	405,514	405,514
Other Liabilities	65,375,844	(118,252,394)	75,495,019	(46,586,954)
Total	16,260,158	78,811,712	41,197,247	105,664,318
Rounding	-	-	-	-
Cash Flows from Operating Activities	\$16,260,158	\$78,811,712	\$41,197,247	\$105,664,318
Variance	\$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF FEBRUARY 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	106,175	57,240	144,297	28,813	48,506	385,031	6,211	191	391,433
Revenue	\$34,939,324	\$31,074,338	\$91,695,575	\$50,934,977	\$43,680,487	\$252,324,700	\$3,371,893	\$418,847	\$256,115,440
Medical Expense	\$12,782,569	\$18,301,415	\$57,590,714	\$33,426,484	\$33,489,271	\$155,590,453	\$4,070,597	\$653,367	\$160,314,418
Gross Margin	\$22,156,755	\$12,772,922	\$34,104,861	\$17,508,492	\$10,191,217	\$96,734,247	(\$698,704)	(\$234,521)	\$95,801,022
Administrative Expense	\$474,196	\$1,192,547	\$3,405,602	\$2,764,749	\$1,959,614	\$9,796,708	\$211,781	\$656,036	\$10,664,525
MCO Tax Expense	\$17,955,488	\$9,646,972	\$24,213,646	\$4,920,205	\$8,257,783	\$64,994,094	\$0	\$0	\$64,994,094
Operating Income / (Expense)	\$3,727,070	\$1,933,403	\$6,485,614	\$9,823,538	(\$26,180)	\$21,943,445	(\$910,485)	(\$890,557)	\$20,142,403
Other Income / (Expense)	\$78,321	\$186,381	\$531,129	\$492,114	\$302,589	\$1,590,533	\$24,008	\$589	\$1,615,130
Net Income / (Loss)	\$3,805,391	\$2,119,784	\$7,016,743	\$10,315,652	\$276,408	\$23,533,978	(\$886,477)	(\$889,968)	\$21,757,533
PMPM Metrics:									
Revenue PMPM	\$329.07	\$542.88	\$635.46	\$1,767.78	\$900.52	\$655.34	\$542.89	\$2,192.91	\$654.30
Medical Expense PMPM	\$120.39	\$319.73	\$399.11	\$1,160.12	\$690.42	\$404.10	\$655.39	\$3,420.77	\$409.56
Gross Margin PMPM	\$208.68	\$223.15	\$236.35	\$607.66	\$210.10	\$251.24	(\$112.49)	(\$1,227.86)	\$244.74
Administrative Expense PMPM	\$4.47	\$20.83	\$23.60	\$95.95	\$40.40	\$25.44	\$34.10	\$3,434.75	\$27.24
MCO Tax Expense PMPM	\$169.11	\$168.54	\$167.80	\$170.76	\$170.24	\$168.80	\$0.00	\$0.00	\$166.04
Operating Income / (Expense) PMPM	\$35.10	\$33.78	\$44.95	\$340.94	(\$0.54)	\$56.99	(\$146.59)	(\$4,662.60)	\$51.46
Other Income / (Expense) PMPM	\$0.74	\$3.26	\$3.68	\$17.08	\$6.24	\$4.13	\$3.87	\$3.08	\$4.13
Net Income / (Loss) PMPM	\$35.84	\$37.03	\$48.63	\$358.02	\$5.70	\$61.12	(\$142.73)	(\$4,659.52)	\$55.58
Ratio:									
Medical Loss Ratio	75.3%	85.4%	85.3%	72.6%	94.5%	83.1%	120.7%	156.0%	83.9%
Administrative Expense Ratio	2.8%	5.6%	5.0%	6.0%	5.5%	5.2%	6.3%	156.6%	5.6%
Net Income Ratio	10.9%	6.8%	7.7%	20.3%	0.6%	9.3%	-26.3%	-212.5%	8.5%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE FEBRUARY 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	861,772	476,549	1,203,292	235,880	393,463	3,170,956	48,698	361	3,220,015
Revenue	\$281,674,881	\$257,783,265	\$735,587,462	\$395,157,210	\$345,451,088	\$2,015,653,906	\$26,595,709	\$782,900	\$2,043,032,515
Medical Expense	\$111,387,651	\$160,745,793	\$479,397,197	\$333,879,485	\$293,066,083	\$1,378,476,209	\$26,927,873	\$1,282,127	\$1,406,686,209
Gross Margin	\$170,287,230	\$97,037,471	\$256,190,265	\$61,277,725	\$52,385,005	\$637,177,697	(\$332,164)	(\$499,228)	\$636,346,305
Administrative Expense	\$3,792,589	\$8,584,294	\$26,011,748	\$22,163,236	\$12,912,288	\$73,464,155	\$1,584,497	\$6,890,526	\$81,939,178
MCO Tax Expense	\$141,211,758	\$77,803,322	\$196,116,194	\$39,089,142	\$64,964,317	\$519,184,732	\$0	\$0	\$519,184,732
Operating Income / (Expense)	\$25,282,883	\$10,649,856	\$34,062,324	\$25,347	(\$25,491,599)	\$44,528,810	(\$1,916,661)	(\$7,389,754)	\$35,222,395
Other Income / (Expense)	\$886,860	\$2,107,975	\$6,007,185	\$5,560,333	\$3,423,133	\$17,985,486	\$271,831	\$101	\$18,257,419
Net Income / (Loss)	\$26,169,742	\$12,757,831	\$40,069,509	\$5,585,680	(\$22,068,466)	\$62,514,296	(\$1,644,830)	(\$7,389,653)	\$53,479,813
PMPM Metrics:									
Revenue PMPM	\$326.86	\$540.94	\$611.31	\$1,675.25	\$877.98	\$635.66	\$546.14	\$2,168.70	\$634.48
Medical Expense PMPM	\$129.25	\$337.31	\$398.40	\$1,415.46	\$744.84	\$434.72	\$552.96	\$3,551.60	\$436.86
Gross Margin PMPM	\$197.60	\$203.63	\$212.91	\$259.78	\$133.14	\$200.94	(\$6.82)	(\$1,382.90)	\$197.62
Administrative Expense PMPM	\$4.40	\$18.01	\$21.62	\$93.96	\$32.82	\$23.17	\$32.54	\$19,087.33	\$25.45
MCO Tax Expense PMPM	\$163.86	\$163.26	\$162.98	\$165.72	\$165.11	\$163.73	\$0.00	\$0.00	\$161.24
Operating Income / (Expense) PMPM	\$29.34	\$22.35	\$28.31	\$0.11	(\$64.79)	\$14.04	(\$39.36)	(\$20,470.23)	\$10.94
Other Income / (Expense) PMPM	\$1.03	\$4.42	\$4.99	\$23.57	\$8.70	\$5.67	\$5.58	\$0.28	\$5.67
Net Income / (Loss) PMPM	\$30.37	\$26.77	\$33.30	\$23.68	(\$56.09)	\$19.71	(\$33.78)	(\$20,469.95)	\$16.61
Ratio:									
Medical Loss Ratio	79.3%	89.3%	88.9%	93.8%	104.5%	92.1%	101.2%	163.8%	92.3%
Administrative Expense Ratio	2.7%	4.8%	4.8%	6.2%	4.6%	4.9%	6.0%	880.1%	5.4%
Net Income Ratio	9.3%	4.9%	5.4%	1.4%	-6.4%	3.1%	-6.2%	-943.9%	2.6%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 28 February, 2026

CURRENT MONTH				Account Description	FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)		Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
ADMINISTRATIVE EXPENSES SUMMARY (ADMIN. DEPT. ONLY)								
\$6,502,376	\$6,355,851	(\$146,526)	(2.3%)	Personnel Expenses	\$51,445,817	\$54,169,585	\$2,723,768	5.0%
(\$9,216)	\$92,659	\$101,875	109.9%	Benefits Administration Expense	\$414,699	\$761,434	\$346,735	45.5%
\$2,438,306	\$2,484,890	\$46,584	1.9%	Purchased & Professional Services	\$16,603,947	\$18,992,301	\$2,388,355	12.6%
\$583,445	\$491,532	(\$91,912)	(18.7%)	Occupancy	\$3,949,412	\$3,884,782	(\$64,630)	(1.7%)
\$774,745	\$647,307	(\$127,438)	(19.7%)	Printing Postage & Promotion	\$2,531,697	(\$919,238)	(\$3,450,935)	375.4%
(\$33,385)	\$342,326	\$375,712	109.8%	Licenses Insurance & Fees	\$2,938,055	\$4,380,216	\$1,442,161	32.9%
\$408,255	\$542,661	\$134,406	24.8%	Other Administrative Expense	\$4,055,551	\$7,106,609	\$3,051,058	42.9%
\$4,162,149	\$4,601,375	\$439,226	9.5%	Total Other Administrative Expenses (excludes Personnel Expenses)	\$30,493,361	\$34,206,104	\$3,712,744	10.9%
\$10,664,525	\$10,957,226	\$292,701	2.7%	Total Administrative Expenses	\$81,939,178	\$88,375,689	\$6,436,512	7.3%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 28 February, 2026

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
3,896,239	3,701,203	(195,036)	(5.3%)	Salaries & Wages	33,554,527	34,853,287	1,298,760	3.7%
757,800	381,627	(376,172)	(98.6%)	Paid Time Off	3,308,721	3,295,006	(13,714)	(0.4%)
0	110,725	110,725	100.0%	Compensated Incentives	7,801	143,748	135,948	94.6%
0	0	0	0.0%	Severance	0	400,000	400,000	100.0%
51,747	90,121	38,374	42.6%	Payroll Taxes	695,469	819,527	124,058	15.1%
91,925	47,845	(44,080)	(92.1%)	Overtime	539,320	507,219	(32,101)	(6.3%)
354,162	333,204	(20,958)	(6.3%)	CalPERS ER Match	2,840,357	2,746,702	(93,656)	(3.4%)
1,154,088	1,264,257	110,169	8.7%	Employee Benefits	9,030,375	9,306,470	276,095	3.0%
3,212	0	(3,212)	0.0%	Personal Floating Holiday	208,167	218,795	10,628	4.9%
21,345	39,500	18,155	46.0%	Language Pay	177,823	243,272	65,449	26.9%
3,300	0	(3,300)	0.0%	Med Ins Opted Out Stipend	29,300	12,100	(17,200)	(142.1%)
99,857	0	(99,857)	0.0%	Sick Leave	488,421	77,895	(410,527)	(527.0%)
340	48,692	48,352	99.3%	Compensated Employee Relations	(252)	151,335	151,587	100.2%
30,190	25,540	(4,650)	(18.2%)	Work from Home Stipend	176,700	183,540	6,840	3.7%
1,553	3,022	1,469	48.6%	Mileage, Parking & Local Travel	9,065	21,092	12,027	57.0%
1,027	25,068	24,041	95.9%	Travel & Lodging	26,392	151,573	125,181	82.6%
20,748	165,336	144,588	87.5%	Temporary Help Services	194,799	609,607	414,808	68.0%
13,120	49,552	36,432	73.5%	Staff Development/Training	115,461	288,642	173,181	60.0%
1,724	70,158	68,435	97.5%	Staff Recruitment/Advertisement	43,371	139,776	96,405	69.0%
6,502,376	6,355,851	(146,526)	(2.3%)	Personnel Expense	51,445,817	54,169,585	2,723,768	5.0%
28,052	31,827	3,775	11.9%	Pharmacy Administrative Fees	212,240	219,207	6,967	3.2%
(100,000)	0	100,000	0.0%	Behavioral Hlth Administration	(236,422)	0	236,422	0.0%
0	10,000	10,000	100.0%	M3P Admin Fees	0	125,000	125,000	100.0%
12,422	222	(12,200)	(5,495.7%)	OTC Administrative	22,422	382	(22,041)	(5,775.9%)
108	0	(108)	0.0%	Capitation Admin Fees	186	0	(186)	0.0%
50,201	50,609	408	0.8%	Telemedicine Admin. Fees	416,273	416,845	572	0.1%
(9,216)	92,659	101,875	109.9%	Benefits Administration Expense	414,699	761,434	346,735	45.5%
505,008	865,621	360,613	41.7%	Consultant Fees - Non Medical	4,202,373	5,548,428	1,346,054	24.3%
479,049	427,150	(51,899)	(12.2%)	Computer Support Services	3,361,204	3,729,468	368,264	9.9%
13,083	11,750	(1,333)	(11.3%)	Audit Fees	118,787	113,455	(5,332)	(4.7%)
0	0	0	0.0%	Consultant Fees - Medical	17,593	117,593	100,000	85.0%
571,118	349,752	(221,366)	(63.3%)	Other Purchased Services	2,041,304	2,132,553	91,249	4.3%
0	1,879	1,879	100.0%	Maint.&Repair-Office Equipment	0	7,516	7,516	100.0%
35,225	62,267	27,043	43.4%	Legal Fees	362,684	448,039	85,355	19.1%
0	0	0	0.0%	Member Health Education	(25)	(17)	8	(50.0%)
72,422	26,000	(46,422)	(178.5%)	Translation Services	449,681	351,523	(98,158)	(27.9%)
101,043	151,900	50,857	33.5%	Medical Refund Recovery Fees	1,403,190	1,433,750	30,560	2.1%
567,007	418,196	(148,811)	(35.6%)	Software - IT Licenses & Subsc	4,305,928	4,346,628	40,700	0.9%
90,438	109,975	19,537	17.8%	Hardware (Non-Capital)	311,189	504,833	193,645	38.4%
3,913	60,400	56,487	93.5%	Provider Credentialing	30,039	258,533	228,494	88.4%
2,438,306	2,484,890	46,584	1.9%	Purchased & Professional Services	16,603,947	18,992,301	2,388,355	12.6%
62,445	76,126	13,681	18.0%	Depreciation	496,892	517,218	20,327	3.9%
8,092	13,845	5,753	41.6%	Lease Rented Office Equipment	43,078	75,590	32,511	43.0%
17,059	21,965	4,907	22.3%	Utilities	143,718	147,653	3,935	2.7%
85,810	108,156	22,346	20.7%	Telephone	719,793	808,640	88,847	11.0%
18,337	21,440	3,103	14.5%	Building Maintenance	136,588	209,527	72,939	34.8%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 28 February, 2026

CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
391,703	250,000	(141,703)	(56.7%)	GASB96 SBITA Amort. Expense	2,409,343	2,126,154	(283,189)	(13.3%)
583,445	491,532	(91,912)	(18.7%)	Occupancy	3,949,412	3,884,782	(64,630)	(1.7%)
163,273	148,105	(15,168)	(10.2%)	Postage	728,825	809,942	81,117	10.0%
17,111	5,700	(11,411)	(200.2%)	Design & Layout	63,782	42,342	(21,440)	(50.6%)
444,807	431,643	(13,164)	(3.0%)	Printing Services	1,340,157	1,288,694	(51,463)	(4.0%)
120,698	15,600	(105,098)	(673.7%)	Mailing Services	233,808	75,865	(157,944)	(208.2%)
8,148	13,489	5,341	39.6%	Courier/Delivery Service	52,814	77,689	24,875	32.0%
0	2,070	2,070	100.0%	Pre-Printed Materials & Public	0	3,654	3,654	100.0%
3,861	0	(3,861)	0.0%	Promotional Products	8,283	32,500	24,217	74.5%
0	150	150	100.0%	Promotional Services	358	5,958	5,600	94.0%
16,847	30,550	13,703	44.9%	Community Relations	103,670	(3,255,882)	(3,359,552)	103.2%
774,745	647,307	(127,438)	(19.7%)	Printing Postage & Promotion	2,531,697	(919,238)	(3,450,935)	375.4%
(46,000)	0	46,000	0.0%	Regulatory Penalties	0	150,000	150,000	100.0%
40,426	45,500	5,075	11.2%	Bank Fees	336,764	350,638	13,874	4.0%
0	200	200	100.0%	Insurance Premium	1,043,881	1,044,681	800	0.1%
(127,344)	173,906	301,250	173.2%	License,Permits, & Fee - NonIT	959,313	1,998,568	1,039,255	52.0%
99,533	122,720	23,188	18.9%	Subscriptions and Dues - NonIT	598,096	836,328	238,232	28.5%
(33,385)	342,326	375,712	109.8%	License Insurance & Fees	2,938,055	4,380,216	1,442,161	32.9%
(1,361)	5,885	7,246	123.1%	Office and Other Supplies	17,558	35,741	18,183	50.9%
0	1,000	1,000	100.0%	Furniture & Equipment	0	3,000	3,000	100.0%
2,743	15,376	12,633	82.2%	Ergonomic Supplies	82,393	149,978	67,585	45.1%
10,601	19,510	8,909	45.7%	Meals and Entertainment	101,219	121,062	19,843	16.4%
0	0	0	0.0%	Miscellaneous	(703,091)	(245,248)	457,843	(186.7%)
0	3,125	3,125	100.0%	Member Incentive	0	12,500	12,500	100.0%
234,605	164,432	(70,173)	(42.7%)	Provider Interest (All Depts)	1,509,137	1,592,985	83,848	5.3%
161,667	333,333	171,666	51.5%	Community Reinvestment Expense	3,048,336	5,436,592	2,388,256	43.9%
408,255	542,661	134,406	24.8%	Other Administrative Expense	4,055,551	7,106,609	3,051,058	42.9%
4,162,149	4,601,375	439,226	9.5%	Total Other Administrative ExpenseS (excludes Personnel Expenses)	30,493,361	34,206,104	3,712,744	10.9%
10,664,525	10,957,226	292,701	2.7%	TOTAL ADMINISTRATIVE EXPENSES	81,939,178	88,375,689	6,436,512	7.3%

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	\$ 8,550	\$ 11,177	\$ 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	\$ 903	\$ -	\$ 903	\$ 6,500	\$ 5,597
1240 Exterior Landscaping	FA-FY26-04	\$ 15,000	\$ -	\$ 15,000	\$ 15,000	\$ -
1240 Exterior Landscaping	FA-FY26-04	\$ -	\$ -	\$ -	\$ 15,000	\$ 15,000
Building Improvement Subtotal		\$ 24,453	\$ 11,177	\$ 35,630	\$ 121,500	\$ 85,870
GRAND TOTAL		\$ 24,453	\$ 11,177	\$ 35,630	\$ 1,366,500	\$ 1,330,870

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 2/28/26	\$ 39,005,035
Fixed Assets @ Cost - 6/30/25	\$ 38,969,405
Fixed Assets Acquired YTD	\$ 35,630

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
FOR THE MONTH AND FISCAL YTD ENDED FEBRUARY 28, 2026

<u>TANGIBLE NET EQUITY (TNE)</u>	QRT. END Jun-25	Jul-25	Aug-25	QRT. END Sep-25	Oct-25	Nov-25	QRT. END Dec-25	Jan-26	Feb-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
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
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
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
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
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
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
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
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
<u>LIQUID TANGIBLE NET EQUITY</u>									
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
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)
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)
CD Pledged to DMHC	(353,866)	(354,839)	(355,847)	(356,859)	(357,840)	(358,857)	(359,844)	(360,866)	(361,892)
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
Liquid TNE as Multiple of Required	2.00	2.01	2.08	2.10	2.20	2.30	2.29	2.39	2.74

**ALAMEDA ALLIANCE FOR HEALTH
TRENDING ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2026**

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

	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					861,772
Adult	61,536	60,679	60,106	59,780	59,806	59,312	58,090	57,240					476,549
ACA OE	155,533	153,348	152,196	151,404	150,677	149,473	146,364	144,297					1,203,292
SPD with LTC	29,833	29,686	29,708	29,631	29,590	29,500	29,119	28,813					235,880
Duals with LTC	49,509	49,371	49,390	49,401	49,334	49,277	48,675	48,506					393,463
Medi-Cal Program	405,662	401,587	399,483	398,047	397,301	394,986	388,859	385,031					3,170,956
Group Care Program	5,957	5,974	6,054	6,081	6,092	6,138	6,191	6,211					48,698
Medicare Program	0	0	0	0	0	0	170	191					361
Total	411,619	407,561	405,537	404,128	403,393	401,124	395,220	391,433					3,220,015
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change:													
Child	(323)	(748)	(420)	(252)	63	(470)	(813)	(436)					(3,399)
Adult	(133)	(857)	(573)	(326)	26	(494)	(1,222)	(850)					(4,429)
ACA OE	357	(2,185)	(1,152)	(792)	(727)	(1,204)	(3,109)	(2,067)					(10,879)
SPD with LTC	83	(147)	22	(77)	(41)	(90)	(381)	(306)					(937)
Duals with LTC	205	(138)	19	11	(67)	(57)	(602)	(169)					(798)
Medi-Cal Program	189	(4,075)	(2,104)	(1,436)	(746)	(2,315)	(6,127)	(3,828)					(20,442)
Group Care Program	47	17	80	27	11	46	53	20					301
Medicare Program	0	0	0	0	0	0	170	21					191
Total	236	(4,058)	(2,024)	(1,409)	(735)	(2,269)	(5,904)	(3,787)					(19,950)
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%					27.2%
Adult % of Medi-Cal	15.2%	15.1%	15.0%	15.0%	15.1%	15.0%	14.9%	14.9%					15.0%
ACA OE % of Medi-Cal	38.3%	38.2%	38.1%	38.0%	37.9%	37.8%	37.6%	37.5%					37.9%
SPD with LTC % of Medi-Cal	7.4%	7.4%	7.4%	7.4%	7.4%	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%					12.4%
Medi-Cal Program % of Total	98.6%	98.5%	98.5%	98.5%	98.5%	98.5%	98.4%	98.4%					98.5%
Group Care Program % of Total	1.4%	1.5%	1.5%	1.5%	1.5%	1.5%	1.6%	1.6%					1.5%
Medicare Program % of Total	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%					0.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					800.0%

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

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

	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					738,613
Alameda Health System	92,861	91,758	91,032	91,084	90,621	90,714	88,985	87,443					724,498
Directly-Contracted Subtotal	186,794	185,026	184,631	183,754	184,036	182,180	179,024	177,666					1,463,111
Delegated:													
CFMG	43,381	42,852	42,253	42,053	41,790	41,683	41,247	40,893					336,152
CHCN	181,444	179,683	178,653	178,321	177,567	177,261	174,949	172,874					1,420,752
Delegated Subtotal	224,825	222,535	220,906	220,374	219,357	218,944	216,196	213,767					1,756,904
Total	411,619	407,561	405,537	404,128	403,393	401,124	395,220	391,433					3,220,015
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(518)	(1,768)	(395)	(877)	282	(1,856)	(3,156)	(1,358)					(9,646)
Delegated:													
CFMG	(128)	(529)	(599)	(200)	(263)	(107)	(436)	(354)					(2,616)
CHCN	882	(1,761)	(1,030)	(332)	(754)	(306)	(2,312)	(2,075)					(7,688)
Delegated Subtotal	754	(2,290)	(1,629)	(532)	(1,017)	(413)	(2,748)	(2,429)					(10,304)
Total	236	(4,058)	(2,024)	(1,409)	(735)	(2,269)	(5,904)	(3,787)					(19,950)
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	45.4%	45.4%	45.5%	45.5%	45.6%	45.4%	45.3%	45.4%					45.4%
Delegated:													
CFMG	10.5%	10.5%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%					10.4%
CHCN	44.1%	44.1%	44.1%	44.1%	44.0%	44.2%	44.3%	44.2%					44.1%
Delegated Subtotal	54.6%	54.6%	54.5%	54.5%	54.4%	54.6%	54.7%	54.6%					54.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					100.0%

**ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 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
TRENDEN 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					1,253
Adult	0	0	0	0	505	534	108	43					1,190
ACA OE	0	0	0	0	216	(9)	572	2,092					2,871
Total	0	0	0	0	16	44	7,308	7,147					14,515
Duals with LTC*	0	0	0	0	139	205	(7,794)	(7,838)					(15,288)
Medi-Cal Program	0	0	0	0	1,147	1,184	397	1,813					4,541
Group Care Program	0	0	0	0	13	53	112	126					304
Medicare Program	0	0	0	0	0	0	(96)	(179)					(275)
Total			0	0	1,160	1,237	413	1,760					4,570
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	5	(1,480)	(4,741)	(3,585)					(9,801)
Alameda Health System	0	0	0	0	296	961	1,564	1,544					4,365
Directly-Contracted Subtotal	0	0	0	0	301	(519)	(3,177)	(2,041)					(5,436)
Delegated:													
CFMG	0	0	0	0	117	236	534	437					1,324
CHCN	0	0	0	0	742	1,520	3,056	3,364					8,682
Delegated Subtotal	0	0	0	0	859	1,756	3,590	3,801					10,006
Total	0	0	0	0	1,160	1,237	413	1,760					4,570

**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 28 FEBRUARY, 2026**

CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
<u>CAPITATED MEDICAL EXPENSES</u>								
\$1,531,811	\$1,503,635	(\$28,176)	(1.9%)	PCP Capitation	\$17,178,417	\$17,053,025	(\$125,392)	(0.7%)
6,293,787	5,951,783	(342,004)	(5.7%)	PCP Capitation FQHC	57,871,845	56,848,382	(1,023,463)	(1.8%)
452,021	443,656	(8,365)	(1.9%)	Specialty Capitation	3,725,762	3,689,856	(35,906)	(1.0%)
5,138,653	5,133,157	(5,496)	(0.1%)	Specialty Capitation FQHC	41,230,963	41,730,308	499,345	1.2%
765,559	727,228	(38,331)	(5.3%)	Laboratory Capitation	6,319,224	6,152,480	(166,744)	(2.7%)
337,972	325,970	(12,003)	(3.7%)	Vision Capitation	2,713,994	2,684,921	(29,073)	(1.1%)
102,811	100,909	(1,902)	(1.9%)	CFMG Capitation	847,426	839,260	(8,166)	(1.0%)
817,888	793,019	(24,868)	(3.1%)	ANC IPA Admin Capitation FQHC	7,205,428	7,165,533	(39,895)	(0.6%)
0	0	0	0.0%	Kaiser Capitation	(16,872)	(12,511)	4,361	(34.9%)
1,002,561	942,914	(59,646)	(6.3%)	DME Capitation	8,219,773	8,072,475	(147,298)	(1.8%)
575	1,080	505	46.8%	Dental Capitation	1,054	1,857	803	43.2%
16,443,638	15,923,351	(520,286)	(3.3%)	7. TOTAL CAPITATED EXPENSES	145,297,013	144,225,586	(1,071,426)	(0.7%)
<u>FEE FOR SERVICE MEDICAL EXPENSES</u>								
(23,435,923)	0	23,435,923	0.0%	IBNR Inpatient Services	(35,102,511)	(20,241,559)	14,860,952	(73.4%)
(703,078)	0	703,078	0.0%	IBNR Settlement (IP)	(1,053,076)	(607,245)	445,831	(73.4%)
(1,874,872)	0	1,874,872	0.0%	IBNR Claims Fluctuation (IP)	(2,808,201)	(1,619,325)	1,188,876	(73.4%)
63,963,682	41,910,786	(22,052,896)	(52.6%)	Inpatient Hospitalization FFS	370,339,521	370,572,720	233,199	0.1%
2,916,819	3,189,720	272,901	8.6%	IP OB - Mom & NB	26,153,382	27,504,915	1,351,533	4.9%
354,160	134,279	(219,881)	(163.7%)	IP Behavioral Health	2,014,685	1,493,948	(520,737)	(34.9%)
1,562,736	1,287,570	(275,166)	(21.4%)	Inpatient Facility Rehab FFS	10,763,493	11,130,936	367,444	3.3%
42,783,524	46,522,355	3,738,831	8.0%	8. Inpatient Hospital Expense	370,307,293	388,234,391	17,927,098	4.6%
(935,311)	0	935,311	0.0%	IBNR PCP	1,386,235	3,433,331	2,047,096	59.6%
(28,060)	0	28,060	0.0%	IBNR Settlement (PCP)	41,585	103,000	61,415	59.6%
(74,825)	0	74,825	0.0%	IBNR Claims Fluctuation (PCP)	110,899	274,669	163,770	59.6%
2,893,466	2,998,983	105,517	3.5%	PCP FFS	22,847,647	26,224,273	3,376,627	12.9%
0	0	0	0.0%	Special Needs Medical Expense	278	278	0	0.0%
562,052	377,732	(184,320)	(48.8%)	PCP FQHC FFS	4,061,176	3,446,100	(615,076)	(17.8%)
0	0	0	0.0%	Prop 56 Physician Pmt	(3,778)	(3,778)	0	0.0%
21,558	0	(21,558)	0.0%	Prop 56 Hyde	139,576	64,417	(75,160)	(116.7%)
104,523	0	(104,523)	0.0%	Prop 56 Trauma Screening	664,210	303,469	(360,741)	(118.9%)
109,023	0	(109,023)	0.0%	Prop 56 Developmentl Screening	760,870	361,844	(399,025)	(110.3%)
661,340	845,364	184,024	21.8%	Prop 56 Family Planning	5,228,407	5,994,302	765,894	12.8%
0	0	0	0.0%	Prop 56 VBP	(259)	(259)	0	0.0%
3,313,765	4,222,079	908,313	21.5%	9. Primary Care Physician Expense	35,236,846	40,201,646	4,964,800	12.3%
(2,458,713)	0	2,458,713	0.0%	IBNR Specialist	89,823	(334,249)	(424,072)	126.9%
(73,761)	0	73,761	0.0%	IBNR Settlement (SCP)	2,695	(10,026)	(12,721)	126.9%
(196,696)	0	196,696	0.0%	IBNR Claims Fluctuation (SCP)	7,184	(26,743)	(33,927)	126.9%
694,649	4,539	(690,111)	(15,205.7%)	Psychiatrist FFS	5,208,893	2,747,434	(2,461,459)	(89.6%)
3,739,526	7,506,516	3,766,990	50.2%	Specialty Care FFS	26,934,477	47,883,934	20,949,457	43.8%
304,739	0	(304,739)	0.0%	Specialty Anesthesiology	2,431,284	1,349,666	(1,081,617)	(80.1%)
2,392,361	0	(2,392,361)	0.0%	Specialty Imaging FFS	13,874,200	6,999,284	(6,874,916)	(98.2%)
35,153	0	(35,153)	0.0%	Obstetrics FFS	400,376	236,824	(163,553)	(69.1%)
380,526	0	(380,526)	0.0%	Specialty IP Surgery FFS	3,585,433	1,954,243	(1,631,190)	(83.5%)
992,019	0	(992,019)	0.0%	Specialty OP Surgery FFS	8,189,491	4,456,894	(3,732,598)	(83.7%)
574,238	0	(574,238)	0.0%	Specialty IP Physician	5,168,343	2,930,480	(2,237,863)	(76.4%)
163,619	124,221	(39,398)	(31.7%)	Specialist FQHC FFS	1,318,976	1,199,425	(119,551)	(10.0%)
6,547,660	7,635,275	1,087,615	14.2%	10. Specialty Care Physician Expense	67,211,175	69,387,167	2,175,992	3.1%
(1,986,034)	0	1,986,034	0.0%	IBNR Ancillary (ANC)	(1,807,361)	(3,205,959)	(1,398,598)	43.6%
(59,580)	0	59,580	0.0%	IBNR Settlement (ANC)	(54,224)	(96,181)	(41,957)	43.6%

**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 28 FEBRUARY, 2026**

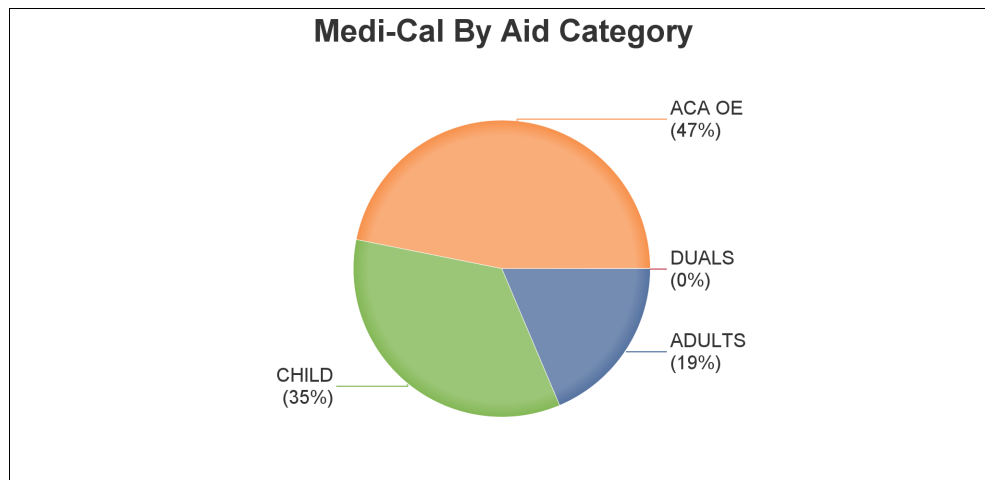
CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
(158,883)	0	158,883	0.0%	IBNR Claims Fluctuation (ANC)	(144,589)	(256,479)	(111,890)	43.6%
218,124	0	(218,124)	0.0%	IBNR Transportation FFS	71,748	(320,108)	(391,856)	122.4%
3,171,290	2,352,975	(818,315)	(34.8%)	Behavioral Health Therapy FFS	24,846,275	23,009,991	(1,836,284)	(8.0%)
2,907,801	0	(2,907,801)	0.0%	Psychologist & Other MH Prof	21,819,133	10,562,380	(11,256,753)	(106.6%)
831,393	0	(831,393)	0.0%	Other Medical Professional	5,414,612	2,326,374	(3,088,239)	(132.7%)
234,067	1,147	(232,920)	(20,306.9%)	Hearing Devices	1,343,518	685,248	(658,270)	(96.1%)
27,794	0	(27,794)	0.0%	ANC Imaging	234,067	138,286	(95,781)	(69.3%)
7,501	0	(7,501)	0.0%	Vision FFS	516,752	330,028	(186,724)	(56.6%)
0	0	0	0.0%	Family Planning	5	5	0	0.0%
814,300	745,335	(68,965)	(9.3%)	Laboratory FFS	5,885,997	6,234,918	348,920	5.6%
209,789	0	(209,789)	0.0%	ANC Therapist	1,354,240	667,783	(686,457)	(102.8%)
0	11,100	11,100	100.0%	OTC Card	0	19,080	19,080	100.0%
1,829,797	1,580,367	(249,430)	(15.8%)	Transp/Ambulance FFS	14,334,081	14,100,200	(233,881)	(1.7%)
0	46	46	100.0%	Worldwide Emergency Benefit	0	80	80	100.0%
3,414,019	2,563,903	(850,117)	(33.2%)	Non-ER Transportation FFS	21,291,476	20,320,744	(970,732)	(4.8%)
1,527,621	2,012,641	485,020	24.1%	Hospice FFS	12,993,476	15,699,018	2,705,542	17.2%
2,917,394	3,111,398	194,004	6.2%	Home Health Services	20,817,910	23,117,415	2,299,505	9.9%
0	45,970	45,970	100.0%	Other Medical FFS	2,450	81,469	79,019	97.0%
(411,778)	0	411,778	0.0%	Medical Refunds through HMS	(1,930,707)	(883,969)	1,046,738	(118.4%)
22,912	1,743,571	1,720,660	98.7%	DME & Medical Supplies FFS	170,785	7,785,014	7,614,229	97.8%
3,492,124	3,262,170	(229,954)	(7.0%)	ECM Base/Outreach FFS ANC	22,547,790	21,807,400	(740,389)	(3.4%)
158,689	173,409	14,719	8.5%	CS Housing Deposits FFS ANC	1,319,115	1,386,960	67,845	4.9%
756,961	669,630	(87,331)	(13.0%)	CS Housing Tenancy FFS ANC	6,389,607	6,458,358	68,751	1.1%
447,395	401,073	(46,323)	(11.5%)	CS Housing Navi Servic FFS ANC	3,923,809	4,024,652	100,842	2.5%
415,348	339,564	(75,784)	(22.3%)	CS Medical Respite FFS ANC	2,413,353	2,815,759	402,406	14.3%
207,564	256,614	49,050	19.1%	CS Med. Tailored Meals FFS ANC	1,662,249	1,958,173	295,925	15.1%
14,921	20,701	5,780	27.9%	CS Asthma Remediation FFS ANC	182,455	184,845	2,390	1.3%
0	0	0	0.0%	MOT Wrap Around (Non Med MOT)	6,868	6,868	0	0.0%
539	2,518	1,978	78.6%	CS Home Modifications FFS ANC	2,925	10,341	7,416	71.7%
51,538	82,170	30,632	37.3%	CS P.Care & Hmker Svcs FFS ANC	459,060	656,331	197,272	30.1%
0	5,927	5,927	100.0%	CS Cgiver Respite Svcs FFS ANC	12,483	33,221	20,738	62.4%
0	(70)	(70)	100.0%	CS ST PostHospital Housing FFS	0	(38)	(38)	100.0%
1,630	983	(647)	(65.7%)	CS Housing Outreach	4,780	5,155	375	7.3%
548,271	0	(548,271)	0.0%	CommunityBased Adult Svc(CBAS)	3,683,930	1,519,540	(2,164,390)	(142.4%)
16,629	10,831	(5,798)	(53.5%)	CS LTC to ALF Transition FFS ANC	135,717	107,172	(28,545)	(26.6%)
0	5,003	5,003	100.0%	CS LTC to Home Transition FFS ANC	18,800	37,865	19,065	50.3%
21,629,138	19,398,977	(2,230,161)	(11.5%)	11. Ancillary Medical Expense	169,922,583	161,327,939	(8,594,644)	(5.3%)
(3,092,265)	0	3,092,265	0.0%	IBNR Outpatient	(889,692)	1,452,995	2,342,687	161.2%
(92,768)	0	92,768	0.0%	IBNR Settlement (OP)	(26,692)	43,588	70,280	161.2%
(247,380)	0	247,380	0.0%	IBNR Claims Fluctuation (OP)	(71,173)	116,241	187,414	161.2%
3,429,374	5,304,642	1,875,268	35.4%	Outpatient FFS	24,050,369	35,329,530	11,279,161	31.9%
3,313,129	76,949	(3,236,179)	(4,205.6%)	OP Ambul Surgery FFS	24,444,075	13,724,101	(10,719,974)	(78.1%)
2,546,105	3,190,538	644,433	20.2%	Imaging Services FFS	22,450,234	26,264,372	3,814,138	14.5%
119,145	0	(119,145)	0.0%	Behavioral Health FFS	993,814	493,539	(500,274)	(101.4%)
1,017,201	0	(1,017,201)	0.0%	Outpatient Facility Lab FFS	6,780,646	3,448,349	(3,332,297)	(96.6%)
277,784	0	(277,784)	0.0%	Outpatient Facility Cardio FFS	1,902,661	1,028,586	(874,074)	(85.0%)
127,267	0	(127,267)	0.0%	OP Facility PT/OT/ST FFS	924,816	461,172	(463,644)	(100.5%)
2,403,713	2,665,816	262,103	9.8%	OP Facility Dialysis Ctr FFS	23,474,819	25,112,593	1,637,774	6.5%
9,801,305	11,237,945	1,436,640	12.8%	12. Outpatient Medical Expense	104,033,877	107,475,067	3,441,190	3.2%
(1,134,896)	0	1,134,896	0.0%	IBNR Emergency	(2,857,951)	(2,513,669)	344,282	(13.7%)
(34,046)	0	34,046	0.0%	IBNR Settlement (ER)	(85,736)	(75,408)	10,328	(13.7%)
(90,792)	0	90,792	0.0%	IBNR Claims Fluctuation (ER)	(228,636)	(201,094)	27,542	(13.7%)
9,817,271	9,669,807	(147,464)	(1.5%)	ER Facility	75,659,935	80,670,256	5,010,320	6.2%
1,291,752	0	(1,291,752)	0.0%	Specialty ER Physician FFS	9,761,594	4,951,779	(4,809,816)	(97.1%)
9,849,289	9,669,807	(179,482)	(1.9%)	13. Emergency Expense	82,249,206	82,831,863	582,657	0.7%

**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 28 FEBRUARY, 2026**

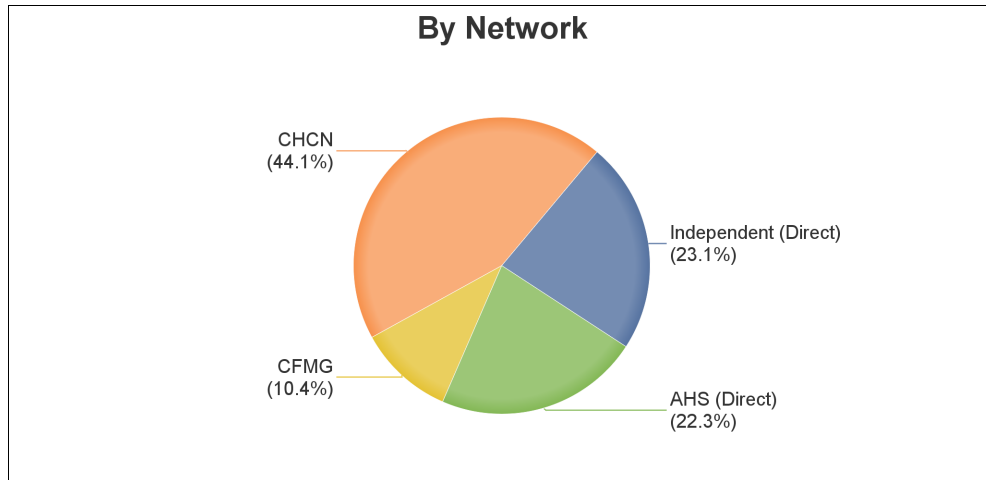
CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
(2,357,115)	0	2,357,115	0.0%	IBNR Pharmacy (OP)	(1,775,385)	(2,257,911)	(482,526)	21.4%
(70,715)	0	70,715	0.0%	IBNR Settlement Rx (OP)	(53,260)	(67,734)	(14,474)	21.4%
(188,568)	0	188,568	0.0%	IBNR Claims Fluctuation Rx(OP)	(142,029)	(180,633)	(38,604)	21.4%
734,059	877,540	143,482	16.4%	Pharmacy FFS (OP)	5,942,643	6,369,099	426,456	6.7%
229,457	0	(229,457)	0.0%	Pharmacy Non PBM FFS Other-ANC	1,098,139	479,027	(619,112)	(129.2%)
11,098,388	10,710,758	(387,629)	(3.6%)	Pharmacy Non PBM FFS OP-FAC	58,679,151	68,786,639	10,107,488	14.7%
405,748	0	(405,748)	0.0%	Pharmacy Non PBM FFS PCP	2,648,621	1,140,883	(1,507,739)	(132.2%)
4,057,732	0	(4,057,732)	0.0%	Pharmacy Non PBM FFS SCP	25,475,161	11,779,726	(13,695,435)	(116.3%)
115,133	0	(115,133)	0.0%	Pharmacy Non PBM FFS FQHC	463,586	165,336	(298,249)	(180.4%)
8,059	0	(8,059)	0.0%	Pharmacy Non PBM FFS HH	129,413	78,426	(50,987)	(65.0%)
(40,000)	(81,958)	(41,958)	51.2%	Medical Expenses Pharm Rebate	(663,935)	(670,585)	(6,650)	1.0%
13,992,176	11,506,340	(2,485,836)	(21.6%)	14. Pharmacy Expense	91,802,105	85,622,273	(6,179,832)	(7.2%)
(2,444,435)	0	2,444,435	0.0%	IBNR LTC	5,065,818	(5,530,063)	(10,595,881)	191.6%
(73,333)	0	73,333	0.0%	IBNR Settlement (LTC)	151,974	(165,902)	(317,876)	191.6%
(195,554)	0	195,554	0.0%	IBNR Claims Fluctuation (LTC)	405,263	(442,407)	(847,670)	191.6%
1,563,100	1,855,207	292,107	15.7%	LTC - ICF/DD	14,534,760	15,572,295	1,037,536	6.7%
21,504,737	27,321,685	5,816,948	21.3%	LTC Custodial Care	210,280,453	227,104,974	16,824,521	7.4%
9,018,607	7,437,801	(1,580,806)	(21.3%)	LTC SNF	68,740,939	68,207,070	(533,869)	(0.8%)
29,373,122	36,614,693	7,241,571	19.8%	15. Long Term Care Expense	299,179,207	304,745,968	5,566,760	1.8%
137,289,978	146,807,471	9,517,493	6.5%	16. TOTAL FFS MEDICAL EXPENSES	1,219,942,291	1,239,826,313	19,884,022	1.6%
0	(609,821)	(609,821)	100.0%	Clinical Vacancy #102	0	25,648	25,648	100.0%
446,000	249,663	(196,337)	(78.6%)	Quality Analytics #123	1,661,219	2,475,972	814,752	32.9%
381,331	400,163	18,832	4.7%	LongTerm Services and Support #139	3,112,508	3,163,294	50,786	1.6%
899,375	1,027,095	127,720	12.4%	Utilization Management #140	7,518,421	7,856,202	337,781	4.3%
753,308	928,023	174,715	18.8%	Case & Disease Management #185	5,941,171	6,452,962	511,791	7.9%
259,487	319,172	59,685	18.7%	Medical Management #230	(676,094)	(480,900)	195,194	(40.6%)
1,248,276	1,411,267	162,991	11.5%	Quality Improvement #235	9,013,748	10,962,827	1,949,080	17.8%
370,639	460,446	89,808	19.5%	HCS Behavioral Health #238	3,170,720	3,416,825	246,106	7.2%
120,502	259,476	138,975	53.6%	Pharmacy Services #245	1,118,406	1,624,241	505,835	31.1%
0	0	0	0.0%	Regulatory Readiness #268	(4,027)	(5,289)	(1,262)	23.9%
4,478,917	4,445,485	(33,432)	(0.8%)	17. Other Benefits & Services	30,856,071	35,491,782	4,635,711	13.1%
(2,301,481)	(1,663,913)	637,568	(38.3%)	Reinsurance Recoveries	(18,645,177)	(17,579,688)	1,065,489	(6.1%)
2,363,366	2,218,550	(144,816)	(6.5%)	Reinsurance Premium	19,496,913	19,217,190	(279,722)	(1.5%)
61,885	554,638	492,753	88.8%	18. Reinsurance (Net)	851,736	1,637,503	785,767	48.0%
2,040,000	2,040,000	0	0.0%	P4P Risk Pool Provider Incenti	9,739,099	6,699,099	(3,040,000)	(45.4%)
2,040,000	2,040,000	0	0.0%	19. Risk Pool Distribution	9,739,099	6,699,099	(3,040,000)	(45.4%)
160,314,418	169,770,945	9,456,527	5.6%	20. TOTAL MEDICAL EXPENSES	1,406,686,209	1,427,880,283	21,194,074	1.5%

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend						
Category of Aid	Feb 2026	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	57,402	15%	11,799	14,217	0	31,386
CHILD	106,333	28%	9,894	13,808	37,900	44,731
SPD	0	0%	0	0	0	0
ACA OE	144,320	37%	26,690	49,338	1,510	66,782
DUALS	43	0%	40	3	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	28,815	7%	8,384	5,390	1,521	13,520
SPD-LTC/Full Dual	48,514	13%	31,329	3,513	0	13,672
Other	0		0	0	0	0
Medi-Cal	385,427		88,136	86,269	40,931	170,091
Group Care	6,207		2,224	1,233	0	2,750
D-SNP	193		67	17	0	109
Total	391,827	100%	90,427	87,519	40,931	172,950
Other %	0.0%		0.0%	0.0%	0.0%	0.0%
Medi-Cal %	98.4%		97.5%	98.6%	100.0%	98.3%
Group Care %	1.6%		2.5%	1.4%	0.0%	1.6%
D-SNP %	0.0%		0.1%	0.0%	0.0%	0.1%
Network Distribution			23.1%	22.3%	10.4%	44.1%
			% Direct:	45%	% Delegated:	55%

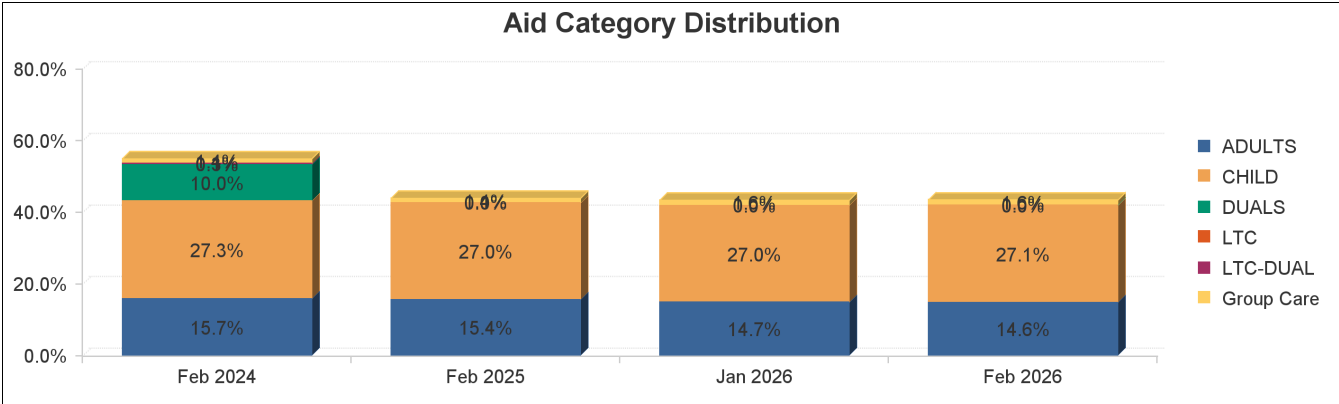


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

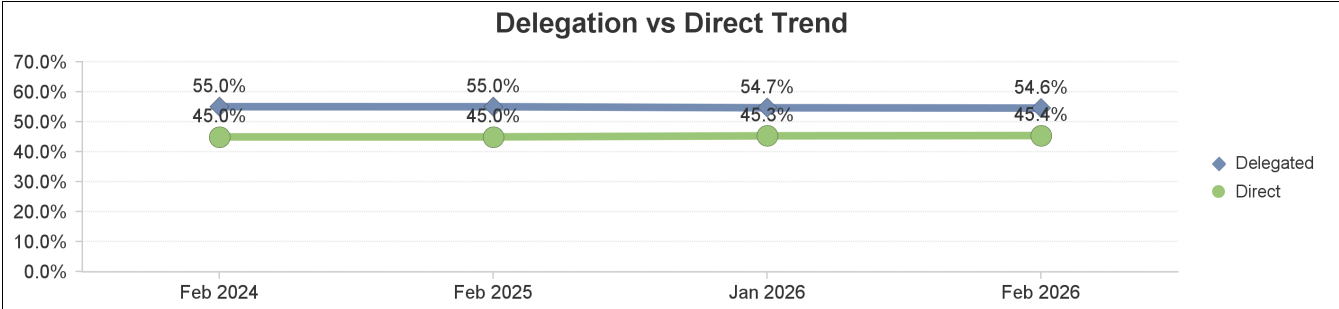


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend											
Category of Aid	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
ADULTS	63,130	63,758	58,220	57,402	15.7%	15.4%	14.7%	14.6%	1.0%	-11.1%	-1.4%
CHILD	109,957	111,576	106,746	106,333	27.3%	27.0%	27.0%	27.1%	1.5%	-4.9%	-0.4%
SPD	34,876	0	0	0	8.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ACA OE	146,758	154,609	146,364	144,320	36.5%	37.4%	37.0%	36.8%	5.1%	-7.1%	-1.4%
DUALS	40,403	2	41	43	10.0%	0.0%	0.0%	0.0%	#####	95.3%	4.7%
LTC	217	0	0	0	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LTC-DUAL	1,329	0	0	0	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SPD-LTC	0	29,497	29,119	28,815	0.0%	7.1%	7.4%	7.4%	100.0%	-2.4%	-1.1%
SPD-LTC/ Full Dual	0	48,100	48,675	48,514	0.0%	11.6%	12.3%	12.4%	100.0%	0.9%	-0.3%
Other	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medi-Cal	396,670	407,542	389,165	385,427	98.6%	98.6%	98.4%	98.4%	2.7%	-5.7%	-1.0%
Group Care	5,608	5,812	6,191	6,207	1.4%	1.4%	1.6%	1.6%	3.5%	6.4%	0.3%
D-SNP	0	0	170	193	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	402,278	413,354	395,526	391,827	100.0%	100.0%	100.0%	100.0%	2.7%	-5.5%	-1.0%

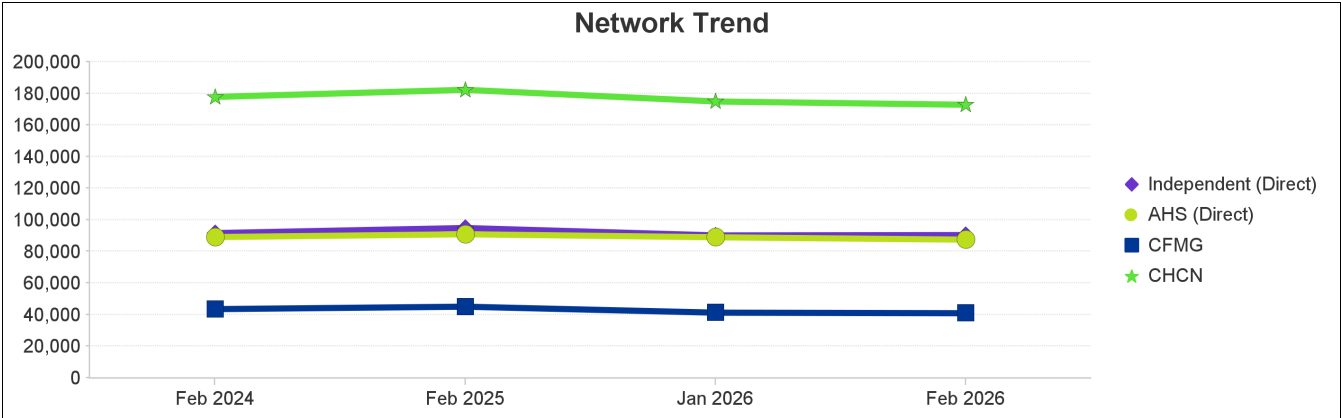


Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
Delegated	221,438	227,504	216,298	213,881	55.0%	55.0%	54.7%	54.6%	2.7%	-6.4%	-1.1%
Direct	180,840	185,850	179,228	177,946	45.0%	45.0%	45.3%	45.4%	2.7%	-4.5%	-0.7%
Total	402,278	413,354	395,526	391,827	100.0%	100.0%	100.0%	100.0%	2.7%	-5.5%	-1.0%



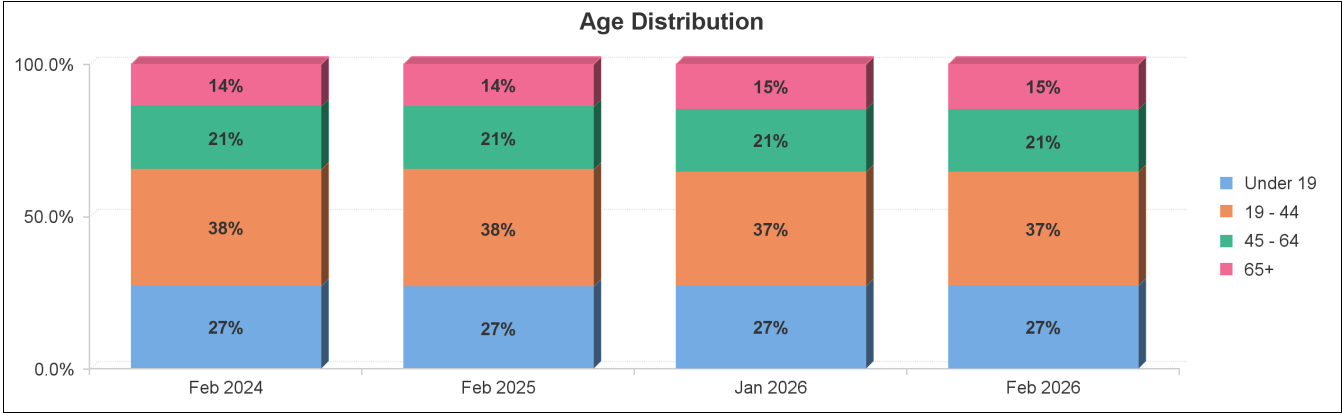
Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Network Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
Independent (Direct)	91,671	94,899	90,191	90,427	22.8%	23.0%	22.8%	23.1%	3.4%	-5.0%	0.3%
AHS (Direct)	89,169	90,951	89,037	87,519	22.2%	22.0%	22.5%	22.3%	2.0%	-3.9%	-1.7%
CFMG	43,528	45,079	41,278	40,931	10.8%	10.9%	10.4%	10.4%	3.4%	-10.1%	-0.8%
CHCN	177,910	182,425	175,020	172,950	44.2%	44.1%	44.2%	44.1%	2.5%	-5.5%	-1.2%
KAISER	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	402,278	413,354	395,526	391,827	100.0%	100.0%	100.0%	100.0%	2.7%	-5.5%	-1.0%

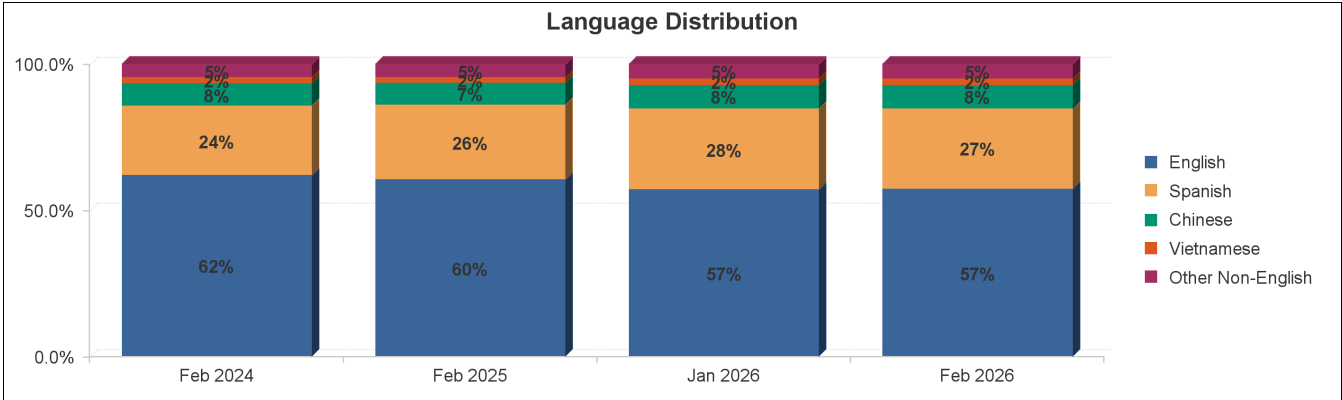


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Age Category Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
Under 19	108,207	110,599	106,640	106,246	27%	27%	27%	27%	2%	-4%	0%
19 - 44	154,277	159,068	147,945	145,855	38%	38%	37%	37%	3%	-9%	-1%
45 - 64	83,582	85,271	81,599	80,798	21%	21%	21%	21%	2%	-6%	-1%
65+	56,212	58,416	59,172	58,735	14%	14%	15%	15%	4%	1%	-1%
Total	402,278	413,354	395,356	391,634	100%	100%	100%	100%	3%	-6%	-1%

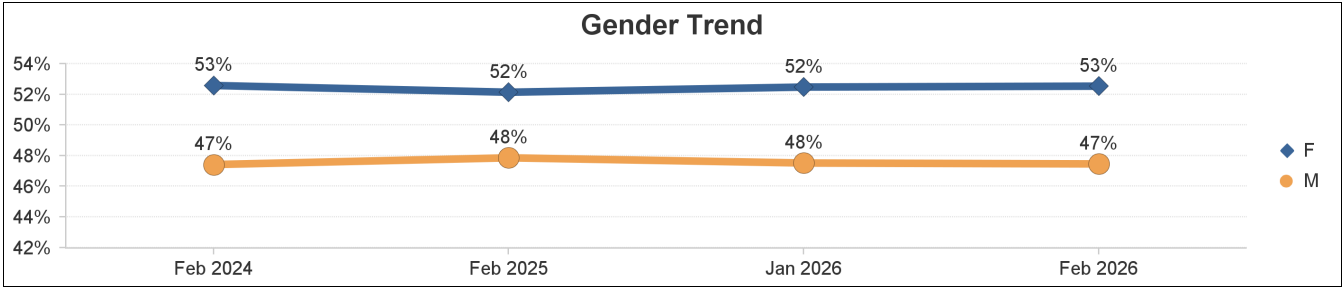


Language Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
English	248,268	248,996	224,692	223,411	62%	60%	57%	57%	0%	-11%	-1%
Spanish	95,947	105,721	109,447	107,488	24%	26%	28%	27%	9%	2%	-2%
Chinese	30,706	30,594	31,587	31,427	8%	7%	8%	8%	0%	3%	-1%
Vietnamese	8,516	8,238	8,924	8,864	2%	2%	2%	2%	-3%	7%	-1%
Other Non-English	18,841	19,805	20,706	20,444	5%	5%	5%	5%	5%	3%	-1%
Total	402,278	413,354	395,356	391,634	100%	100%	100%	100%	3%	-6%	-1%

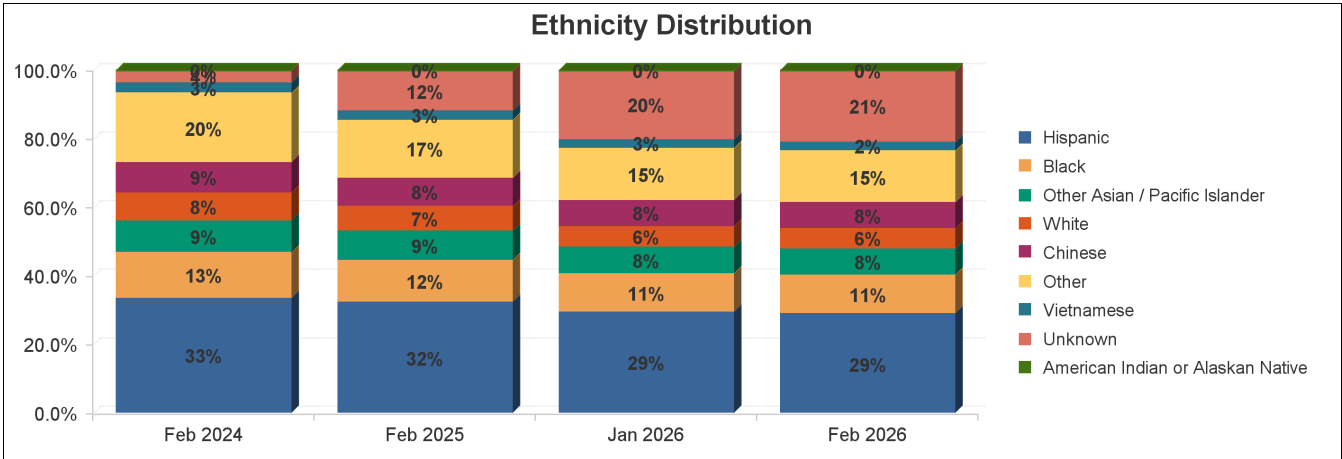


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Gender Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
F	211,525	215,525	207,573	205,863	53%	52%	52%	53%	2%	-5%	-1%
M	190,753	197,829	187,953	185,964	47%	48%	48%	47%	4%	-6%	-1%
Total	402,278	413,354	395,526	391,827	100%	100%	100%	100%	3%	-6%	-1%



Ethnicity Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
Hispanic	134,527	133,402	116,069	113,383	33%	32%	29%	29%	-1%	-18%	-2%
Black	53,620	50,373	44,698	44,121	13%	12%	11%	11%	-6%	-14%	-1%
Other Asian / Pacific Islander	37,048	35,321	30,167	29,520	9%	9%	8%	8%	-5%	-20%	-2%
White	32,781	29,853	23,965	23,432	8%	7%	6%	6%	-10%	-28%	-2%
Chinese	35,685	33,774	30,204	29,804	9%	8%	8%	8%	-6%	-13%	-1%
Other	81,682	70,242	60,151	59,121	20%	17%	15%	15%	-16%	-19%	-2%
Vietnamese	12,017	11,084	9,894	9,776	3%	3%	3%	2%	-8%	-13%	-1%
Unknown	14,108	48,550	79,760	82,071	4%	12%	20%	21%	71%	41%	3%
American Indian or Alaskan Native	810	755	618	599	0%	0%	0%	0%	-7%	-26%	-3%
Total	402,278	413,354	395,526	391,827	100%	100%	100%	100%	3%	-6%	-1%



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

Medi-Cal By City						
City	Feb 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	153,040	40%	22,996	41,305	16,124	72,615
HAYWARD	49,846	13%	11,465	14,036	5,368	18,977
FREMONT	37,125	10%	15,466	6,432	2,025	13,202
SAN LEANDRO	24,217	6%	6,640	4,041	2,940	10,596
UNION CITY	13,881	4%	5,587	2,473	785	5,036
ALAMEDA	13,254	3%	3,330	2,502	2,011	5,411
BERKELEY	15,905	4%	3,608	2,624	1,681	7,992
LIVERMORE	12,553	3%	2,075	390	1,988	8,100
NEWARK	8,851	2%	2,683	3,667	467	2,034
CASTRO VALLEY	10,807	3%	3,231	1,662	1,662	4,252
SAN LORENZO	5,857	2%	1,218	1,384	671	2,584
PLEASANTON	7,740	2%	2,283	303	803	4,351
DUBLIN	7,560	2%	2,550	306	854	3,850
EMERYVILLE	2,981	1%	603	679	509	1,190
ALBANY	2,518	1%	536	293	550	1,139
PIEDMONT	466	0%	107	183	70	106
SUNOL	88	0%	31	9	7	41
ANTIOCH	31	0%	5	14	1	11
Other	18,707	5%	3,722	3,966	2,415	8,604
Total	385,427	100%	88,136	86,269	40,931	170,091

Group Care By City						
City	Feb 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,885	30%	342	451	0	1,092
HAYWARD	720	12%	316	206	0	198
FREMONT	697	11%	434	99	0	164
SAN LEANDRO	673	11%	268	116	0	289
UNION CITY	290	5%	171	58	0	61
ALAMEDA	314	5%	91	42	0	181
BERKELEY	158	3%	42	18	0	98
LIVERMORE	102	2%	31	1	0	70
NEWARK	150	2%	86	38	0	26
CASTRO VALLEY	226	4%	98	35	0	93
SAN LORENZO	164	3%	51	40	0	73
PLEASANTON	83	1%	31	4	0	48
DUBLIN	132	2%	50	9	0	73
EMERYVILLE	44	1%	12	8	0	24
ALBANY	22	0%	10	2	0	10
PIEDMONT	6	0%	0	3	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	26	0%	8	5	0	13
Other	514	8%	182	98	0	234
Total	6,207	100%	2,224	1,233	0	2,750

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

D-SNP By City						
City	Feb 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	74	38%	18	4	0	52
HAYWARD	23	12%	11	3	0	9
FREMONT	18	9%	6	0	0	12
SAN LEANDRO	12	6%	6	2	0	4
UNION CITY	2	1%	1	0	0	1
ALAMEDA	15	8%	5	4	0	6
BERKELEY	10	5%	0	2	0	8
LIVERMORE	9	5%	2	1	0	6
NEWARK	4	2%	4	0	0	0
CASTRO VALLEY	3	2%	2	0	0	1
SAN LORENZO	4	2%	3	0	0	1
PLEASANTON	6	3%	2	0	0	4
DUBLIN	3	2%	0	0	0	3
EMERYVILLE	1	1%	1	0	0	0
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	9	5%	6	1	0	2
Sum:			2,224	1,233	0	2,750

Total By City						
City	Feb 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	154,925	40%	23,338	41,756	16,124	73,707
HAYWARD	50,566	13%	11,781	14,242	5,368	19,175
FREMONT	37,822	10%	15,900	6,531	2,025	13,366
SAN LEANDRO	24,890	6%	6,908	4,157	2,940	10,885
UNION CITY	14,171	4%	5,758	2,531	785	5,097
ALAMEDA	13,568	3%	3,421	2,544	2,011	5,592
BERKELEY	16,063	4%	3,650	2,642	1,681	8,090
LIVERMORE	12,655	3%	2,106	391	1,988	8,170
NEWARK	9,001	2%	2,769	3,705	467	2,060
CASTRO VALLEY	11,033	3%	3,329	1,697	1,662	4,345
SAN LORENZO	6,021	2%	1,269	1,424	671	2,657
PLEASANTON	7,823	2%	2,314	307	803	4,399
DUBLIN	7,692	2%	2,600	315	854	3,923
EMERYVILLE	3,025	1%	615	687	509	1,214
ALBANY	2,540	1%	546	295	550	1,149
PIEDMONT	472	0%	107	186	70	109
SUNOL	89	0%	32	9	7	41

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

ANTIOCH	57	0%	13	19	1	24
Other	19,221	5%	3,904	4,064	2,415	8,838
Total	391,634	100%	90,360	87,502	40,931	172,841



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

Operations

Ruth Watson

To: Alameda Alliance for Health Board of Governors

From: Ruth Watson, Chief Operating Officer

Date: April 10th, 2026

Subject: Operations Report

Member Services

- The Member Services Department received 20,652 calls in March 2026 compared to 17,256 in March 2025 and represents a 19.7% increase in calls.
 - The abandonment rate for March 2026 was 2% compared to 4% in March 2025.
 - The Department's service level was 97% in March 2026, compared to 95% in March 2025. The average speed to answer (ASA) was eight seconds (00:08) compared to eleven seconds (00:11) in March 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 twenty seconds (7:20) for March 2026 compared to seven minutes and twenty-nine seconds (7:29) for March 2025.
 - 100% of calls were answered within 10 minutes for March 2026 and 100% of calls were answered within 10 minutes for March 2025.
 - Outbound calls totaled 10,819 in March 2026 compared to 9,163 in March 2025.
 - The top five (5) call reasons for March 2026 were 1) Eligibility/Enrollment, 2), Grievances/Appeals 3), Change of PCP, 4) Benefits, and 5) Provider Network Information. The top five (5) call reasons for March 2025 were: 1) Change of PCP, 2), Eligibility/Enrollment 3) Grievances/Appeals, 4) Benefits, and 5) Provider Network Information.
 - March utilization for the member automated eligibility IVR system totaled 1,336 in March 2026 compared to 1,207 in March 2025.
 - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests, and in-person). The Department responded to 1,015 web-based requests in March 2026 compared to 1,186 in March 2025. The top three (3) web reason requests for March 2026 were: 1). Change of PCP, 2) ID Card Requests, and 3) Update Contact Information. Sixty-four members were assisted in-person in March 2026 compared to forty-seven in March 2025.
- MS Behavioral Health:
 - The Member Services Behavioral Health (MS BH) Unit received a total of 1,059 calls in March 2026 compared to 1,255 in March 2025.
 - The abandonment rate was 2% in March 2026 compared to 5% in March 2025.

- The service level was 94% in March 2026 and 86% in March 2025.
- The average speed to answer (ASA) was fifteen seconds (00:15) compared to thirty-eight seconds (00:38) in March 2025.
- In both March 2025 and March 2026, 100% of calls were answered within 10 minutes.
- The Average Talk Time (ATT) was nine minutes and fifty-six seconds (09:56) compared to eight minutes and twenty-nine seconds (08:29) in March 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.
- 1,702 outbound calls were completed in March 2026 compared to 1,142 in March 2025.
- 155 screenings were completed in March 2026 compared to 136 in March 2025.
- 31 referrals were made to the County (ACCESS) in March 2026 compared to 36 March 2025.
- 18 members were referred to Center Point for SUD services in March 2026 compared to 12 in March 2025.
- D-SNP Member Services blended:
 - The Member Services D-SNP Unit received a total of 709 calls in March 2026.
 - The abandonment rate was 2%.
 - The Average Speed to Answer (ASA) was seven seconds (00:07).
 - The service level was 100%.
 - The Average Talk Time (ATT) was seven minutes and twelve seconds (7:12).
 - The top five (5) call reasons were: 1) Eligibility/Enrollment, 2), Appeals/Grievances, 3) Change of PCP, 4). Benefits, and 5). Provider Network.

Claims

- 12-Month Trend Summary:
 - The Claims Department received 388,901 claims for all lines of business in March 2026 compared to 347,469 in March 2025.
 - The Auto Adjudication rate was 85% in March 2026 compared to 86% in March 2025.
 - Claims compliance for the 30-day turn-around time was 90.5% in March 2026 compared to 90.5% in March 2025.
 - Routine training is being conducted remotely and onsite by the Claims Trainer.
- Medi-Cal/Group Care Monthly Analysis:

- In March, we received a total of 388,603 claims in the HEALTHsuite system, which represents a minimal increase of 2.8% from February 2026. It is also 11.8% higher than the number of claims received in March 2025 (347,469).
- 89% of claims were received via EDI, and 11% of claims via paper during March.
- The Auto Adjudication rate was 85.3% for March.
- D-SNP Monthly Analysis:
 - In March, we received a total of 649 claims in the HEALTHsuite system, which represents a 17.3% increase from February 2026, when 553 claims were received.
 - 513 claims (79%) were received via EDI and 136 claims (21%) were received via paper in March.
 - Out of 649 claims, 171 claims have been finalized.
 - The Auto Adjudication rate was 57% for March.
- D-SNP YTD Analysis
 - A total of 1,462 D-SNP claims have been received since the January 1st, 2026, go live, and 905 claims have been finalized.

Provider Dispute Resolution

- 12-Month Trend Summary:
 - In March 2026, the Provider Dispute Resolution (PDR) team received 3,394 PDRs versus 4,707 in March 2025.
 - The PDR team resolved 2,273 cases in March 2026 compared to 1,857 cases in March 2025.
 - In March 2026, the PDR team upheld 73% of cases versus 65% in March 2025.
 - The PDR team resolved 99.6% of cases within the compliance standard of 95% within 45 working days in March 2026, compared to 99.5% in March 2025.
- Monthly Analysis:
 - In March 2026, the Provider Dispute Resolution (PDR) team received 3,394 PDRs versus 2,849 in February 2026. This represents an increase of 19% from February 2026.
 - In March 2026, 2,273 PDRs were resolved, with 1,663 upheld and 610 overturned.
 - 2,265 of 2,273 cases were resolved within 45 working days, resulting in a 99.6% compliance rate.
 - The average turnaround time for resolving PDRs in February was 38 days.
 - There were 4,001 PDRs pending resolution as of March 31st, with no cases older than 45 working days.
 - The overturn rate for PDRs was 27%, which did not meet our goal of 25% or less.
 - Primary reasons for the missed goal include:

- Member OHC corrections – 185 cases with incorrect claim denials.
- Authorization issues –141 cases with incorrect claim denial (claim denied in error; authorization was on file).
- Incorrect Rate Configuration – 116 cases were underpaid due to the contract not being loaded in the system correctly.
- The full breakdown of all **610** overturned PDRs is as follows:

Category	# of Cases	% of Cases	Comments
System Related Issues	64	11%	
General configuration issues	19	3%	Non-covered code, modifier, NDC etc.
Financial responsibility	40	7%	Member Not Found
Claims Editing System (CES)	5	1%	
Authorization Issues	141	24%	
Processor error	69	12%	Authorization was on file
UM/retro auth review	58	10%	Retro medical necessity review
Auth System error	14	2%	
OHC Issues	185	30%	Inaccurate OHC Member TPL data
Incorrect Rates	116	19%	
Incorrect rate - System	41	7%	Contract not updated in the system at the time of claim processing
Letter of Agreement (LOA)	9	1%	Underpaid; LOA on file
COB calculation	17	3%	Incorrectly calculated
Incorrect rate – Processor	49	8%	The processor did not calculate the rate correctly according to the contract or rate sheet.
Claim Processing Error	63	10%	
Duplicate claim	49	8%	The claim was not a duplicate; the processor denied it in error
Incorrect Manual Denial	5	1%	The claim was manually denied incorrectly
Overpayment	9	1%	Provider requests recoupment due to overpayment
Additional Documentation	41	6%	
Provider duplicate claim	26	4%	The documentation received confirmed that the claim was not a duplicate
Timely filing	15	2%	The documentation received confirmed that the claim was submitted on time
PDR Overturn Totals	610	100%	

Grievances & Appeals (MCAL & IHSS)

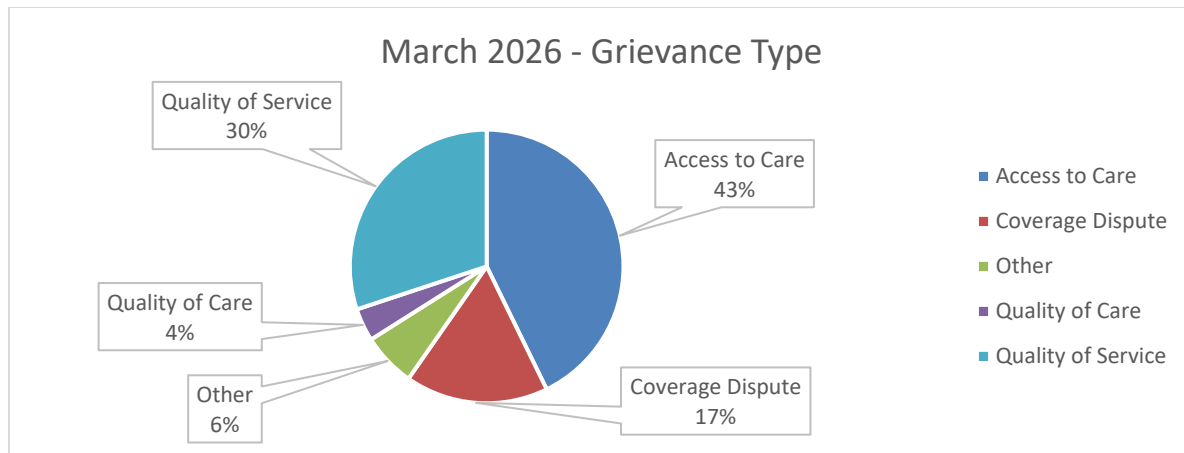
- Standard Grievance cases were not resolved within the goal of 95% of regulatory timeframes.
- Expedited Grievance cases were resolved within the goal of 95% of regulatory timeframes.
- Exempt Grievance cases were resolved within the goal of 95% of regulatory timeframes.
- Standard Appeal and Expedited Appeal cases were resolved within the goal of 95% of regulatory timeframes.
- Total Unique grievances resolved in March were 9.24 complaints per 1,000 members.

March 2026 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,511	30 Calendar Days	95% compliance within standard	2,246	89.4%	5.17
Expedited Grievance	12	72 Hours	95% compliance within standard	12	100.0%	0.23
Exempt Grievance	1,810	Next Business Day	95% compliance within standard	1,809	99.9%	4.04
Standard Appeal	56	30 Calendar Days	95% compliance within standard	56	100.0%	0.14
Expedited Appeal	2	72 Hours	95% compliance within standard	2	100.0%	0.00
Total Cases:	4,391		95% compliance within standard	4,125	93.9%	9.24

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

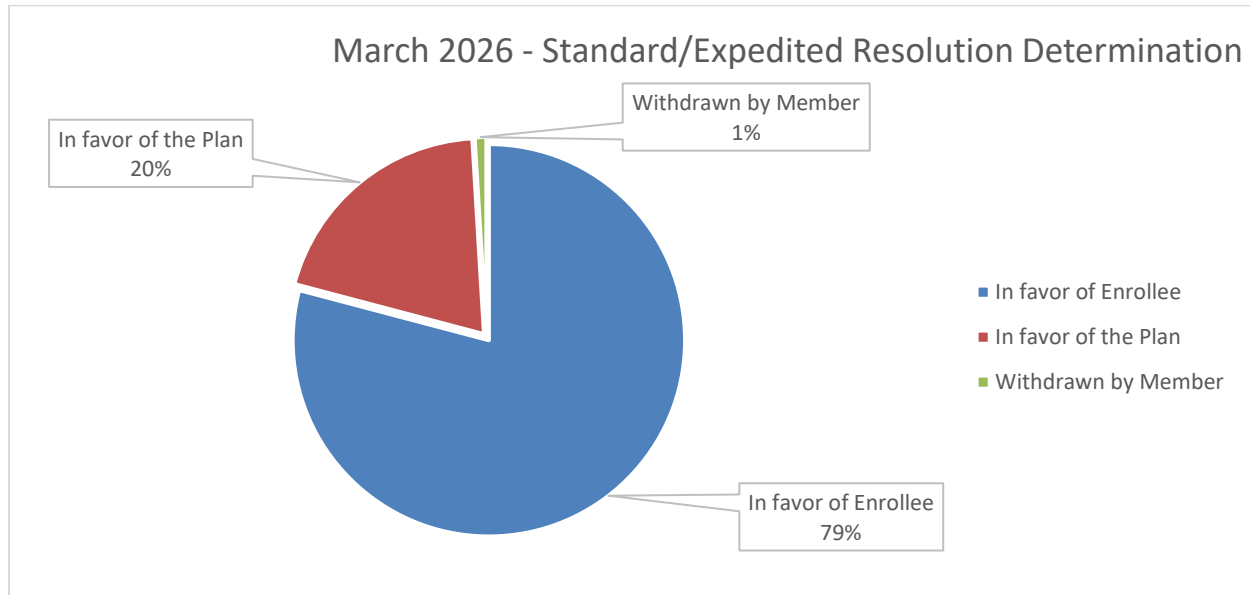
Standard Grievances:

There were 1,992 unique grievance cases resolved during the reporting period, with a total of 2,511 grievances including 519 shadow cases.



- **1,079** of 2,523 (43%) cases were related to Access to Care; the following are the top four (4) categories:
 - Timely Access – 346
 - Technology/telephone – 304
 - Authorization – 156
 - Provider Availability – 116
- **759** of 2,523 (30%) cases were related to Quality of Service; the following are the top four (4) categories:
 - Provider/Staff Attitude – 163
 - Plan Customer Service – 155
 - Authorization – 144
 - Referral – 122
- **427** of 2,523 (17%) cases were related to Coverage Dispute; the following are the top two (2) categories:
 - Provider Direct Member Billing – 212
 - Provider Balance Billing – 140

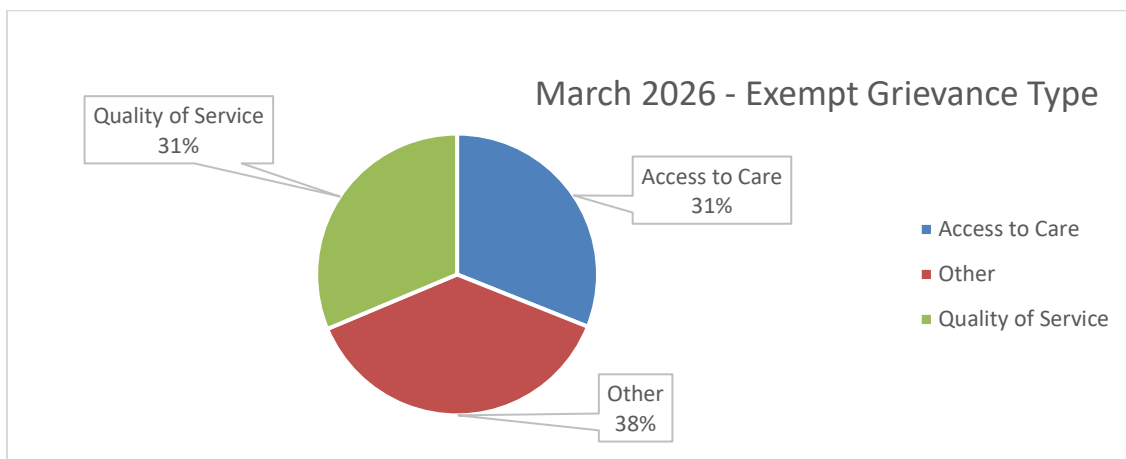
Resolution Determination:



- **1,996** of 2,523 (79%) cases were resolved In Favor of Enrollee.
- **503** of 2,523 (20%) cases were resolved In Favor of the Plan.
- **24** of 2,523 (1%) cases were Withdrawn by Member.

Exempt Grievances:

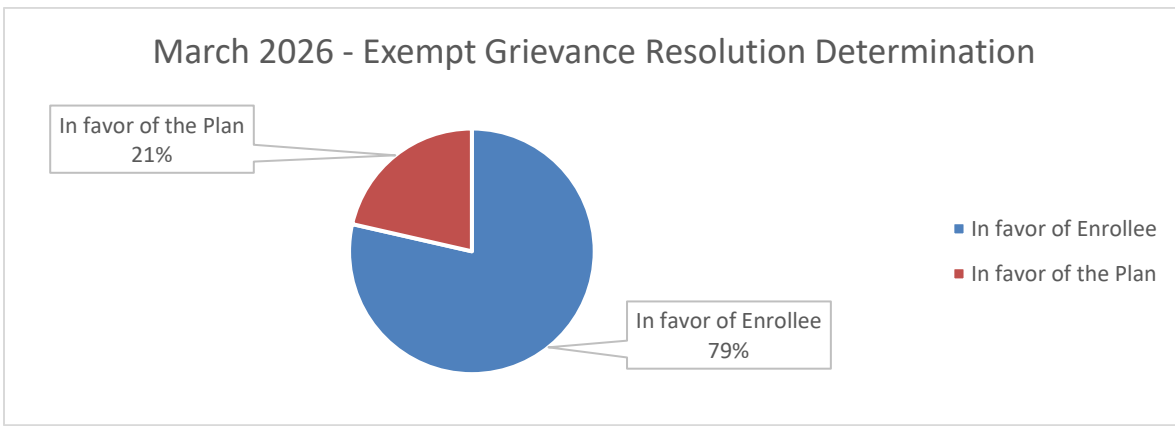
There were 1,560 unique exempt grievance cases resolved during the reporting period, with a total of 1,810 exempt grievances including 250 shadow cases.



- **681** of 1,810 (38%) cases were related to Other; the following are the top two (2) categories:
 - Enrollment – 604
 - Eligibility – 77

- **567** of 1,810 (31%) cases were related to Quality of Service; the following are the top two (2) categories:
 - Plan Customer Service – 360
 - Provider/Staff Attitude – 169
- **562** of 1,810 (31%) cases were related to Access to Care; the following are the top two (2) categories:
 - Provider Availability – 312
 - Technology / Telephone – 144

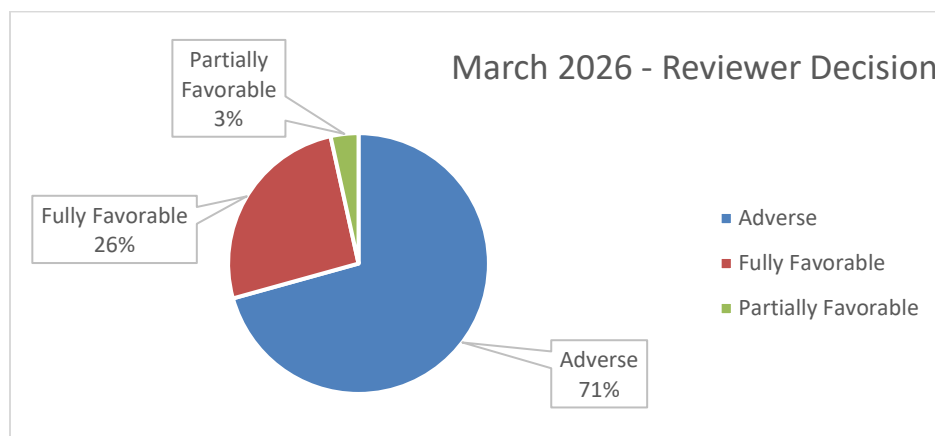
Resolution Determination:



- **1,422** of 1,810 (79%) cases were resolved In Favor of Enrollee.
- **388** of 1,810 (21%) 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 March 2026, we did not meet our goal with a 26% fully favorable (overturn) rate.



- **41** out of 58 (71%) cases had an adverse decision (upheld/denied) for the month of March 2026:
 - Disputes Involving Medical Necessity – 29
 - Out of Network – 11
 - Coverage Disputes – 1
- **15** out of 58 (26%) cases had a fully favorable decision (overturned) for the month of March 2026:
 - Disputes Involving Medical Necessity – 14
 - Out of Network – 1
- **2** out of 58 (3%) cases had a partially favorable decision for the month of March 2026:
 - Disputes Involving Medical Necessity – 2

D-SNP Grievances & Appeals (Resolved)

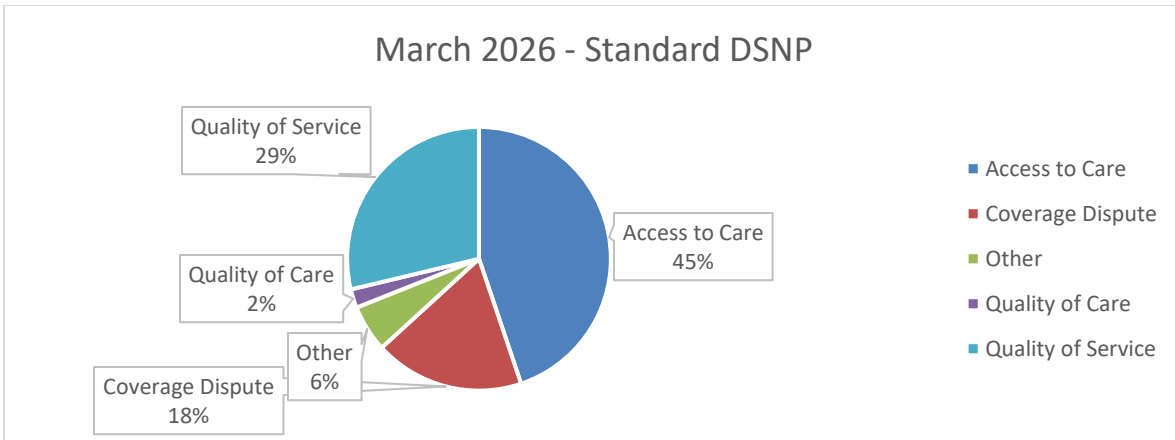
- Standard Grievance and First Call Resolution cases were resolved within the goal of 95% of regulatory timeframes.
- Standard Appeal cases were resolved within the goal of 95% of regulatory timeframes.
- There were no Expedited Appeal cases filed in March 2026.

March 2026 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate
Standard Grievance	87	30 Calendar Days	95% compliance within standard	85	97.7%
Expedited Grievance	0	72 Hours	95% compliance within standard	0	N/A
First Call Resolution	49	Next Business Day	95% compliance within standard	48	97.9%
Standard Appeal	1	30 Calendar Days	95% compliance within standard	1	100.0%
Expedited Appeal	0	72 Hours	95% compliance within standard	0	N/A
Total Cases:	137		95% compliance within standard	134	97.8%

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

Standard Grievances:

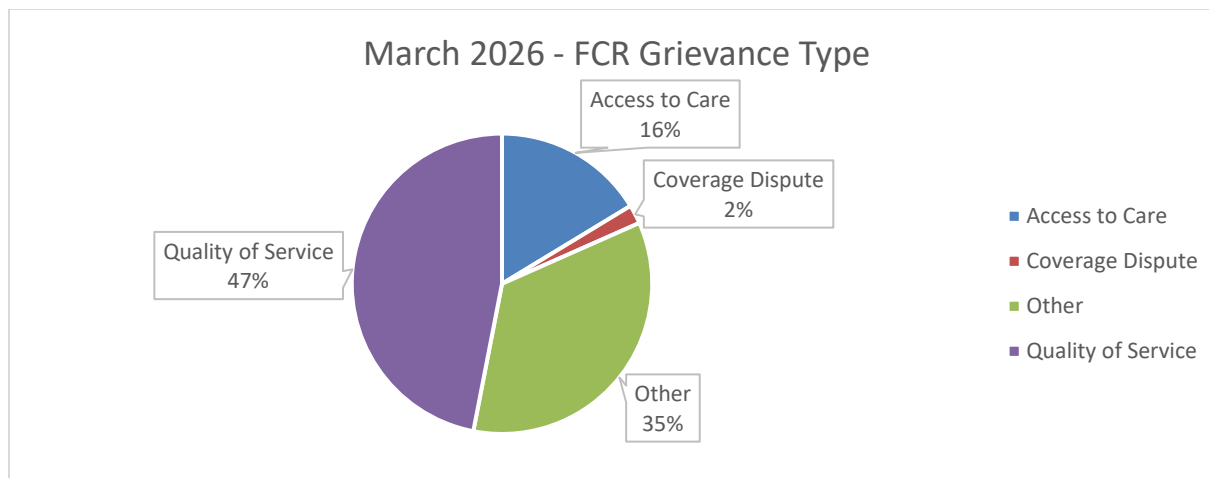
There were 52 unique grievance cases resolved during the reporting period, with a total of 87 grievances including 35 shadow cases.



- **39** of 87 (45%) cases were related to Access to care; the top 3 categories were:
 - Out of Network – 10
 - Technology / Telephone – 9
 - Timely Access – 9
- **25** of 87 (29%) cases were related to Quality of Service; the top two (2) categories were:
 - Plan Customer Service – 7
 - Against Sales Customer Service Team – 5
 - Case Management / Care Coordination – 6
- **16** of 87 (18%) cases were related to Coverage Dispute; the top category was:
 - Benefit – 11
- **5** of 87 (6%) cases were related to Other; the top two (2) categories were:
 - Eligibility – 3
 - Enrollment – 2
- **2** of 87 (2%) cases were related to Quality of Care; the top case was:
 - Quality of Care – 2

First Call Resolution (FCR) Grievances:

There were 47 unique exempt grievance cases resolved during the reporting period, with a total of 49 grievances including 2 shadow cases.

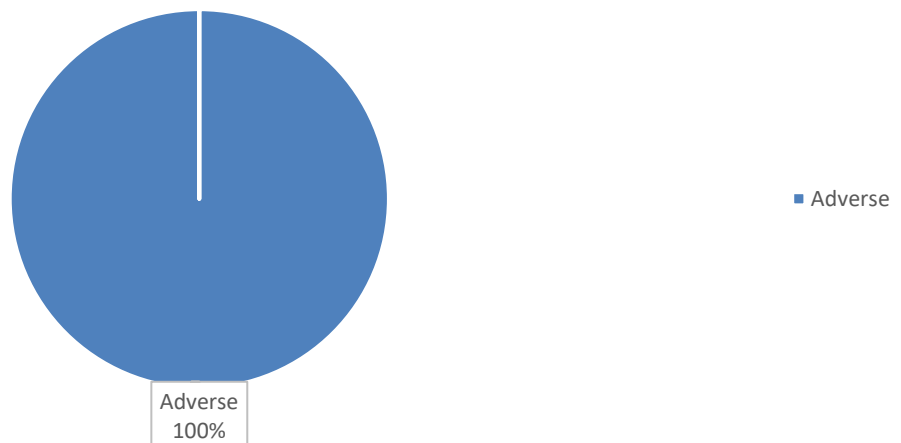


- **23** of 49 (47%) cases were related to Quality of Service; the top 2 categories were:
 - Plan Customer Service – 14
 - Against Member Services Department – 8
 - Member Informing Materials – 8
- **17** of 49 (35%) cases were related to Other; the top 2 categories were:
 - Enrollment – 12
 - Eligibility – 5
- **8** of 49 (16%) cases were related to Access to Care; the top categories were:
 - Technology / Telephone – 5
 - Authorization – 1
 - Out-of-Network – 1
 - Provider Availability – 1
- **1** of 49 (2%) case was related to Coverage Dispute; the top category was:
 - Benefit – 1

Appeals:

The Alliance's goal is to have an overturn rate of less than 25%; for the reporting period of March 2026, we did meet our goal since there were no overturns in the month of March.

Reviewer Decision - March 2026



- 1 case had an adverse decision (upheld/denied) for the month of March 2026:
 - Out-of-Network – 1

CTM Information for March 2026:

- Closed CTM – 3:
 - 2 complaints filed under Marketing; the complaint subcategories were:
 - 1.30: Allegation of inappropriate marketing by plan, plan representative, or agent/broker (EX)*
 - 2.30: Allegation of inappropriate marketing by plan, plan representative, or agent/broker
 - 1 complaint filed under Enrollment / Disenrollment; the complaint subcategory was:
 - 2.10: Beneficiary is experiencing an enrollment issue that may require reinstatement or enrollment change

*Cases with subcategories that end with "(EX)" and/or where field Complaint Lead is marked as "CMS Lead" are excluded from plan performance metrics.

Provider Services

- 12-Month Trend Summary:
 - The Provider Services department's call volume in March 2026 was 7,919 calls compared to 8,303 calls in March 2025.
- Monthly Analysis:
 - The Provider Services department completed 497 calls/visits during March 2026.

- The Provider Services department answered 6,639 calls for March 2026 and made 474 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 March 17th, 2025, there were 182 initial network providers approved; 14 primary care providers, 4 specialists, 20 ancillary providers, 9 midlevel providers, and 135 behavioral health providers. Additionally, 123 providers were re-credentialed at this meeting; 10 primary care providers, 19 specialists, 2 ancillary providers, 13 midlevel providers and 79 behavioral health providers.
 - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Community Relations and Outreach

- 12-Month Trend Summary:
 - In Q3 2026, the Alliance completed 1,654 member orientation outreach calls and 155 member orientations by phone.
 - The C&O Department reached 144,409 people (2,063 identified as Alliance members) during outreach activities, compared to 3,268 individuals (61% identified as Alliance members) in Q3 2025.
 - The C&O Department spent \$11,150.00 on donations, fees, and/or sponsorships, compared to \$750.00 in Q3 2025.
 - The C&O Department reached members in 17 cities/unincorporated areas throughout Alameda County, the Bay Area, and the U.S., compared to 20 cities in Q3 2025.
- Quarterly Analysis:
 - In Q3 2026, the C&O Department completed 1,654 member orientation outreach calls and 146 member orientations by phone.
 - Among the 144,409 people reached, 2,063 (1.4%) identified as Alliance members.
 - The C&O Department reached members in 17 locations throughout Alameda County, the Bay Area, and the U.S.
- Monthly Analysis:

- In March 2026, the C&O Department completed 424 member orientation outreach calls, 50 member orientations by phone, 31 Alliance website inquiries, 7 community events, and 5 member education events.
- Among the 2,104 people reached, 736 (35%) identified as Alliance members.
- The C&O Department reached members in 14 locations throughout Alameda County, the Bay Area, and the U.S.
- Please see attached **Addendum A**.

Incentives & Reporting

Current Incentive and Grant Programs

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

- The Alliance earned \$38M out of \$44M available under this program based on submission of deliverables and achievement of DHCS-defined metrics
 - \$26.9M has been paid to our HHIP partners to date
- A HHIP funding opportunity was released in June 2024 to LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
 - The Alliance received applications from 10 LEAs totaling \$1.3M in requests; all submitted applications were approved and work on the funded programs continues
- In a separate HHIP-funded initiative, the Alliance awarded \$11.2M in funding to 10 community partners through a program that supports the HHIP goals of reducing and preventing homelessness
 - Projects continue with activities taking place through 2030 related to capacity building, innovation, diversity and health equity, and housing stability
- The Alliance continues to review partner project deliverables prior to payment and meet with partners to discuss program activities and barriers
- Planning was initiated to potentially release another application cycle to award any remaining HHIP funds; Housing team experts have been included to target funds towards high need areas for members

Provider Recruitment Initiative (PRI) – internal Alliance program with funding up to \$2M in both FY 2024-25 and FY 2025-26

- 2024-25 Program highlights:
 - Launched on June 1st, 2024
 - 15 applications received totaling \$6M in funding requests
- 2025-26 Program status:
 - PRI program was renewed for FY 2025-26 and launched July 1st, 2025
 - Received \$2,135,375 in requests
 - 13 applications received from eligible applicants
 - \$1,890,375 in requests were approved; applicants were notified and MOUs have been fully executed

- FY 2024-25 and FY 2025-26 overview of funding:

Awards Funded	FY 2024-25	FY 2025-26
MD/DO	4	8
OB/GYN	2	0
NP/PA	8	3
BH	4	3
Community Health Workers	34	127
Medical Assistants	Not applicable	4
Bilingual Positions	5	4
Housing Relocation	0	1
Total Awarded*	\$1,820,750	\$1,890,375
Total Paid to date	\$710,145	\$206,250
Total Dollars Retracted**	\$85,000	\$0

**Total Awarded has been updated to reflect hiring changes that may have been made due to staffing challenges or practices not hiring positions as originally intended*

***Total Retracted dollars were removed from Total Awarded amount*

Equity and Practice Transformation (EPT) Payments Program – DHCS launched a one-time primary care provider practice transformation program in 2024 called the Equity and Practice Transformation (EPT) Payments Program; the program is designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment models

- The original funding was \$700 million over five (5) years; however, due to state budget constraints, the funding was reduced to \$140 million over three (3) years
- Alameda Health System (AHS) was the only Alliance-associated applicant selected by DHCS to participate
 - The Population Health Learning Center (PHLC) requested MCPs sign a Data Sharing Agreement (DSA) so they can work with a third-party vendor, Innovaccer, to help calculate Healthcare Effectiveness Data and Information Set (HEDIS) rates; the DSA was fully executed on September 11th
 - The Analytics team continues to support analytic requests from the EPT and Innovaccer teams
 - The Incentives & Reporting team met with AHS in February and March to discuss potential investment areas for the dollars earned through the related MCP Initial Provider Planning Incentive Payments program
 - AHS continues to submit program related deliverables and, to date, has earned the following payments from DHCS of the total eligible \$1.9M:

Milestone Submission	Amount Earned	Alliance Payment to AHS
CY 2024 (Year 1)	\$302,463.84	Paid June 15, 2025
May 2025	\$302,463.84	Paid January 15, 2026
December 2025	\$151,231.92	Payment scheduled for April 6, 2026
May 2026	N/A	N/A
November 2026	N/A	N/A

Doula Scholarship Program – the Alliance Health Care Services team launched this program in December 2024 with a goal to grow the Doula provider network aimed at increasing access to these services for members; I&R is providing administrative support.

- Scholarships are intended to offset costs related to the following:
 - Medi-Cal Provider Application and Validation for Enrollment (PAVE)
 - Contracting and credentialing with the Alliance
 - Continued education, training, and administrative and operational support required to be a Doula
- FY 2024-25 Program highlights:
 - Scholarships of up to \$1,000 per person were available for Doulas both intending to contract with the Alliance and Doulas already contracted with the Alliance
 - MOUs for the 20 scholarship awardees were signed, including seven (7) awards to support currently contracted Doulas and 13 awards for Doulas that intend to contract with the Alliance
- FY 2025-26 Program status:
 - I&R and Health Care Services launched a new funding cycle on October 31st, 2025 for Doulas intending to contract with the Alliance
 - 15 applications have been selected for funding to date

Funding Status	FY 2024-25	FY 2025-26
Total Available Funds	\$20,000	\$40,000
Total Awarded	\$20,000	\$18,750
Total Paid to date	\$14,000	\$12,750
Withdrawn	\$1,500	N/A

Grant Program Updates

- The Incentives and Reporting (I&R) team implemented a grant management software system, Submittable, to support the various grant and incentive programs the Alliance participates in
 - Submittable creates an online application process for community partners, an electronic evaluation process, reporting for fund management, and awardee deliverable tracking
 - The Alliance is working with Submittable to create a dashboard to manage and track program related deliverables, including fund distribution

- Project activities kicked off on September 24th, 2025, and the dashboard has been created and is under final review until April 24th; the first set of final revisions were submitted in February
- California Improvement Network – the Alliance was selected, along with 24 other partners, to participate in an opportunity through the California Improvement Network (CIN), which is a learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading good ideas, and implementing improvements
 - CIN participation provides the Alliance with an opportunity to partner and connect with other organizations that are also working to improve health equity
 - The Director, Health Equity is participating in the equity focused learning network and leading project initiatives; I&R provides application and program management support
 - Participants of the CIN project were invited to apply for an Action Project award to support implementation efforts for partners
 - The Alliance submitted an application for and was awarded a \$20,000 CIN Action Project grant with the California Health Care Foundation (CHCF)
 - The project's goals are to support efforts to improve Well Child-Care visits and immunization rates and decrease maternal depression for Black members through group classes with integrated pediatric visits
 - This project is led by Dr. Simms-Mackey at Alameda Health System (AHS) with support from the Health Equity team
- The First 5 Alameda County was awarded a grant for \$1.1M to support quality-related activities through June 2026
 - \$210,000 has been paid for deliverables to-date
- On January 27th, Black Women Birthing Justice (BWBJ) was notified that they were selected for a grant through the California Maternal Health Innovation initiative
 - The Alliance I&R and HCS teams supported BWBJ in identifying and writing the application and will be an unfunded partner on the project; project activities kicked-off in February 2026
 - As a part of this project, BWBJ will expand the doula workforce by partnering with Alliance subject matter experts to explore challenges related to credentialing and billing
 - The group will also look at opportunities to streamline contracting efforts with the Alliance
 - In February, the Alliance Health Care Services, Claims, Credentialing, and Incentives & Reporting teams met to discuss and outline related workflows for this project
- A Letter of Intent is under review to seek funding for a Registered Behavior Technicians (RBTs) workforce pipeline grant

Recruiting and Staffing

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

Incentive and Grant Program Descriptions

Housing and Homelessness Incentive Program (HHIP) – program launched in January 2022 and is part of the Home and Community-Based (HCBS) Spending Plan.

- Enables MCPs to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health
- MCPs must collaborate with local homeless Continuums of Care (CoCs) and submit a Local Homelessness Plan (LHP) to be eligible for HHIP funding
- The program ended December 31st, 2023

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

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

Doula Scholarship Program – program launched in December 2024 to grow the Doula provider network to increase access to these services for members.



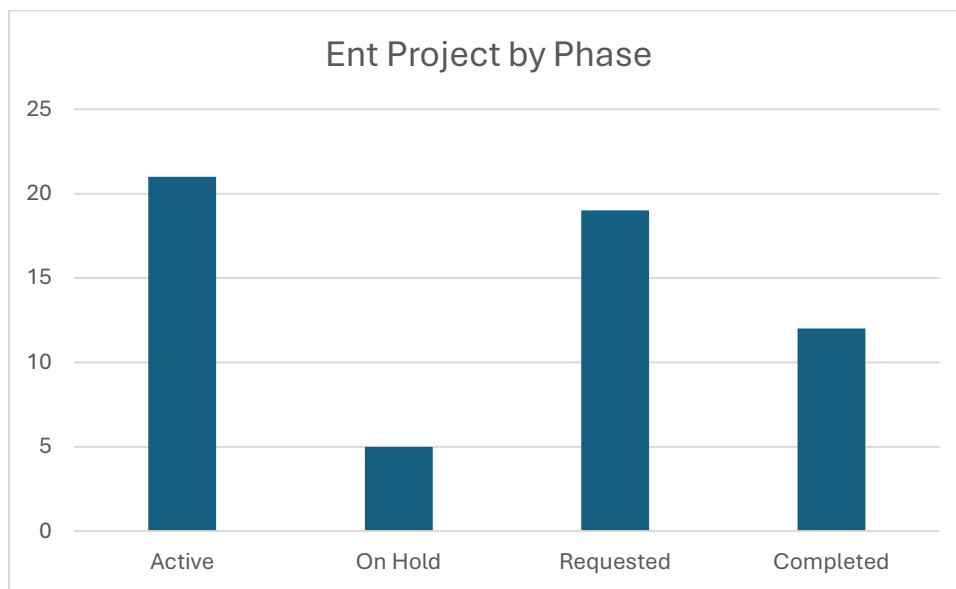
Health care you can count on.
Service you can trust.

Integrated Planning

Ruth Watson

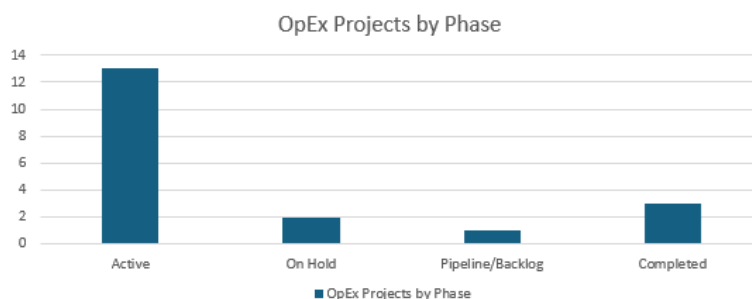
Integrated Planning

- Enterprise Portfolio
 - 57 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio.
 - 21 Active projects (discovery, initiation, planning, execution, warranty)
 - 5 On Hold projects
 - 19 Requested and Approved Projects
 - 12 Completed Projects (F-YTD)



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

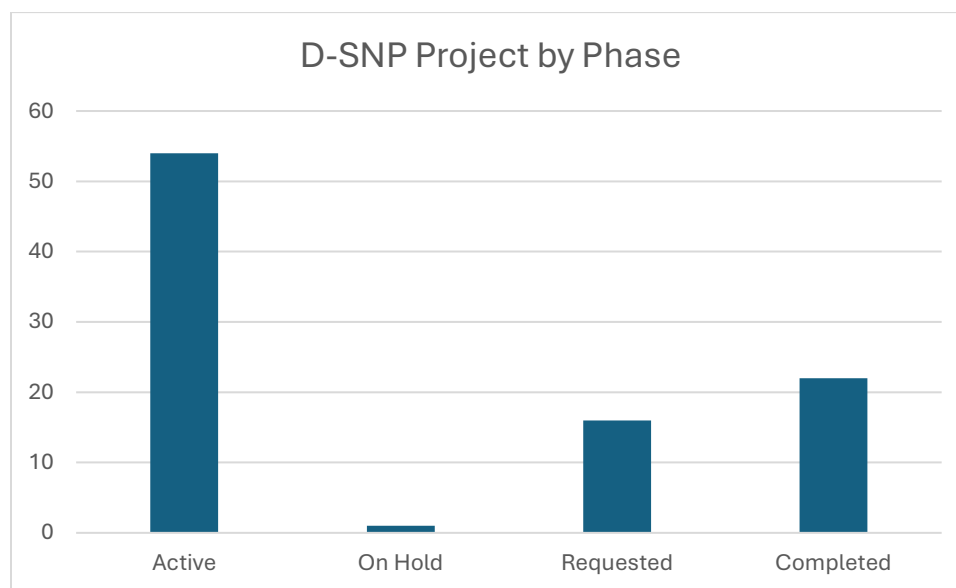
OpEx Portfolio Stats



- 19 initiatives under OpEx
 - 13 Active projects
 - 2 On Hold projects
 - 1 in Pipeline/Backlog
 - 3 Completed Projects

■ D-SNP Portfolio

- 71 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio.
 - 54 Active projects (discovery, initiation, planning, execution, warranty)
 - 1 On Hold
 - 16 Requested Projects
 - 22 Completed in Total



- **Enterprise Portfolio (Active Projects) for all Lines of Business**

- (CMS-0057-F) Interoperability and Prior Authorization Final Rule (TDX ID 5816)
 - Project Phase: *Planning
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Business Case Finalized in TDX
 - Completed Project Charter
 - High Level Milestones (In Flight in March):
 - Full 57-F Kickoff Meeting (4/1/26)
 - Fit Gap Analysis (FGA) with Edifecs to identify all work to be done
- Coordination of Care between BH Providers & Primary Care Physician (TDX ID 8323)
 - Project Phase: *Planning
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Work Sessions for BRD Requirements
 - High Level Milestones (In Flight in March):
 - None
- CS Policy Guide 04.30.25 changes (TDX ID 13085)
 - Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Testing of CS DSNP Codes and Modifiers
 - High Level Milestones (In Flight in March):
 - Pending completion of the AC Health Contract (ETA April)
- CYBHI Fee Schedule (TDX ID 4186)
 - Project Phase: *Execution
 - Project Health: **Green
 - Risk: ID 4736 BAA - A fully executed BAA is required before AAH can proceed with the transfer of member data; a test file is scheduled for submission to Carelon on 4/20. Without the BAA, this will delay project efforts.
 - High Level Milestones:
 - Process Flow
 - MOU
 - BAA
 - Requirements
 - Carelon BRD - Execution
 - High Level Milestones (In Flight in March):
 - Process Flow – completed and approved

- MOU in review with Provider Contracting
 - BAA must be effectuated – in progress with Provider Contracting
 - Requirements elicitation
 - Carelon BRDs
 - Eligibility – Executed
 - Encounters – In review / in progress.
- D-SNP: 1A Contracting & Credentialing (TDX ID 6924)
- Project Phase: *Execution
 - Project Health: **Red
 - Issue 4735: Provider Contract Termination was a missed requirement prior to 1/1/26 deployment. Efforts actively in progress.
 - High Level Milestones (Completed in March):
 - Provider Contracting Termination process flow completed and approved.
 - Live Agent Call Script and Robo Call Script developed.
 - High Level Milestones (In Flight in March):
 - Live Agent Call Script and Robo Call Script with translation services for threshold languages.
 - Development of SOP
- D-SNP: 1J Policies, SOPs, & KPIs (TDX ID 6934)
- Project Phase: *Closing
 - Project Health: **Red
 - Issue 4379: Provider Services submitted KPIs for monitoring network adequacy to Compliance, however, must determine if they must be presented at AOC or not, and confirm if it will be for monitoring purposes only.
 - High Level Milestones (Completed in March):
 - KPI Documentation and submission to Compliance.
 - High Level Milestones (In Flight in March):
 - Project closure documentation developed and ready to present to AAH leadership.
- D-SNP: 2B Quality Program (TDX ID 6919)
- Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Committee Members for QIHE/UMC Committee Selected and Charter presented
 - First Community Advisory Committee (CAC) was held, and minutes were submitted to DHCS.
 - High Level Milestones (In Flight in March):
 - Approval of QIHE/UMC Charter.
 - Completion of draft D-SNP Quality Evaluation Template .

- D-SNP: 2D Chronic Care Improvement Program (TDX ID 6936)
 - Project Phase: *Initiation
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Project Kick-Off Meeting.
 - Project Plan buildout.
 - Project Charter completed.
 - High Level Milestones (In Flight in March):
 - Gather data for identification of CCIP Target Populations.
 - Project Charter Approvals.

- D-SNP: 3A Utilization Management (TDX ID 6825)
 - Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - UM Program Description updated with D-SNP elements.
 - DSNP mock UM audits completed and outcomes pending.
 - High Level Milestones (In Flight in March):
 - Project closure activities.
 - UM/CM Trilogy documents approvals.

- D-SNP: 3C Case Management & Care Coordination (TDX ID 7015)
 - Project Phase: *Execution
 - Project Health: **Yellow
 - Issue 4575: Care Management/Care Coordination interventions were not implemented on 1/1/26 as required.
 - Mitigation Plan: The business is working to implement programs and increase engagement using Care Opportunities and Trucare Actions in Trucare.
 - Risk 4668: Low CM program engagement to include CICM due to not having a way to identify these Members on Day 1 and delays with executing CICM, palliative and the most vulnerable population.
 - Mitigation Plan: Reporting developed to identify CICM Members for outreach.
 - DSNP CM mock audits were completed to assess Q1 performance and regulatory compliance.
 - High Level Milestones (Completed in March):
 - D-SNP CM mock audit completed and outcomes pending.
 - Program Description updated with D-SNP elements.
 - High Level Milestones (In Flight in March):
 - Present DSNP CM Mock audit findings to leadership.

- D-SNP: 6G Organizational Training (TDX ID 6908)
 - Project Phase: *Execution

- Project Health: **Yellow
 - High Level Milestones Completed in March:
 - Completed content build of Pharmacy training into Percipio and has been assigned out to Pharmacy team.
 - Member Services content testing has been completed and ready for departmental assignments.
 - High Level Milestones in Progress:
 - Claims training content is in the process of being converted into format for Percipio. We have started testing the first module. Next steps will be testing and loading content into Percipio.
 - HR Claims content testing in progress
- D-SNP: 6J Liberty Dental (TDX ID 12526)
- Project Phase: *Execution
 - Project Health: **Yellow
 - Issue 4203: 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. Regular checkpoints in place to follow-up
 - High Level Milestones (Completed in March):
 - Liberty Dental published Medicare reporting packet - Part C; Provider Directory; Report Card; ODAG Table 1 &3; Fraud, Waste and Abuse (FWA) report
 - High Level Milestones (In Flight in March):
 - Encounters Testing
- D-SNP: 7D Audit Monitoring & Readiness (TDX ID 6946)
- Project Phase *Execution
 - Project Health **Yellow
 - Issue 4672: Timeline - Project in progress with Internal Audit Team. Several deliverables pending review and approval by SLT.
 - High Level Milestones (Completed in March):
 - Review and Approve DSNP Evaluation Tools.
 - Internal Road Shows.
 - High Level Milestones (In Flight in March):
 - Review and Approve DSNP Evaluation Tools.
 - Internal Road Shows completed.
- D-SNP: 8A (TDX ID 6996) and 16K Claims (TDX ID 10170)
- Project Phase: *Execution
 - Project Health: **Yellow
 - Issue 4285: Claims deployments had to be phased to address custom configurations required to support the benefit offerings and complete UAT as not all functionalities can be fully tested without actual claims.

- High Level Milestones (Completed in March):
 - Sprint 5 – IDN Letters configurations, Analytic Reports, Coordination of Benefits (COB) configuration.
 - Sprint 6 – Accumulator Files and RAM configuration, WES form, MOOP Letter.
- High Level Milestones (In Flight in March):
 - Sprint 7 – Preclusion List and Continuity of Care.
- D-SNP: 9E Retention (TDX ID 7099)
 - Project Phase: *Closing
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Business validation of Retention report in Cirrus meeting requirements.
 - High Level Milestones (In Flight in March):
 - Project Close-out form.
- D-SNP: 10A PBM Implementation (TDX ID 7046)
 - Project Phase: *Execution
 - Project Health: **Yellow
 - Ongoing delays with receiving letter proofs for the M3P program from Echo Health (PerformRx's M3P Vendor). English proofs received contained several formatting errors. 8 of 12 of the proofs received for Spanish and Chinese. No ETA for the remaining 3 languages as of 4/1.
 - One field in the eligibility file for PerformRx, 80G, required additional data tables to be built to pull required data and populate within the file. This indicator is used for specific diagnoses and conditions in support of authorizations for certain types of drugs. IT team has been working diligently to source required data, build tables, and update the coding in the eligibility file to display correctly. Final production file is targeted for 4/9/26.
 - High Level Milestones (Completed in March):
 - Pharmacy and Medical Accumulator files shared and received between AAH and PerformRx without any errors.
 - High Level Milestones (In Flight in March):
 - All 80G Indicators in production eligibility file; targeting 4/9/26.
 - M3P Program member letter proofs received from Echo Health in all threshold languages, reviewed & approved by C&O, material ID assigned by CMS via Compliance, and then configured in Echo Health's platform.
 - DMP Program Lock-in/Lock-out process in development with PerformRx and Abarca.

- D-SNP: 16B Enrollment Process & Nations Benefits / D-SNP Member Incentives (TDX ID 9945)
 - Project Phase: *Execution
 - Project Health: **Yellow
 - Issue 4715: Sales commission and bonus automation in Cirrus (Nations CRM system) for the April payroll period did not complete full validation in time due to functionality instability. A controlled manual process is now the focus for the April payout, with automation now targeted for the May pay period, pending required remediation, re-baselined milestones, and QA/UAT completion.
 - High Level Milestones (Completed in March):
 - Initial functionality walkthrough and AAH test case development.
 - Automated capture of CMS full enrollment and DTRR files in ODS.
 - High Level Milestones (In Flight in March):
 - Manual commission and bonus statement generation and reconciliation for April payout, with remediation and re-baselined automation path ahead of the May payroll run.
 - Layered releases supported by IT, including on-demand ID card printing for frontline member staff and OHI-COB letter automation with post-fulfillment reporting.

- D-SNP: 16F Call Center (TDX ID 9949)
 - Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Completion of ODS Viewer changes to support the display of procedure codes.
 - Transcription and Translation of voicemail messages.
 - High Level Milestones (In Flight in March):
 - Member Portal ID card data configuration in process. Note: There is a temporary card currently available on the portal.

- D-SNP 16G Network and Credential & Contracting (TDX ID 9950)
 - Project Phase *Executing
 - Project Health **Green
 - High Level Milestones (Completed in March):
 - Provider Portal
 - Active Deeming Feature UAT sign off.
 - Care Plan Information Feature UAT sign off.
 - Provider Instruction Guide Feature QA Sign Off.
 - High Level Milestones (In Flight in March):
 - Provider Portal
 - Active Deeming Feature - Deployed
 - Care Plan Information Feature – Deployed.

- Provider Instruction Guide Feature – UAT signed off.
- D-SNP: 16L Encounters (TDX ID 11343)
 - Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Outbound OPTUM QA – Complete.
 - Outbound OPTUM UAT – Complete.
 - Outbound OPTUM System Go-Live.
 - Post OPTUM Development – Complete.
 - Post OPTUM QA – Complete.
 - Post OPTUM UAT – Complete.
 - High Level Milestones (In Flight in March):
 - Pending receipt of Liberty Dental encounter file needed to finalize testing.
- D-SNP: 17D Stars Risk Adjustment (TDX ID 10265)
 - Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - AAH delivered Member, Member PCP, Member Eligibility and Provider production files to Optum and CMS submission is in progress.
 - High Level Milestones (In Flight in March):
 - Optum is setting up monthly meetings with AAH to facilitate communication and address any submission-related issues. Based on the date the production files were received, the planned go-live is set for May 1st; an earlier launch may be possible provided the internal onboarding process proceeds smoothly.
- D-SNP: 17E Stars Pharmacy (TDX ID 13447)
 - Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - G&A Team confirmed that they have a SOP in-place to handle pharmacy grievances. Member Services Team confirmed that they have completed secret shopper and received Part D training.
 - High Level Milestones (In Flight in March):
 - Working sessions in progress to Develop Process for Conducting Pharmacist Reviews to Ensure Appropriateness and Document Exclusions. Dashboard reporting meeting deferred till April CMS updates.
- D-SNP: IT HEALTHsuite Program (RAM) (TDX ID 7211)
 - Project Phase: *Execution

- Project Health: **Green
 - High Level Milestones (Completed in March):
 - IT team is continuing to update PCP contracts into HEALTHsuite platform. Team has weekly check-ins to review open production incidents, 31 total issues logged / 28 issues resolved.
 - High Level Milestones (In Flight in March):
 - Team will continue to meet and monitor production incidents.
- D-SNP Branding & Medi-Cal / GC Brand Refresh (TDX ID 12536)
- Project Phase: *Closing
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - None.
 - High Level Milestones (In Flight in March):
 - Project closure.
- D-SNP Medicare Reporting (TDX ID 14876)
- Project Phase *Planning
 - Project Health **Red
 - Issue 4723: Regulatory Reports for Business areas in process of being identified and dates due (Q1, Q2, Q3, Q4). Due to volume of reports, potential issue of reports not being developed and submitted on time.
 - High Level Milestones (Completed in March):
 - None
 - High Level Milestones (In Flight in March):
 - Development of Charter.
 - Development of Process Flow.
 - Identify Report Owners.
- DHCS APL 25-008 Hospice Services and Medi-Cal Managed Care (TDX ID 12655)
- Project Phase: *Execution
 - Project Health: **Yellow
 - Issue 4380: Change requests for displaying Hospice Flag in TruCare will push to production environment on 4/16 (a 2-week delay) to align with the application release schedule.
 - Risk 3968: Issue of non-compliance with APL due to time needed to complete necessary technical enhancements in TruCare and HEALTHsuite. Once all CRs are pushed to production, this issue will be resolved (tentatively 4/16 [see above]).
 - High Level Milestones (Completed in March):

- Completion and approval of provider FaxBlast communication regarding the new hospice benefit.
 - Completion of configuration and testing for 4 IT CRs to display hospice flag and support operational workflows for this APL.
- High Level Milestones (In Flight in March):
 - Finalization of P&Ps; awaiting approval from DHCS.
- DHCS APL 25-011 Fed Payments to Prohibited Entities (TDX ID 13246)
 - Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed March):
 - Updated claim codes for affected services from suspended to denied.
 - High Level Milestones in Progress:
 - 66 claims have been moved to denied state so far in 2026.
 - Project moving to closing state if we do not receive any updates from DHCS.
- DHCS APL 25-015 Data Sharing and Quality Rate Production (TDX ID 14146)
 - Project Phase: *Planning
 - Project Health: **Green
 - High Level Milestones (Completed March):
 - Completed updates to Analytics P&P and submitted for April AOC meeting.
 - High Level Milestones in Process:
 - Created Smartsheet for Non-Claim PDR process and is in final review with the project team.
- DMHC APL 25-021 Infertility and Fertility Services (TDX ID 14637)
 - Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Project kickoff was held on 3/6/26.
 - Project charter has been approved.
 - DMHC Regulatory Filing submitted 3/19/26.
 - Provider network adequacy analysis completed.
 - High Level Milestones (In Flight in March):
 - Policies and Procedures development initiated.
 - Cryopreservation facility research and coordination with sister plans.
 - Fertility Provider outreach initiated.
 - GroupCare Evidence of Coverage review and revisions initiated.

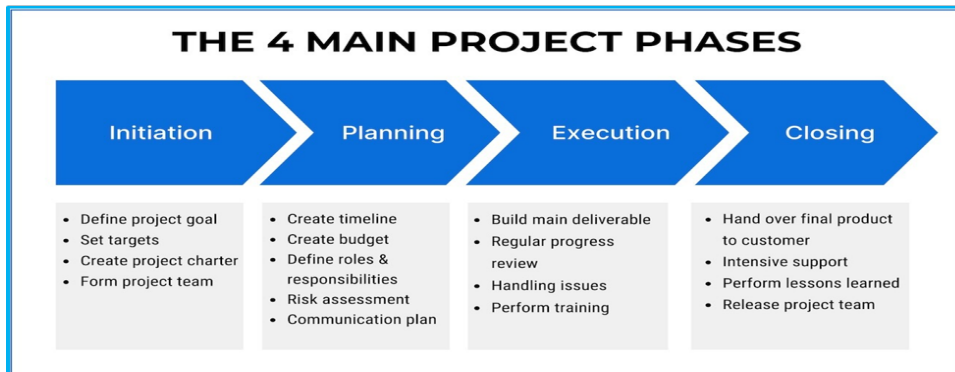
- Member Correspondence (TDX ID 12697)
 - Project Phase: *Planning
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Charter Completion.
 - High Level Milestones (In Flight in March):
 - High-level business requirements completion.

- PY2027-D-SNP Bid Strategy, Submission & Approval (TDX ID 14636)
 - Project Phase: *Planning
 - Project Health: **Green
 - Risk 4674: New PBM selection and related governance approvals are being monitored due to their dependency on the 6/1 CMS bid and formulary submission timeline.
 - High Level Milestones (Completed in March):
 - Decision made to not participate in CMS BALANCE model (designed to expand GLP-1 medication access for weight management) due to uncertain cost and volume impact and adverse selection risk.
 - Core assumptions for the D-SNP bid, including projected vendor cost inputs, were completed for actuarial modeling.
 - Milliman SOW was executed with reduced scope from the prior year.
 - High Level Milestones (In Flight in March):
 - All D-SNP actuarial assumptions finalized for Milliman ahead of the late-April actuarial modeling.
 - Administrative cost projection, allocation methodology, Part C and Part D allocation details are being finalized to support the late April modeling run, pending internal SLT alignment on pricing and administrative cost projections.
 - CY2027 pharmacy benefit scenarios finalized, including Medi-Cal Value-Added Service direction and if M3P remains required.

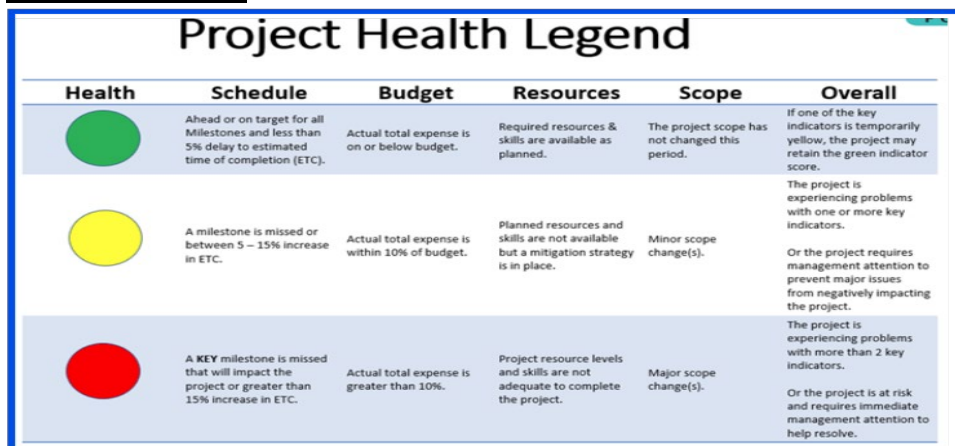
- Readily AI Platform Implementation (TDX ID 13788)
 - Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Readily AI platform access is completed for all business users. IT shared draft AI governance policy and its pending AOC approval.
 - Completed demonstration of Incident reporting module to users.
 - High Level Milestones (In Flight in March):

- Project Charter approval is in progress. Reached out to Navex to discuss integration with Readily AI for policy documents ingestion.
- Receiving, Storing, and Retrieving SOGI Data (TDX ID 6623)
 - Project Phase: *Planning
 - Project Health: **Green
 - High Level Milestones (Completed March):
 - Updated project charter with new NCQA requirements.
 - Updated P&P PH-001, PH-005, CLS-003, CLS-005 and CLS-008.
 - High Level Milestones in Progress:
 - Updating SOP for new NCQA requirements.
 - Updating SOP Sexual Orientation (HO 2B).
 - Updating SOP Geographic Classification (HO 2F).
 - Updating SOP Race Ethnicity.
 - Updating P&Ps with Elements A, B, C, D and E.
- Security Remediation (TDX 11339)
 - Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Project Team is working on remediating issues identified in 2025 Penetration test and 2025 Security Risk Assessment (SRA).
 - 13 issues in penetration testing fixed: Critical - 2; High - 6; Medium – 5.
 - 6 issues in 2025 Security Risk Assessment (SRA) fixed: High - 1; Medium – 5.
 - High Level Milestones (In Flight in March):
 - Team will continue resolving pending issues. Team to add new issues as a part of Stryker Security Event - Customer Advisory.
- VSP Vision Project (TDX ID 12537)
 - Project Phase: *Closing
 - Project Health: **Green
 - High Level Milestones (Completed in March):
 - Warranty Period.
 - High Level Milestones (In Flight in March):
 - None.
- **Recruiting and Staffing**
 - Integrated Planning Open position(s):
 - Sr. Business Analyst, Integrated Planning – Posting request in process
 - Backfill Business Process Analyst, Integrated Planning – on hold

- ***Project Phase**



- ****Project Health**



Medicare Operations

- **D-SNP Key Initiatives and Dates:**

- DMHC Material Modification Submission – MA Service Area Expansion – March 2024 - COMPLETE
- DMHC Material Modification Submission – D-SNP Product – August 2024
- CMS Notice of Intent to Apply – November 2024 - COMPLETE
- CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025 - COMPLETE
- CMS Formulary & Bid Submission (Benefit Determination) – June 2nd, 2025 - COMPLETE
- Medication Therapy Management (MTM) program submission – June 4th, 2025 - COMPLETE
- CMS SMAC Submission – July 7th, 2025 - COMPLETE
- Rebate Allocation with CMS and Health Plan – July / August 2025 – COMPLETE
- Annual Enrollment Period (AEP) – October thru December 2025 – COMPLETE

- IT System Readiness – COMPLETE
- Open Enrollment Period (OEP) Begins – January 1st, 2026 – IN PROCESS
- **D-SNP Activities – March 2026**
 - Medicare Product Updates:
 - Enrollment and Eligibility
 - Deployed D-SNP PCP Auto Assignment logic.
 - Liberty Dental
 - Liberty Dental plan is active and processing incoming Medicare dental claims.
 - Project Team is waiting for a paid dental claim to complete encounter testing with Optum.
 - Liberty Dental requested approval for Subcontractor (Firstsource) to handle Call Center and Claims processing. Vendor Management is engaged and pre-delegation audit is in progress.
 - Currently working through rate renewal discussions with Liberty.
 - VSP
 - VSP is continuing its efforts to expand provider recruitment, including outreach to FQHCs and additional network partners.
 - The Alameda team is partnering with VSP to develop and implement a revised process for managing 837 files through a clearinghouse rather than relying on the current PDF-based workflow.
 - Nations OTC and Hearing
 - Working through 834 encounter files errors and rejections.
 - Ongoing monitoring of member questions and grievances.
 - 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.
 - 2027 Medicare Bid Submission.
 - Weekly meetings with key stakeholders and external Actuarial team to discuss the approach to the 2027 plan design and to provide deliverables needed to meet bid submission requirements.
 - Medicare Sales & Retention Updates:
 - Interview process started for Medicare Field Sales Agent (bilingual).
 - Continued development of Cirrus reporting dashboards for enrollment and retention data.
 - Translation of all sale scripts in threshold languages.
 - Finesse “agent queue” functionality initiated.

- PerformRx enhancements requested.
 - SOPs for Commission, Retention, and HRA payouts initiated.
 - Alameda Alliance for Health Caller ID implemented for higher connect rate with prospective members.
 - New PCP assignment process implemented during D-SNP enrollment.
 - Individual D-SNP Sales queues created within Finesse for improved prospective member experience.
 - Data field requirements completed for PowerBi Dashboard (enrollment/disenrollment and retention).
 - FQHC On-site Visit SOP created.
 - 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.
 - Individual agent queues set for implementation by EOM.
 - Voicemail transcription functionality for threshold languages complete.
 - Outbound campaign to all CHCN leads is targeting EOM for completion.
 - Call disposition list completed and ready for implementation.
 - Sales and Retention Commission SOP targeting completion by 4/8.
 - Voicemail transcription and translation to e-mail completed on 3/26.
- Medicare Marketing, Communications & Branding Updates:
 - **Marketing Vendor Assessment & Selection:** Marketing has identified a set of qualified vendors and is currently in the interview process. The goal is to select a preferred vendor 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.
 - **D-SNP Centralized Website:** Marketing is defining 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.
 - **FQHC Clinic Branding:** D-SNP branded materials and promotional items are being developed for sales use in clinic settings.
 - **D-SNP Organizational Training:** Assessing organizational training needs in preparation for 2026.

- **CHCN Marketing Blitz:** Completed three (3) waves of postcard marketing blitz to CHCN leads, which drove up sales and brand awareness.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	March 2026
Incoming Calls (R/V)	20,652
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	20,344
Average Speed to Answer (ASA)	00:08
Calls Answered in 30 Seconds (R/V)	97%
Average Talk Time (ATT)	07:20
Calls Answered in 10 minutes	100%
Outbound Calls	10,819

Top 5 Call Reasons (Medi-Cal and Group Care) March 2026

Eligibility/Enrollment
Grievances and Appeals
Change of PCP
Benefits
Provider Network Information

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) March 2026

Change PCP
ID Card Requests
Update Contact Information

Member Services Behavioral Health	March 2026
Incoming Calls (R/V)	1,059
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	1038
Average Speed to Answer (ASA)	00:15
Calls Answered in 30 Seconds (R/V)	94%
Average Talk Time (ATT)	09:56
Calls Answered in 10 minutes	100%
Outbound Calls	1,702
Screenings Completed	155
ACBH Referrals	31
SUD referrals to Center Point	18

Blended Call Results

DSNP Blended Results	March 2026
Incoming Calls (R/V)	709
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	696
Average Speed to Answer (ASA)	00:08
Calls Answered in 30 Seconds (R/V)	99%
Average Talk Time (ATT)	07:41
Calls Answered in 2 minutes	100%

Top 5 Call Reasons (D-SNP) March 2026
Eligibility/Enrollment
Appeals/Grievances
Benefits/Org Determinations
Provider Network Information
Change of PCP

Claims Department
February 2026 Final and March 2026 Final

METRICS

Claims Compliance	Feb-26	Mar-26
90% of clean claims processed within 30 calendar days	81.6%	90.5%
Claims Volume (Received)	Feb-26	Mar-26
Paper claims	44,429	41,746
EDI claims	334,496	347,804
Claim Volume Total	378,925	389,550
	(includes D-SNP)	(includes D-SNP)
Percentage of Claims Volume by Submission Method	Feb-26	Mar-26
% Paper	11.7%	10.7%
% EDI	88.3%	89.3%
Claims Processed	Feb-26	Mar-26
HEALTHsuite Paid (original claims)	272,676	265,804
HEALTHsuite Denied (original claims)	84,885	117,726
HEALTHsuite Original Claims Sub-Total	357,561	383,530
HEALTHsuite Adjustments	4,199	23,348
HEALTHsuite Total	361,760	406,878
Claims Expense	Feb-26	Mar-26
Medical Claims Paid	\$170,873,805	\$162,936,405
Interest Paid	\$234,601	\$388,564
Auto Adjudication	Feb-26	Mar-26
Claims Auto Adjudicated	161,930	327,319
% Auto Adjudicated	82.9%	85.3%
Average Days from Receipt to Payment	Feb-26	Mar-26
HEALTHsuite	19	20
Pended Claim Age	Feb-26	Mar-26
0-30 calendar days	41,858	37,465
HEALTHsuite		
31-62 calendar days	3,450	333
HEALTHsuite		
Over 63 calendar days	62	3
HEALTHsuite		
Overall Denial Rate	Feb-26	Mar-26
Claims denied in HEALTHsuite	84,885	117,726
% Denied	23.5%	28.9%

Claims Department

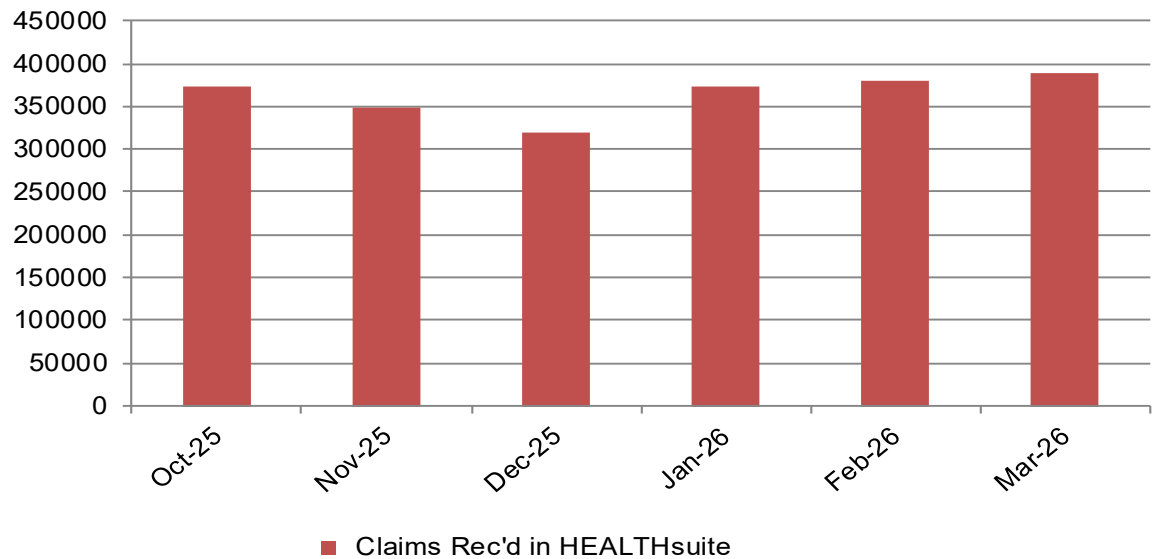
February 2026 Final and March 2026 Final

Mar-26

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	19%
Service Not Eligible For Separate Payment for Place Of Service	12%
No Benefits Found For Dates Of Service	10%
Non-Covered Benefit For This Plan	10%
Must Submit Paper Claim With Copy of Primary Payor EOB	9%
% Total of all denials	60%

Claims Received By Month

	11/1/2025	12/1/2025	1/1/2026	2/1/2026	3/1/2026	4/1/2026
Claims Received Through	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Claims Rec'd in HEALTHsuite	372,246	349,052	320,327	373,154	378,925	389,550



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing March 2026 to March 2025 as follows: 30 Days - 90.5% (2026) vs 90.5% (2025)	* 90% of clean claims in 30 calendar days (effective 1/1/2026) * 99% of all claims in 90 calendar days <i>(interest is required on any claim paid after 30 calendar days)</i>	* 90% of clean claims in 30 calendar days (effective 1/1/2026) * 99% of all claims in 90 calendar days <i>(interest is required on any claim paid after 30 calendar days)</i>
Claims Received - AAH received 389,550 claims for all lines of business in March 2026 vs 347,469 in March 2025	N/A	N/A
EDI - the volume of EDI submissions was 85.3% which is slightly above the normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 383,530 in March 2026 (22 working days) vs 327,795 in March 2025 (21 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in March 2026 was \$162,936,405 (4 check runs) vs \$143,774,747 in March 2025 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in March 2026 was \$388,564 vs \$148,561 in March 2025	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in March 2026 was 85.3% vs 85.8% in March 2025	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in March 2026 was 20 days vs 16 days in March 2025	N/A	<= 25 days
Pended Claim Age - comparing March 2026 to March 2025 as follows: 0-30 calendar days - 37,465 (2026) vs 44,970 (2025) 31-62 calendar days - 333 (2026) vs 22,786 (2025) Over 63 calendar days - 3 (2026) vs 49,196 (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 March 2026 to March 2025	N/A	N/A

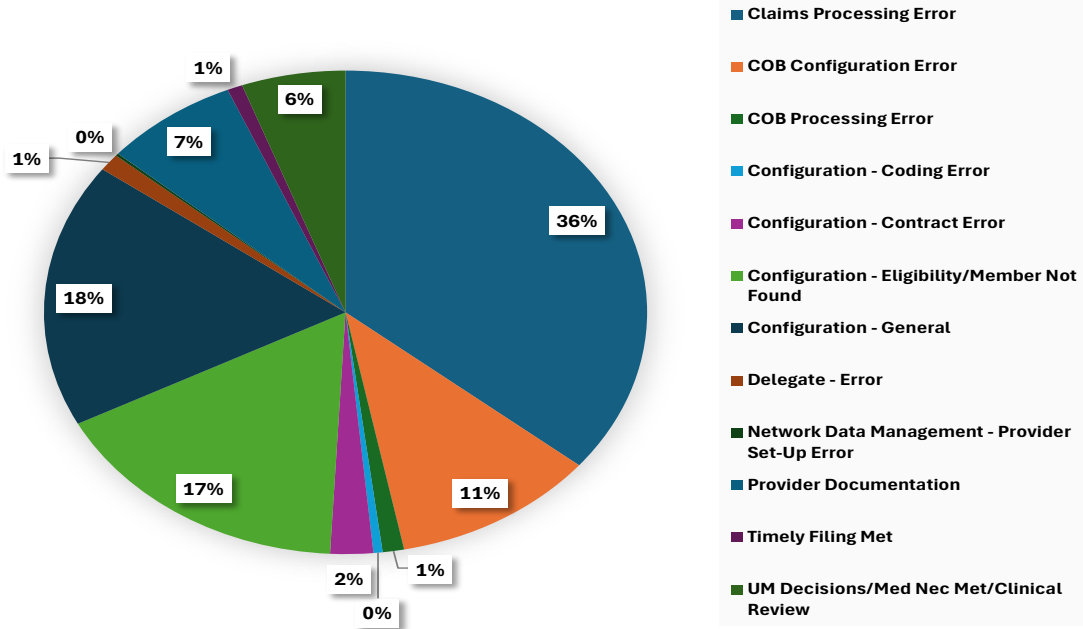
Provider Dispute Resolution		
February 2026 and March 2026		
METRICS		
PDR Compliance	Feb-26	Mar-26
# of PDRs Resolved	2,384	2,273
# Resolved Within 45 Working Days	2,376	2,265
% of PDRs Resolved Within 45 Working Days	99.8%	99.6%
PDRs Received	Feb-26	Mar-26
# of PDRs Received	2,849	3,394
PDR Volume Total	2,849	3,394
PDRs Resolved	Feb-26	Mar-26
# of PDRs Upheld	1,694	1,663
% of PDRs Upheld	71%	73%
# of PDRs Overturned	690	610
% of PDRs Overturned	29%	27%
Total # of PDRs Resolved	2,384	2,273
Average Turnaround Time	Feb-26	Mar-26
Average # of Days to Resolve PDRs	40	38
Oldest Resolved PDR in Days	268	291
Unresolved PDR Age	Feb-26	Mar-26
0-45 Working Days	3,972	4,001
Over 45 Working Days	0	0
Total # of Unresolved PDRs	3,972	4,001

Provider Dispute Resolution February 2026 and March 2026

Mar-26

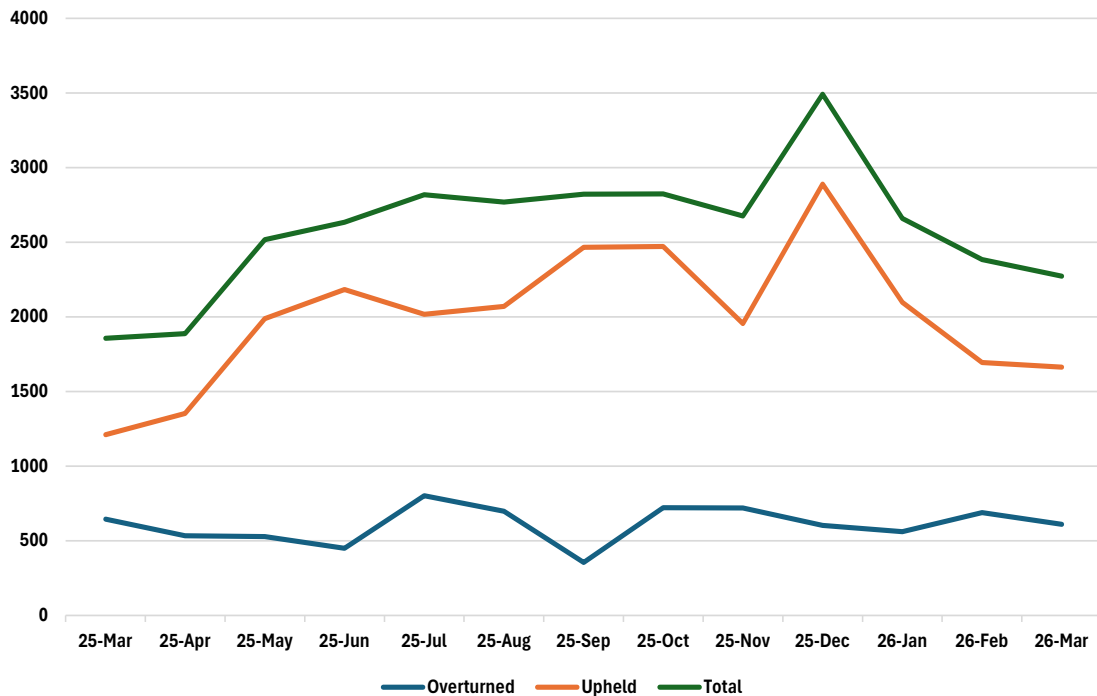
PDR Resolved Case Overturn Reasons

March 2026



Rolling 12-Month PDR Trend Line

March 2026



Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Resolved -2,273 in March 2026 vs 1,857 in March 2025	N/A	N/A
# of PDRs Received -3,394 in March 2026 vs 4,707 in March 2025	N/A	N/A
# of PDRs Resolved within 45 working days -2,265 in March 2026 vs 1,849 in March 2025	N/A	N/A
% of PDRs Resolved within 45 working days - 99.6% in March 2026 vs 99.5% in March 2025	95%	95%
Average # of Days to Resolve PDRs - 38 days in March 2026 vs 37 days in March 2025	N/A	30
Oldest Resolved PDR in Days - 291 days in March 2026 vs 124 days in March 2025	N/A	N/A
# of PDRs Upheld - 1,663 in March 2026 vs 1,121 in March 2025	N/A	N/A
% of PDRs Upheld - 73% in March 2026 vs 65% in March 2025	N/A	> 75%
# of PDRs Overturned - 610 in March 2026 vs 645 in March 2025	N/A	N/A
% of PDRs Overturned - 27% in March 2026 vs 35% in March 2025	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 36% (2026) vs 46% (2025) Configuration errors - 38% (2026) vs 34% (2025) COB - 12% (2026) vs 7% (2025) Clinical Review/UM Decisions/Medical Necessity Met - 14% (2026) vs 13% (2025)	N/A	N/A

Provider Relations Call Reasons & Field Visits Dashboard

Line of Businesses: D-SNP, Medi-cal and Group Care

[illegible]

Field Visit Activity Details

[illegible]

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALIAED PRACTITIONERS - March 2026						
Practitioners		PCP 411	SPEC 794	AHP 806	BH/ABA 3,803	PCP/SPEC 12
Direct Network vs Delegated Network Breakdown			AAH 4,537	AHS 303	CHCN 638	COMBINATION OF GROUPS 348
Facilities	457					
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	71	2	Y	Y	Y	
Recred Files in Process	152	25	Y	Y	Y	
Expirables updated						
Insurance, License, DEA, Board Certifications					Y	
Files currently in process	223					
* 25 business days = 35 calendar days						
March 2026 Peer Review and Credentialing Committee Approvals						
Initial Credentialing	Number					
PCP	14					
SPEC	4					
ANCILLARY	20					
MIDLEVEL/AHP	9					
BH/ABA	135					
Sub-total	182					
Recredentialing						
PCP	10					
SPEC	19					
ANCILLARY	2					
MIDLEVEL/AHP	13					
BH/ABA	79					
Sub-total	123					
TOTAL	305					
March 2026 Facility Approvals						
Initial Credentialing	2					
Recredentialing	13					
Sub-total	15					
Facility Files in Process	16					
March 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	INITIALS RECREDs	CRED DATE
Abraham	Robin	BH/ABA-Telehealth	INITIAL	3/17/2026
Agos-Fikiri	Celeste	BH/ABA	INITIAL	3/17/2026
Aguilar	Nadirah	Doula	INITIAL	3/17/2026
Agustin	Merlissa	BH/ABA-Telehealth	INITIAL	3/17/2026
Alder	Keelia	Doula	INITIAL	3/17/2026
Almendarez	Karina	BH/ABA	INITIAL	3/17/2026
Alvarez	Amy	BH/ABA-Telehealth	INITIAL	3/17/2026
Anderson	Grace	BH/ABA-Telehealth	INITIAL	3/17/2026
Anderson	Lyndsae	BH/ABA	INITIAL	3/17/2026
Anhold-Tung	Alisa	BH/ABA-Telehealth	INITIAL	3/17/2026
Arias	Jennifer	BH/ABA-Telehealth	INITIAL	3/17/2026
Armendariz	Jessica	BH/ABA-Telehealth	INITIAL	3/17/2026
Arrazati	Veronica	BH/ABA-Telehealth	INITIAL	3/17/2026
Arty	Aidalix	Allied Health	INITIAL	3/17/2026
Au	Sara	BH/ABA-Telehealth	INITIAL	3/17/2026
Avila-Garcia	Silvia	BH/ABA	INITIAL	3/17/2026
Ayers	Namiko	BH/ABA-Telehealth	INITIAL	3/17/2026
Bakal	Arthur	Primary Care Physicia	INITIAL	3/17/2026
Bauer	Valeriya	BH/ABA-Telehealth	INITIAL	3/17/2026
Behrens	Kelly	BH/ABA-Telehealth	INITIAL	3/17/2026
Berger	Carly	BH/ABA-Telehealth	INITIAL	3/17/2026
Blank	Diana	BH/ABA-Telehealth	INITIAL	3/17/2026
Blaylock	Nicole	Doula	INITIAL	3/17/2026
Boquet	Cameron	BH/ABA	INITIAL	3/17/2026
Bridges	Christina	Specialist	INITIAL	3/17/2026
Briggs	Rebecca	BH/ABA-Telehealth	INITIAL	3/17/2026
Bulsara	Alessia	BH/ABA-Telehealth	INITIAL	3/17/2026
Burke	Julia Marguerite	BH/ABA-Telehealth	INITIAL	3/17/2026
Carter	Katrina	BH/ABA-Telehealth	INITIAL	3/17/2026
Carter Owens	Renee	Specialist	INITIAL	3/17/2026
Castillo	David	BH/ABA	INITIAL	3/17/2026
Castro	Guadalupe	BH/ABA-Telehealth	INITIAL	3/17/2026
Celis	Jessica	BH/ABA-Telehealth	INITIAL	3/17/2026
Cervantes	Armando	Primary Care Physicia	INITIAL	3/17/2026
Chavez	Nadia	BH/ABA-Telehealth	INITIAL	3/17/2026
Chen	Lawrence	BH/ABA-Telehealth	INITIAL	3/17/2026
Chodavadiya	Krupaben	Allied Health	INITIAL	3/17/2026
Chow-Kwan	Mei	Primary Care Physicia	INITIAL	3/17/2026
Cline	Ashley	BH/ABA-Telehealth	INITIAL	3/17/2026
Conrady	Chelsea	BH/ABA-Telehealth	INITIAL	3/17/2026
Crawford	Mar'Leesia	BH/ABA-Telehealth	INITIAL	3/17/2026
Cremmin	Stefanie	BH/ABA-Telehealth	INITIAL	3/17/2026
Cubillo	Stephanie	BH/ABA-Telehealth	INITIAL	3/17/2026
Cummings	Hilleary	BH/ABA-Telehealth	INITIAL	3/17/2026
Cunningham	Paul	Ancillary	INITIAL	3/17/2026
Dadabhoy	Tasneem	BH/ABA-Telehealth	INITIAL	3/17/2026
Darwish	Yasemine	BH/ABA	INITIAL	3/17/2026
Daza	Kirstie	Doula	INITIAL	3/17/2026
De Jonk	Sandra	BH/ABA-Telehealth	INITIAL	3/17/2026
Dean	Hafsah	Specialist	INITIAL	3/17/2026
Delbarrio	Jaycob	Ancillary	INITIAL	3/17/2026
Delgado	Andrew	BH/ABA-Telehealth	INITIAL	3/17/2026
Dhaliwal	Simarjit	Specialist	INITIAL	3/17/2026
Dietz Roberts	Keren	BH/ABA	INITIAL	3/17/2026
Difino	Kathryn	BH/ABA-Telehealth	INITIAL	3/17/2026

LAST NAME	FIRST NAME	CATEGORY	INITIALS RECREDs	CRED DATE
Dizon	Alyssa	Ancillary	INITIAL	3/17/2026
Dony	Cheryl	Allied Health	INITIAL	3/17/2026
Doshi	Bhavin	Primary Care Physicia	INITIAL	3/17/2026
Edwards	Kara	Doula	INITIAL	3/17/2026
Eichelberg	Valerie	BH/ABA-Telehealth	INITIAL	3/17/2026
Engleman	Marissa	BH/ABA	INITIAL	3/17/2026
Esparza	Alyssa	BH/ABA-Telehealth	INITIAL	3/17/2026
Esplana	John	BH/ABA-Telehealth	INITIAL	3/17/2026
Farooq	Fariha	Allied Health	INITIAL	3/17/2026
Fowler	Benjamin	BH/ABA-Telehealth	INITIAL	3/17/2026
Francis	Gillian	BH/ABA-Telehealth	INITIAL	3/17/2026
Fulbright	Veronica	Doula	INITIAL	3/17/2026
Gabriel	Kristen	BH/ABA-Telehealth	INITIAL	3/17/2026
Gandhi	Melody	Allied Health	INITIAL	3/17/2026
Gandhi	Paayal	BH/ABA-Telehealth	INITIAL	3/17/2026
Garcia Valente	Marisol	BH/ABA-Telehealth	INITIAL	3/17/2026
Gayton	Emily	Ancillary	INITIAL	3/17/2026
Giambrone	Renee	BH/ABA	INITIAL	3/17/2026
Gill	April	Ancillary	INITIAL	3/17/2026
Gonzalez	Brittany	BH/ABA-Telehealth	INITIAL	3/17/2026
Gonzalez	Jennifer	BH/ABA-Telehealth	INITIAL	3/17/2026
Gonzalez	Judith	BH/ABA-Telehealth	INITIAL	3/17/2026
Grayson	Denisha	BH/ABA	INITIAL	3/17/2026
Guiang	Mary Grace	BH/ABA	INITIAL	3/17/2026
Head	Shaughn	Primary Care Physicia	INITIAL	3/17/2026
Herrera	Brandey	BH/ABA	INITIAL	3/17/2026
Higueros	Erwin	BH/ABA	INITIAL	3/17/2026
Hoang	Taman	Primary Care Physicia	INITIAL	3/17/2026
Hudson	Hannah	BH/ABA-Telehealth	INITIAL	3/17/2026
Hughey	Lauren	BH/ABA-Telehealth	INITIAL	3/17/2026
Huston	Michelle-Dawne	BH/ABA-Telehealth	INITIAL	3/17/2026
Inami	Bona	BH/ABA-Telehealth	INITIAL	3/17/2026
Irby	Kalaya	BH/ABA	INITIAL	3/17/2026
Ireland	Haley	BH/ABA	INITIAL	3/17/2026
Johnstone	Noelle V	Primary Care Physicia	INITIAL	3/17/2026
Kaisarieh	Angelina	Primary Care Physicia	INITIAL	3/17/2026
Kaufman	Adam	BH/ABA	INITIAL	3/17/2026
Khakhiashvili	Nutsa	BH/ABA-Telehealth	INITIAL	3/17/2026
Khan	Zoya	Doula	INITIAL	3/17/2026
Khine	Khin	Primary Care Physicia	INITIAL	3/17/2026
Klein	Kyleigh	BH/ABA-Telehealth	INITIAL	3/17/2026
La	Belinda	BH/ABA-Telehealth	INITIAL	3/17/2026
Lama Tamang	Tenchee	BH/ABA-Telehealth	INITIAL	3/17/2026
LaMoy	Stefanie	BH/ABA	INITIAL	3/17/2026
Le	Nghia	BH/ABA-Telehealth	INITIAL	3/17/2026
Lee	Maiyia	BH/ABA-Telehealth	INITIAL	3/17/2026
Leguizamon	Paola	BH/ABA	INITIAL	3/17/2026
Leung	Cynthia	Allied Health	INITIAL	3/17/2026
Levine	Joanne	BH/ABA-Telehealth	INITIAL	3/17/2026
Lomongsod	Alexa	Allied Health	INITIAL	3/17/2026
Lonon	Laticia	Doula	INITIAL	3/17/2026
Lopez	Marta	BH/ABA-Telehealth	INITIAL	3/17/2026
Lucas	Carlos	BH/ABA-Telehealth	INITIAL	3/17/2026
MacKenzie	Onagh	Primary Care Physicia	INITIAL	3/17/2026
Martin	Benita	AHP SP_CHW	INITIAL	3/17/2026
Marty	Kaitlyn	Doula	INITIAL	3/17/2026
Marvin	Andrea	BH/ABA-Telehealth	INITIAL	3/17/2026

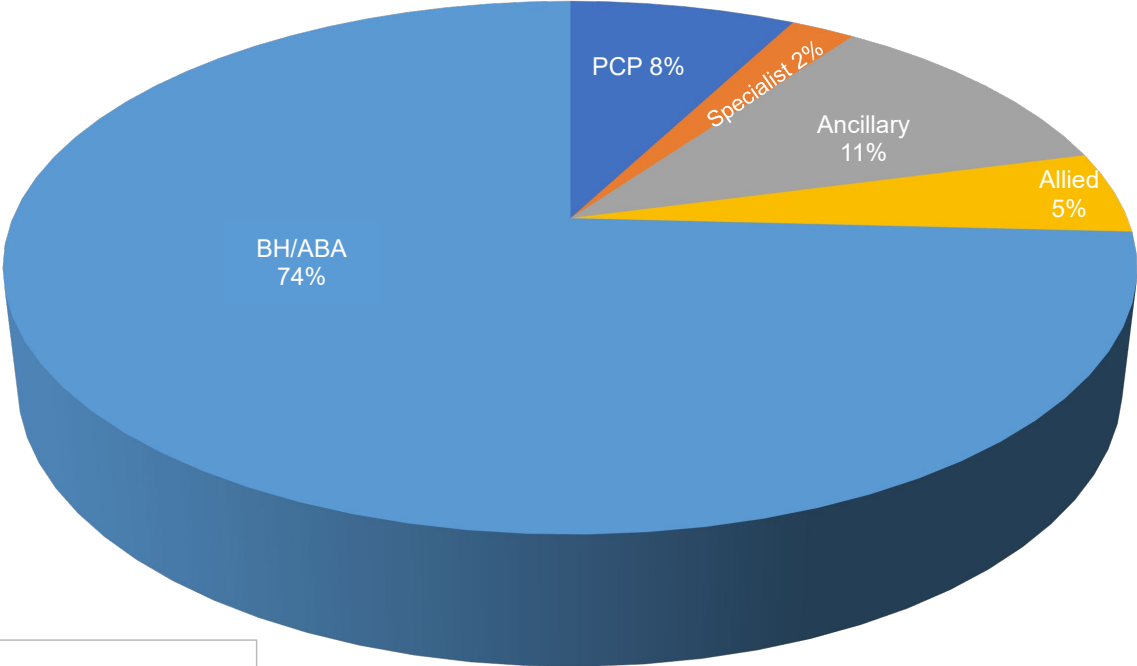
LAST NAME	FIRST NAME	CATEGORY	INITIALS RECREDS	CRED DATE
Matecki	Wayne	Ancillary	INITIAL	3/17/2026
McCrory	Devon	BH/ABA-Telehealth	INITIAL	3/17/2026
McNamara	Revati	BH/ABA-Telehealth	INITIAL	3/17/2026
Mendoza	Blanca	BH/ABA-Telehealth	INITIAL	3/17/2026
Monasterio	Andrew	BH/ABA-Telehealth	INITIAL	3/17/2026
Mudd	Marta	BH/ABA-Telehealth	INITIAL	3/17/2026
Nawawi	Camille	BH/ABA-Telehealth	INITIAL	3/17/2026
Nelson	Amanda	BH/ABA-Telehealth	INITIAL	3/17/2026
Neves	Lisa	BH/ABA-Telehealth	INITIAL	3/17/2026
Ng	Joseph	BH/ABA-Telehealth	INITIAL	3/17/2026
Nguyen	Hoang-Kim	BH/ABA-Telehealth	INITIAL	3/17/2026
O'Brien	Erin	BH/ABA-Telehealth	INITIAL	3/17/2026
Orabueze	Michelle	Primary Care Physicia	INITIAL	3/17/2026
Ornelas Black	Adrianne	BH/ABA-Telehealth	INITIAL	3/17/2026
Orr	Riva	BH/ABA-Telehealth	INITIAL	3/17/2026
Osorio	Erick	BH/ABA-Telehealth	INITIAL	3/17/2026
Osorio	Rabita	BH/ABA-Telehealth	INITIAL	3/17/2026
Overton	Julie	Doula	INITIAL	3/17/2026
Patel	Meg	BH/ABA-Telehealth	INITIAL	3/17/2026
Penny	Tynesha	BH/ABA-Telehealth	INITIAL	3/17/2026
Perez	Rose	BH/ABA-Telehealth	INITIAL	3/17/2026
Pichardo-Gomez	David	Primary Care Physicia	INITIAL	3/17/2026
Pierce	Amy	BH/ABA-Telehealth	INITIAL	3/17/2026
Pierre	Judith	Allied Health	INITIAL	3/17/2026
Pinzon	Yuri	BH/ABA-Telehealth	INITIAL	3/17/2026
Prado	Gisselle	BH/ABA-Telehealth	INITIAL	3/17/2026
Prete	Dion	BH/ABA	INITIAL	3/17/2026
Quan	Kristen	BH/ABA-Telehealth	INITIAL	3/17/2026
Rajan	Nivedha	Primary Care Physicia	INITIAL	3/17/2026
Rajmohan	Shruti	BH/ABA	INITIAL	3/17/2026
Rami	Falu	BH/ABA-Telehealth	INITIAL	3/17/2026
Randazzo	Sheryll	Doula	INITIAL	3/17/2026
Ray	Mariah	BH/ABA	INITIAL	3/17/2026
Rodriguez	Daniela	BH/ABA-Telehealth	INITIAL	3/17/2026
Rotella	Sara	BH/ABA-Telehealth	INITIAL	3/17/2026
Saleh	Melonie	BH/ABA-Telehealth	INITIAL	3/17/2026
Sanchez	Diana	BH/ABA-Telehealth	INITIAL	3/17/2026
Sansivero	Jamie	BH/ABA-Telehealth	INITIAL	3/17/2026
Schwartz	Aria	Doula	INITIAL	3/17/2026
Short	Claire	BH/ABA-Telehealth	INITIAL	3/17/2026
Singh	Kristine	BH/ABA-Telehealth	INITIAL	3/17/2026
Smith	Chelsea	BH/ABA-Telehealth	INITIAL	3/17/2026
Smolinski	Stephanie	BH/ABA-Telehealth	INITIAL	3/17/2026
Snipes	Tyrone	Primary Care Physicia	INITIAL	3/17/2026
So	Felix	BH/ABA-Telehealth	INITIAL	3/17/2026
Sosa Manrique	Stephanie	BH/ABA-Telehealth	INITIAL	3/17/2026
Starnes	Benjamin	BH/ABA-Telehealth	INITIAL	3/17/2026
Stewart	Gabrielle	BH/ABA-Telehealth	INITIAL	3/17/2026
Stewart-Bey	Malika	BH/ABA-Telehealth	INITIAL	3/17/2026
Tallent	Robin	BH/ABA	INITIAL	3/17/2026
Tamiz	Khatima	Doula	INITIAL	3/17/2026
Tani	Marina	BH/ABA	INITIAL	3/17/2026
Thomas	Annalisa	BH/ABA-Telehealth	INITIAL	3/17/2026
Thompson	Lacy	BH/ABA	INITIAL	3/17/2026
Tiede	Aidan	BH/ABA-Telehealth	INITIAL	3/17/2026
Trejo	Viviana	BH/ABA-Telehealth	INITIAL	3/17/2026

LAST NAME	FIRST NAME	CATEGORY	INITIALS	RECRED S	CRED DATE
Tuli	Jasleen	BH/ABA-Telehealth	INITIAL		3/17/2026
Ulmer	Laroysha	BH/ABA-Telehealth	INITIAL		3/17/2026
Vallejo	Teresa	BH/ABA-Telehealth	INITIAL		3/17/2026
Vamvouris	Katarina	BH/ABA-Telehealth	INITIAL		3/17/2026
Wadhwani	Ravina	BH/ABA-Telehealth	INITIAL		3/17/2026
Warwick	Annette	Allied Health	INITIAL		3/17/2026
Watkins	Isela	BH/ABA	INITIAL		3/17/2026
Watt	Erin	BH/ABA-Telehealth	INITIAL		3/17/2026
White	Elizabeth	BH/ABA-Telehealth	INITIAL		3/17/2026
Williams	Seth	BH/ABA-Telehealth	INITIAL		3/17/2026
Wyek	Alanna	BH/ABA	INITIAL		3/17/2026
Zeiger	Ashley	BH/ABA-Telehealth	INITIAL		3/17/2026
Zelin	Nicole	BH/ABA-Telehealth	INITIAL		3/17/2026
Zerrudo	Joseph	BH/ABA-Telehealth	INITIAL		3/17/2026
Alter	Gregory	BH/ABA	RECRED S		3/17/2026
Atme-Bahrani	Nicole	Allied Health	RECRED S		3/17/2026
Baksi-Banerjee	Maitrayee	BH/ABA	RECRED S		3/17/2026
Baldor	Denine	BH/ABA	RECRED S		3/17/2026
Branum	Faye	BH/ABA-Telehealth	RECRED S		3/17/2026
Brown	Anissa	BH/ABA	RECRED S		3/17/2026
Carpentieri	Anthony	BH/ABA	RECRED S		3/17/2026
Catalina	Ellen	BH/ABA	RECRED S		3/17/2026
Chang	Shurong	Specialist	RECRED S		3/17/2026
Chang	Warren	Specialist	RECRED S		3/17/2026
Chen	Xiaochuan	Primary Care Physicia	RECRED S		3/17/2026
Chon	Jennifer	BH/ABA-Telehealth	RECRED S		3/17/2026
Clark	Melissa	Allied Health	RECRED S		3/17/2026
Cobbey	Margaret	Allied Health	RECRED S		3/17/2026
Cruz	Christian	Specialist	RECRED S		3/17/2026
Curran	Steven	Primary Care Physicia	RECRED S		3/17/2026
Davidow	Talia	BH/ABA	RECRED S		3/17/2026
Dela Cruz	Rhodora	Primary Care Physicia	RECRED S		3/17/2026
DeSouza	Neha	Specialist	RECRED S		3/17/2026
Ettelson	Richard	BH/ABA	RECRED S		3/17/2026
Fisher	Robyn	BH/ABA-Telehealth	RECRED S		3/17/2026
Fraino	Joan	Allied Health	RECRED S		3/17/2026
Franks	Ariel	Primary Care Physicia	RECRED S		3/17/2026
Gayle	Gregory	BH/ABA	RECRED S		3/17/2026
Gill	Amarpreet	BH/ABA	RECRED S		3/17/2026
Gonzalez	Micael	BH/ABA	RECRED S		3/17/2026
Gray	Alexandra	Allied Health	RECRED S		3/17/2026
Gregori	Jeffery	Specialist	RECRED S		3/17/2026
Grewal	Suneet	Specialist	RECRED S		3/17/2026
Gutierrez	Kimberly	BH/ABA	RECRED S		3/17/2026
Hall	Kimberly	BH/ABA-Telehealth	RECRED S		3/17/2026
He	Chenyin	Specialist	RECRED S		3/17/2026
Heart	Anita	Primary Care Physicia	RECRED S		3/17/2026
Hickman	Norval	BH/ABA	RECRED S		3/17/2026
Himelstein	Samuel	BH/ABA	RECRED S		3/17/2026
Hoffman	Holli	BH/ABA	RECRED S		3/17/2026
Holland	Amy	BH/ABA-Telehealth	RECRED S		3/17/2026
Iqbal	Zarah	Primary Care Physicia	RECRED S		3/17/2026
Karwacki	Andrzej	BH/ABA-Telehealth	RECRED S		3/17/2026
Khan	Ghazala	BH/ABA	RECRED S		3/17/2026
Khan	Muhammad	Allied Health	RECRED S		3/17/2026

LAST NAME	FIRST NAME	CATEGORY	INITIALS RECREDs	CRED DATE
Khuu	Duke	Specialist	RECREDs	3/17/2026
Kim	Paul	BH/ABA-Telehealth	RECREDs	3/17/2026
Kinney	Benton	BH/ABA	RECREDs	3/17/2026
Kochenburger	Richard	Specialist	RECREDs	3/17/2026
Krueger	Bonnie	BH/ABA-Telehealth	RECREDs	3/17/2026
Lagoy	Julian	BH/ABA-Telehealth	RECREDs	3/17/2026
Laine	Ritva	Ancillary	RECREDs	3/17/2026
Lane	Michelle	BH/ABA	RECREDs	3/17/2026
Lane	Victoria	BH/ABA	RECREDs	3/17/2026
Lang	Thalia	BH/ABA-Telehealth	RECREDs	3/17/2026
Larson	Gregory	BH/ABA	RECREDs	3/17/2026
Lask Knizek	Mauricio	BH/ABA	RECREDs	3/17/2026
Lau	Cindy-Heung	BH/ABA	RECREDs	3/17/2026
Law	Jason	Specialist	RECREDs	3/17/2026
Lawler	Raina	BH/ABA	RECREDs	3/17/2026
Lee	Yujin	BH/ABA	RECREDs	3/17/2026
Levin	Yael	BH/ABA	RECREDs	3/17/2026
Lin	Minda	BH/ABA	RECREDs	3/17/2026
Lo	Ernest	Specialist	RECREDs	3/17/2026
Lohrey	Sarah	BH/ABA-Telehealth	RECREDs	3/17/2026
Lum-Levine	Rosemary	BH/ABA	RECREDs	3/17/2026
Macaraeg	Lauren	Specialist	RECREDs	3/17/2026
Mangan	Sandra	BH/ABA	RECREDs	3/17/2026
Marino	Julia	Primary Care Physicia	RECREDs	3/17/2026
Martinez	Breanne	BH/ABA-Telehealth	RECREDs	3/17/2026
Martinez	Melissa	BH/ABA	RECREDs	3/17/2026
Maxwell	Andrew	Specialist	RECREDs	3/17/2026
Mehta	Surbhee	BH/ABA	RECREDs	3/17/2026
Messerschmidt	Margaret	BH/ABA-Telehealth	RECREDs	3/17/2026
Middleton	Elise	BH/ABA	RECREDs	3/17/2026
Miyamoto	Satoko	BH/ABA	RECREDs	3/17/2026
Mody	Sitar	BH/ABA-Telehealth	RECREDs	3/17/2026
Moulds	Jacob	BH/ABA	RECREDs	3/17/2026
Mueller	Lauren	BH/ABA	RECREDs	3/17/2026
Munoz	Cindia	BH/ABA	RECREDs	3/17/2026
Murphy	Michael	Specialist	RECREDs	3/17/2026
Murtinty	Padmaja	Allied Health	RECREDs	3/17/2026
Myint	San-San	Primary Care Physicia	RECREDs	3/17/2026
Nainani	Neha	Specialist	RECREDs	3/17/2026
Naranjo	Jaime	BH/ABA	RECREDs	3/17/2026
Needens	Brandon	BH/ABA-Telehealth	RECREDs	3/17/2026
Nelson	Britta	Allied Health	RECREDs	3/17/2026
Netherland	Lisa	Specialist	RECREDs	3/17/2026
Newman	Zoe	BH/ABA-Telehealth	RECREDs	3/17/2026
Nguyen	Anh	Ancillary	RECREDs	3/17/2026
Nguyen	Christine	BH/ABA	RECREDs	3/17/2026
Nguyen	Myngoc	Specialist	RECREDs	3/17/2026
Nielsen	Welby	BH/ABA-Telehealth	RECREDs	3/17/2026
Ochoa	Candice	BH/ABA-Telehealth	RECREDs	3/17/2026
Outlaw	Jaseon	BH/ABA	RECREDs	3/17/2026
Parmar	Rashmi	BH/ABA	RECREDs	3/17/2026
Passey	Natalie	Allied Health	RECREDs	3/17/2026
Perez	Genesis	BH/ABA	RECREDs	3/17/2026
Peterson	Shannon	BH/ABA	RECREDs	3/17/2026
Petrovich	Rashida	Allied Health	RECREDs	3/17/2026

LAST NAME	FIRST NAME	CATEGORY	INITIALS RECREDs	CRED DATE
Pizarro	Erika Paula	BH/ABA	RECREDs	3/17/2026
Post	Stephen	Specialist	RECREDs	3/17/2026
Priyanka	Priyanka	BH/ABA	RECREDs	3/17/2026
Rahadyan	Angga	BH/ABA-Telehealth	RECREDs	3/17/2026
Ramos	Ruth	Allied Health	RECREDs	3/17/2026
Reboja-Dirige	Frances	BH/ABA-Telehealth	RECREDs	3/17/2026
Rector	Lea	BH/ABA-Telehealth	RECREDs	3/17/2026
Reddy	Narendra	BH/ABA	RECREDs	3/17/2026
Revilla	Ana	Primary Care Physicia	RECREDs	3/17/2026
Romero	Irma	BH/ABA	RECREDs	3/17/2026
Rosen	Lynne	Primary Care Physicia	RECREDs	3/17/2026
Rosenberg	Shoshana	BH/ABA	RECREDs	3/17/2026
Rouche	Lynde	Allied Health	RECREDs	3/17/2026
Rubin	Joan	BH/ABA	RECREDs	3/17/2026
Ruiz	Jennifer	BH/ABA	RECREDs	3/17/2026
Runyon	Theresa	Allied Health	RECREDs	3/17/2026
Saleem	Hala	BH/ABA-Telehealth	RECREDs	3/17/2026
Sampson	Charnay	BH/ABA-Telehealth	RECREDs	3/17/2026
Sanchez	Christina	BH/ABA	RECREDs	3/17/2026
Sinnappan	Christopher	BH/ABA	RECREDs	3/17/2026
Terry	Benelia	BH/ABA-Telehealth	RECREDs	3/17/2026
Testard	Aaron	BH/ABA	RECREDs	3/17/2026
Tuan	David	Specialist	RECREDs	3/17/2026
Turrini	Corinne	BH/ABA-Telehealth	RECREDs	3/17/2026
Washington	Tiana	BH/ABA	RECREDs	3/17/2026
Xie	Yuhuan	BH/ABA	RECREDs	3/17/2026
Young	Diana	BH/ABA	RECREDs	3/17/2026

**MARCH PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY**



PCP	14
SPECIALIST	4
ANCILLARY	20
ALLIED HEALTH	9
BH/ABA	135
TOTAL	182

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2025 - 2026 | 3RD QUARTER (Q3) OUTREACH REPORT

ALLIANCE IN THE COMMUNITY

FY 2025 - 2026 | 3RD QUARTER (Q3) OUTREACH REPORT

Between January 2026 and March 2026, the Alliance completed **1,654** member orientation outreach calls among net new members and non-utilizers and conducted **146** net new member orientations and **9** non-utilizer member orientations (**23%** member participation rate). In addition, the Outreach team completed **31** Alliance website inquiries, **22** service requests, **13** community events, **11** member education events and **1** Community Meeting/Presentation events in Q3. Our sponsorships for the OCCC Chinatown Lunar New Year event and the Black Joy Parade were \$5,000 and \$6,000, respectively, engaging more than **20,000** and **120,000** participants through these two events. We also participated in the Black Joy Parade for the first time, walking in the parade to celebrate Black History Month and 30 years of the Alliance serving the community.

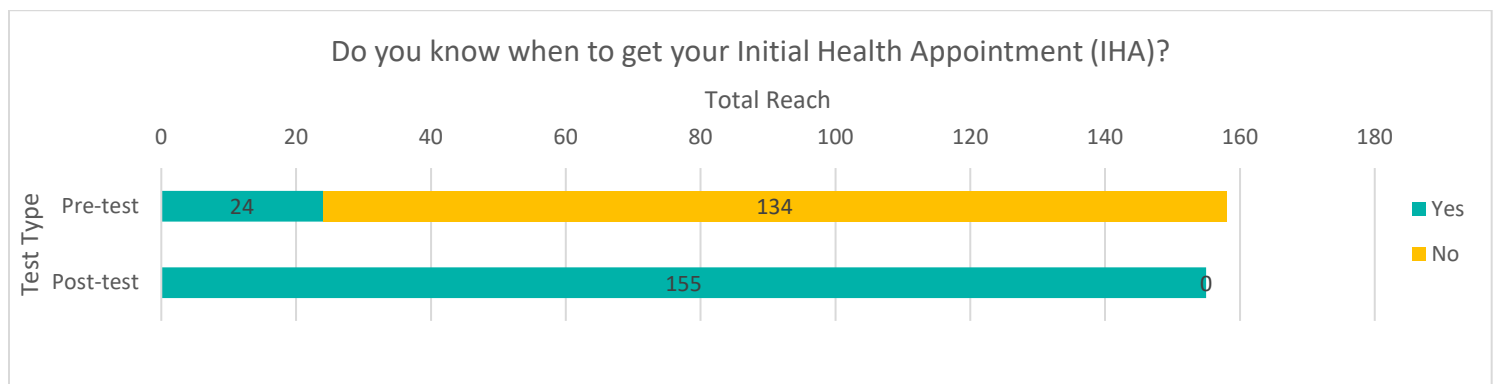
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, approximately **45,650** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020**, the Alliance began conducting member orientations by phone. As of **Tuesday, March 31, 2026**, the Outreach Team has completed **56,267** member orientation outreach calls and conducted **10,390** orientations, achieving a **18.5%** participation rate.

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18, 2020, through March 31, 2026, **10,390** members completed our MO program by phone.

After completing a MO, **100%** of members who completed the post-test survey in Q3 FY 25-26 reported knowing when to get their IHA, compared to only **15.2%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 25-26\Q3\March 2026**

ALLIANCE IN THE COMMUNITY

FY 2025 - 2026 | 3RD QUARTER (Q3) OUTREACH REPORT

Q3 FY 2025-2026 TOTALS



13 COMMUNITY EVENTS

11 MEMBER EDUCATION
EVENTS

155 MEMBER ORIENTATIONS

1 MEETINGS/ PRESENTATIONS

31 TOTAL INITIATED/INVITED
EVENTS

180 TOTAL EVENTS



142406 TOTAL REACHED AT
COMMUNITY EVENTS

1773 TOTAL REACHED AT MEMBER
EDUCATION EVENTS

155 TOTAL REACHED AT
MEMBER ORIENTATIONS

75 TOTAL REACHED AT
MEETINGS/PRESENTATIONS

2063 TOTAL MEMBERS REACHED
AT EVENTS

144409 TOTAL REACHED AT ALL
EVENTS



ALAMEDA
ASHLAND
BERKELEY

CASTRO
VALLEY
DUBLIN

FREMONT
HAYWARD
LIVERMORE

NEWARK
OAKLAND
PLEASANTON

SAN LEANDRO
SAN LORENZO
UNION CITY

TOTAL REACH 17 CITIES

Cities represent the mailing addresses for members who completed a Member Orientation by phone. The following cities had <1% reach during Q3 2026: Albany, Emeryville, and Fairview. The C&O Department started including these cities in the Q3 FY21 Outreach Report.



\$11150.00

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

* Includes refundable deposit.

COMMUNICATIONS & OUTREACH DEPARTMENT

SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | March 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 **March 1, 2026**, and **March 31, 2026**:

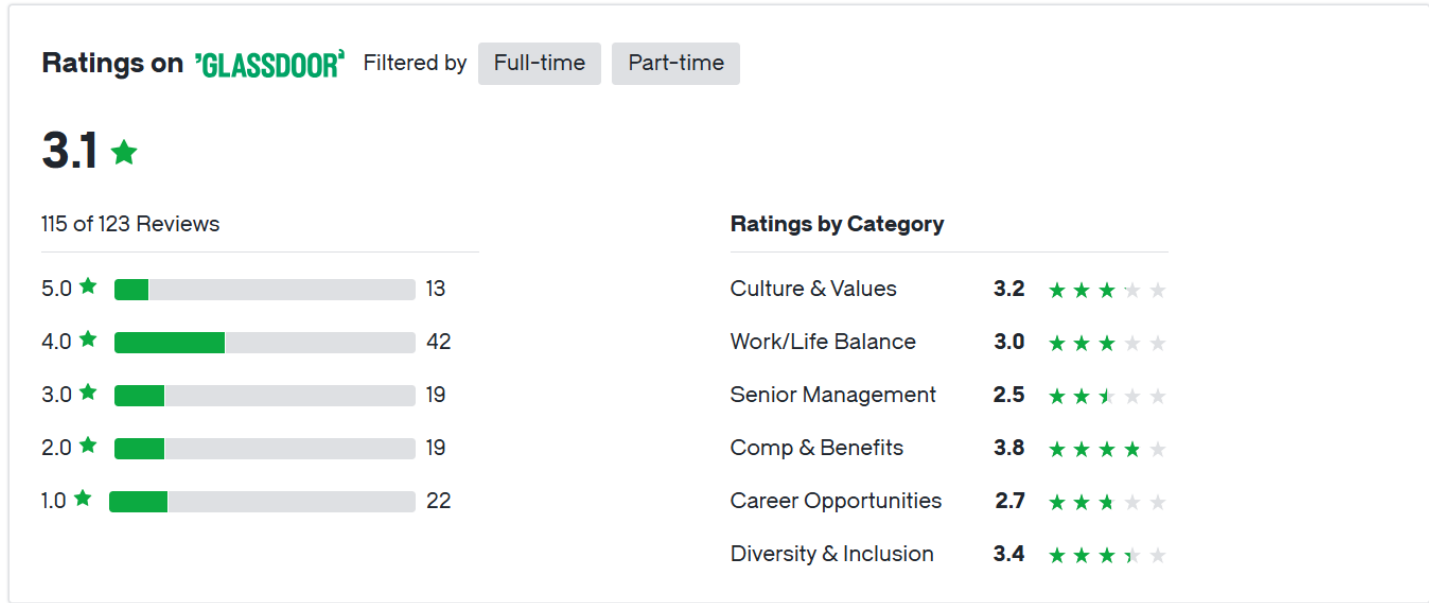
1. Alliance Website:
 - Received **147,222** unique visits
 - Served more than **1,007,279** page visits
 - The top **10** website page visits were:
 - i. Homepage
 - ii. Find a Doctor
 - iii. Providers
 - iv. Provider Portal
 - v. Benefits and Covered Services
 - vi. Medi-Cal Members
 - vii. Members
 - viii. Get a New ID Card
 - ix. Contact Us
 - x. Careers
2. Facebook Page:
 - Decreased followers from **696** to **695**
 - Did not receive any reviews in **March 2026**
3. Glassdoor Page:
 - Maintained **3.1** out of a **5-star** overall rating
 - Did not receive any reviews in **March 2026**
4. Google Page:
 - **2,184** website clicks were made from the business profile
 - **1,812** calls were made from the business profile
 - Did not receive any reviews in **March 2026**
5. Instagram Page:
 - Increased in followers from **724** to **726**
6. LinkedIn Page:
 - Increased followers from **7.3k** to **7.4k**
 - Received **9** page clicks
7. X (previously Twitter) Page:
 - Maintained followers at **352**
8. Yelp Page:
 - Page visits **85**
 - Appeared in Yelp searches **154** times
 - Received one (1) review in **March 2026**

COMMUNICATIONS & OUTREACH DEPARTMENT

SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | March 2026

GLASSDOOR OVERVIEW



Ratings by category

3.2	Culture & values
3.4	Diversity, Equity & Inclusion
3.0	Work/Life balance
2.5	Senior management
3.8	Compensation and benefits
2.7	Career opportunities

Ratings distribution

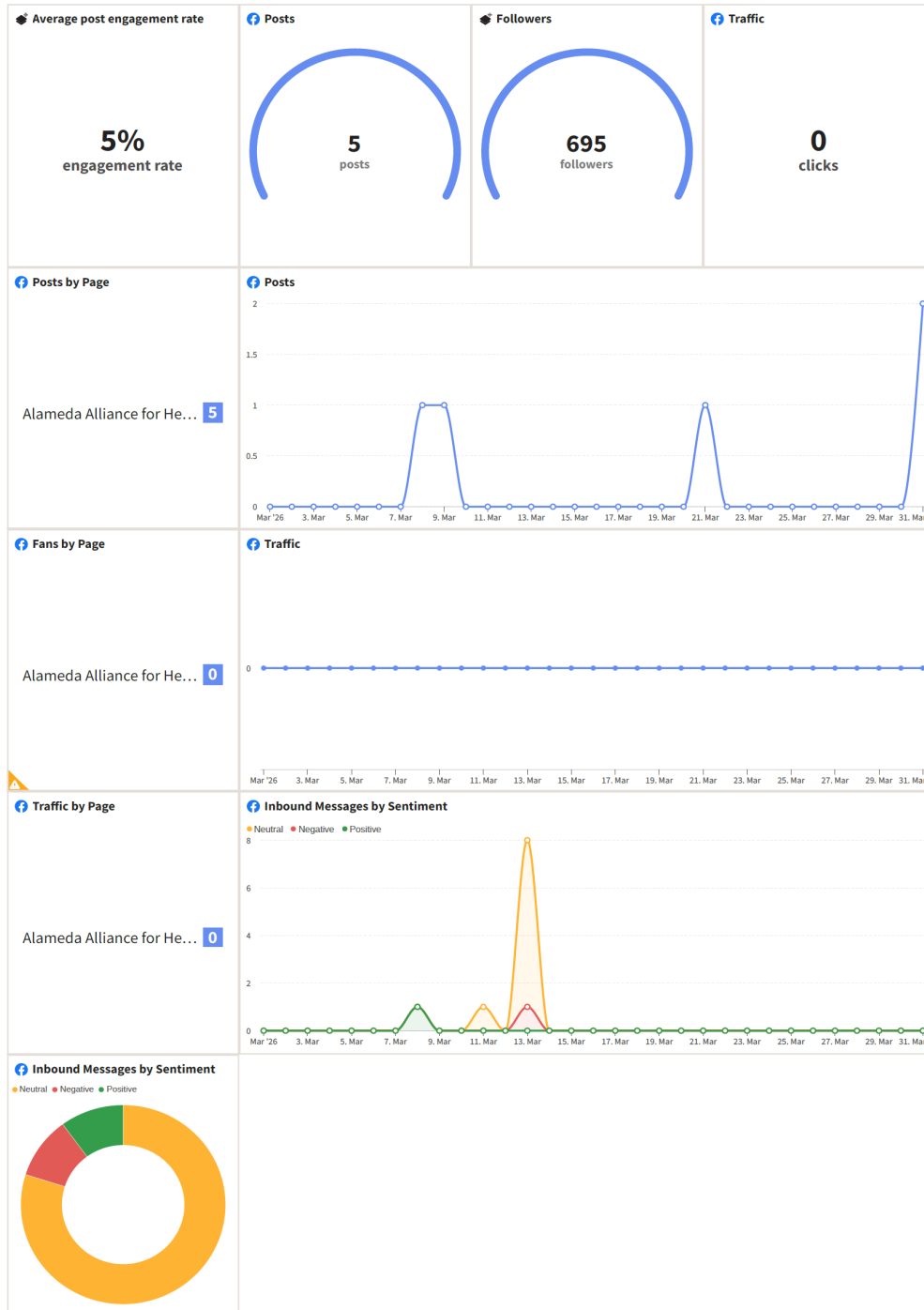
5 stars		11%
4 stars		37%
3 stars		17%
2 stars		17%
1 star		19%

All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q2\3. March 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | March 2026

FACEBOOK OVERVIEW

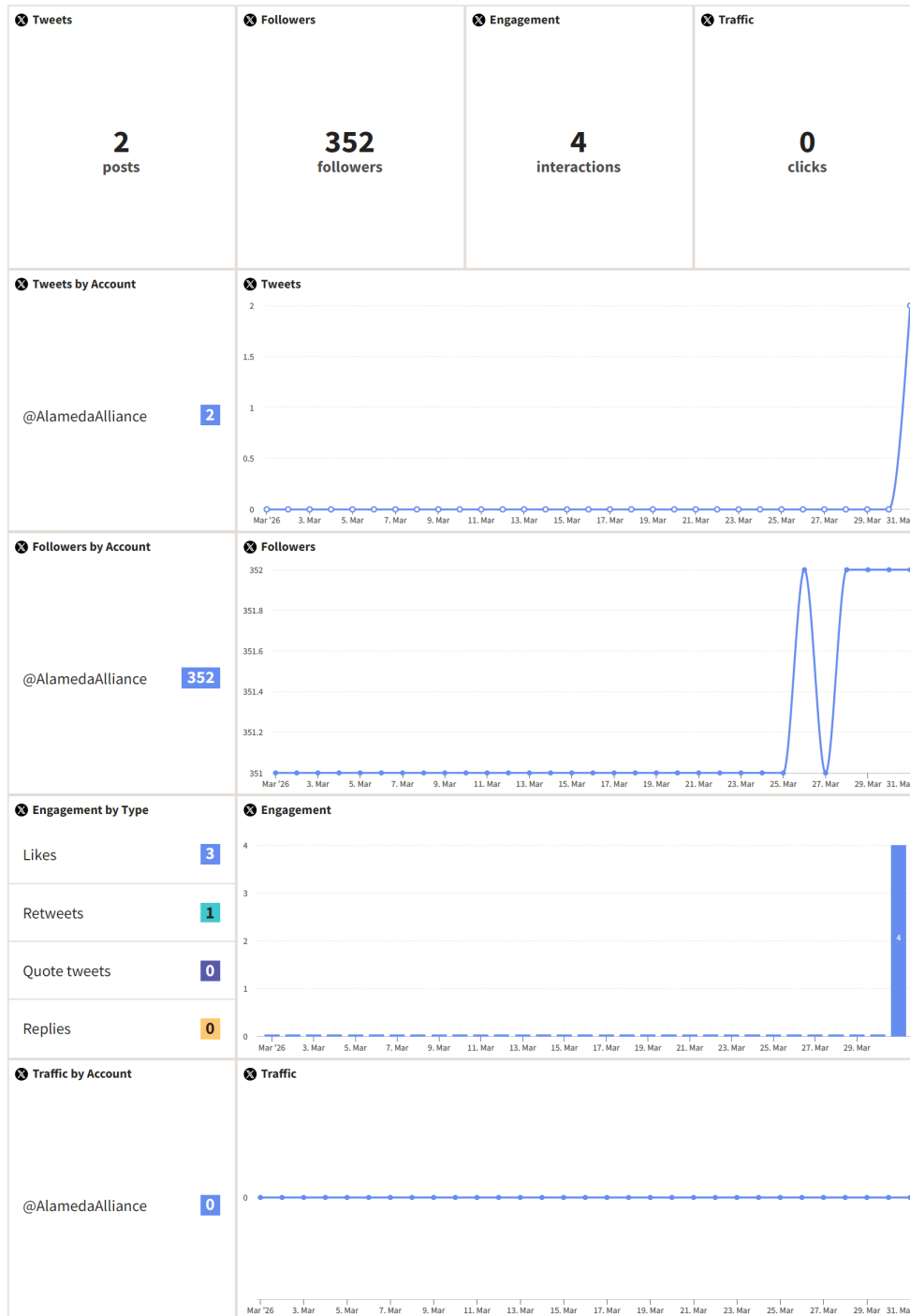


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q2\3. March 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | March 2026

X (previously TWITTER) OVERVIEW

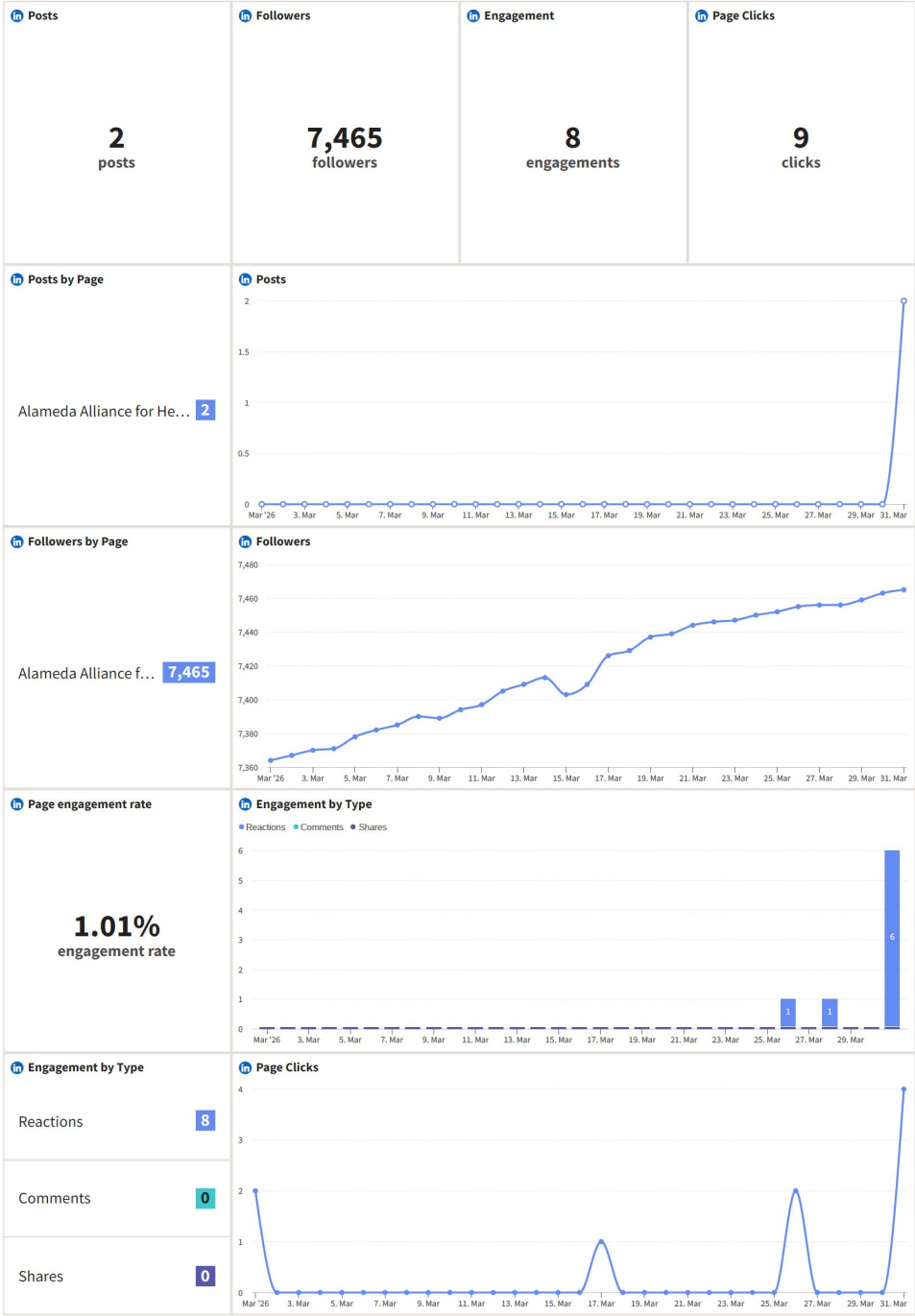


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q2\3. March 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | March 2026

LINKEDIN OVERVIEW

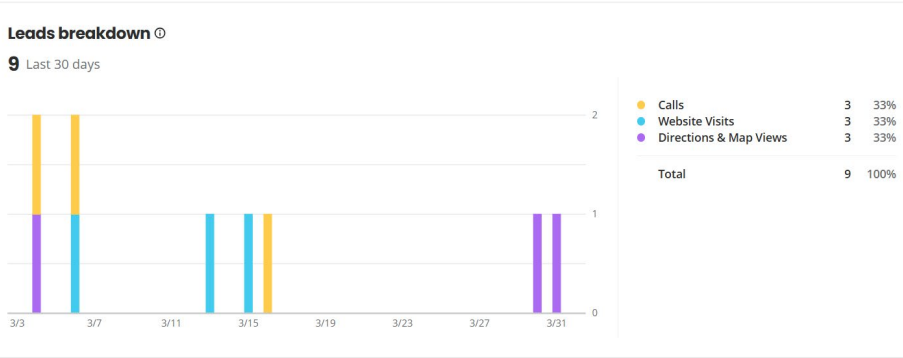
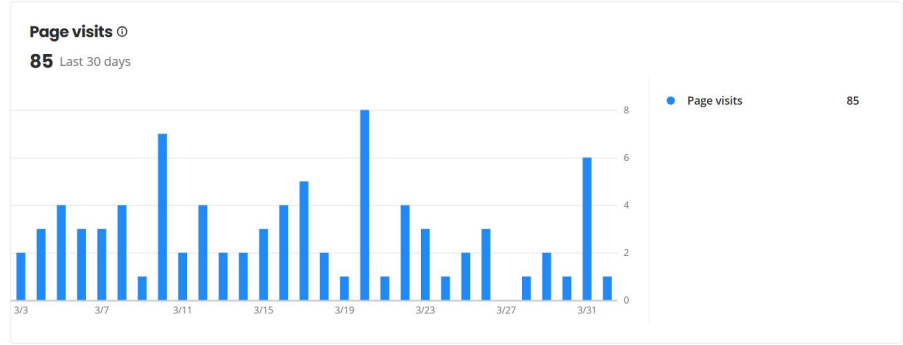
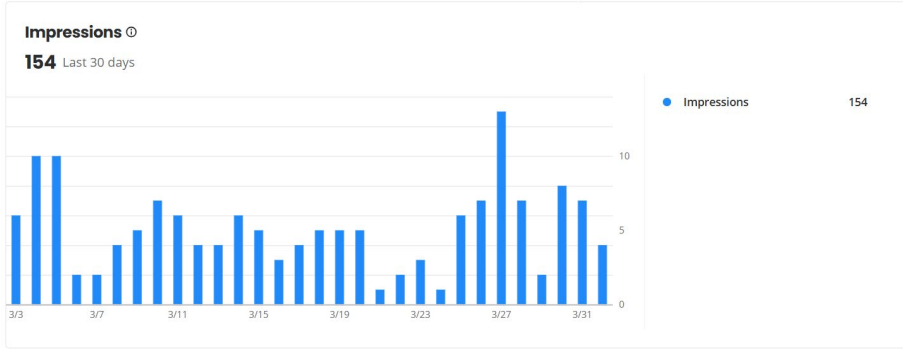
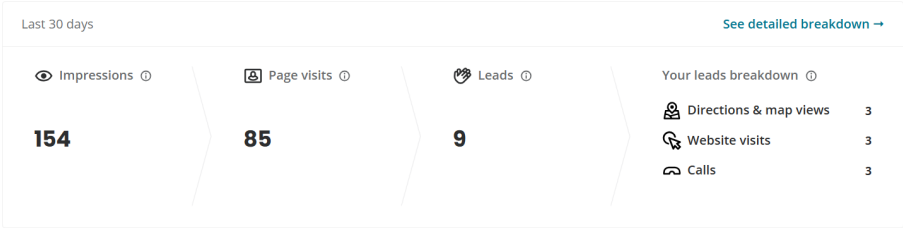


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q2\3. March 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | March 2026

YELP OVERVIEW

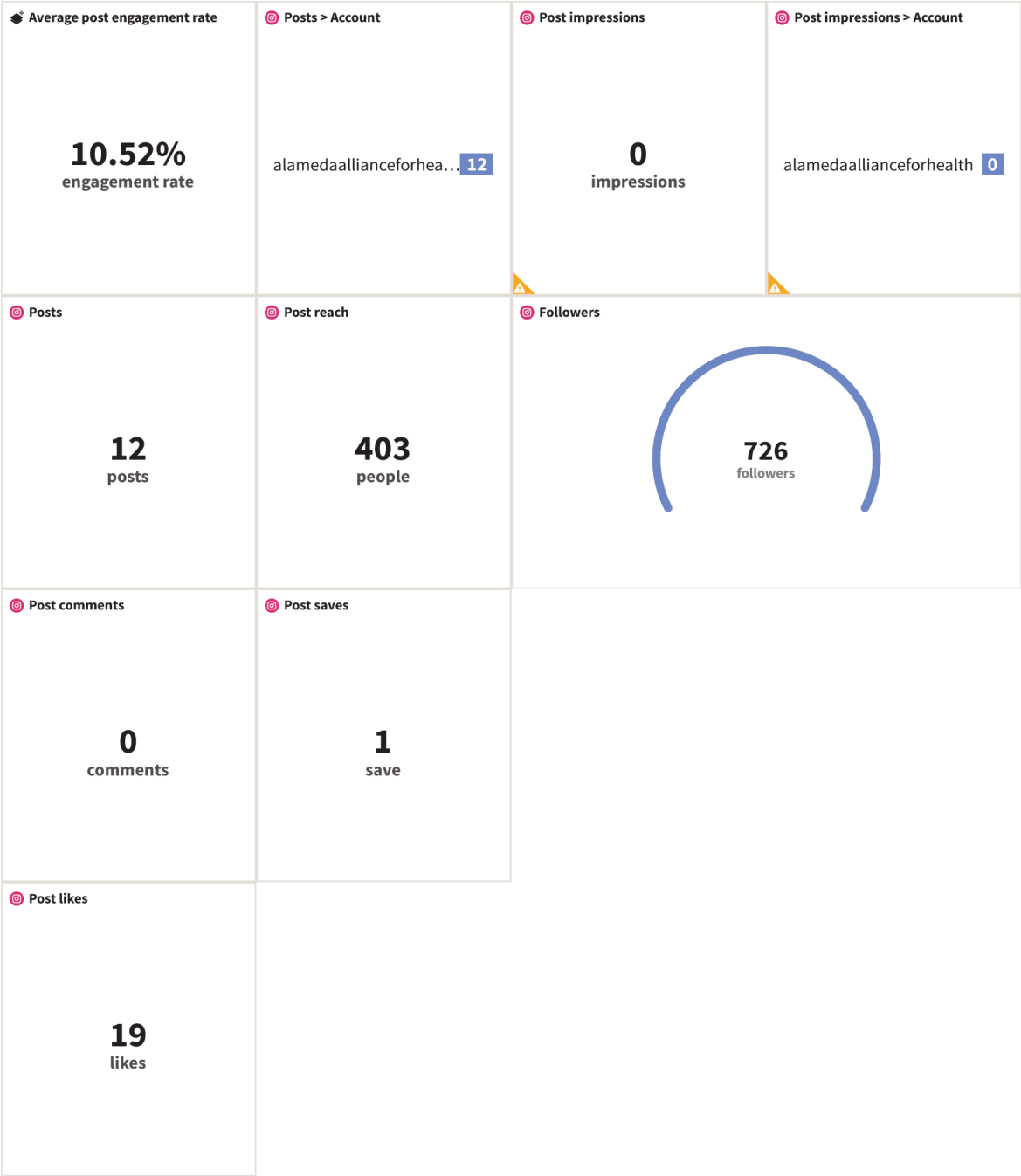


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q2\3. March 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | March 2026

INSTAGRAM OVERVIEW:

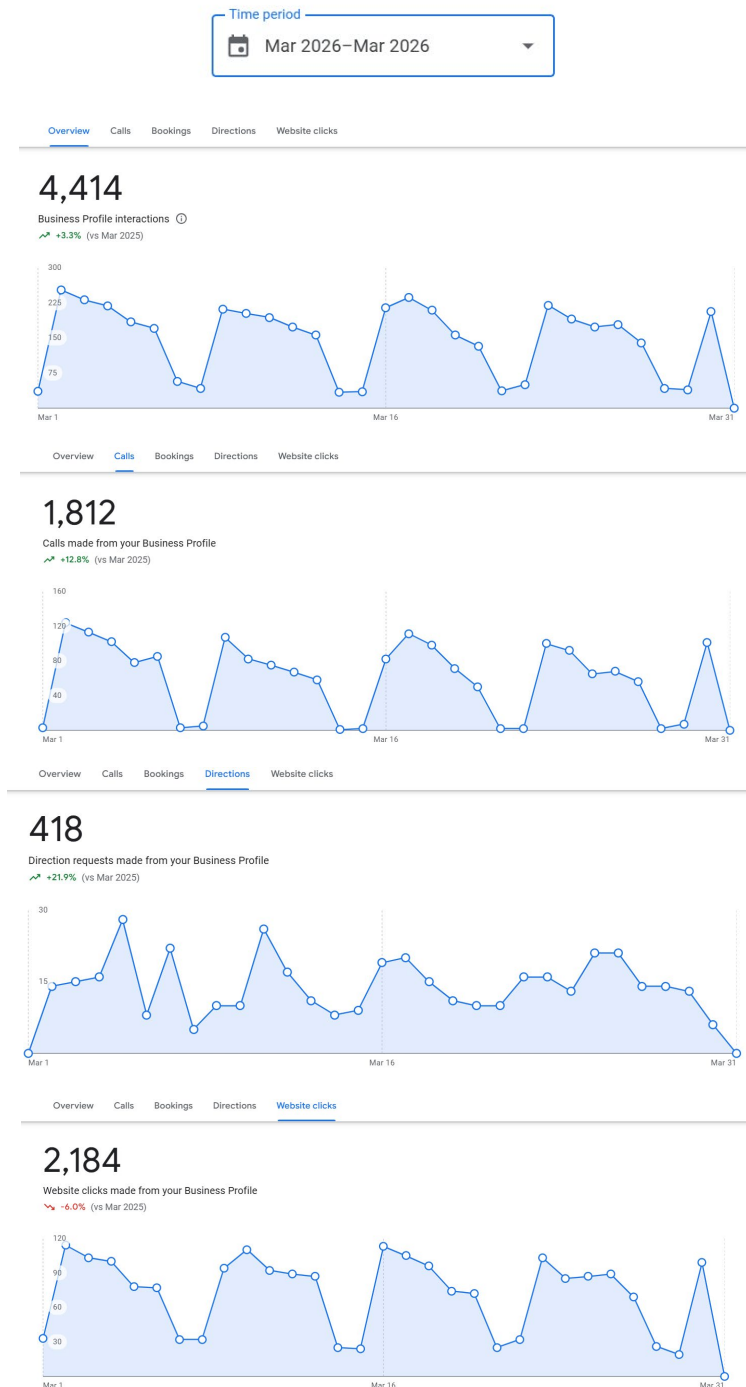


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q2\3. March 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | March 2026

GOOGLE OVERVIEW:

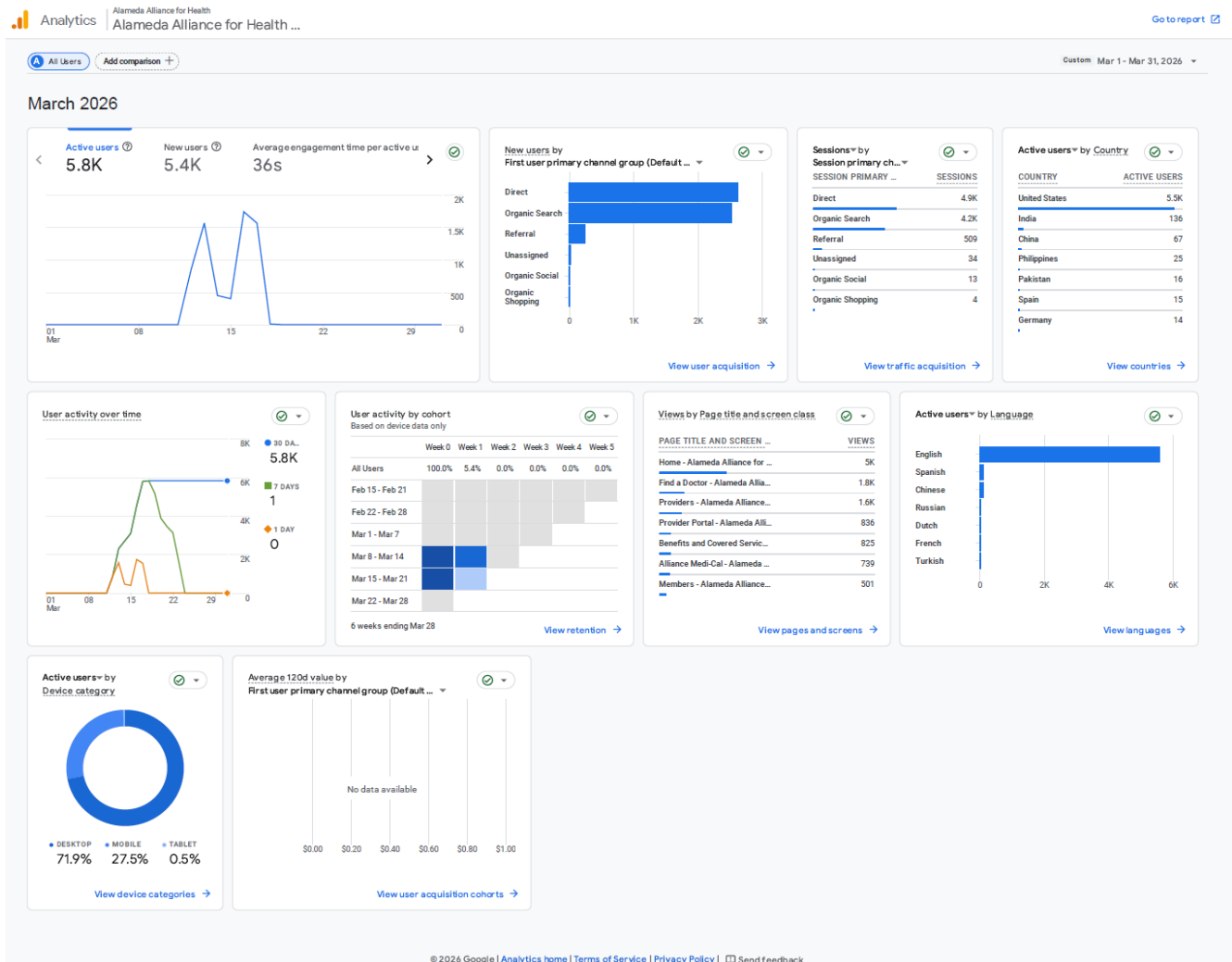


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q2\3. March 2026

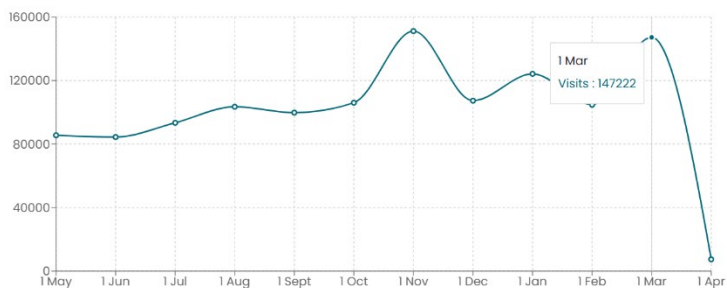
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | March 2026

ALLIANCE WEBSITE OVERVIEW:



Visits for the last 12 months



Pages served for the last 12 months



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q2\3. March 2026

Projects and Programs

Supporting Documents



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

Compliance

Richard Golfin III

To: Alameda Alliance for Health Board of Governors

From: Richard Golfin III, Chief Compliance & Privacy Officer

Date: April 10th, 2026

Subject: Compliance Division Report

Enterprise Audit Updates

- 2023 Department of Managed Health Care (DMHC) Health Equity and Quality Performance CAP
 - The Plan received the 2023 Health Equity and Quality Performance Findings Report from the Department of Managed Health Care (DMHC) on September 2nd, 2025. The Plan submitted its CAP response timely on December 1st, 2025, and is currently awaiting guidance from DMHC.
- 2025 Department of Managed Health Care (DMHC) Routine Full Medical Survey
 - The Plan received the Department's preliminary report on December 31st, 2025, identifying sixteen (16) findings, including two (2) repeat findings, across the following areas: Quality Assurance; Grievances and Appeals (repeat); Access and Availability of Services; Utilization Management, Prescription Drug Coverage (repeat); and Behavioral Health (SB 855). The Plan's CAP response was submitted to the Department on February 17th, 2026. The Plan is awaiting the final report from the DMHC.
- 2025 Department of Managed Health Care (DMHC) Financial Examination
 - The Plan submitted its approved policies and procedures to support its CAP response on March 2nd, 2026. The Plan is awaiting CAP closure by the DMHC.
- 2026 Department of Health Care Services (DHCS) Routine Survey
 - The Plan has completed its annual audit with DHCS. The Department held a 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 repeat finding under Appeals

and one area of concern related to Quality. The Plan is awaiting receipt of the final preliminary report.

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 March 11th, 2026, DMHC sent subsequent comments that the Plan responded to on March 26th, 2026. The Plan awaits additional comments or closure by April 25th, 2026.
- Network Adequacy Submissions
 - DMHC Reporting Year (RY) 2026 Timely Access and Annual Network Reporting Web Portal opened on January 14th, 2026. Health plans are required to submit both the Timely Access Compliance Report, Measurement Year (MY) 2025, and the Annual Network Report (RY 2026) through the DMHC portal. The combined submission is due to DMHC by May 1st, 2026. To support internal teams, the Compliance Division hosted weekly office hours in March and move to bi-weekly sessions in April through submission.
 - 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.
 - 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.

- 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 statutes, one is not applicable to the Alliance and two statutes for which the Plan is awaiting additional DMHC guidance. The Compliance team is primarily working with Pharmacy, Contracting, and Vendor Management subject matter experts to implement the statutes and submitted a compliance to the DMHC on March 19th, 2026.
 - DMHC published APL 25-021 on December 30th, 2025. The APL provides guidance and outlines the 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 Compliance Division filed initial submission to DMHC on March 19th, 2026 and expects comments from DMHC by April 18th, 2026.
- CY 2027 Medicare Final Rule – Implementation Planning
 - The Compliance Division will continue to coordinate closely with Medicare Operations, Integrated Planning & Delivery (IPD), and Government Affairs to support implementation planning for the CY 2027 Medicare Final Rule. Efforts will focus on reviewing CMS guidance as it is issued, assessing operational impacts and policy gaps, and coordinating responsibilities across enrollment, benefits, member communications, and systems readiness. Implementation activities will be advanced through established governance structures, supplemented by targeted policy triage discussions and Functional Area Delegate (FAD) meetings, to support timely and compliant execution.

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

- Training Update
 - The Privacy Office is conducting targeted, department-specific quarterly training to address incident trends and audit findings, ensuring staff receive

practical guidance tailored to their workflows, risk exposure, and regulatory obligations.

- On March 26th, 2026, the Privacy Office attended the Case Management team meeting and delivered focused training to Case Management covering privacy incident identification, DHCS 24-hour reporting requirements, and confidentiality obligations for minor consent and sensitive services.
- Also, on March 26th, 2026, the Privacy Office attended both the am and pm sessions of the Member Services team meeting and delivered two focused trainings on how to recognize privacy incidents, how to route privacy incidents to Privacy (including dual routing to multiple departments when required), and the impact identification and routing have on meeting DHCS timeliness expectations as highlighted in the most recent DHCS Medical Audit.
- The Privacy Office is conducting monthly refreshers at the All-Staff meeting, reinforcing organization-wide privacy expectations, and addressing risks that cut across departments and roles rather than being isolated to a single operational area.
 - On March 25th, 2026, the Privacy Office delivered Privacy Practices training that touched on minimum necessary principles, using secure communications, and timely outreach to the Privacy Office.

Alameda Alliance Special Investigations Unit: Operational Updates

- Fraud, Waste, and Abuse Program Overview and Performance
 - The Special Investigations Unit (SIU) continues to actively investigate potential fraud, waste, and abuse (FWA) allegations received through internal and external reporting channels, while maintaining focus on timely case progression and appropriate case resolution
 - In an effort to continually strengthen our processes and procedures, the SIU has initiated proactive updates to FWA related processes that were a focus area during the recent annual DHCS audit. These efforts include reviewing and strengthening procedures related to verification of services to ensure clear documentation, consistency, and alignment with regulatory expectations.

- In parallel with process improvement efforts the SIU continues to advise active investigations and pursue case closures where appropriate, ensuring investigative resources are applied efficiently.
- The SIU's structured case-management review process remains in place to support prioritization of higher-risk investigations, with particular emphasis on cases presenting greater potential financial implications and regulatory impact.
- Ongoing cross-functional collaboration meetings with Claims, Provider Services, Finance, Analytics, and Compliance department partners continues to support identification of emerging risk areas, reinforce verification and investigative controls, and inform continuous improvement across FWA prevention and detection activities.

Enterprise Risk Management (ERM) and Operational Oversight Updates

- Enterprise Risk Management (ERM): ERM continues to advance the Alliance's Risk Taxonomy, including initial risk ownership recommendations. Current efforts are focused on validating risks with supporting data, developing an initial risk ranking, and partnering with subject matter experts—laying the foundation for a consistent, enterprise-wide view of risk.
- Internal Audit (IA): IA continues to strengthen its operating model through updated Policies, Procedures, and SOPs aligned to refreshed processes. Enhanced reporting is being finalized to improve transparency into audit activity, corrective action progress, and key metrics, alongside expanded monitoring and access to higher-risk data sources to support ongoing oversight.
- ERM–IA Office Hours (Q1 Completion): Management successfully completed the first six ERM–Internal Audit Office Hours sessions in Q1, reaching approximately 50% of Alliance staff and engaging 265 unique participants across diverse tenure and functional backgrounds. Feedback and polling results show a marked improvement in staff understanding of Internal Audit and ERM's role in strengthening processes, controls, and mission delivery, with strong recognition that these functions support proactive risk management and continuous improvement. Based on participation and positive outcomes, management plans to continue Office Hours quarterly to reinforce a risk-aware and control-conscious culture.

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.

COMPLIANCE DASHBOARD SUMMARY													
OVERALL FINDINGS	Resource	Type										TOTAL	% Completed
			2018	2019	2020	2021	2022	2023	2024	2025	2026		
	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		190	
		Total In Progress	0	0	0	0	0	3	2	0	0	5	96%
		Total Completed	50	28	7	35	15	23	24	3		185	
		Total Findings	50	28	7	35	15	26	26	3	2	192	
	DMHC	Total State Audit Findings			5	6	8	3		16		22	
		Total Self-Identified Issues			3	0	0	0		6		9	
		Total Findings			8	6	8	3		22		47	
		Total In Progress			0	0	0	2		22		24	74%
		Total Completed			8	6	8	1		0		23	
		Total Findings	NA	NA	8	6	8	3	NA	22	NA	31	
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		2	82%	
	Total Completed		5			4			1		9		
	Total Findings	NA	5	NA	NA	4	NA	NA	2	NA	11		
STATE AUDIT FINDINGS		In Progress	0	0	0	0	0	5	2	17		24	89%
		Completed	38	33	12	39	27	22	18	1		190	
		Total Findings	38	33	12	39	27	27	20	18		214	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	6	2	8	78%	
		Completed	12	0	3	2	0	2	6	3	0		28
		Total Findings	12	0	3	2	0	2	6	9	2		36
TOTAL OVERALL FINDINGS			50	33	15	41	27	29	26	27	2	248	

COMPLIANCE DASHBOARD SUMMARY													
OVERALL FINDINGS	Resource	Type										TOTAL	% Completed
			2018	2019	2020	2021	2022	2023	2024	2025	2026		
	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		190	
		Total In Progress	0	0	0	0	0	3	2	0	0	5	96%
		Total Completed	50	28	7	35	15	23	24	3		185	
		Total Findings	50	28	7	35	15	26	26	3	2	192	
	DMHC	Total State Audit Findings			5	6	8	3		16		22	
		Total Self-Identified Issues			3	0	0	0		6		9	
		Total Findings			8	6	8	3		22		47	
		Total In Progress			0	0	0	2		22		24	74%
		Total Completed			8	6	8	1		0		23	
		Total Findings	NA	NA	8	6	8	3	NA	22	NA	31	
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		2	82%	
	Total Completed		5			4			1		9		
	Total Findings	NA	5	NA	NA	4	NA	NA	2	NA	11		
STATE AUDIT FINDINGS		In Progress	0	0	0	0	0	5	2	17		24	89%
		Completed	38	33	12	39	27	22	18	1		190	
		Total Findings	38	33	12	39	27	27	20	18		214	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	6	2		8	78%
		Completed	12	0	3	2	0	2	6	3	0	28	
		Total Findings	12	0	3	2	0	2	6	9	2	36	
TOTAL OVERALL FINDINGS			50	33	15	41	27	29	26	27	2	248	

Compliance Dashboard Summary

COMPLIANCE DASHBOARD SUMMARY			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	214	86%
	Total Self-Identified Issues	36	14%
	Total Findings	250	
	Total In Progress	30	12%
	Total Completed	218	88%
	Total Findings	248	
STATE AUDIT FINDINGS	In Progress	24	11%
	Completed	190	89%
	Total Findings	214	
SELF-IDENTIFIED FINDINGS	In Progress	8	22%
	Completed	28	78%
	Total Findings	36	

2026 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	16	73%
	Total Self-Identified Issues	6	27%
	Total Findings	22	
	Total In Progress	22	100%
	Total Completed	0	0%
	Total Findings	22	

Compliance Dashboard Summary

2024 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	20	77%
	Total Self-Identified Issues	6	23%
	Total Findings	26	
	Total In Progress	2	8%
	Total Completed	24	92%
	Total Findings	26	

2023 DMHC Follow-Up Review			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	3	
	Total In Progress	2	67%
	Total Completed	1	33%
	Total Findings	3	

Compliance Dashboard Summary

2023 DHCS Focused Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	3	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	3	

Compliance Dashboard Summary

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

2022 DMHC Financial Services Summary			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	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			
OVERALL FINDINGS	Type	TOTAL	%
	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	

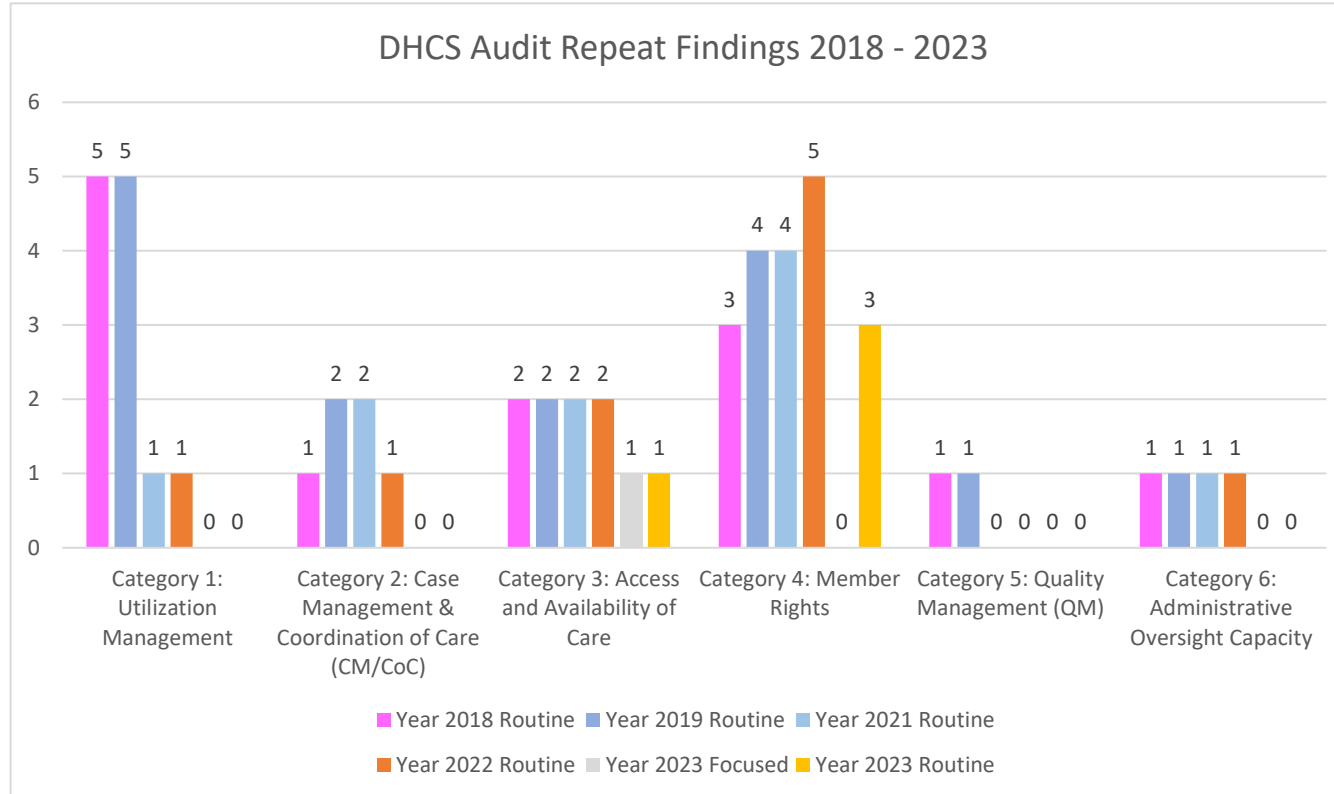
2018 DHCS Medical Services Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	38	76%
	Total Self-Identified Issues	12	24%
	Total Findings	50	
	Total In Progress	0	0%
	Total Completed	50	100%
	Total Findings	50	

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

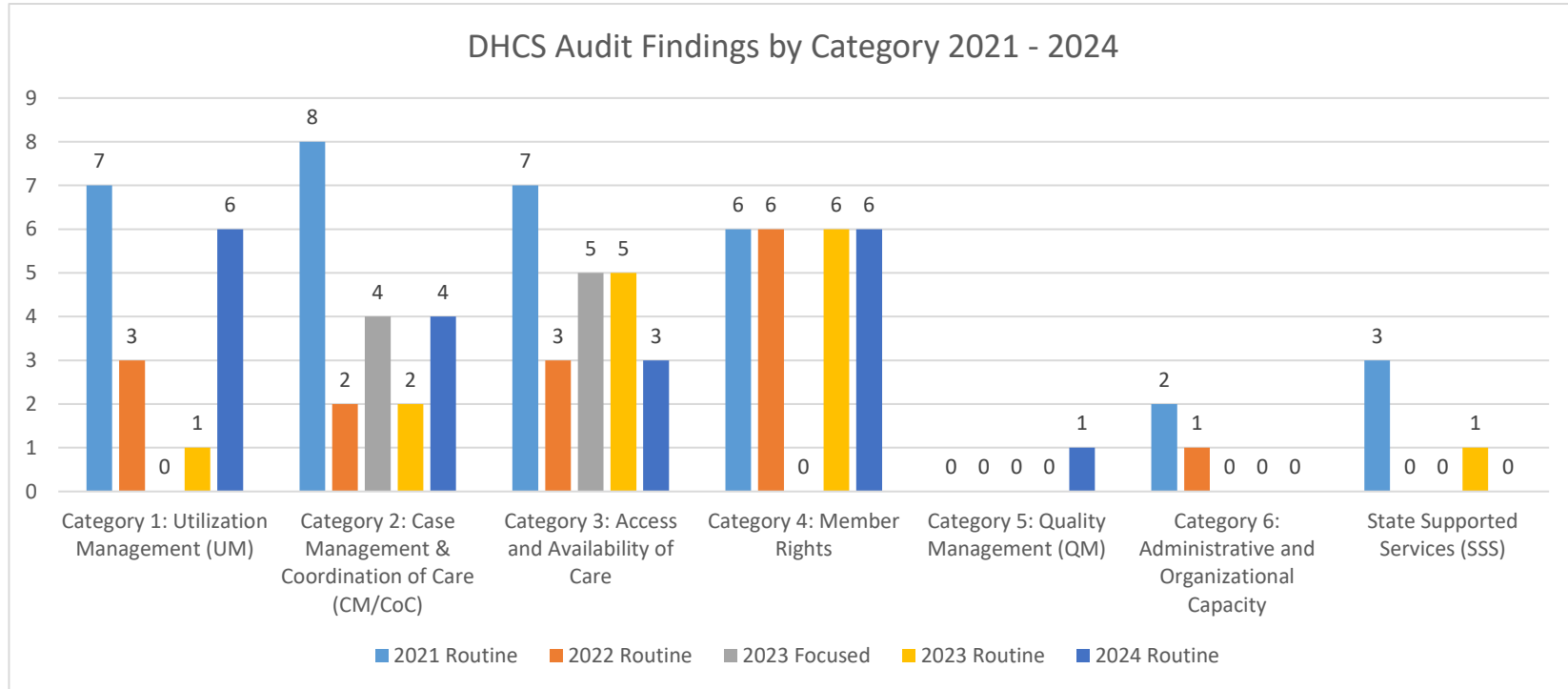


Compliance Dashboard Summary

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



DHCS Repeat Findings by Year 2018 - 2023

Category	Finding	Year						TOTAL
		2018 Routine	2019 Routine	2021 Routine	2022 Routine	2023 Focused	2023 Routine	
Category 1: Utilization Management	Completion of Ownership and Disclosure Forms	1	1	1	1			4
Category 1: Utilization Management	Monitoring and Oversight of UM Delegates	1	1					2
Category 1: Utilization Management	Prior Authorization Referral Tracking	1	1					2
Category 1: Utilization Management	Retrospective Prior Authorization Review	1	1					2
Category 1: Utilization Management	UM Notice of Action Letters	1	1					2
Category 1: Utilization Management	TOTAL	5	5	1	1	0	0	12
Category 2: Case Management & Coordination of Care (CM/CoC)	The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP			1	1			2
Category 2: Case Management & Coordination of Care (CM/CoC)	Conduct HRAs within Required Timeframes		1	1				2
Category 2: Case Management & Coordination of Care (CM/CoC)	Monitoring of CCM Program	1	1					2
Category 2: Case Management & Coordination of Care (CM/CoC)	TOTAL	1	2	2	1	0	0	6
Category 3: Access and Availability of Care	PCS Forms			1	1	1	1	4
Category 3: Access and Availability of Care	Monitoring of Network Providers' Compliance with Requirements for Appointment Extensions			1	1			2
Category 3: Access and Availability of Care	Monitoring of Provider Directory Accuracy	1	1					2
Category 3: Access and Availability of Care	Monitoring the Provision of Drugs Prescribed in Emergency Situations	1	1					2
Category 3: Access and Availability of Care	TOTAL	2	2	2	2	1	1	10
Category 4: Member Rights	Grievance Acknowledgement and Resolution Letter Timeframes		1	1	1		1	4
Category 4: Member Rights	Grievance Letters in Threshold Languages			1	1		1	3
Category 4: Member Rights	Written Notification of Grievance Resolution Delays				1		1	2
Category 4: Member Rights	Investigate and Resolve Grievances Prior to Sending Resolution Letters	1	1	1	1			4
Category 4: Member Rights	Reporting Unauthorized Disclosures of PHI to DHCS Withing Timeframes			1	1			2
Category 4: Member Rights	Quality of Care Grievances Reviewed by MD	1	1					2
Category 4: Member Rights	Capturing All Complaints as Grievances	1	1					2
Category 4: Member Rights	TOTAL	3	4	4	5	0	3	19
Category 5: Quality Management (QM)	New Provider Training Completion	1	1					2
Category 5: Quality Management (QM)	TOTAL	1	1					2
Category 6: Administrative Oversight Capacity	Reporting Preliminary Investigations of FWA to DHCS Within Timeframes	1	1	1	1			4
Category 6: Administrative Oversight Capacity	TOTAL	1	1	1	1			4
Total Repeat Findings by Year		13	15	10	10	1	4	53

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
Yellow = Plan Observations
Orange = Plan Observations (Not Included in the Preliminary Report)
White = State Finding in the final report that was not a Plan Observation
R = Repeat Findings

2026 DHCS Audit - Audit Review Period March 1, 2025 to December 31, 2025 Virtual Audit Dates March 2, 2026 to March 13, 2026						
#	Category	Preliminary Findings	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
1	PMH & 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.				Provider Services
2	PMH & CoC (Pregnant & Postpartum Members)	Regarding CPSP reimbursement, the Plan does not have an oversight mechanism in place for CPSP providers.				Credentialing Provider Services Claims

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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White = State Finding in the final report that was not a Plan Observation
R = Repeat Findings

2025 DMHC Routine Fiscal Examination - Audit Review Period January 1, 2025 to March 31, 2025 Audit Date August 4, 2025						
#	Category	Preliminary Findings	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).	TBD	In Progress	Compliance - DO Claims

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY	
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Orange	= Plan Observations (Not Included in the Preliminary Report)
White	= State Finding in the final report that was not a Plan Observation
R	= Repeat Findings

2025 DHCS Audit - Audit Review Period 6/1/2024 - 2/28/2025 Audit Onsite Dates - March 3, 2025 to March 7, 2025							
#	Category	DHCS Exit Conference March 20, 2025	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status
1	UM	(1.6.1) The Plan did not ensure that a medical director, or licensed physician acting on behalf of the Plan's medical director, reviewed post-stabilization authorization requests to determine medical necessity of post-stabilization care services.	Medical Directors are available 24 hours a day, seven days a week. There is an on call Medical Directors schedule maintained to ensure there is always a Medical Director on call.	8/1/2025	Completed	UM	
2	UM	The Plan did not consistently obtain timely authorization for medically necessary Post Stabilization Care, or ensure contractors' compliance with APL 23-009.	The UM team has revised operational workflow to include in the process the input of a note and authorization in the clinical information system at the same time a post-stabilization request is received outside of business hours. <u>Update 5/15/25:</u> UM-051 P&P updates approved.	5/15/2025	Completed	UM	
3	UM	The Plan did not transfer out-of-network hospitalized members to in-network providers as required.	Alliance contracted and non-contracted hospitals do have 24-hour access to the Alliance UM department to make authorization requests, and medical directors and RNs are available to facilitate the process to transfer to an in-network provider from the ER as needed. <u>Update 5/15/25:</u> The Plan considers this item closed; the current process is in alignment with regulation requirements and no further action is needed.	5/15/2025	Completed	UM	

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
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Orange = Plan Observations (Not Included in the Preliminary Report)
White = State Finding in the final report that was not a Plan Observation
R = Repeat Findings

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
22	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).	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 insured 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.	TBD	Behavioral Health
21	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).	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.	TBD	Behavioral Health
20	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
19	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
18	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. The Plan agrees with the findings. In regards to the Carelton/ Beacon findings, the Plan took proactive steps to de-delegate Carelton/ Beacon and transitioned all UM responsibilities for behavioral and mental health services in house, with all functions performed by the Alliance effective April 2023.	TBD	Pharmacy
17	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).	With respect to CFMG Delegate oversight, 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
16	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.	In regards to the Carelton/ Beacon findings, the plan has taken the proactive steps to de-delegate Carelton/ 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 oversight, 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 provide 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 oversight 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
15	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
14	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
13	Access and Availability	The Plan did not have a process to monitor whether its provider networks experienced a 10 percent change.	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).	TBD	Provider Services
12	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.	TBD	Provider Services
11	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
10	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.	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
9	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.	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. <u>Monthly internal audits are conducted for expedited grievances and appeals.</u>	TBD	G&A
8	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.	TBD	G&A
7	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.	TBD	Quality Assurance
1	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.	Already in Place Already in Place Already in Place TBD	Compliance
2	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
3	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
4	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

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
5	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
6	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. <u>Update 2/15/2025</u> : 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. <u>5/9/2025</u> : 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. <u>Update 1/15/2025</u> : 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. <u>Update 5/9/2025</u> : 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 <u>Update 7/11/2025</u> : The Plan confirmed attestations for APLS 24-009 and	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. <u>5/9/2025</u> : 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. <u>Updated 1/15/2025</u> : 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. <u>Update 2/15/2025</u> : 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. <u>Update 7/11/2025</u> : 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. <u>Update 2/15/2025</u> : 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 reviewed at the Quality Improvement Health Equity Committee meetings. <u>Update 5/9/2025</u> : The IHA audit was completed for Q3 2025	In Progress	Completed	QI		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
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 insured 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 BCBA's 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. <u>Update 5/9/2025</u>; 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. <u>Update 7/11/2025</u>; Training for updated BHT-ABA Forms was completed on 4/30/2025 and BHT Utilization is being reported out at UM Committee. 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 BCBA's 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. <u>Update 2/15/2025</u>; Fields are undergoing validation to ensure accuracy with a goal to have a functional report ready by March 31, 2025 for monitoring and oversight. <u>Update 5/9/2025</u>; Draft Caregiver Update Report created that outlines criteria and dashboard. <u>Update 7/11/2025</u>; SOP created for monitoring and auditing process for timely caregiver updates 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. <u>Update 5/9/2025</u>; The standard operating procedure for the monitoring and auditing process for timely caregiver updates has been created. <u>Update 7/11/2025</u>; The monitoring and auditing report has been successfully deployed and is now utilized for monitoring and oversight.	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. <u>Update 5/9/2025</u>; 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. <u>Update 7/11/2025</u>; 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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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency
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. <u>Update 5/9/2025</u> : 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. <u>Update 5/9/2025</u> : 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. <u>Update 5/9/2025</u> : Internal audits were started in February 2025. <u>Update 7/11/2025</u> : 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. <u>Update 5/9/2025</u> : 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. <u>Update 5/9/2025</u> : Internal audits started in February 2025 <u>Update 7/11/2025</u> : Audits are continuing monthly and findings are shared with the G&A supervisor for retraining and coaching if needed. <u>Update 12/17/2025</u> : Audit reports were presented during AOC meeting.	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. <u>Update 5/9/2025</u> : 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 <u>Update 5/9/2025</u> : Internal audits started in February 2025. <u>Update 7/11/2025</u> : Audits are continuing monthly and findings are shared with the G&A supervisor for retraining and coaching if needed. <u>Update 12/17/2025</u> : Audit reports were presented during AOC meeting.	12/17/2025	Completed	G&A		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
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. <u>Update 5/9/2025</u> : Internal audits started in February 2025. <u>Update 7/11/2025</u> : 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. <u>Update 5/9/2025</u> : 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. <u>Update 5/9/2025</u> : 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. <u>Update 5/9/2025</u> : 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. <u>Update 7/11/2025</u> : Annual Plan wide training was completed, and ad hoc training and escalation is done in the case of late reporting. 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. <u>3/14/2025</u> : 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. <u>3/14/2025</u> : 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. <u>Update 5/9/2025</u> : 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 <u>Update 5/9/2025</u> : 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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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
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. 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.	In Progress	5. Completed 4/15/2025 6. Completed 4/15/2025 7. In Progress 8. In Progress 9. In Progress	Operations		State	DHCS

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2023 DHCS Focused Audit - Audit Review Period 4/1/2022 - 3/31/2023 Audit Onsite Dates - April 17, 2023 - April 28, 2023						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
1	BH	(2.1) Case Management and Care Coordination The Plan did not ensure the provision of coordination of care to deliver mental health care services to its members. Recommendation: Revise and implement policies and procedures to ensure the Plan coordinates care with the MHP.	1. On April 1, 2023 the Plan insourced behavioral health. The Plan met with the County to identify mechanisms for care coordination. A process was identified for data sharing for mental health, pending system implementation. To support care coordination, and MOU was executed on 4/2023. A manual process has been put in place to include by-weekly case discussions and TOC tools. <u>Update 1/1/2025</u> : ACBH and AAH tracking outgoing and incoming TOC tools monthly and are continuing collaborations and care coordination during workgroup meetings. 2. Policy BH-005 has been updated for written procedure for care coordinators role in care coordination and is going through the committee approval process. <u>Update 12/13/2024</u> : Policy BH-005 was approved at QIHEC on 11/15/2024, and will be presented for review and approval at the Administrative Oversight Committee (AOC) on 12/18/2024. <u>Update 3/14/2025</u> : Policy BH-005 approved at AOC on 12/18/2024	3/4/2025	Completed	Behavioral Health UM Provider Services
2	BH	(2.2) Information Exchange with the County Mental Health Plan (MHP) The Plan did not follow the written policies and procedures in its MOU for the timely sharing of medical information with the MHP. Recommendation: Implement policies and procedures to ensure the Plan follows agreed upon written policies and procedures in its MOU for the timely exchange of medical information with the MHP.	1. The Plan and the County collaborated to revise the agreed-upon MOU for multiple state and federal requirements, including information exchange between both systems for state mental health services with implementation date of 04/04/2023. 2. The Plan and the County established a plan for data exchange to support coordination of care and closed-loop referrals, which is currently in the final stages. We have continued to monitor the county's progress with data issues caused by its new electronic health management system. <u>Update 12/13/2024</u> : The Plan and the County continue to work together on the data sharing and electronic health systems. <u>Update 3/14/2025</u> : File exchange testing in process and bi-weekly case conferences continue. <u>Update 7/11/2025</u> : Internal IT teams are currently working on the data sharing process	In Progress	1. Completed 4/4/2023 2. In Progress	Behavioral Health UM Privacy IT
3	BH	(2.3) Confirmation of Referred Treatments for Substance Use Disorder (SUD) The Plan did not make good faith efforts to confirm whether members received referred treatment for SUD and document when and where treatment was received, and any next steps following treatment. Recommendation: Revise and implement policies and procedures to ensure the Plan makes good faith efforts to confirm whether members received referred SUD treatment and document when and where treatment was received, and any next steps following treatment.	1. The Behavioral Health Department has developed and implemented a department-specific policy for the care of coordination for SUD on 3/19/2024. <u>Update 11/10/2024</u> : Care coordination policies for MH and SUD members have been combined into policy BH-005. <u>Update 12/13/2024</u> : Policy BH-005 has been approved by QIHEC, and is scheduled to go to AOC on 12/18/2024 for final review and approval. <u>Update 3/14/2025</u> : Policy approved at AOC on 12/18/2024. 2. The issue of 42 CFR posing a barrier to care coordination for individuals with SUD is a standing agenda item in leadership meetings with the Plan and the County. Issues with signed releases from members are preventing confirmation of SUD referrals, however a newly established MOU has a written policy to encourage Medi-Cal Managed Care beneficiaries for signed release for members starting or currently in treatment until this has been operationalized at the county. <u>Update 12/13/2024</u> : Discussions around universal release forms for SUD members are continuing. <u>Update 3/14/2025</u> : Continuing work to integrate operations to increase care coordination activities, with an estimated completion date of June 2026. <u>Update 7/11/2025</u> : Leadership at both organizations continue to meet and this item is kept open on the agenda. 3. Update MOU to include an agreement that Medi-Cal managed care beneficiaries will be encouraged to complete the form. 4. Establish and implement process for regular exchange of information between the Plan and the County to ensure compliance with 42 CFR. <u>Update 3/14/2025</u> : Continuing work to integrate operations to increase care coordination activities, with an estimated completion date of June 2026. <u>Update 7/11/2025</u> : Leadership at both organizations continue to meet and this item is kept open on the agenda.	In Progress	1. Completed 12/18/2024 2. In Progress 3. Completed 11/10/2024 4. In Progress	Behavioral Health UM Continuity of Care

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2023 DHCS Focused Audit - Audit Review Period 4/1/2022 - 3/31/2023 Audit Onsite Dates - April 17, 2023 - April 28, 2023						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
4	BH	(2.4) Follow Up for Referred Substance Use Disorder Treatments The Plan did not follow up with members who did not receive referred treatments to understand barriers and make subsequent adjustments to referrals. Recommendation: Revise and implement policies and procedures to ensure the Plan awareness of members who did not receive referred SUD treatments, to understand barriers and make subsequent adjustment to referrals, if warranted.	1. Develop form in coordination with county efforts for Enhanced Care Management for disclosure to support care coordination between the County, the MCP, and practitioners providing SUD and physical health services to the beneficiary. <u>Update 12/13/2024</u> : Discussion continues regarding universal release forms to accomplish care coordination for SUD members. <u>Update 3/14/2025</u> : Continuing work to integrate operations to increase care coordination activities, with an estimated completion date of June 2026. <u>Update 7/11/2025</u> : Leadership at both organizations continue to meet and this item is kept open on the agenda. 2. Information regarding the Plan's PCP legal process for coordination of care for SUD members was included in P&P BH-006. <u>Update 12/13/2024</u> : Policy BH-005 and BH-006 were combined, and BH-005 was approved at QIHEC on 11/15/2024, and will be presented for review and approval at the Administrative Oversight Committee on 12/18/2024. <u>Update 3/14/2025</u> : Policy approved at AOC on 12/18/2024. 3. When the BH department identifies a member who needs to be referred for SUD treatment, a referral is completed and the receipt of the referral is confirmed and communicated during routine coordination meetings with the Plan and the County, as well as front line staff. There are reporting challenges with SUD treatment due to 42 CFR and the County and the Plan are working to address this. <u>Update 12/14/2024</u> : Ongoing Bi-weekly case discussions, TOC tools with the County regarding SUD members. <u>Update 3/14/2025</u> : Continuing work to integrate operations to increase care coordination activities, with an estimated completion date of June 2026. <u>Update 7/11/2025</u> : Leadership at both organizations continue to meet and this item is kept open on the agenda.	In Progress	1. In Progress 2. Completed 12/18/2024 3. In Progress	Behavioral Health UM Case Management
5	NMT & NEMT	(3.1) Door-to-Door Assistance The Plan did not have a process in place to ensure that door-to-door assistance was provided for all members receiving NEMT services. Recommendation: Revise and implement policies and procedures to ensure door-to-door assistance is being provided for all members receiving NEMT services.	1. Remediating this involves an Alliance policy update and additional training of our transportation vendor. The Transportation Vendor has training and oversight in place in the form of repeat random audits of their transportation providers. Since the 2023 audit, this process was updated by the transportation provider. Additionally, AAH will participate in at least five (5) transportation trips per quarter with the broker to ensure door-to-door assistance is being provided when applicable. <u>Update 12/13/2024</u> : The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips. <u>Update 3/14/2025</u> : Q1 2025 field audit and training completed. No additional training was needed based on the observed field observations.	4/11/2025	Completed	Vendor Management
6	NMT & NEMT	(3.2) Monitoring of Door-to-Door Assistance The Plan did not conduct monitoring activities to verify NEMT providers were providing door-to-door assistance for members receiving NEMT services, per APL 22-008 Recommendation: Revise and implement policies and procedures to ensure the Plan conducts monitoring activities, to ensure providers provide door-to-door assistance, for all members receiving NEMT services.	1. This is a policy and process update. To ensure that the broker is appropriately spot checking NEMT and NMT transportation providers for the correct level of service, AAH will participate in at least five (5) transportation trips per quarter with the broker. <u>Update 12/13/2024</u> : The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips. <u>Update 3/14/2025</u> : Q1 2025 field audit and training completed. No additional training was needed based on the observed field observations.	3/4/2025	Completed	Vendor Management
7	NMT & NEMT	(3.3) Transportation Liaison The Plan did not have a direct line to the transportation liaison that it provided to providers and members, and the transportation liaison did not process authorizations after business hours. Recommendation: Revise and implement policies and procedures to ensure there is a direct line to the transportation liaison and authorizations are processed after business hours.	To improve member access to transportation services and ensure that after-hours authorizations are being properly handled, the Plan will implement the following measures: Inclusion of Transportation Liaison Contact Information: The Plan will include the transportation liaison's phone number in the member handbook and on the Health Plan's website. This will ensure that members have easy access to contact information for transportation-related inquiries and support. Reporting of After-Hours Trip Reservations: The Plan will require subcontractors to report any trip reservations that could not be completed or authorized during after-hours periods. This reporting requirement will help the Plan track issues and address them effectively. Follow-Up with Members: The Transportation Liaison and the Case Management Team will follow up with members regarding any issues related to trip reservations that were not completed or authorized after hours. This proactive approach will ensure that members receive the support they need and that any problems are resolved in a timely manner. <u>Update 12/13/2024</u> : On track and awaiting publication of the new edition of member handbook with liaison contact number. <u>Update 5/9/2025</u> : Member handbook and Providers Manual with liaison contact information published to public site.	4/9/2025	Completed	CM

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
8	NMT & NEMT	(3.4) R Physician Certification Statement Forms The Plan did not ensure that members had the required PCS forms for NEMT services, nor did the Plan ensure that PCS forms contained all required components. Recommendation: Implement policies and procedures to ensure PCS forms are on file for all members receiving NEMT services and that the forms contain all the required components.	1. The PCS form intake was insourced beginning 3/1/2023, and AAH staff was hired to coordinate the PCS form effort and transportation.	3/1/2023	Completed	CM
9	NMT & NEMT	(3.5) Ambulatory Door-to-Door The Plan did not ensure its delegate, provided the appropriate level of service for members requiring ambulatory door-to-door service. Recommendation: Revise and implement policies and procedures to ensure its delegate provides the appropriate level of service for members requiring ambulatory door-to-door service.	. Remediating this involves an Alliance policy update and additional training of our transportation vendor. The Transportation Vendor has training and oversight in place in the form of repeat random audits of their transportation providers. Since the 2023 audit, this process was updated by the transportation provider. Additionally, the Plan will participate in at least five (5) transportation trips per quarter with the broker to ensure door-to-door assistance is being provided when applicable. <u>Update 12/13/2024</u> : The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips. <u>Update 3/14/2025</u> : Q1 2025 field audit and training completed. No additional training was needed based on the observed field observations.	3/4/2025	Completed	Vendor Management

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2023 DMHC Follow-Up Review : Audit Review Period 11/1/2022 - 05/31/2023 Audit Onsite Dates - 10/23/2023 - 10/27/2023						INTERNAL AUDITS				
#	Category	Deficiency	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Grievances & Appeals	When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform complainants of their right to contact the Department.			G&A		State	DMHC	2023	
3	Grievances & Appeals	The Plan does not correctly display the statement required by Section 1368.02(b) in all required enrollee communications. Update 7/9/25 ; IA conducted an audit of this area in March 2025; the Final Report was issued to G&A on 7/9/2025. This item is resolved.	7/9/2025	Completed	G&A Member Services UM Rx		State	DMHC	2023	
6	Prescription (Rx) Drug Coverage	The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.			Rx		State	DMHC	2023	

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	UM	(1.5.1) Notice of Action (NOA) Letters The Plan did not ensure a delegate sent NOA letters to providers and members.	The Plan received the delegate's Root Cause Analysis (RCA) and CAP on 04/14/2023. After review and evaluation of the delegate's document the Plan issued a formal CAP on 05/31/2023 and received the delegate's CAP response on 06/27/2023. The initial corrective actions completed by the delegate includes updating their IT script and ensuring the identified missing NOA letters were sent out to the members and that outreach was completed to confirm that services approved or had denial modification authorizations were utilized by members. The delegate also developed workflows to detect and mitigate failures. The CAP includes the delegate's implementation of a remediation plan. The remediation plan includes updates in their workflow, training, and an internal monthly audit- with results submitted to The Alliance for review. The Plan reviewed and evaluated the delegate's CAP implementation and progress during the interim and provided guidance. The CAP was approved and closed on 09/25/2023. (Completed) The delegate is expected to continue its internal monthly audit for the NOA letters and fax confirmation. The Plan will continue to monitor the audit results for compliance. Please see document 1.5.1_AAHH Response for full details. (On Track) Additionally, the Plan will review the UM delegates' P&P's to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation and these will be evaluated annually at minimum. (On Track) 1a. Monitoring of the delegate's monthly internal audit is ongoing. (On Track) 2. Review the UM delegates' policies and procedures to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation. (On Track) Update 3/8/2024 P&P review complete and P&P deemed adequate. Review of the delegate's P&P regarding NOAs is ongoing and The Alliance will continue to meet with the delegate to have P&P appropriately updated. <u>Update 4/5/2024</u> The delegates have submitted all requested policies for review. The policies have been reviewed and the delegates have made all necessary revisions.	3/31/2024	Completed	Compliance UM		State	DHCS	2023

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2023 DHCS Audit - Audit Review Period 4/1/2022 - 3/31/2023 Audit Onsite Dates - April 17, 2023 - April 28, 2023							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
2	QI	(2.1.1) Provision of an Initial Health Assessment (IHA) The Plan did not ensure the provision of a complete IHA for new members.	1. Update IHA policy QI-124 (On Track) <u>Update 4/5/2024</u>: Policy updated and approved at Compliance Committee on 3/19/2024 1a. Update IHA policy 124 to include requirement regarding outreach attempts (On Track) <u>Update 4/5/2024</u>: Policy updated and approved at Compliance Committee on 3/19/2024 2. Provider education and feedback through Joint Operational Meetings (On going) <u>Update 4/5/2024</u>: Presented at JOMs with delegates in December 2023 2a. Deliver provider education webinars with information about IHA requirements (On Track) <u>Update 4/5/2024</u>: Webinars with delegates scheduled through May 2024 2b. Develop a "Measure Highlights" tool for providers. This tool will encompass outreach requirements, IHA elements, USPSTF screenings, and claim codes used to account for IHA completion 3. Expand code set to include additional codes for capturing IHA-related activities (On Track) <u>Update 3/8/2024</u>: Codes updated and included in policy QI-124. 3a. Communicate and provide code sets to providers (On Track) <u>Update 4/5/2024</u>: Codes updated and included in policy QI-124 4. Monitor IHA rates (Ongoing) <u>Update 4/5/2024</u>: Non-compliance providers and missing elements identified, CAPs issued. 5. Enhance the volume of medical records subjected to review for completeness, including review of USPSTF requirements. (On Track)	3/31/2024	Completed	Quality		State	DHCS	2023
3	BHT	(2.3.1) Behavioral Health Treatment (BHT) Plan Elements The Plan did not ensure members' BHT treatment plans contained all the required elements.	1. The Behavioral Health team developed the attached Treatment Plan Guidelines for our ABA Providers (please see attachment). This document outlines the treatment plan elements that are listed in APL 23-010. All treatment plans and prior-authorization requests for ABA services are reviewed by Board Certified Behavior Analysts (BCBA).The guidelines were emailed to all providers and will also be available on-line for providers to access. In addition to the document, the ABA clinicians worked with the Provider communication team to send out updates/reminders to providers regarding the treatment plan guidelines. Our team is also available to meet with providers and educate them on how to apply the guidelines to their treatment plan templates. (Completed) 1a. Pending Project: We are currently developing an on-line treatment plan template/form that will be utilized by our ABA providers when completing the initial assessment and subsequent progress reports. This form includes the treatment plan elements required in APL 23-010 and providers will be required to complete this form when submitting the initial assessment/FBA and subsequent progress reports. This will ensure that all ABA providers use the same template and include the required elements in their reports/assessments. (On Track) In the interim while the project is pending, if information is missing from the Treatment Plan, the Plan will inform the provider and ask that they add the information and re-submit. <u>Update 4/5/2024</u>: Policy BH-004 is scheduled to be approved at April Compliance Committee. <u>Update 5/10/2024</u>: Policy BH-004 was approved at Compliance Committee on 4/10/2024. 1b. The Plan intends to conduct audits on our Treatment Review documentation to ensure that all required elements are covered in the review process in compliance with the requirements in the APL. The expected implementation date of this audit is Q1 of 2024. <u>Update 5/10/2024</u>: Q1 2024 treatment plan audits are in progress pending completion at end of March. The next audit period (Q2) will go through June. 1c. The Provider/PCP Manual is also pending updates that will include a FAQ for PCPs, provider education regarding the prior authorization process, and the referral process. This is currently under review-pending completion. <u>Update 5/10/2024</u>: Provider Manual revised and submitted to DHCS Plan Communications Department, who is reviewing proposed revisions and once	5/10/2024	Completed	Behavioral Health		State	DHCS	2023
4	Access and Availability	(3.1.1) First Prenatal Visit The Plan's policies and procedures for a first prenatal visit for a pregnant member is not compliant with the standard of two weeks upon request.	The Plan has edited Timely Access Standard table, policy QI-107 and QI-114 to reflect the first prenatal visit standard within 2 weeks of the request. (Completed)	Q4 2023	Completed	Quality		State	DHCS	2023

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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2023 DHCS Audit - Audit Review Period 4/1/2022 - 3/31/2023 Audit Onsite Dates - April 17, 2023 - April 28, 2023							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
5	Family Planning and State Supported Services	(3.6.1) Non-contracted Provider Payments The Plan did not pay non-contracted providers at the appropriate Medi-Cal fee-for-service rate.	A Change Request was entered to change non-contract mid-level providers reimbursements to 100% of the Medi-Cal rate moving forward. (Completed)	11/16/2023	Completed	Claims		State	DHCS	2023
6	Family Planning and State Supported Services	(3.6.2) Proposition 56 Family Planning Payments The Plan did not distribute add-on payments for institutional family planning service claims as required by APL 22-011.	1. P&P has been revised to ensure that Family Planning services paid on institutional claims are paid As part of Prop 56 payments. 1a. The Plan's Analytics Team is in the midst of preparing the payment details for the retro payment on the FP institutional data and looking to complete by 11/30/2023 timeline. (On Track) 2. The Analytics dept has calculated the retroactive payments due to facilities as a result of finding 3.6.2, APL 22-011 and APL 23-008. (On Track) 2a. Payments will be distributed to providers prior to or latest by Nov 30, 2023. (On Track) 2b. Facility providers with qualifying Family Planning services as per APL 23-008 will be included as part of our monthly Prop 56 payment processing going forward starting Dec 2023. (On Track)	1/15/2024	Completed	Claims		State	DHCS	2023
7	NMT & NEMT	(3.8.1) Ⓜ Physician Certificate Statement (PCS) Forms The Plan did not ensure PCS forms were on file for members receiving NEMT services.	1.The Plan made the decision to no longer allow courtesy NEMT trips for members without a PCS form on file and the decision to insource PCS form acquisition to the Plan's Case Management Department beginning 3/1/23. Working alongside the Plan's transportation subcontractor, the Plan created new workflows to ensure the transportation subcontractor was not scheduling NEMT trips for members unless there was a confirmed valid PCS form on file, or the Plan provided a verbal authorization due to a trip being of an urgent nature. The Plan hired two transportation coordinators to focus on PCS acquisition leveraging the Plan's preexisting relationships with the provider network and access to EHR's. Through the end of 2022 and beginning of 2023, the Plan's transportation subcontractor trained its call center agents on the new workflow. On 2/14/23, the Plan trained its transportation coordinators on PCS acquisition. On 2/21/23, the Plan trained its entire case management team, that participates in phone shifts for the Plan's case management phone line, on the parameters for verbal authorizations for NEMT trips of an urgent nature. The Plan continues to report on the success of the new workflows at the Plan's UM Committee. (On Track) 1a.The Plan is working with its analytics team to create a report using PCS data elements to match up against subcontractor's report of all NEMT trips taken each month. This report will assist in finding any gaps in PCS compliance. The Plan estimates this report to go live 12/1/2023. (On Track)	12/15/2023	Completed	Case Management		State	DHCS	2023
8	NMT & NEMT	(3.8.2) Transportation Providers' Medi-Cal Enrollment Status The Plan did not ensure all transportation providers were enrolled in the Medi-Cal program.	The Plan has updated the P&P VMG-005 from reviewing the Transportation Providers (TP) on a quarterly review to a monthly review. Attached for reference is the updated P&P. The Plan began reviewing the TP monthly for the utilization from April 2023 to current. (Completed and Ongoing)	4/1/2023	Completed	Vendor Management		State	DHCS	2023

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2023 DHCS Audit - Audit Review Period 4/1/2022 - 3/31/2023 Audit Onsite Dates - April 17, 2023 - April 28, 2023							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
9	Member Rights	(4.1.1) R Grievance Acknowledgement and Resolution Letter Timeframes The Plan did not send acknowledgement and resolution letters within the required timeframes.	A grievance processing timeline was created to outline the grievance 30 calendar day process, day by day. The timeline outlines that by day 5, acknowledgement letters will be sent out. We will continue to monitor the daily aging report to ensure that acknowledgement letters are sent in a timely manner. The timeline also outlines that on Day 20, "If response is not received, after at least two follow-up attempts, task to a Medical Director in Quality Suite." Complying with this process will ensure that the Medical Director has sufficient time to reach out to the provider or facility to assist in obtaining a response. The Grievance and Appeals staff were trained on the new timeline on 8/1/2023, copies of the timeline were distributed to the department. (Completed and Ongoing)	8/1/2023	Completed	G&A		State	DHCS	2023
10	Member Rights	(4.1.2) R Grievance Letters in Threshold Languages The Plan did not send acknowledgement, resolution delay, and resolution letters in threshold languages.	The Plan's Grievance and Appeals Department has created a reporting mechanism in our daily aging reports to monitor what cases are still pending translation and when was the request for translation sent out, this was implemented on 4/12/2023. We have then assigned one specific team member to be responsible for following up on translation letters to ensure that they are getting the attention that they need to be completed in a timely manner. The Grievance Processing Timeline will be updated to include when a request for translation needs to be sent out and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted on 10/10/2023. (Completed and ongoing)	10/10/2023	Completed	G&A		State	DHCS	2023
11	Member Rights	(4.1.3) R Written Notification of Grievance Resolution Delays The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days and did not resolve grievances by the estimated resolution date in the delay letters.	The Plan's Grievance and Appeals Department will be updating our system, Quality Suite, to better capture data on if and/or when a delay letter is sent out. Once the system is updated, we will be able to create a reporting mechanism in our daily aging reports to monitor for when a case needs a delay letter and if the letter was sent out. The Grievance Processing Timeline will also be updated to include the process for sending out a delay letter and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted. (Completed and Ongoing)	12/1/2023	Completed	G&A		State	DHCS	2023
12	Member Rights	(4.1.4) Grievance Delay Timeframes The Plan inappropriately utilized a 14 calendar day delay timeframe for grievance resolutions.	In review of our current policy and procedures, and workflows; they were in line with the APL requirements. There was miscommunication in the staff training to use 14 calendar days instead of an estimated resolution date in the delay letters. There was a refresher training for the Grievance and Appeals staff held on 4/18/2023, the staff was provided the requirement and were reminded to provide an estimated resolution date in the delay letters if a resolution is not reached within 30 calendar days. (Completed)	4/18/2023	Completed	G&A		State	DHCS	2023
13	Member Rights	(4.1.5) Exempt Grievance Resolution The Plan did not resolve exempt grievances by close of the next business day.	In conjunction with the Grievance Department, the Member Services Grievance Guide was revised on 10/9/2023. (Completed) Training was provided to all Member Services staff on these revisions by 11/1/2023. (Completed)	11/1/2023	Completed	Member Services		State	DHCS	2023
14	Member Rights	(4.1.6) Grievance Identification The Plan did not process and resolve all member expressions of dissatisfaction as grievances.	Member Services has implemented a process to identify expressions of dissatisfaction that were not classified appropriately. (Completed) A Member Services Supervisor works with the agent to ensure the case is classified accurately and resolved in a timely manner. (Completed)	3/15/2023	Completed	Member Services		State	DHCS	2023
15	State Supported Services	(SSS.1) Minimum Proposition 56 Payments The Plan did not distribute minimum payments for a State Supported Services claim as described in APL 19-013.	The claims system configuration team has corrected the fee schedule for the provider and adjusted the impacted claims to pay the correct rate. (Completed)	4/26/2023	Completed	Claims		State	DHCS	2023
16	CM	(2.2) PCP and members are not consistently notified of Case Management case closures	Configuration made in TruCare to ensure consistent notification	4/26/2023	Completed	Case Management		Self	DHCS	2023

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Repeat Findings

2023 DHCS Audit - Audit Review Period 4/1/2022 - 3/31/2023 Audit Onsite Dates - April 17, 2023 - April 28, 2023							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
17	Fraud and Abuse	(6.2) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness Training provided to staff and new tools being used consistently	4/26/2023	Completed	Compliance		Self	DHCS	2023

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2022 DMHC Behavioral Health Investigation - Audit Review Period 4/1/2020 - 4/30/2022 Audit Onsite Dates - September 7, 2022 - September 8, 2022							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency
1	UM	The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855)	The Alliance reviews and/or updates all policy and procedures at least annually, to ensure our policy and procedures content is reflective of current regulatory requirements. All UM policy and procedures including any updates and the UM Program Description, are reviewed in the Utilization Management Committee (UMC), subsequently reviewed, and approved at our Board Delegated Quality Improvement Health Equity Committee (QIHEC) which reports directly to the Alliance Board of Governors. In response and in compliance with SB 855, The Alliance has updated UM-063 - Gender Affirmation Surgery and Transgender Services and the Alliance UM Program Description. Both bodies of work are aligned with current WPATH Standards of Care. The Alliance is contracted with WPATH to provide training on WPATH Standards of Care - all UM decision makers (including RNs and physicians) are required to complete WPATH training to ensure the most current WPATH standards required by SB 855 are used for medical necessity decision-making. 100% of current UM reviewers will complete WPATH Training by Q2 2024 & 100% of newly hired UM reviewers will complete WPATH Training within 90-days of their start date. <u>Update 3/14/2025</u>: WPATH trainings completed 9/23/2024. The Alliance also conducts annual Inter-Rater Reliability Studies (IRR) with all UM decision makers to ensure that documented criteria is being applied consistently and accurately by decision makers. Additional training and testing is conducted when a passing score is not met. Annual IRR: 100% of UM reviewers will complete the Annual IRR Studies by Q3 2024. <u>Update 3/14/2025</u>: IRR completed 9/24/2024. Passing rate 98% for UM reviewers.	9/27/2024	Completed	UM Behavioral Health		State	DMHC
2	Quality Assurance	The Plan does not ensure its delegate consistently documents quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.	As of 4/1/2023, The Alliance has terminated its contract with the delegate. Since termination, The Alliance has insourced all mental and behavioral health services and processes all quality of care issues identified. The Alliance follows its internal policy and procedures and workflows to ensure that all quality of care problems are identified, reviewed and further, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.	4/1/2023	Completed	UM Quality Assurance Behavioral Health Compliance		State	DMHC
#	Category	Barriers to Care	Plan Response	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency
1	Pharmacy Services	The Plan has limited ability to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy and lacks policies and procedures for these treatments.	Members access OBOT and OTP therapy through Medication Assisted Treatment (MAT) providers in primary care, inpatient hospitals, emergency departments, and other contracted medical settings per BH-005. PCPs, BH, and ED providers are responsible for identifying members with substance abuse disorder issues and arranging the MAT services; under the CA Bridge Program EDs can provide immediate access to MAT. If members contact the Alliance's MSD or BHD, it will provide appropriate referrals to MAT providers. MAT providers are providers that can prescribe opioid use disorder medications and have current Drug Enforcement Administration registration with Schedule III authority.	12/31/2024	Completed	UM Behavioral Health Pharmacy Provider Contracting	✓	State	DMHC
2	Cultural Competency and Health Equity	Neither the Plan nor its delegate conduct assessments pertaining to cultural competency and health equity specific to the Plan's enrollee population.	The Alliance conducts the following assessments for cultural competency and health equity: Annual NCQA population assessment, member experience surveys (i.e. CG CAHPS, CAHPS, and TAR), provider satisfaction survey. Additionally, the Alliance utilizes various data sources to identify and determine intervention and quality activities to improve health needs and health disparities. Data sources include, but are not limited to, member demographic data, DHCS Alliance Specific health disparity data, claims, and encounter data. <u>The Alliance monitors and addresses disparities, OIPs and PIPs. These projects are driven by quantitative and qualitative data and are included</u>	12/31/2024	Completed	Quality Assurance Behavioral Health	✓	State	DMHC
3	Enrollee Experience	Enrollees experience difficulties obtaining appointments.	The Alliance started insourcing behavioral health services on April 1, 2023, and no longer delegates behavioral health services. The Alliance does not require prior authorization for behavioral health services (except for psychological and neuropsychological testing), and members can directly contact Alliance behavioral health providers to schedule appointments.	4/1/2023	Completed	Quality Assurance Behavioral Health	✓	State	DMHC

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

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2022 DMHC RBO Audit: Delegate - Audit Review Period 1/1/2022 - 3/31/2022

INTERNAL AUDITS

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

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

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2022 DHCS AUDIT FINDINGS: Audit Review Period 1/1/2021 - 3/31/2022

INTERNAL AUDITS

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY

Yellow = Plan Observations (included in final report)

R = Repeat Findings

2022 DHCS AUDIT FINDINGS: Audit Review Period 1/1/2021 - 3/31/2022

INTERNAL AUDITS

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
4	QI	(2.1.1) The Plan did not document attempts to contact members and schedule the IHA.	1. The plan will continue to inform members of the IHA through the EOC, welcome letters to all new members, and videos. - In addition, all members are eligible for a new member orientation (including a financial incentive). - Information regarding the IHA will be included in the member newsletter. The Alliance will initiate a new phone campaign where all new members will receive a phone call encouraging the member to receive an IHA. This phone log will be appropriately documented. The Alliance will create a call script for new member phone calls. 2. The plan will create a report to identify new plan members. <u>Update 5/12/2023</u>: Fulfillment Report created to track mailing of member Orientation reports that contain reminder to schedule IHA to new members. Member Orientation Service Request tracking report tracks outreach attempts to members to complete new member orientation, which includes communication about scheduling IHAs 3. The plan will create workflows for informing members of the IHA. <u>Update 5/12/2023</u>: Clinical QI Program Coordinator will review IVR reports to determine all new members have received an outreach call. 4. The plan will update the IHA P&P to reflect the updated workflows. <u>Update 3/10/2023</u>: Draft policy QI-124 completed, IVR outreach is pending DHCS approval of script. Upon DHCS approval we will continue to develop the process for IVR outreach and develop desktop procedures. <u>Update 4/15/2023</u>: The updated P&P was approved at Compliance Committee 3/21/2023 5. The plan will create a phone call campaign, create a script, and work with the state for approval. <u>Update 3/10/2023</u>: Awaiting DHCS approval of script. <u>Update 6/9/2023</u>: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreach attempts via providers, by reviewing documentation as part of FSRs.	9/8/2023	Completed	QI		State	DHCS	2022
5	CM	R(2.5.1) The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.	1. The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with the MHP to review redline changes to the MOU. The MHP is currently under review of the redline changes and will notify the Alliance when they can move forward with signing the MOU. The MHP MOU vetting process includes County Board of Supervisor (BOS) approval. Therefore, the Alliance is hoping to execute the MOU by the end of 2022.	12/31/2023	Completed	Provider Relations		State	DHCS	2022
6	Provider Relations	R(3.1.1) The Plan did not monitor the network providers' compliance with requirements for when appointments were extended.	1. The Provider Manual was edited to update the requirements, providers were advised in the Quarterly Provider Packet, and The Alliance Provider Representatives advised providers during PCP visits. Additionally, fax blasts were sent to providers regarding the updated requirements, and the Provider Education document was updated to reflect the requirements. 2. Edit P&P and Quality of Access Workflow to ensure all cases are reviewed by a QI Nurse. If a case is determined to be related to access, QI / A&A staff will review data for ED / Inpatient Stays as a result of delay in appointment. If the member does have an ED / IP Claim, the QI RN will then work the case up as a PQI / Quality of Care. This will be reviewed by the Medical Director and follow the PQI process. Finally, all QOA cases with available MRs will be reviewed to ensure the appropriate provider documentation. <u>Update 03/10/2023</u>: Policy QI-114 has been updated and is awaiting approval at committee <u>Update 4/14/2023</u>: P&P QI-114 was approved at Compliance Committee 3/21/2023	3/21/2023	Completed	Provider Relations QI		State	DHCS	2022

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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2022 DHCS AUDIT FINDINGS: Audit Review Period 1/1/2021 - 3/31/2022

INTERNAL AUDITS

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
7	Claims	(3.6.1) The Plan improperly denied emergency services claims.	1. Case #7 – The claim was paid on 8/11/2021. The vendor was notified of the finding on 5/19/2022 and asked to review their internal process to ensure that codes on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. 2. Case #20 –The vender was notified of the issue on 5/19/2022 and asked to review their internal process to ensure that dates on clams are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. In addition, an edit was enhanced to ensure that the date range order is correct. 3. The claim was paid on 1/5/2022 correctly. The Claims Processor was shown the claim finding for review along with the correct workflow document that shows the correct process to help ensure moving forward this does not occur again. This workflow was also reviewed by the Claim Processor team and training occurred.	10/11/2022	Completed	Claims		State	DHCS	2022
8	Access and Availability	R(3.8.1) The Plan did not use PCS forms for NEMT services.	1. The Plan will educate providers on PCS requirements. Update 3/10/2023: Provider Alert PCS Form Reminder and Form was sent out to Providers in a fax blast on Tuesday, 12/27/22. 2. Refine PCS workflows to meet all regulatory requirements. Update 3/10/2023: Workflow updated. 3. The Plan will conduct staff trainings on process workflow changes. <u>Update 4/15/2023</u>: Training completed 1/31/2023. 4. The Plan will ensure that the transportation subcontractor trains their staff on the PCS process workflow changes. The transportation subcontractor will provide training materials and sign in sheets. <u>Update 4/15/2023</u>: Training completed 1/31/2023. 5. The Plan will develop reports on PCS form outcomes using both transportation subcontractor information and the Plan's process to obtain PCS forms. <u>Update 4/15/2023</u>: Reports developed and presented at UM Committee Q4 2022. 6. The Plan will monitor process workflows from the transportation subcontractor and the Plan to obtain missing PCS forms <u>Update 4/15/2023</u>: Reports developed and presented at UM Committee Q4 2022. 7. The Plan will analyze trends in provider practices and provide feedback to providers regarding PCS form requirements. <u>Update 4/15/2023</u>: Reports developed and presented at UM Committee Q4 2022, where trends analyzed. 8. The plan will evaluate whether to continue having the transportation subcontractor manage the PCS forms or take the direct management of PCS forms back into the Plan. <u>Update 4/15/2023</u>: Reports developed and presented at UM Committee Q4 2022. Will continue to analyze quarterly. 9. The Plan will provide a quarterly report to UM Committee <u>Update 4/15/2023</u>: Reports developed and presented at UM Committee Q4 2022.	4/1/2023	Completed	UM		State	DHCS	2022
9	Member Rights	R(4.1.1) The Plan did not send acknowledgement and resolution letters within the required timeframes.	1. The G & A Department Leadership and Quality Assurance Specialist will reference the daily reports to ensure the acknowledgement and resolution letters are sent timely 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement and resolution letters. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/2022	Completed	G&A		State	DHCS	2022

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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2022 DHCS AUDIT FINDINGS: Audit Review Period 1/1/2021 - 3/31/2022

INTERNAL AUDITS

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

**ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD**

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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R = Repeat Findings

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

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R = Repeat Findings

2021 DHCS JOINT AUDIT FINDINGS: Audit Review Period 6/1/2019 - 3/31/2021											
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	INTERNAL AUDITS			
								Validation Status	State/Self Identified	Agency	Year
4	UM	(1.5.2) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The delegate did not ensure that requests to see out of network providers were reviewed and decisions were made by a qualified health care professional. It did not include the decision-maker's name in the NOA.	1.The Plan will inform Delegate of DHCS findings about qualified health care professional did not always make decisions to deny or only authorized an amount, duration, or scope that was less than requested, and the lack of name and contact information on the NOA of the decision-maker. <u>Update 11/12/2021</u>: On 10/8/2021 a letter was sent to delegate to advise of the audit findings. 2.The Plan will re-educate delegates on standard UM requirement that only qualified health care professionals make decisions to deny or authorize an amount, duration, or scope that is less than requested, including out of network requests, and on the requirement to have the decision-makers' name and contact information on the NOA. <u>Update 11/12/2021</u>: The Alliance met with the delegate on 10/28/2021 to provide re-education. 3.The Plan will audit delegate's cases during the annual audit to ensure that only qualified health care professionals make decisions on denials and authorizations of the amount, duration, and scope less than requested, and contact information for the decision maker. <u>Update 02/11/2022</u>: The annual delegation audit started on 12/20/2021 and is in progress. The audit is expected to be completed on 4/1/2022. <u>Update 09/09/2022</u>: The delegate audit is in progress. And is expected to be completed by 9/23/2022	Medium	12/20/2021	Completed	UM Compliance		State	DHCS	2021
5	UM	R (1.5.3) The Plan did not ensure complete ownership and control disclosure information were collected from its delegates.	1.The Plan has updated its documentation, Provider Services Standard Operating Procedure – Ownership and Control Disclosure Reviews for Delegates, to include collecting required disclosures from the managing employees, or board of directors and senior management team in cases where the entity is a non-profit with no majority ownership and/or owned by physician shareholders.	Low	9/14/2021	Completed	Provider Network Vendor Management		State	DHCS	2021
6	UM	(1.5.4) The Plan did not ensure the written agreements with its delegates included the requirement to allow specified departments, agencies, and officials to audit, inspect, and evaluate the Plan's facilities, records, and systems related to good and services provided to Medi-Cal members.	1.The Plan is adding the Comptroller General in the Behavioral Health contract, Amendment 7. <u>Update 11/12/2021</u>:The Comptroller General was added to the contract, Amendment 7, as of 10/13/2021 2.The Plan is currently working with its delegate on a new contract and delegation agreement which will include the provision and requirement to allow governmental and specified agencies and officials to audit records and systems. <u>Update 1/14/2022</u>: The draft agreement has been completed and is expected to be fully executed in January 2022. <u>Update 2/11/2022</u>: Full execution of the draft agreement is still in progress. <u>Update 09/09/2022</u>: Full execution of the draft agreement is expected by the end of September 2022 3.The Plan will conduct a review of all of its delegated agreements and update the agreements to ensure that all of the language requirements are included. <u>Update 1/14/2022</u>: The agreement has been reviewed and updated. <u>Update 2/11/2022</u>: The Plan conducts annual oversight of its Delegates via an Annual Delegation Audit, as described in CMP-019 – Delegation Oversight. The Plan has updated its Compliance Audit tool to ensure the audit includes a review of the Delegation Agreement to confirm it contains the required language.	Medium	12/31/2022	Completed	Provider Network Vendor Management Compliance		State	DHCS	2021
7	UM	(1.5.5) The Plan did not have policies and procedures for imposing financial sanctions on its delegate and delegated entities.	1.The Plan has created a new Policy, CMP-030 Sanction and Escalation. This Policy describes the standards by which the Plan may impose sanctions against Delegated Entities (DE), providers and vendors for non-compliance or failure to comply with Corrective Actions Plan (CAP) deficiencies, or for breach of any material term, covenant or condition of an agreement and/or for failure to comply with applicable federal or state statutes, regulations, and rules. <u>Update 12/10/2021</u> : Policy CMP-030 was approved at Compliance Committee on 11/23/2021	Low	12/1/2021	Completed	Compliance		State	DHCS	2021
8	Case Management	R (2.1.1) The Plan did not conduct HRAs within the required timeframes for newly enrolled SPD members in 2019 and 2020.	1. The Plan revised the HRA process to track all incoming HRAs via a Log, documenting date of receipt. 2. The Plan revised current process for HRAs received past due to be entered into the system of record TruCare (TC) during the month of receipt. 2.a. The Plan updated workflows. 3. The Plan re-trained staff on the HRA process. 4. The Plan will monitor the Log weekly to ensure adherence to the new process. <u>Update 10/8/2021</u>: The log has been created and is being monitored weekly 5. The Plan will report outcomes up to UMC quarterly. <u>Update 2/11/2022</u>: As of the December UM Committee meeting, outcomes are now being reported at the UMC.	Low	12/31/2021	Completed	Case Management		State	DHCS	2021

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R = Repeat Findings

2021 DHCS JOINT AUDIT FINDINGS: Audit Review Period 6/1/2019 - 3/31/2021								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
9	Case Management	(2.1.2) The Plan did not ensure coordination of care in certain cases where EPSDT services were medically necessary.	1.The Plan will develop training on EPSDT PA requests to identify and refer members who need coordination of their care. <u>Update 11/12/2021</u> : Training developed 2.The Plan will provide training to UM and CM staff. <u>Update 11/12/2021</u> : Training completed for UM and CM staff 3.The Plan will create a reporting system to capture referrals to CM and the provision of care coordination. <u>Update 11/12/2021</u> : Reporting system to capture referrals has been created, change in reporting will be reflected mid-December 4.The Plan will report outcomes at UMC on a quarterly basis. <u>Update 5/13/2022</u> : Outcomes reported at January and March 2022 UMC Meetings.	Medium	5/13/2022	Completed	Case Management		State	DHCS	2021
10	Case Management	(2.2.1) The Plan did not ensure the completion of Individualized Care Plans for members enrolled in Complex Case Management.	1. The Plan revised its CCM ICP workflow and added the requirement that all staff complete ICPs for all members in CCM. 2. The Plan re-trained staff to complete ICPs for all members in CCM. 3. The Plan will revise its CM Aging Report to capture completion of ICPs for daily management and reporting outcomes. <u>Update 10/8/2021</u> : Aging report has been updated to capture completion of ICPs 4. The Plan will develop a monitoring workflow. <u>Update 10/8/2021</u> : The monitoring workflow has been completed 5. The Plan will routinely monitor completion of the ICPs. <u>Update 10/8/2021</u> : The log has been created and is being monitored weekly 6. The Plan will report outcomes at UMC quarterly. <u>Update 09/09/2022</u> : Monitoring of the ICPs is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
11	Case Management	(2.2.2) The Plan did not ensure development of care plans in collaboration with the PCP.	1. The Plan re-trained staff on policy regarding developing care plans in collaboration with PCP. 2. The Plan will revise its CM Aging Report to capture the date the letter regarding Care Plans was sent to the PCP. <u>10/8/2021</u> : The CM Aging Report has been updated to capture the date the letter regarding Care Plans was sent to the PCP 3. The Plan will monitor, on an ongoing basis, the CM Aging Report to ensure CP letters are being sent to PCPs. <u>Update 10/8/2021</u> : Monitoring has begun, automation of this report is in progress 4. The Plan will report outcomes to UMC quarterly. <u>Update 09/09/2022</u> : Monitoring of the development of care plans with the PCP is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
12	Case Management	(2.2.3) The Plan did not conduct periodic evaluations to ensure the provision of complex case management based on the member's medical needs. The Plan did not implement procedures for monitoring time frame standards or maintaining monthly contact with members.	1. The Plan developed a workflow to maintain regular contact with members and ensure that the continuation of CCM is based on medical needs by using the Complex Criteria Checklist. 2. The Plan conducted staff training. 3. The Plan will revise its CM Aging Report to capture provision of CCM and maintaining monthly contact with member. <u>10/8/2021</u> : The CM Aging Report has been revised to capture the provision of CCM and maintaining monthly contact with member 4. The Plan will monitor, on an ongoing basis, the CM Aging Report. <u>10/8/2021</u> : Monitoring has begun, automation of this report is in progress 5. The Plan will report outcomes quarterly to UMC. <u>Update 09/09/2022</u> : Monitoring of the CM Aging Report is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
13	Case Management	(2.2.4) The Plan did not ensure that interdisciplinary team assessments were included in the updating of members' care plans. The Plan did not ensure timely documentation of the interdisciplinary team meeting notes.	1. The Plan created an additional column in the Complex Case Log to monitor timely entry of IDT Round note into system of record. 2. The Plan will develop a workflow for staff to include the IDT note in the updated care plans. <u>Update 10/8/2021</u> : The workflow has been updated to include the IDT note in the updated care plans. 3. The Plan will develop a monitoring workflow. Monitoring will be done on a bi-weekly basis. <u>Update 9/9/2022</u> : Monitoring is now being completed on a bi-weekly basis 4. The Plan conducted a staff training on the process. 5. The Plan will use Complex Case Log to monitor adherence to procedure. <u>Update 11/12/2021</u> : The Plan is now using the Complex Case Log to monitor adherence 6. The Plan will report outcomes quarterly to UMC. <u>Update 09/09/2022</u> : Monitoring of the IDT assessments is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	UM		State	DHCS	2021

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2021 DHCS JOINT AUDIT FINDINGS: Audit Review Period 6/1/2019 - 3/31/2021											
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	INTERNAL AUDITS			
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14	Case Management	(2.5.1) The Plan's MOU with the County MHP did not meet all the requirements specified in APL 18-015.	1. The Plan will conduct annual meetings with the County to ensure that the MOU is being updated (when appropriate). <u>Update 1/14/2022</u> ; Due to staffing availability, the meeting with the County to review the MOU was not able to take place in December, and will be scheduled for early 2022. <u>Update 2/11/2022</u> : The first meeting with the county took place on 1/31/2022. 1.a. The Plan will develop meeting minutes to demonstrate topic of discussions. The Plan will submit meeting minutes to DHCS. <u>Update 2/11/2022</u> ; Meeting minutes completed for first meeting on 1/31/2022. 2. The Plan's internal departments will work together to ensure clinical and quality components that are not present be updated in the MOU to reflect the requirements in APL-018. <u>Update 2/11/2022</u> ; MOU has been updated to ensure clinical and quality components reflected.	Low	1/31/2022	Completed	Case Management Provider Network		State	DHCS	2021
15	Case Management	(2.5.2) The Plan's MOU with the County MHP did not specify policies, procedures, and reports to address quality improvements requirements specified in APL 18-015. The Plan did not conduct semi-annual calendar year reviews of referral and care coordination processes, generate semi-annual reports, or develop performance measures and quality improvement initiatives during the audit period.	1. The Plan will establish a cross-functional workgroup to develop specific P&Ps and QI performance metrics, in addition to referral and care coordination reports. <u>Update 12/10/2021</u> ; The cross-functional workgroup was established and held it's first meeting on 10/20/2021. County JOMs will begin January 2022.	High	12/10/2021	Completed	Case Management Provider Network		State	DHCS	2021
16	Access	(3.1.1) The Plan did not enforce and monitor providers' compliance with the requirement to document when timeframes for appointments were extended.	1. The Plan revised P&P QI-107 to include appointment extension language and will be submitted to committee for approval. <u>Update 11/12/2021</u> ; The P&P has been revised and is awaiting approval at committee on 11/23/2021. <u>Update 12/10/2021</u> : The policy was approved at Compliance Committee on 11/23/2021. 2. The Plan revised Timely Access Standards Provider Communication Sheet and will be submitted to committee for approval. <u>Update 11/12/2021</u> ; The Timely Access Standards Provider Communication Sheet has been revised and is awaiting approval at committee on 11/18/2021. <u>Update 12/10/2021</u> ; The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021.	Low	11/23/2021	Completed	QI		State	DHCS	2021
17	Access	(3.1.2) The Plan did not continuously review, evaluate and improve access to and availability of the first prenatal appointment.	1. The Plan revised P&P QI-107 to indicate current Access Standards for First Prenatal Appointment from 2 weeks from date of request to 10 days for PCP OB/GYN and 15 days from request for OB/GYN Specialty Care. P&P will be submitted to committee for approval. <u>Update 11/12/2021</u> ; Awaiting clarification and further guidance from DHCS Contract Manager. <u>Update 12/10/2021</u> ; QI-107 was approved at the Compliance Committee on 11/23/2021. 2. The Plan revised Timely Access Standards Provider Communications Sheet. <u>Update 11/12/2021</u> ; Awaiting clarification and further guidance from DHCS Contract Manager. <u>Update 12/10/2021</u> ; The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021. 3. The Plan will be implementing a tracking and trending report of First Prenatal PQIs. <u>Update 11/12/2021</u> ; Awaiting clarification and further guidance from DHCS Contract Manager. <u>Update 12/10/2021</u> ; The Tracking and Trending report of First Prenatal PQIs has been implemented	Medium	11/23/2021	Completed	QI		State	DHCS	2021

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18	Access	(3.4.1) The Plan did not ensure standing referral determinations and processing were made within the required timeframes.	1. The Plan will develop a standing referral workflow. <u>11/12/2021</u>; Standing referral workflow has been developed 2. The Plan will update The Alliance system of record for UM and CM, TruCare (TC) to add user define field in order to identify standing referral status to ensure correct TAT, which would include a reportable field for monthly reporting. <u>Update 12/10/2021</u>; TruCare has been updated to add the user defined field. 3. The Plan will revise TruCare (TC) to capture timeframes for processing Standing Referrals. <u>Update 12/10/2021</u>; The reporting TAT has been scheduled to begin in December, with the first report, containing December data, due in January. 4. The Plan will revise Authorization Aging report for day to day management and to report on timeframes for Standing Referrals. <u>Update 01/14/2022</u>; Revision of aging report complete 5. The Plan will conduct staff training on standard work for Standing Referrals. <u>Update 01/14/2022</u>; Staff training on standing referrals completed 11/16/2021 6. The Plan will monitor Standing Referral timeframes with the daily Authorization Aging report. 7. The Plan will report results quarterly to UMC. <u>Update 09/09/2022</u>; Standing referrals are now being tracked and reported on during UM Committee quarterly	High	3/25/2022	Completed	UM Case Management	Completed	State	DHCS	2021
19	Access	(3.6.1) The Plan improperly denied emergency services claims and family planning claims.	1. The Plan updated its monitoring report criteria to include a denial code (code:0630) which would allow us to identify claims prior to finalizing adjudication.	Low	3/26/2021	Completed	Claims IT (Config)		State	DHCS	2021
20	Access	(3.6.2) The Plan did not pay interest for family planning claims not completely reimbursed within 45 working days of receipt.	1. The Plan reviewed the issue thru Claims Processor & Specialist training to ensure staff understands the issue that resulted in no interest. The trainings were completed in May 2021.	Low	5/1/2021	Completed	Claims		State	DHCS	2021
21	Access	(3.8.1) The Plan did not ensure its transportation broker's NEMT providers were enrolled in the Medi-Cal program.	1. The Plan notified its transportation broker that remaining unenrolled NEMT providers need to complete PAVE application by 12/01/2021. <u>Update 12/10/2021</u>; The notification letter was sent to the transportation broker on 12/1/2021, 2. The Plan will audit transportation broker providers to ensure drivers are enrolled in the Medi-Cal program. This was last completed August 27, 2021. Monitoring will be conducted on an annual basis.	Low	12/31/2022	Completed	Vendor Management		State	DHCS	2021
22	Access	(3.8.2) The Plan did not require PCS forms for NEMT services.	1. The Plan will require transportation broker to provide ongoing reports on rates of obtaining PCS forms from providers: <u>Update 11/12/2021</u>; UM Team working with Vendor Management and the transportation broker to obtain needed reports. <u>Update 12/10/2021</u>; The report was received from transportation broker on 10/28/2021. 2. The Plan will analyze trends in provider practices on a quarterly basis. <u>Update 12/10/2021</u>; The first report will be given at UMC in January 2022. <u>Update 2/11/2022</u>; Awaiting reports from the transportation broker 3. The Plan will educate providers on PCS requirements and provide data on their performance: <u>Update 2/11/2022</u>; Awaiting reports from the transportation broker 3.a. Provider newsletter. <u>Update 2/11/2022</u>; Awaiting reports from the transportation broker 3.b. Individual office contacts 4. The Plan will finalize process workflow to obtain missing PCS forms. <u>Update 11/12/2021</u>; UM Team working with Vendor Management and the transportation broker to obtain needed reports. <u>Update 12/10/2021</u>; The workflow has been finalized based on the reports received from the transportation broker 5. The Plan will conduct staff trainings on process workflow. <u>Update 12/10/2021</u>; Training was completed 11/8/2021. 6. The Plan will provide a quarterly report to UMC. <u>Update 01/14/2021</u>; Reporting will begin at UMC in Q1 2022. <u>Update 2/11/2022</u>; Awaiting reports from the transportation broker <u>Update 09/09/2022</u>; NEMT services are now being tracked and reported quarterly at the UM Committee.	Medium	12/31/2022	Completed	Vendor Management UM		State	DHCS	2021
23	Member Rights	(4.1.1) The Plan did not ensure that the medical director fully resolved QOC grievances prior to sending resolution letters.	1. The Plan updated G&A-003 Grievance and Appeals Receipt, Review and Resolution to include the process for the medical director's review and resolution of all levels of quality of care grievances prior to sending a resolution letter to members. The policy will be reviewed at the Health Care Quality Committee on November 18, 2021 and the Compliance Committee Meeting on November 23, 2021. <u>Update 12/10/2021</u>; G&A-003 was approved at the Compliance Committee meeting on 11/23/2021 2. The Plan will provide training to the medical directors to review G&A-003 Grievance and Appeals Receipt, Review and Resolution by November 30, 2021. <u>Update 3/11/2022</u>; Training was completed 1/12/2022	Medium	1/12/2022	Completed	G&A		State	DHCS	2021
24	Member Rights	(4.1.2) The Plan did not consistently implement its procedure for processing grievances. The Plan considered member's grievances resolved and classified as exempt without conducting investigation.	1. The Plan is updating its policy and procedures for processing Exempt Grievances to reflect its current process. The policy MBR-0024 will be reviewed at the Compliance Committee Meeting on November 23, 2021. <u>Update 12/10/2021</u>; MBR-024 was approved at Compliance Committee on 11/23/2021 2. The Plan will provide staff training by November 30, 2021. <u>Update 1/14/2022</u>; Training was completed 11/19/2021	Low	11/30/2021	Completed	Member Services		State	DHCS	2021
25	Member Rights	(4.1.3) The Plan did not send acknowledgement and resolution letters within the required timeframes. The Plan did not promptly notify the members that expedited grievances would not be resolved within the required timeframe.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-003 Grievance and Appeals Receipt, Review and Resolution and G&A-005 Expedited Review of Urgent Grievances. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent within the required timeframes, and to also notify members when expedited grievances would not be resolved within the required timeframe.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
26	Member Rights	(4.1.4) The Plan did not send acknowledgement and resolution letters in threshold languages.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description and CLS-003 Language Assistance Services. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent to members in their threshold languages.	Low	9/21/2021	Completed	G&A		State	DHCS	2021

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

**ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD**

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

**ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD**

2020 DHCS STATE AUDIT FINDINGS - Audit Review Period: 10/01/2018 - 9/30/2020						INTERNAL AUDITS					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
4	UM	The Plan did not notify members and the hospital of continued denial of long term acute care (LTAC) services through NOA letters and "Your Rights" attachments for each concurrent review throughout the members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. <u>Update 10/8/2021</u> Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. <u>Update 10/8/2021</u>: First report to UMC on 8/24/2021. 100% compliance. <u>Update 11/12/2021</u>: The results of the next quarterly audit will be presented at the November UM Committee. <u>Update 12/10/2021</u>: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. <u>Update 04/08/2022</u>: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. <u>Update 5/13/2022</u>: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
5	UM	The Plan provided unclear information about the Plan's decision for denial of long term acute care (LTAC) services in the only NOA letters that were issued to members and the Hospital. Letters contained inaccurate information about denied dates and requesting providers.	1. The automated section of the NOA letter generated by the Plan's system of record, TruCare, was incorrectly configured and displayed inaccurate information about the requesting LTAC provider and the dates of denial. The Plan's system of record, TruCare, was re-configured to display the correct dates and correct requesting provider in the automated portion of the NOA letters. 2. The Plan's In-Patient Utilization Management Leadership will continue to audit the NOA letters to ensure that they contain accurate information and meet the regulatory requirements. Update 5/15/2021: Identified deficiencies have been added to the audit tool and audits of inpatient NOA letters are currently taking place. 3. The Plan will report the results of NOA letter audit at Utilization Management Committee on a quarterly basis, starting Q3 2021. Update 7/9/2021: Manual tracking continues, report will be provided starting in Q3 2021 <u>Update 10/8/2021</u>: Manual tracking continues, awaiting completion of automated report. First report to UMC on 8/24/2021. 100% compliance. <u>Update 11/12/2021</u>: The results of the next quarterly audit will be presented at the November UM Committee. <u>Update 12/10/2021</u>: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. <u>Update 04/08/2022</u>: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. <u>Update 5/13/2022</u>: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress

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

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

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

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

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

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2019 DHCS AUDIT FINDINGS - Audit Review Period: 6/1/2018-5/31/2019							INTERNAL AUDITS					
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required PA for an initial visit with a mental health provider to determine if the member had mild-to-moderate mental health issues, which the contract does not allow.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. <u>Update as of 12/5/2019</u> : The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. <u>Update as of 1/8/2020</u> : Plan reviewed documents and agree with the changes for member self-referral process. Discussing with DHCS prior to final CAP submission.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
2	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required a two-step prior authorization (PA) process for BHT services, which is allowed, but did not send written notification when it denied services at the first step. The delegate did not consistently apply criteria for approving BHT.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. <u>Update as of 12/5/2019</u> : The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. <u>Update as of 1/8/2020</u> : Plan reviewed documents and still have open items not documented. Plan will be meeting with the delegate to discuss criteria and procedures for further documentation needed. <u>Update as of 2/7/2020</u> : Met with the delegate to review their criteria and approval process. Requested policy language changes to meet the regulatory requirements. Policy was approved by Committee on 1/27/20. Updated CAP response submitted to DHCS on 2/7/2020.	No	2/7/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
3	UM Delegation	(1.1.3) R The Plan did not review ownership and control disclosure information for their Utilization Management (UM) delegates	The Plan will ensure that its delegated providers complete the Ownership and Control disclosure forms. The Plan will create a tracking log and document any follow up attempts made with the delegate to ensure accuracy. <u>Update as of 12/2/2019</u> : PR has created a tracking log and is working on a desktop procedure.	Yes	1/1/2020	Completed	Provider Services	✓	State	DHCS	2019	Completed
4	UM Delegation	(1.1.4) R The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan will conduct staff retraining of delegation reporting procedures to ensure all are tracked and monitored for receipt and review. <u>Update as of 12/5/2019</u> : Staff training was conducted on 12/5/2019.	Yes	12/1/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
5	UM Delegation	The Plan's oversight of its delegate did not identify unclear NOA letters, and incorrect appeal and SFH information	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. <u>Update as of 12/5/2019</u> : The delegate has developed on a new process regarding NOA letters, appeal rights and SFH information. The Alliance will review and discuss changes with the delegate on the next Operations call. <u>Update as of 1/8/2020</u> : Plan reviewed documents and agreed with changes of procedure checklist and training materials.	No	1/15/2020	Completed	Utilization Management		State	DHCS	2019	Completed
6	Referral Tracking process	(1.1.6) R The Plan did not track all approved PAs; the specialty referral tracking process did not include modified PAs and in-network approved services.	The UM Department is working with analytics to expand the routine referral tracking report to include all approved authorizations. <u>Update as of 12/5/19</u> : Clarity is being sought from DHCS on the scope of specialty referral tracking. <u>Update as of 1/8/2020</u> : An updated referral tracking report is being developed to include all decision types and specialty services that require authorization. <u>Update as of 2/7/20</u> : Updated report sample generated and submitted to DHCS. Working with Analytics to create routine report that captures all needed data elements. <u>Update as of 3/5/2020</u> UM met with Analytics to create the routine report capturing all needed elements. Report is in development. <u>Update as of 5/8/20</u> Specialty Tracking Report has been created by Analytics, including all required elements, and will now be routinely reported quarterly through UMC and HCQC. Reported at HCQC on 5/21/20. <u>Update as of 6/12/20</u> : Report sent to HCQC on 5/21/20 and reviewed at UMC at 5/29/20.	Yes	5/21/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
7	Prior Authorizations	(1.2.1) R A review of PA data showed non-qualified Plan staff denied retrospective cases for administrative reasons other than non-eligibility for membership. The Plan denied retrospective service requests without review by a medical director if the provider submitted the request more than 30 days after the service delivery date, or if requests did not meet Plan-imposed conditions. The Plan's contract did not specify submission timeframes or other conditions that, if not met, allowed eliminating medical necessity review of retrospective requests for covered services.	Policy and procedure UM-001 Utilization Management will be updated to comply with the contractual requirements. Workflows will be updated to have all retrospective requests reviewed by a medical director. Workflows have been updated to have all retrospective requests reviewed by a medical director. <u>Update as of 12/5/2019</u> : Clarity is being sought from DHCS on allowing a time limit of 30 days. <u>Update as of 1/8/2020</u> : Plan received clarity from DHCS and is updating internal procedures. <u>Update as of 2/7/2020</u> : P&Ps updated to reflect that only an MD can deny retro PA requests. P&Ps approved at HCQC on 1/16/2020.	Yes	1/16/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
8	Prior Authorizations	(1.2.2) The Plan did not ensure it used appropriate processes to review and approve medically necessary covered services when it did not ensure that qualified medical personnel rendered medical decisions. Dependent practitioners reviewed, assessed and approved requests for continued hospital stays	The process for ensuring LVNs perform only within their scope of practice was updated and implemented on 10/2/2019. Additional changes to the UM systems to better track the change in process are being developed. <u>Update as of 12/5/2019</u> : Changes to the UM systems to better track the RN oversight role with the LVNs completed. Other Managed Medi-Cal plans have LVNs performing UM. Clarity is being sought from DHCS on the use of LVNs in UM. Policies and procedures and job descriptions are being reviewed to be aligned with the updated oversight process. <u>Update as of 1/8/2020</u> : Plan received clarity from DHCS and updated procedures for RN oversight.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
9	Prior Authorizations (UM and Rx)	(1.2.3) R The Plan's notice of action (NOA) letters did not follow specifications in Health and Safety Code Section 1267.01. Provider letters in medical cases did not include the decision makers' direct phone number or contained the incorrect number. Letters did not explain the reasons for the denial. Pharmacy NOAs were not concise.	Accurate phone numbers for the decision makers are on the NOA, monitoring will be conducted through internal audits. UM NOA template letters were updated and implemented on 11/4/2019, internal auditing will be conducted monthly to ensure that the letters are clear and concise and explain the reasons for denial. Pharmacy NOA template letters were updated and implemented in April 2019, internal auditing will be conducted at least monthly to ensure that the letters are clear and concise and explain the reasons for denial. The pharmacy team also meets with the PBM on a weekly basis to optimize PA review process, NOA letter language and reasons for denial.	Yes	11/4/2019	Completed	Utilization Management /Pharmacy		State	DHCS	2019	Completed

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2019 DHCS AUDIT FINDINGS - Audit Review Period: 6/1/2018-5/31/2019						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
10	Prior Authorizations	The Plan did not ensure that all contracting practitioners were aware of the procedures for orthotic items; the Plan provided inaccurate information about authorization requirements for orthotic items	The Alliance's Authorization Grid will be updated to include the accurate information about authorization requirements for orthotics. The updated grid will be uploaded on the website. <u>Update as of 12/5/2019</u> : A meeting will be scheduled the week of 12/9 to discuss changes. <u>Update as of 1/8/2020</u> : Meeting was conducted and PA grid will be updated to reflect corrections. <u>Update as of 2/7/2020</u> : PA grid is being updated for all services requiring PA, so that MDs do not receive repeat communication about changes to the PA grid. Orthotics will be included in the comprehensive update. <u>Update as of 3/5/2020</u> : Prior Auth requirement for Orthotics was added to the PA grid on the Provider Portal	No	3/2/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
11	Appeals	The Plan's appeal notification letters did not comply with contractual regulations. NAR letters were not clear or concise, and contained inaccurate information	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. <u>Update as of 12/5/2019</u> : Training conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
12	Case Management & Care Coordination - HRAs	The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members. The Plan did not ensure that HRAs were completed within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk, and within 105 calendar days of enrollment for those identified as lower risk.	HRA tracking had been implemented in early 2019, and continues at present. HRAs are sent out within the required timeframes. Robo calls are made to low risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls are made by CM staff on high risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log is kept to ensure that the required timelines are met.	No	9/16/2019	Completed	Case Management		State	DHCS	2019	Completed
13	Case Management & Care Coordination - Initial Health Assessment (IHA)	The Plan did not ensure that all providers documented all required components of an IHA. Preventive services identified as USPSTF "A" and "B" recommended services were not provided, or status of these recommended services was not documented	The QI Department revised its provider medical record request letter to include: all categories that support IHA completion; a hyperlink and/or copy of the SHA/IHEBA form; and sample documentation of a compliant SHA/IHEBA. Providers were re-educated on the SHA/IHEBA requirements.	No	9/30/2019	Completed	Quality		State	DHCS	2019	Completed
14	Complex Case Management (CCM)	(2.2.1) R The Plan did not implement its monitoring of the CCM program to address member needs. The Plan did not close its CCM cases after 90 days, or present them at Case Rounds as stated in its policy	Existing aging reports are being utilized by the Case Management Department in CCM Rounds to ensure that members' cases are either reviewed and closed, or extended past 90 days.	Yes	10/14/2019	Completed	Case Management	✓	State	DHCS	2019	Completed
15	Access & Availability	(3.1.1) R The Plan did not maintain an accurate provider directory.	The Plan will continue to verify 10 providers per week and has added the following two processes to continuously maintain an accurate provider directory: 1. Provider Data Comparison to manually review provider data received from our delegates started September 2019 and 2. Provider Data Validation Yearly Project to review directly contracted providers who appear in the Provider Directory. In addition, the Provider Relations Department includes a Provider Demographic form in all provider quarterly packets and work with providers to obtain the completed forms during provider visits.	Yes	11/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
16	Emerg Family Planning Claims/SSS	The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-For-Service rate. The Plan's claim system misclassified non-contracted family services as non-billable. The Plan is required to pay all covered family planning services regardless if these services are contracted with the Plan.	This finding is specific to one provider based on the list of services identified in the contract. No other provider was impacted by this issue. The claims system has been re-configured to reimburse services as follows: * services listed in the provider contract will be reimbursed at the contracted rate * covered Medi-Cal services not listed in the contract will be reimbursed at 100% of the prevailing Medi-Cal rate	No	9/5/2019	Completed	Claims	✓	State	DHCS	2019	Completed
17	Emerg Family Planning Claims	The Plan did not inform members of the correct minor consent provision for family planning services in its Evidence of Coverage (EOC).	The Plan has updated its 2020 EOC to include the appropriate minor consent provisions. The EOC was submitted to DHCS for review and approval on 10/7/2019.	No	10/7/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
18	Access to Pharm Services	(3.6.1) R The Plan did not monitor the provision of drugs prescribed in emergency situations.	The Pharmacy Department is working with the PBM to create routine monitoring reports of drugs prescribed in emergency situations. <u>Update as of 1/8/20</u> : Internal meeting was conducted to ensure requirements are clear and next steps for updating policy and monitoring reports. <u>Update as of 2/11/2020</u> : Draft P&P and monitoring log have been created and are under review. <u>Update as of 4/10/2020</u> : The P&P and monitoring log were approved at the most recent P&T Committee meeting.	Yes	3/17/2020	Completed	Pharmacy	✓	State	DHCS	2019	Completed
19	Grievances	(4.1.1) R The Plan did not document review and final resolution of clinical grievances by a qualified health care professional	The G&A workflow for Quality of Care review was updated and implemented on 4/15/2019 to include the CMOs review and final resolution.	Yes	4/15/2019	Completed	G&A	✓	State	DHCS	2019	Completed
20	Grievances	(4.1.2) R The Plan's grievance system did not capture all complaints and expressions of dissatisfaction reported by members.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. <u>Update as of 12/5/2019</u> : Training was conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
21	Grievances	(4.1.4) R The Plan's grievance system did not capture all complaints and expressions of dissatisfaction filed through Plan providers.	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. Clinics will be trained by the delegate to ensure that the Alliance is capturing all complaints. <u>Update as of 1/8/2020</u> : Medical group provided training sign in sheet. The delegate is working on next steps of educating providers. <u>Update as of 2/7/2020</u> : the delegate provided an attestation to complete its provider training by the end of Q1 2020. <u>Update as of 4/10/2020</u> : Meeting medical group week of 4/6 to discuss implementation. <u>Update as of 4/20/2020</u> : Process for forwarding complaints received by medical group has been implemented as of 4/20/2020.	Yes	3/31/2020 5/1/2020	Completed	G&A/Provider Services/ Compliance	✓	State	DHCS	2019	Completed
22	Grievances	4.1.4 The Plan sent member resolution letters without completely resolving all complaints.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. <u>Update as of 12/5/2019</u> : Training was conducted on 11/14/2019.	Yes	11/22/2019	Completed	G&A		State	DHCS	2019	Completed

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#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
23	Quality Program	The QIPD did not list the individuals' qualifications, which was inconsistent with Plan policy.	The 2019 Annual Quality Improvement Program Description (QIPD) was revised to include the leadership positions and their qualifications (Licensure, Education, Work Exp) The program description was presented and approved in the July 18, 2019 Health Care Service oversight committee.	No	7/18/2019	Completed	Quality	✓	State	DHCS	2019	Completed
24	Provider Training	(5.2.1) R The Plan did not ensure provider training was conducted within 10 working days	During the last review period of June 2017 through May 2018, the Plan acknowledged deficiencies in the NPO process to be corrected by the end of December 2018. Since January 2019, the plan is meeting its goal of conducting training with the 10 day working timeframe 100% of the time.	Yes	1/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
25	Fraud, Waste, and Abuse (FWA)	The Plan did not conduct preliminary investigations of all suspected cases of fraud and abuse.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. Staff training of the revised procedure will be completed by 12/01/2019. Update as of 12/5/2019: Staff training will be conducted on 12/11/2019 to review the updated procedure. Update as of 1/8/2020: Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
26	Fraud, Waste, and Abuse (FWA)	The Plan did not investigate all suspected fraud and abuse incidents promptly. The Plan did not conduct a preliminary or follow-up investigation of 4 of 12 suspected fraud and abuse cases until two to six months after it became aware of the incidents.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. All cases will be resolved and closed within 90 days of receipt. Staff training of the revised procedure will be completed by 12/01/2019. Update as of 12/5/2019: Staff training will be conducted on 12/11/2019 to review the updated procedure. Update as of 1/8/2020: Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
27	Fraud, Waste, and Abuse (FWA)	The Plan's compliance officer did not develop and implement fraud, waste, and abuse policies and procedures	The Plan's designated compliance officer will develop and attest to all new and updated policies and procedures prior to committee review.	No	12/13/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
28	State Supportive Services Claims	The Plan did not forward all misdirected claims within 10 working days.	The post-adjudication script that adds the forwarding action was corrected and deployed.	No	7/11/2019	Completed	IT/ Claims	✓	State	DHCS	2019	Completed

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

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

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

**ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD**

2018 DHCS FINAL AUDIT REPORT FINDINGS - Audit Review Period: 6/1/2017-5/31/2018						INTERNAL AUDITS					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
35	Fraud, Waste, and Abuse (FWA)	6.3.1 The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10-working days.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to ensure timely reporting of incidents to DHCS. Staff training on updated procedures was conducted on 7/17/2018. The Plan updated its monitoring tracking log to monitor the reporting timeframe requirement.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
36	Fraud, Waste, and Abuse (FWA)	6.3.2 The Plan did not conduct prompt and complete investigations of all suspected fraud and abuse incidents.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to investigate all suspected incidents and update DHCS until the case closure. Standardized investigation form for documentation was implemented as of 7/17/2018. Staff training on updated procedures was conducted on 7/17/2018.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
37	State Supportive Services	SSS.1 The Plan denied state supported services (SSS) claims containing procedures that normally require prior authorization outside of a SSS setting. These claims were denied based on edits in the Plan's claims system and review by claims analysts; the Plan's process did not include exceptions for FP or ER services.	The Plan updated its system configuration to ensure SSS claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
38	State Supportive Services	SSS.2 The Plan did not disclose the specific rationale used in determining why claims are rejected.	The Plan's Remittance Advice (RA) includes the specific rationale for claims denials. Denial codes can be applied at the Header level, line level or both. The Plan's claims processing system edits each claims and assigns all denial or informational codes that are applicable to the claim. <u>Update as of 1/31/2019:</u> The Plan will provide training to providers to ensure comprehension concerning the remittance advice set-up. <u>Update as of 3/6/19:</u> The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by 5/31/2019. <u>Update 4/8/2019:</u> The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
1	Prior Authorizations	Authorizations were auto-approved for hospital.	Effective 9/17/2018, the Plan started to review and impose standard UM authorization guidelines for hospital authorizations.	9/17/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
2	Appeal	The Plan's expedited appeals checklist does not include a reminder to call the member when the case is de-escalated from urgent to routine.	The expedited appeals checklist has been updated. Staff training will be conducted by 10/1/2018. Checklist includes requirements of De-expedited: Decision to de-expedite must be made within 24 hours. Send ack letter within 3 calendar days notifying of priority change and right to contact DMHC. Follow standard appeal process. If 24 hour TAT is not met, proceed with expedited appeal.	10/1/2018	Completed	Grievance & Appeals	✓	Self Identified	AAH	2018	Completed
3	Delegation Oversight	Some authorization cases included many errors with subcontractor's notices of actions. Plan oversight of authorizations and notices is in process.	Reestablished bi weekly meetings with subcontractors and conducted monthly focused file audit which included NOAs, conducted clinical case rounds for overturned appeals. The plan will continue to monitor during annual audit review process. The Plan will be terminating services subcontractor and consuming this function to review authorization effective 4/1/2019.	12/1/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
4	Care Coordination	The Plan did not annually review the County MOU for CCS services.	<u>Update 9/27/2019:</u> MOUs have transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including CCS. <u>Update as of 12/2/2019:</u> The MOUs have been transitioned to the Provider Services team. The MOU was executed with an effective date of 8/1/2019	8/1/2019	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
5	Care Coordination	The Plan did not annually review the County MOU for Early intervention/development disabilities.	<u>Update 9/27/2019:</u> MOUs have been transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including EI/DD services. <u>Update as of 12/2/2019:</u> The Plan is currently working on developing a full county MOU to include services for early intervention and development disabilities services <u>Update 7/10/2020:</u> The MOU was sent to the County for review on 6/16/2020. <u>Update 10/9/2020:</u> The County has accepted the Alliance's edits and the MOU is currently under review for final approval with the County. <u>Update 11/10/2020:</u> The County has cancelled the November 3rd meeting. This agenda item will be carried over to the December 15th docket. <u>Update 5/14/2021:</u> The MOU was approved by the county board on 4/6/2021.	2/28/20-TBD	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
6	Initial Health Assessment (IHA)	The Plan did not have a process for validating the procedure codes used for IHA completion.	P&P will be updated to include the detail of the process for annual validation and codes. The validated for this year will occur prior to 11/1/2018. <u>Update 11/6/2018:</u> Codes were validated and updated by QM department.	11/1/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
7	Initial Health Assessment (IHA)	The Plan does not have a system in place for monitoring member's missed appointments.	Missed appointments are identified during the Medical Record Review that is part of a FSR. The criteria for missed primary care appointments and outreach efforts, which is part of DHCS's tool. The FSR review nurse evaluates this information and if a deficiency is identified the provider is educated on the importance of outreaching to the member and that documentation of the outreach attempts is required.	11/26/2019	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
8	Access & Availability	The Plan did not monitor appointment wait times.	Policy and procedure is in place for monitoring appointment wait time standards. Standardized process for monitoring and corrective action plan in place as of 9/20/2018.	9/20/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
9	Grievances	Some exempt grievance cases were not resolved within the next business day timeframe (applied to 1-3 cases).	Policies and procedures in place are compliant with the exempt grievance resolution timeframe requirements. Staff training refresher of resolving all exempt grievances by close of next business day was conducted on 10/12/2018.	10/12/2018	Completed	Member Services	✓	Self Identified	AAH	2018	Completed
10	Quality Improvement	Reporting of the HCQC was not consistently reported to the Board.	The Chief Medical Officer will provide HCQC summary updates to the Board starting in November. The meeting minutes will be included in the Board materials.	11/9/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed

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11	Utilization Management	The Plan did not routinely review overturned UM denials for trends & to develop plans for intervention where needed.	The Plan will pull reporting of UM denial trends that will be presented at the UM committee. The first UM committee for presenting the overturn UM denial trends at UM committee will be on 9/28/2018. These findings will be presented to the HCQC and subsequently to the Board of Governors.	9/28/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
12	Utilization Management	The Plan did not have a clear process for peer-to-peer clinician discussions concerning denied services.	Steps Plan took or will take to correct deficiency: 1.Plan develop a desktop procedure on peer to peer discussion by 9/14/2018. 2. Plan to train physicians and pharmacists of desktop procedure and when and how to document peer-to-peer clinician discussions by 9/26/2018. 3.Plan has started a weekly meeting with physicians and pharmacist for peer to peer discussions as of 7/17/2018.	9/26/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed

DASHBOARD KEY

Internal CAP Status Performance Measures

Indicator	Criteria
Green	CAP responses have been completed and fully address the findings

Notes

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



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

Health Care Services

Donna Carey, MD

To: Alameda Alliance for Health Board of Governors
From: Dr. Donna White Carey, Chief Medical Officer
Date: April 10th, 2026
Subject: Health Care Services (HCS) Report

Standing Committee Reports

1) Credentialing Committee

- At the Peer Review and Credentialing (PRCC) meetings held on February 17, 2026, there were one hundred and thirty-six (136) initial network providers approved; nine (9) primary care providers, eleven (11) specialists, seventeen (17) ancillary providers, twenty-four (24) midlevel providers, and seventy-five (75) behavioral health providers.
- Additionally, one hundred and forth-six (146) providers were re-credentialed at this meeting; eleven (11) primary care providers, twenty-six (26) specialists, zero (0) ancillary providers, four (4) midlevel providers, and one hundred and five (105) behavioral health providers.

2) Quality Improvement Health Equity Committee (QIHEC) activities

Background: The Alliance is contractually required to maintain a Quality and Health Equity (QIHE) Program to monitor, evaluate, and improve upon the Health Equity and health care delivered to all members. The Board is accountable for the QIHE Program and delegated the Quality Improvement Health Equity Committee (QIHEC) the authority to oversee the performance activities of the program.

Summary: The following are QIHEC activities of findings, actions, and recommendations from the February 13, 2026 meeting:

- **Update from the Chief Health Equity Officer:** An update was provided on the Health Equity Roadmap, focusing on milestones for social determinants of health and community engagement, resource allocation, and collaboration with quality and DSNP teams.
- **Policies & Procedures:** a total of 32 Policies were reviewed.
 - Quality improvement (QI): 3 Policies
 - Case & Disease Management (CMDM): 14 Policies
 - Utilization Management (UM): 15 Policies

- **Approved Voting Items:** Meeting Minutes
- **D-SNP Overview:**
 - **Launch and Enrollment:** The D-SNP product went live on January 1, 2026 with 165 effectuated members and 5,000+ applications pending review, reflecting strong early demand. Launch issues were minor and did not require state or CMS reporting.
 - **Open Enrollment and Retention:** The first three months remain a high-risk period for member switching. A post-deployment command center is active through March to monitor issues, support member experience, and stabilize operations.
 - **Provider Engagement:** A pilot with CHCN and Bay Well is underway to strengthen provider readiness. 630+ providers have completed Model of Care training, and workflow mapping is helping identify operational improvements.
 - **Strategic Planning:** An RFQ for a marketing and sales vendor is in development, with vendor selection targeted for July–August. Planning for future growth continues, including collaboration with Milliman on the 2027 bid.

Recommendations:

- **Accelerate application processing** to reduce the pending backlog and support timely onboarding.
- **Prioritize member experience** during open enrollment through proactive outreach and rapid issue resolution.
- **Expand provider engagement** by scaling pilot learnings and continuing MOC training cycles.
- **Advance strategic vendor selection** and align 2027 bid planning with early utilization and operational insights.

5. UM Workplan Update:

- **Paid Days & Length of Stay:** Both metrics decreased year over year, indicating improved discharge planning and more efficient care transitions.
- **Admissions & Readmissions:** Admissions per 1,000 declined slightly, but readmissions increased and remain above the 18% goal, with the highest rates in SPD-LTC populations and certain delegates.
- **Inpatient Nurse Pilot:** On-site nurse presence at Washington Hospital is supporting real-time care coordination, with early signs of improved discharge timeliness and reduced avoidable admissions.
- **Denial Rates:** Slight increases in inpatient and outpatient denials, largely driven by stricter radiology criteria. Most inpatient stays continued to meet medical necessity.

Recommendations

- **Reduce Readmissions:** Focus interventions on SPD-LTC members, strengthen post-discharge follow-up, and address performance gaps with high-readmission delegates.
- **Enhance Care Transitions:** Continue refining discharge workflows and partner with post-acute providers to maintain momentum in reducing length of stay.
- **Assess Nurse Pilot Impact:** Review pilot metrics to determine effectiveness and consider expansion to other high-volume hospitals if results remain positive.

Monitor Denial Trends: Reassess radiology criteria, provide provider education, and track patterns to ensure denials align with evidence-based standards.

6. Quality Programs

- **Pay-for-Performance:** 2024 payouts totaled \$4M (65% of pool) with broad HEDIS improvement. For 2026, topical fluoride was added and two low-performing measures were removed.
- **MCAS/HEDIS:** The state expanded the 2026 accountable set to 20 measures, adding colorectal cancer and depression screening requirements.
- **Medicare Stars:** Provider education is expanding through webinars, a new webpage, and a guide. D-SNP gaps-in-care reporting will begin, and a flex-card incentive program was launched to drive preventive care.
- **Performance Monitoring:** Ratings rely on national cut points, and all D-SNP members count toward overall Stars. Early education and cross-department collaboration remain priorities.

Recommendations

- Focus provider outreach on new 2026 measures and reinforce documentation workflows.
- Strengthen data quality and monitoring to support MCAS, HEDIS, and Stars performance.
- Use D-SNP gap reporting and the flex-card incentive to target high-impact care gaps.
- Maintain coordinated, cross-functional quality efforts with earlier annual education cycles.

7. Initial Health Appointment

- **IHA Completion:** Completion within 120 days remained stable, with CFMG leading performance. Delegated groups are adopting automation and enhanced outreach to improve rates.

- **Chart Reviews:** Among 31 records, compliance was strong for children and adults, but lower for adolescents. Gaps were noted in risk assessments and use of validated screening tools for alcohol, drug, and depression screening.
- **Provider Education:** Continued education will focus on risk assessments and screening tools. Audit findings will be shared, the provider guide will be updated, and collaboration with EMR vendors will support workflow improvements.
- **Fluoride Varnish Innovation:** Integrating registered hygienists into well-child visits and exploring tele-dentistry were proposed to improve fluoride varnish rates and early dental home establishment.

Recommendations

- Reinforce provider training on risk assessments, validated screening tools, and adolescent IHA requirements.
- Expand automation and outreach strategies to improve IHA completion consistency across networks.
- Use audit findings to guide targeted coaching and documentation improvements.
- Advance EMR integration to streamline screening workflows.
- Pilot innovative fluoride varnish approaches, including hygienist involvement and tele-dentistry models.

8. PQI Update

- **PQI Volume and Coordination:** PQI case closure increased in Q3 2025 due to the addition of a QI Medical Director, which supported more timely case closures. In addition, there was a process improvement with stronger coordination with the Grievance team that streamline referred cases.
- **Issue Types:** Most PQIs involved quality of access and quality of service concerns.
- **Turnaround Times:** PQI processing has consistently met the 150-day requirement since November.
- **Case Classification:** Most cases were C0 (no quality-of-care issue), with fewer C2 and C3 cases; C4 cases remained minimal.
- **Process Improvements:** September workflow changes reduced duplicate referrals and shifted to tracking and trending to address system-level issues.
- **Training:** State-required PQI training was completed for Member Services, with additional department trainings planned.
- **Corrective Action Plans:** CAPs were primarily associated with C3 cases, and ModivCare continues to be monitored for recurring transportation-related service issues.

Recommendations

- Maintain strong coordination with the Grievance team and QI Medical Director to sustain timely case closures.
- Continue monitoring trends in access and service-related PQIs to identify systemic improvement opportunities.
- Reinforce workflow improvements to prevent duplicate referrals and strengthen tracking consistency.
- Expand PQI training to remaining departments to ensure consistent understanding of requirements.
- Prioritize corrective action oversight for C3 cases and continue focused monitoring of ModivCare to address recurring transportation concerns.

9. CAC Activities & Findings

- Members raised concerns about coverage continuity for undocumented and medically complex individuals, noting that policy and funding changes are affecting access to care and community resources.
- The committee emphasized the need for clear, culturally appropriate communication, stronger engagement from community health workers, and motivational messaging to support preventive screenings.
- Ongoing health inequities and uneven member experiences were highlighted, including communication gaps, survey fatigue, and the need for deeper community partnerships to build trust and address systemic barriers.
- Significant service availability challenges persist, with delays in accessing community-based adult services and, in some cases, the need to travel out of state for care.

Recommendations

- Strengthen strategies to maintain coverage continuity and monitor the impact of policy changes on vulnerable populations.
- Improve outreach and communication through culturally tailored materials, multilingual messaging, and expanded community health worker involvement.
- Advance health equity efforts by reducing survey burden, improving feedback loops, and investing in long-term partnerships with trusted community organizations.
- Address service access gaps by assessing capacity, coordinating across partners, and developing actionable solutions to improve timely access to community-based adult services.

3) P&T Committee – P&T Committee met on 3/17/26

- Reviewed and approved 6 drug classes/monograms
- Reviewed & approved medication class guidelines for 28 classes of drugs – no changes
- Reviewed & approved guidelines for 8 physician administered drugs
- Approved annual review of Pharmacy P&Ps

HCS Depts

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 3,641 authorizations for the month of March. We also processed 386 CCS referrals, of which 114 cases were submitted to our regional CCS office for review. CBAS 5 CEDT, 5 Discharges, 2 ERS, 54 renewals.
- Overall OP Turnaround times exceeded the threshold of 95% for the month of March 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 16 authorizations causing the score to be below the 95% threshold.
- The top 5 categories remain unchanged Radiology, OP Rehab, TQ, Home Health and Outpatient facility. Radiology and Rehab represent >80% 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.
- DSNP staff training has completed as of December, and the leadership team continues to check in with staff for any new questions and concerns. There were 16 Outpatient D-SNP Authorizations created in February and another 16 in March 2026.

Total Outpatient Authorization Volume			
Authorization Status	January 2026	February 2026	March 2026
Approvals	3,429	4,306	3,210
Partial Approvals	0	0	0
Denials	299	56	430
Total	3,728	3,728	3,641

Source: #02569_AuthTAT_Summary

Outpatient Authorization Denial Rates			
Denial Rate Type	December 2025	January 2026	February 2026*
Denial Rate Excluding Partial Denials	3.7%	3.6%	4.4%
Partial Denial Rate	0.2%	0.5%	0.2%
Overall Denial Rate	3.9%	4.1%	4.6%

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

Outpatient Turn Around Time Compliance (benchmark: 95%)			
Line of Business	January 2026	February 2026	March 2026
Overall	99.5%	99.7%	97.1%
Medi-Cal	98.6%	99.3%	98.2%
IHSS	100%	100%	99.3%
D-SNP	99.9%	100%	93.8%

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) increased from 3,159 in February to 3,765 in March.
- Inpatient overall average LOS decreased from 5.5 in January to 5.0 in February. Admits per thousand decreased from 54.7 in January to 48.5 in February. Days per thousand also decreased from 303.2 in January to 241.7 in February. By aid category: the child aid category increased slightly, while the adult ACA and Adult categories saw slight decreases, while the SPD-LTC category decreased significantly.
- IP overall denial rate decreased very slightly from 3.0% in February to 2.9% in March.
- IP Auth TAT compliance surpassed 95% benchmark across all lines of business in March.
- IP UM has 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 19 D-SNP Authorization lines reviewed by the Inpatient Team in March.
- 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 is in its 3rd month at Washington Hospital. 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	January 2026	February 2026	March 2026
Approvals	3685	3142	3,732
Partial Approvals	0	0	0
Denials	75	17	15
Total	3,760	3,159	3,765

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	December 2025	January 2026	February 2026*
Authorized LOS	5.3	5.5	5.0
Admits/1,000	50.6	54.7	48.5
Days/1,000	268.3	303.2	241.7

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

Inpatient Authorization Denial Rates			
Denial Rate Type	January 2025	February 2026	March 2026
Full Denials Rate	1.7%	1.3%	1.2%
Partial Denials	2.7%	1.7%	1.7%
All Types of Denials	4.4%	3.0%	2.9%

Source: #01292_AllAuthDenialsRate

Inpatient Turn Around Time Compliance (benchmark: 95%)			
Line of Business	January 2026	February 2026	March 2026
Overall	98%	99%	99%
Medi-Cal	98%	99%	99%
IHSS	95%	100%	100%
D-SNP	100%	100%	100%

Utilization Management: Long-Term Care

- LTC census during March 2026 was 2,234 members. This is an increase of 1.55% (34 members) from January 2026.
- Month to Month, the admissions and length of stays seem to decrease from December 2025-February 2026 of 59%. Some of this could be due to a lag in claims data being available

Totals	December 2025	January 2026	February 2026
Admissions	181	145	55
Days	1,102	834	286
Readmissions	35	25	12

**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.
- Dedicated RN continue to assist with TCS for members coming back from an acute stay or transitioning from acute into long-term care. The Health Navigator position was filled on 03/29/26.
- The LTC Manager position is vacant effective 03/29/26.
- Authorization processing turn-around time (TAT) has remained at 99%, which is exceeding the threshold of 95%.

Total LTC Authorization Volume			
Authorization Status	January 2026	February 2026	March 2026
Approvals	731	865	987
Partial Approvals	0	0	0
Denials	54	57	54
Total	785	922	1041

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	January 2026	February 2026	March 2026
Medi-Cal	99%	99%	99%

Source: #02569_AuthTAT_Summary

Behavioral Health

- In March, the Behavioral Health Department processed 732 authorizations, 538 Care Coordination referrals, and 231 mental health screenings and transition of care tools.

BH Authorization Volume			
	26-Jan	26-Feb	26-Mar
Approvals	668	659	702
Partial Approval	0	0	0
Denials	14	7	30
Total	682	666	732

Source: 14939_BH_AuthTAT

MH TAT			
*Goal ≥95%	26-Jan	26-Feb	26-Mar
Determination TAT%	97%	98%	94%
Notification TAT%	93%	97%	92%

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
*Goal ≥95%	26-Jan	26-Feb	26-Mar
Determination TAT%	99%	100%	99%
Notification TAT%	98%	98%	99%

Behavioral Health Denial Rates

*Goal ≤ 5%	BH Denial Rates

26-Jan	26-Feb	26-Mar
<1%	<1%	<1%

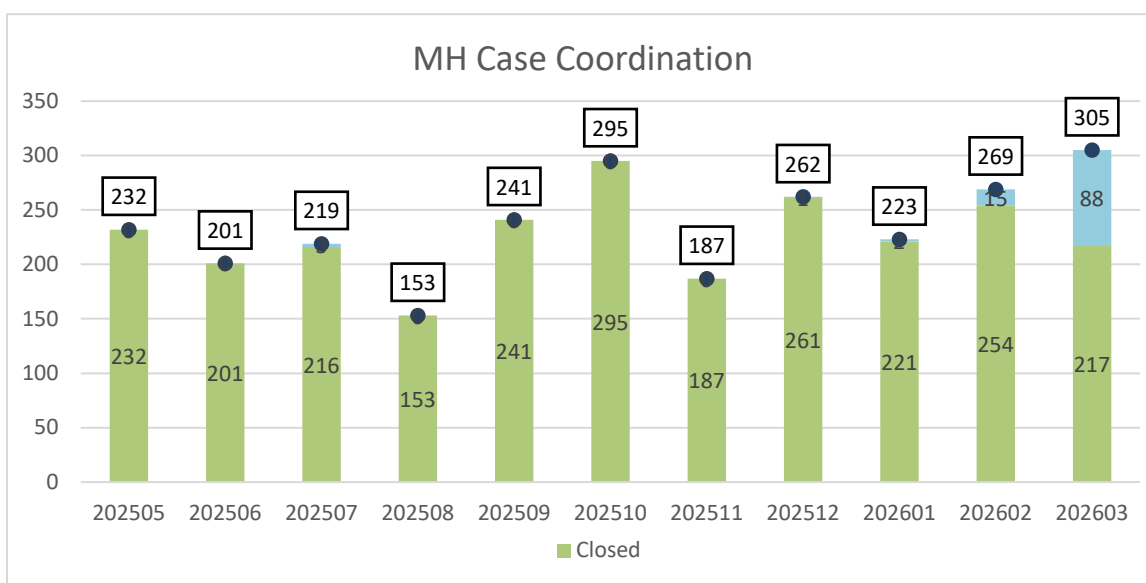
Mental Health Care Coordination

- 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-Jan	26-Feb	26-Mar
Youth Screenings	32	52	70
Adult Screenings	108	111	160
Incoming ACBH Referrals	109	98	102
Outgoing Referrals to ACBH	30	43	47
Transition of Care Tools to ACBH	2	0	1

Source: 16015_MH_Assessments, 16093_BH Referral Report

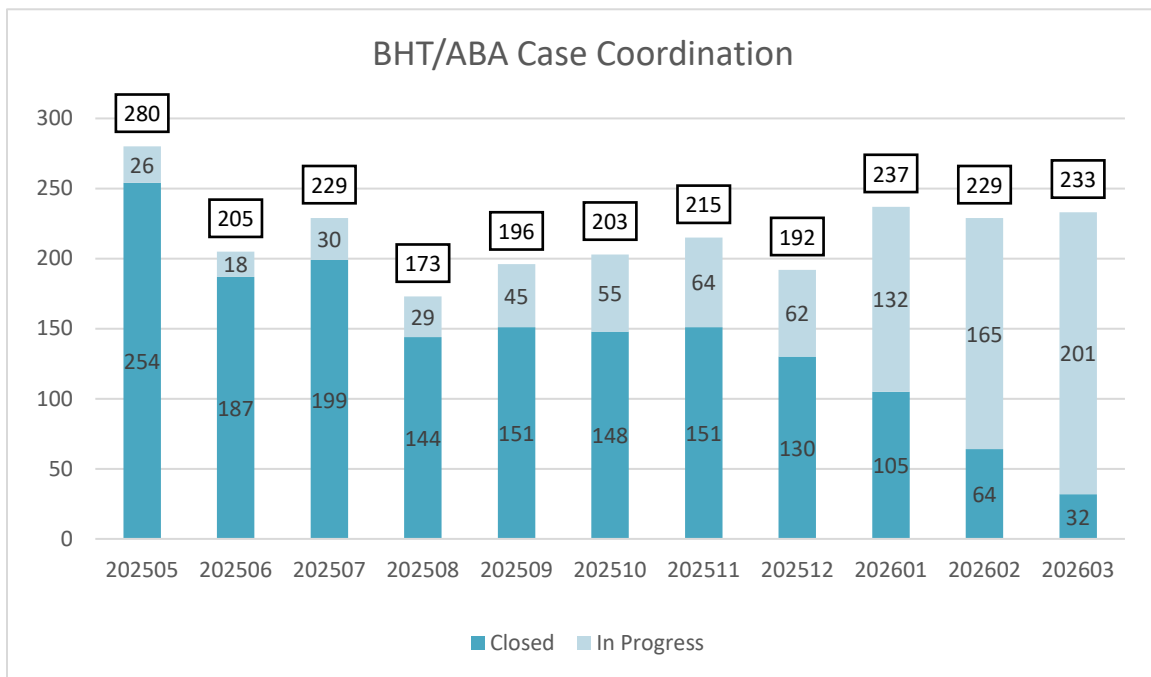
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



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.



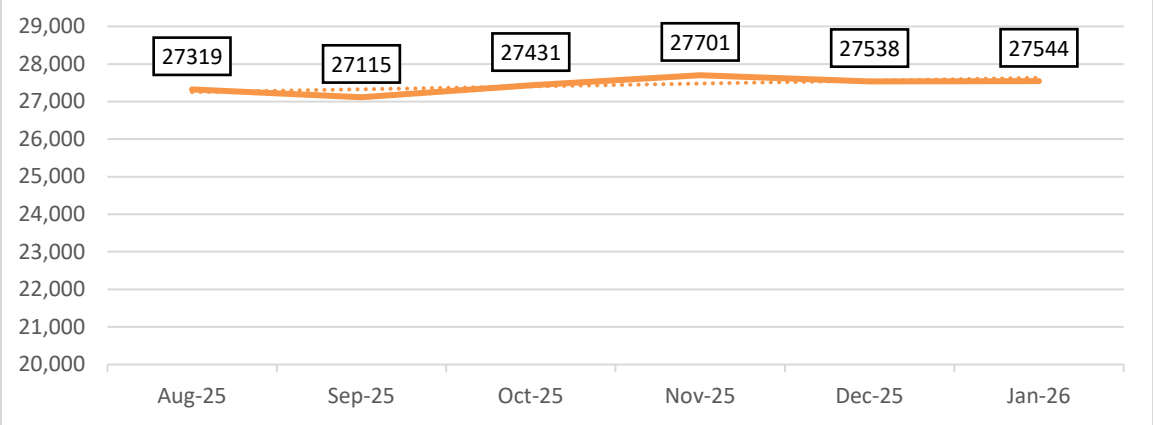
Source: 14665_BH_Cases

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.

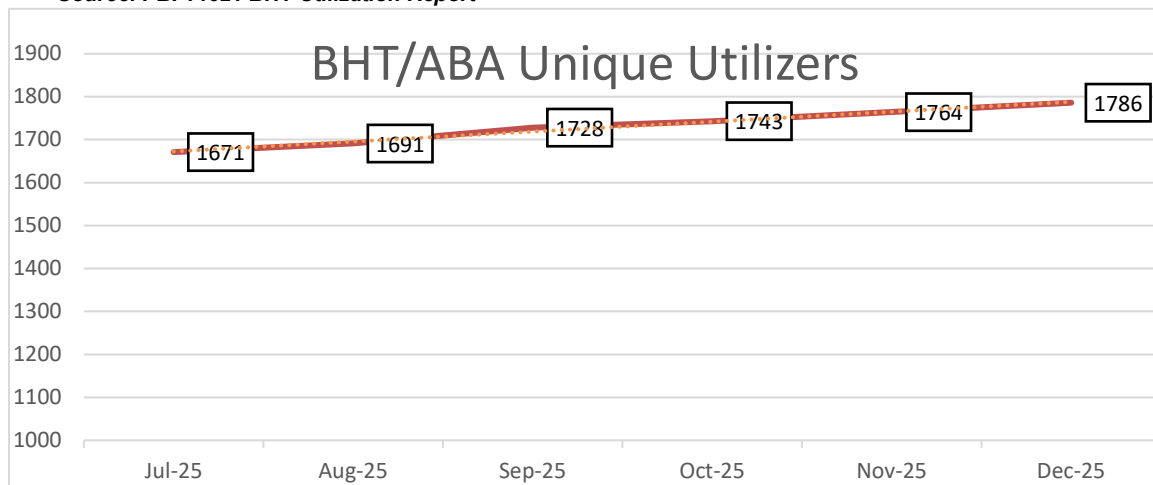
Mental Health Unique Utilizers

MH Unique Utilizers



BHT/ABA Unique Utilizers

Source: PBI 14621 BHT Utilization Report



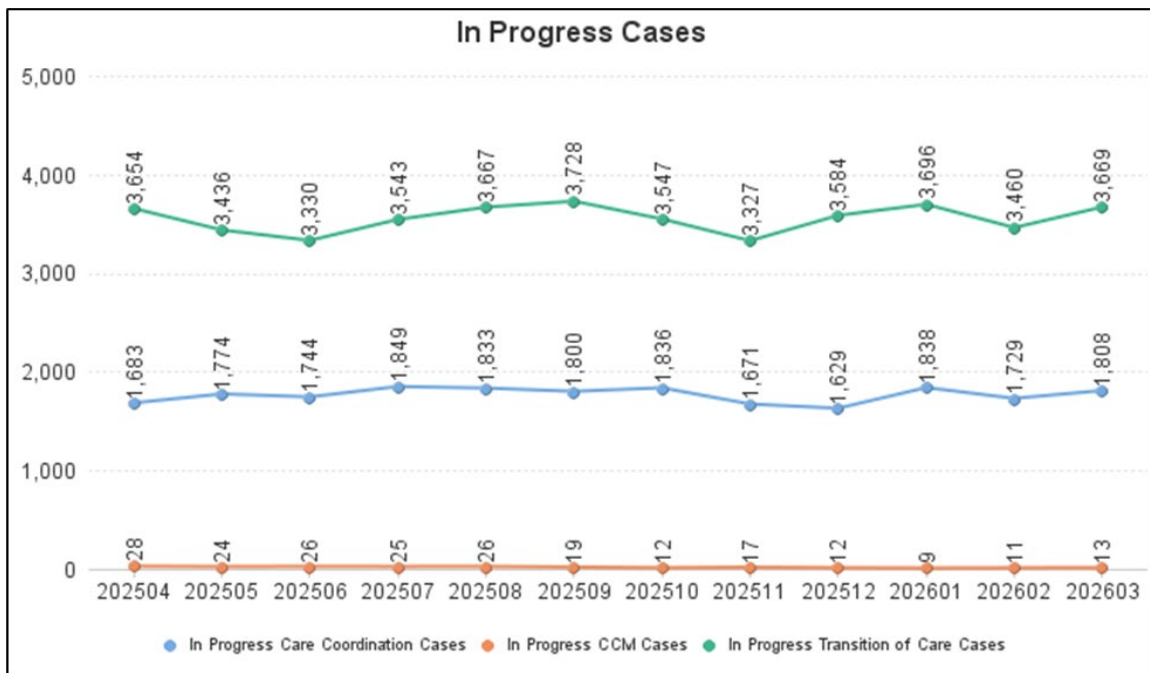
Pharmacy

The Pharmacy Transitional Care Services (TCS) program has screened 21 **Heart Failure** cases, 33 **Sepsis** cases, and received 0 **direct referrals** for the month of March 2026.

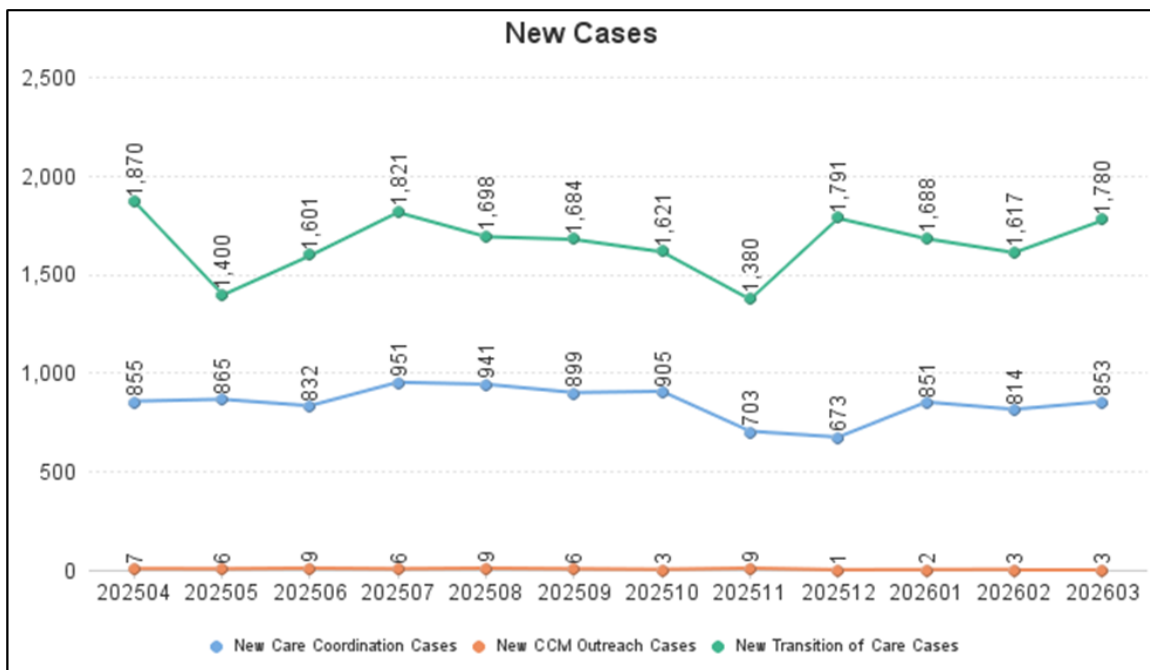
Case and Disease Management

- 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 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.

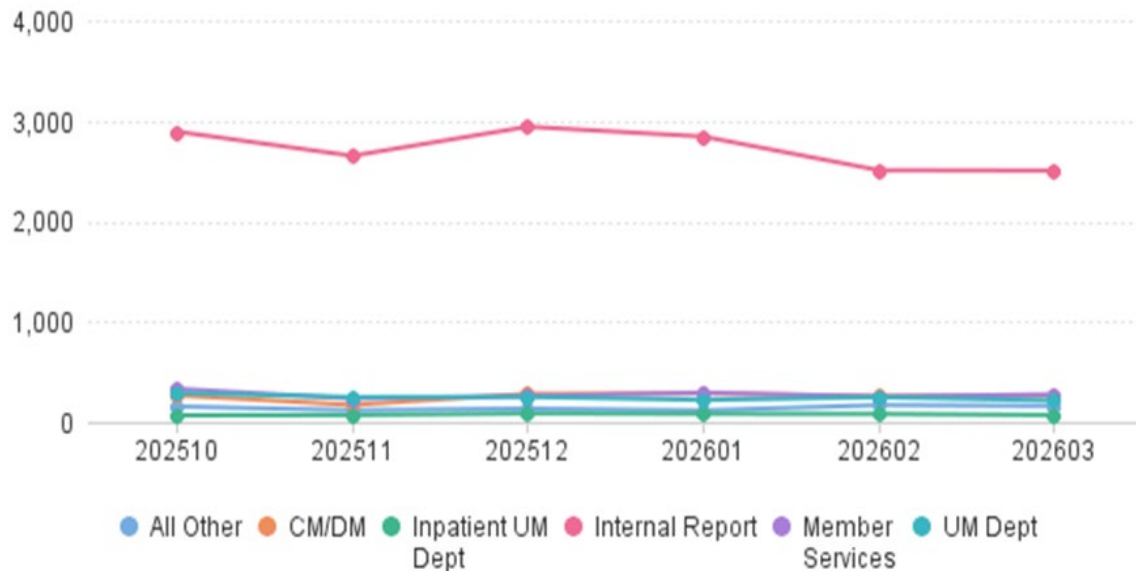


Source: #03342 TruCare Caseload



Source: #03342 TruCare Caseload

Top Referral Sources into CM

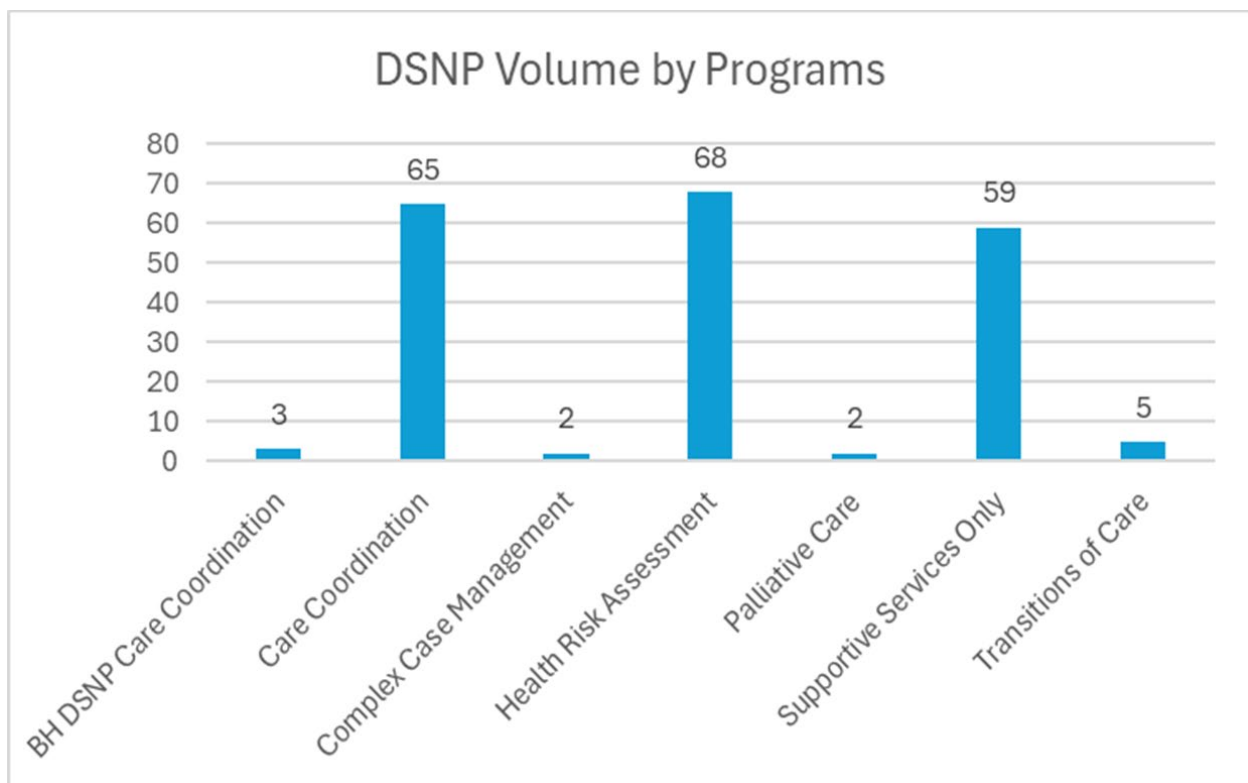


*Internal Report represents Transitional Care Services (TCS) data for recently admitted patients via Admissions Discharges Transfers (ADT) feed from hospital / skilled nursing facility partners

Source: #03881 Case and Disease Management Dashboard - *data available through March 2026

DSNP CM Volume by Program Type

- All programs linked to single DSNP Case
- 65 Members in Care Coordination Program - Engaged members, custom care plan
- 68 Members in Health Risk Assessment Program – Still being outreached to complete HRA
- 59 Supportive Services Only – Unengaged members receiving generic care plan
- 3 BH DSNP (supplemental program) – Member engaged with both Physical Health and Behavioral Health CM teams
- 2 Complex Case Management – Member with Complex CM needs, higher level of CM
- 2 Palliative Care (supplemental program) - Member enrolled in palliative care
- 2 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 preparing for the Spring Audit of the ECM providers. This includes re-evaluating the ECM audit tools for further enhancements (including DHCS Requirements) and encouraging best practices amongst the ECM provider network.
- The ECM team is finalizing the ECM Training Academy to remind the ECM provider network of processes, additional educational trainings and improved workflows. The trainings will begin in April and occur monthly throughout the year. Topics will include ECM referrals and documentation for reauthorizations, Dementia Care Aware are more.

	December 2025		January 2026		February 2026	
ECM Providers	Outreach	Enrolled	Outreach	Enrolled	Outreach	Enrolled
ACBH	-	13	-	13	-	13
Alameda Health System (AHS)	-	224	24	221	11	223
Bay Area Community Services (BACS)	9	166	19	185	39	202
California Cardiovascular Consultants	-	146	-	145	-	145

California Children's Services (CCS)	2	53	5	55	6	53
CHCN	106	1,207	97	1,254	57	1304
East Bay Innovations (EBI)	15	154	11	159	21	160
Full Circle	-	155	-	145	-	141
Institute on Aging	197	254	177	261	141	263
La Familia	58	33	51	37	17	33
MedZed	34	1,135	203	1184	7	1313
Roots Community Health Center (includes Street Medicine)	-	688	-	681	-	603
Seneca Family Services	-	49	7	48	10	50
Pair Team	1	2,512	2	2,243	-	2115
Titanium Health Care	6	1,623	585	1727	314	1797
Tiburcio Vasquez Health Center (Street Medicine)	-	112	-	113	-	113
BACH (Street Medicine)	-	72	-	76	-	75
Lifelong (Street Medicine)	-	448	-	465	1	412

Source: #13360 ECM Dashboard – data available through February 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.
 - Homestyle Direct- A new MTM provider as of 04/01/26
- 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.

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

Community Supports	Services Authorized in January 2026	Services Authorized in February 2026	Services Authorized in March 2026
Housing Navigation	1,265	1,185	1,089
Housing Deposits	423	393	325
Housing Tenancy	1,715	1,667	1,625
Asthma Remediation	134	128	117
Meals	964	1,063	1,011
Medical Respite	55	56	53
Transition to Home	8	8	8
Nursing Facility	2	2	2
Home Modifications	11	10	9
Homemaker Services	31	19	21
Caregiver Respite	1	1	1
Transitional Rent		8	11
Total	4,297	4,435	4,270

Source: #13581 Community Supports Auth Dashboard – data only available through December 2025

- There has been an increase in the amount of authorization requests by 44% from Jan 2026 to March 2026.

Total CS Authorization Volume			
Authorization Status	January 2026	February 2026	March 2026
Approvals	717	772	10008
Partial Approvals	0	0	0
Denials	67	107	124
Total	784	879	1132

Source: #02569_AuthTAT_Summary

- Authorization processing turn-around time (TAT) has remained at between 98%-99%, which is exceeding the threshold of 95%.

CS Turn Around Time Compliance (benchmark: 95%)			
Line of Business	January 2026	February 2026	March 2026
Medi-Cal	99%	98%	99%

Community Health Strategy (CHS) – March 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

March Program Summary:

March was a transformational month for the Community Health Strategy (CHS) Department, marked by organizational realignment, expanded leadership capacity, and continued advancement of strategic community partnerships to strengthen Community Health Worker (CHW)-led interventions across the Alliance.

A major highlight this month was the formal transition of the CHS Department under the Senior Director of Quality. This organizational restructure strengthens alignment across Community Health Strategy, Quality Improvement, and Population Health, creating greater synergy for CHW-led interventions designed to close care gaps, reduce disparities, and advance measurable equity-centered outcomes. This integrated structure further positions CHS as a core quality improvement engine that translates population health priorities and regulatory requirements into culturally responsive, member-level interventions.

A key area of progress in March was the expansion of community-based partnership development to support targeted CHW interventions aligned with member needs and high-priority quality objectives.

CHS advanced discussions with Roots Community Health Center regarding possible expansion of CHW service offerings, including care coordination support in partnership with East Oakland Community Project and Rise East. This work is intended to deepen Alliance reach within Oakland's priority 40x40 neighborhoods and strengthen community-based pathways for members experiencing access barriers and elevated social risk.

Additional expansion discussions continued with Our Roots Community Birth Support to increase perinatal depression screening capacity and strengthen maternal health support services through CHW-led engagement and culturally responsive perinatal interventions.

CHS also initiated collaboration with Alameda County Community Food Bank to explore expansion of health education services through CHW workforce capacity-building supports, with a focus on integrating food access, health literacy, and community-based prevention strategies.

Further outreach with Rubicon Programs centered on strengthening care coordination and health education support for justice-impacted populations, reinforcing the Alliance's commitment to equitable engagement for members experiencing reentry-related barriers.

Engagement with One Love Organization focused on opportunities for on-the-spot CHW interventions and community-based health education to support chronic disease management, self-management education, and member activation in trusted community settings.

In addition, CHS continued partnership development with Ascension Health, a CHW workforce development organization, to support capacity-building pathways for smaller pediatric and community-based facilities requiring trusted CHW-led health education and intervention support delivered by staff with lived experience and community trust.

March also included exploration discussions with Hello Heart to assess digital innovation opportunities that support members in re-engaging with blood pressure self-management education and chronic disease prevention, with the goal of empowering members to take a more active role in managing their cardiovascular health.

CHS also continued collaboration with the Communications and Outreach team through active participation in community tabling activities during March. These efforts strengthen community visibility amongst the Ethiopian community, supported provider relationship development, and reinforce the department's commitment to community-centered engagement and trusted partnership building. CHS is looking forward to continuing our next phase of bringing Quality into community. Which is an enhancement of recruitment strategies of CHW providers who can support targeted interventions to move the needle on closing care gaps and measuring health equity through targeted CHW-Led interventions.

A significant leadership milestone this month was the successful onboarding of the Manager of Community Health Initiatives, which has substantially expanded departmental leadership capacity and strengthened the CHS operating model. With provider coordination, CHW certification meetings, and implementation workflows now supported through dedicated management leadership, the department is positioned to advance more sophisticated technical work across the 2026-2028 workplan.

This increased capacity now allows for greater leadership focus on technical strategy execution, quality-aligned intervention design, measurable outcome objectives, care gap closure strategies, and enterprise workplan integration.

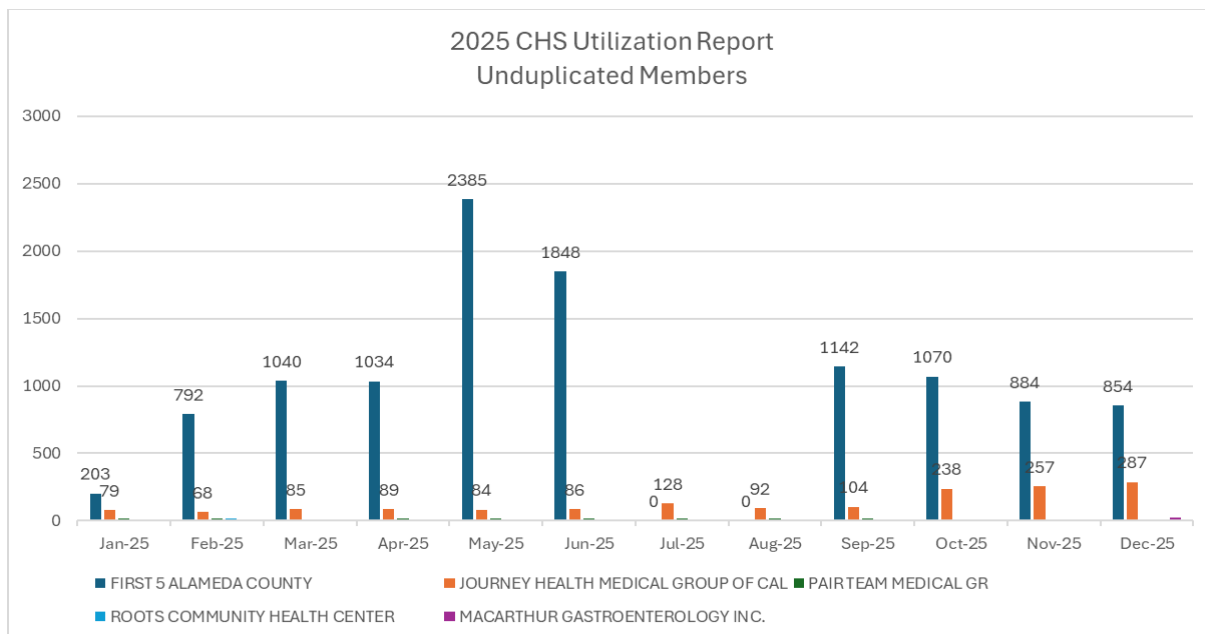
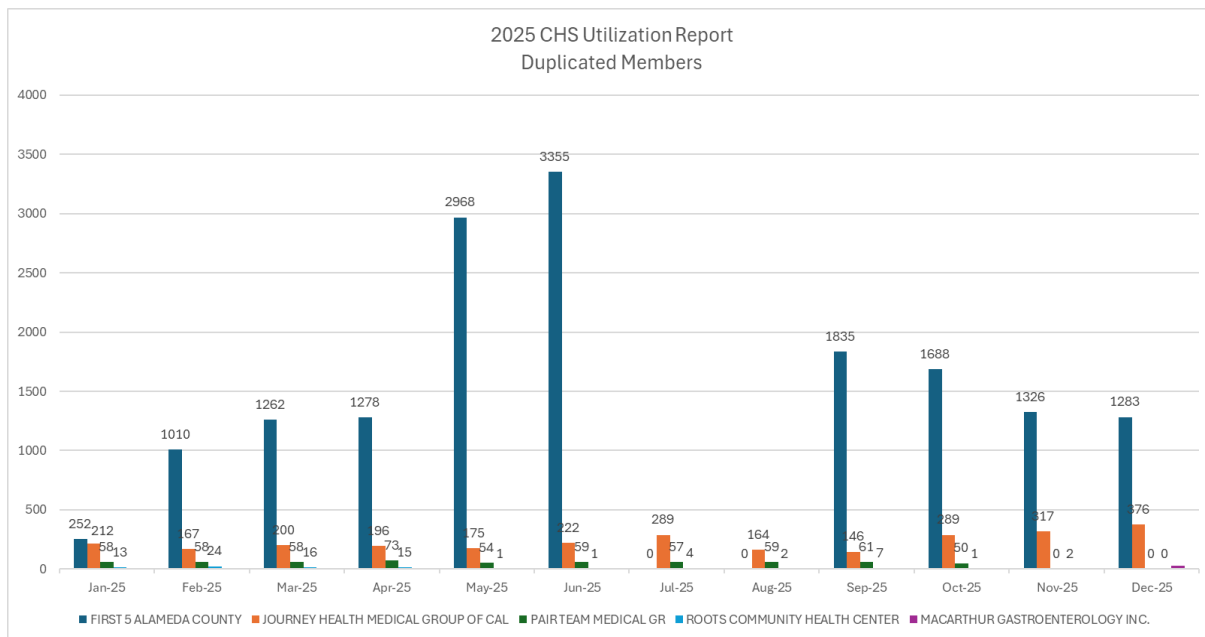
Overall, March was defined by organizational evolution, strengthened leadership capacity, and intentional expansion of community partnerships designed to advance CHW-led quality, population health, and health equity outcomes in 2026.

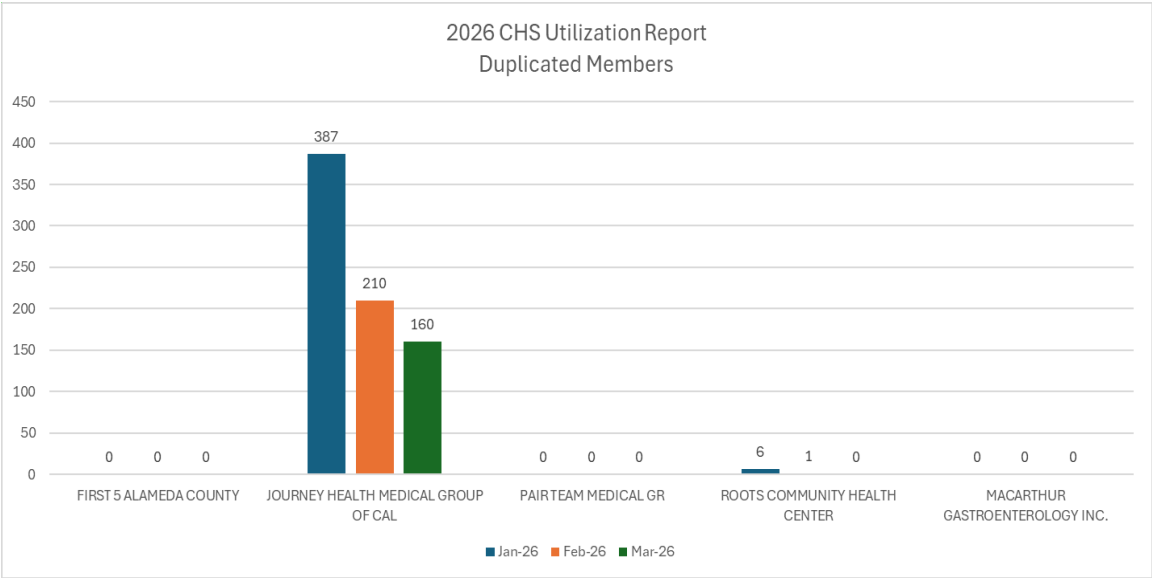
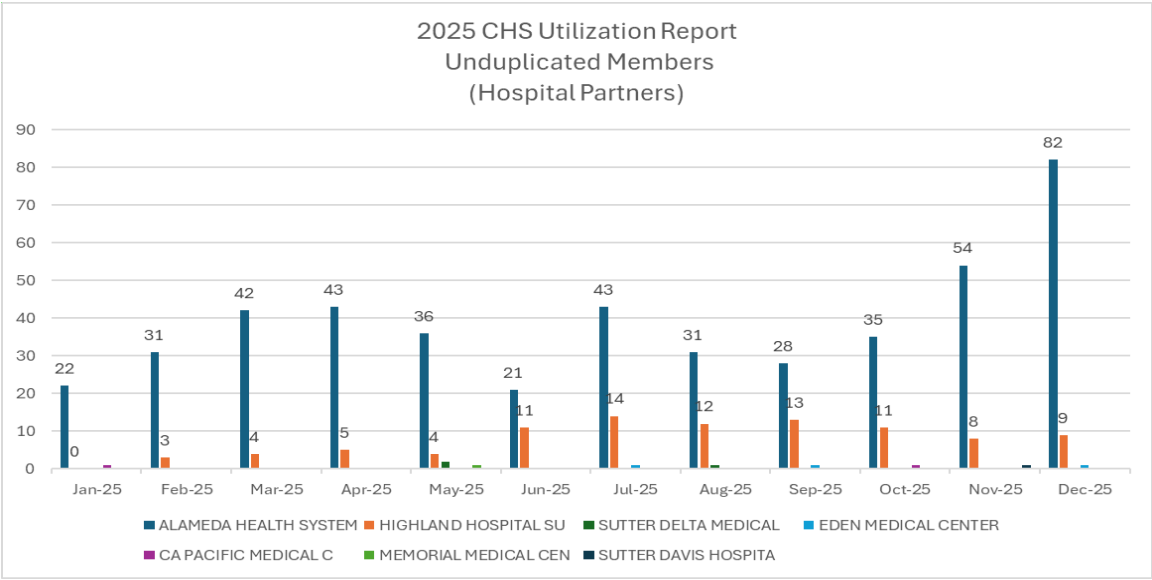
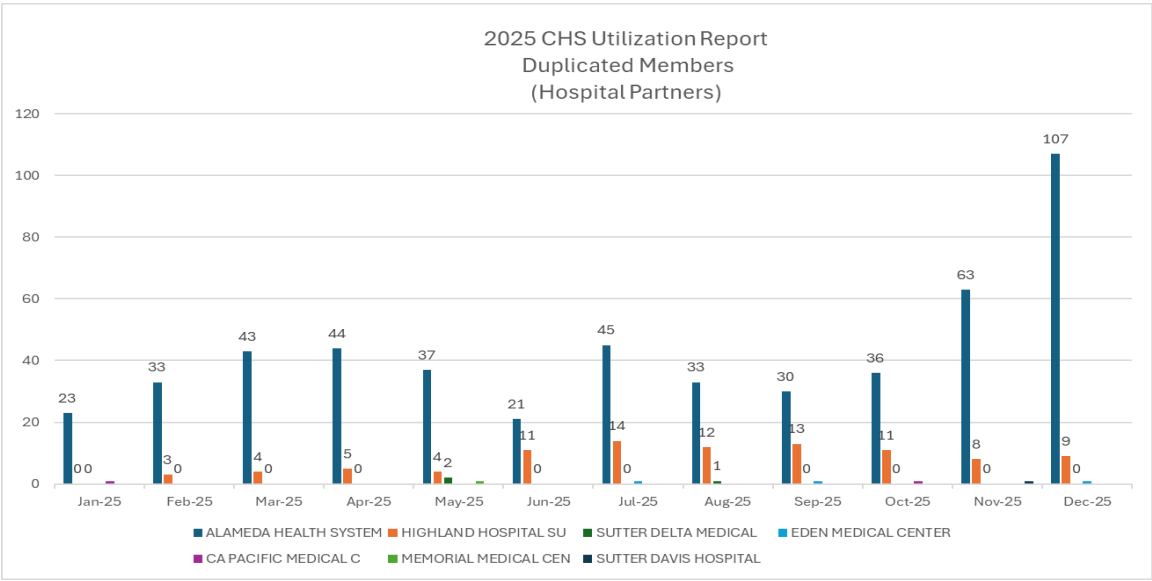
CHS Program – CHW Member Utilization Reports

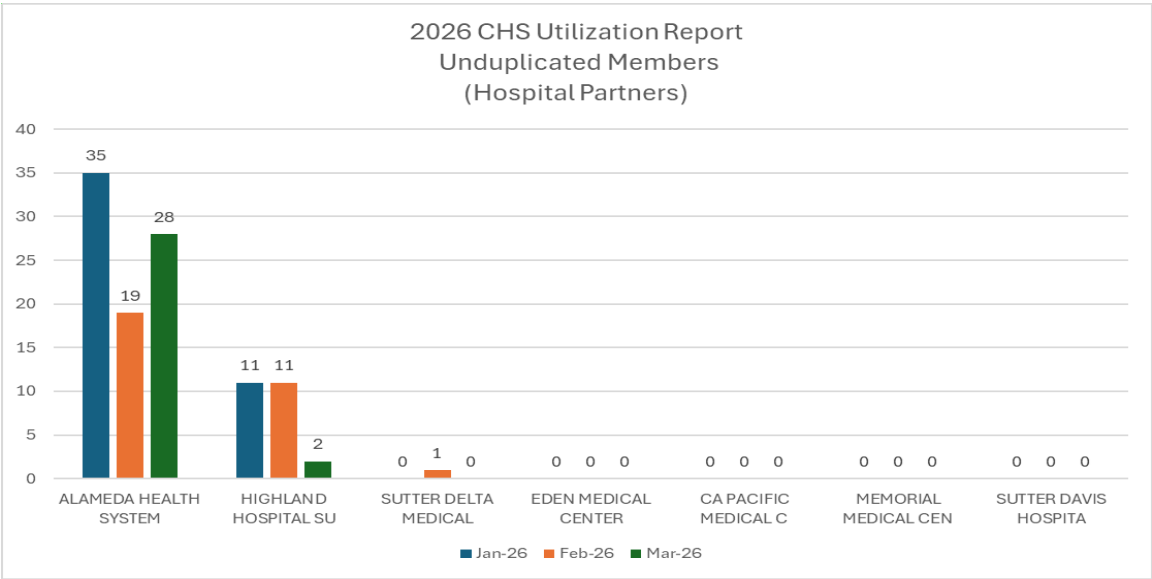
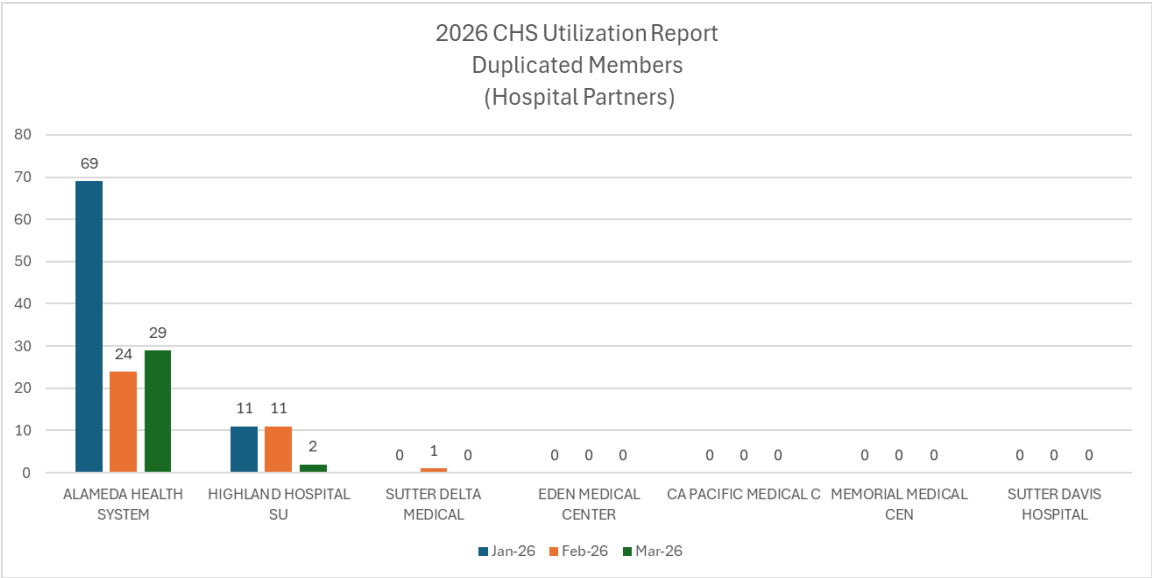
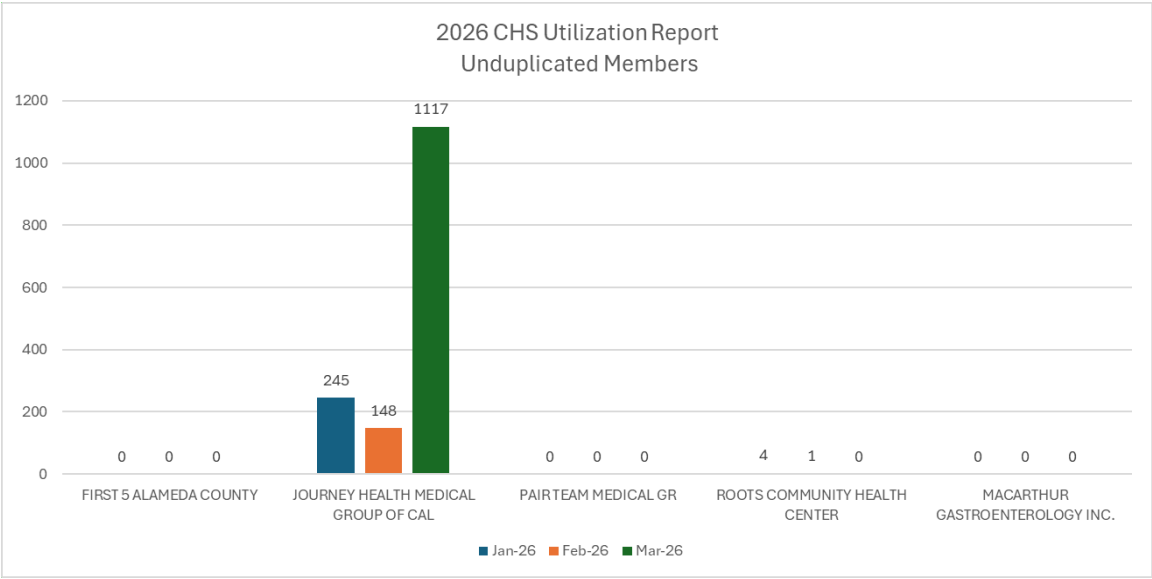
Working Definitions:

- **Duplicated:** Refers to instances where a member received CHW services more than once within the reporting period.
- **Unduplicated:** Represents the count of unique individuals who accessed CHW services, ensuring each member is counted only once, regardless of the number of visits.

- **Hospital Partners:** CHS team has now separated hospital partners into their own graphs to capture Duplicated & Unduplicated trends.







CHW Utilization Reporting Methodology Update

During review of the current Community Health Worker (CHW) utilization reporting process, the Community Health Strategy (CHS) Department identified important limitations associated with claims lag and corrected claim submissions that may affect month-to-month reporting accuracy.

Current utilization reporting has relied on claims COD reports; however, corrected claims may be submitted and reprocessed outside of the original reporting month, and there is not yet a standardized retrospective lookback window that reliably captures when those corrections have fully adjudicated within the reporting system. As a result, monthly utilization totals may temporarily underrepresent actual service activity, particularly during periods of provider billing maturation and claims correction activity.

Given these limitations, CHS is actively partnering with the Claims and Analytics teams to develop an enhanced reporting methodology that more accurately reflects CHW utilization trends over time. This work includes evaluating appropriate claims lookback periods, corrected claims capture logic, and alternative reporting approaches that improve the reliability of utilization tracking.

Until this enhanced methodology is finalized, current utilization figures should be interpreted as preliminary and may represent an underreporting of actual CHW service volume. This effort is intended to strengthen reporting integrity, improve data confidence for leadership decision-making, and support more accurate measurement of CHW program impact as the provider network continues to expand.

CHW Program – Recruitment Efforts:

Alameda Alliance continues to maintain a stable and active Community Health Worker (CHW) provider network while intentionally managing growth through a structured recruitment and readiness pipeline. To strengthen recruitment oversight and pipeline management, CHW developed a Provider Recruitment Tracker within SmartSheet. This tool captures all outreach efforts and tracks providers across recruitment phases, pilot participation, and CHW staffing capacity. As of March, twenty (20) CHW provider organizations are actively contracted and delivering services to members, representing a strong and reliable core delivery network.

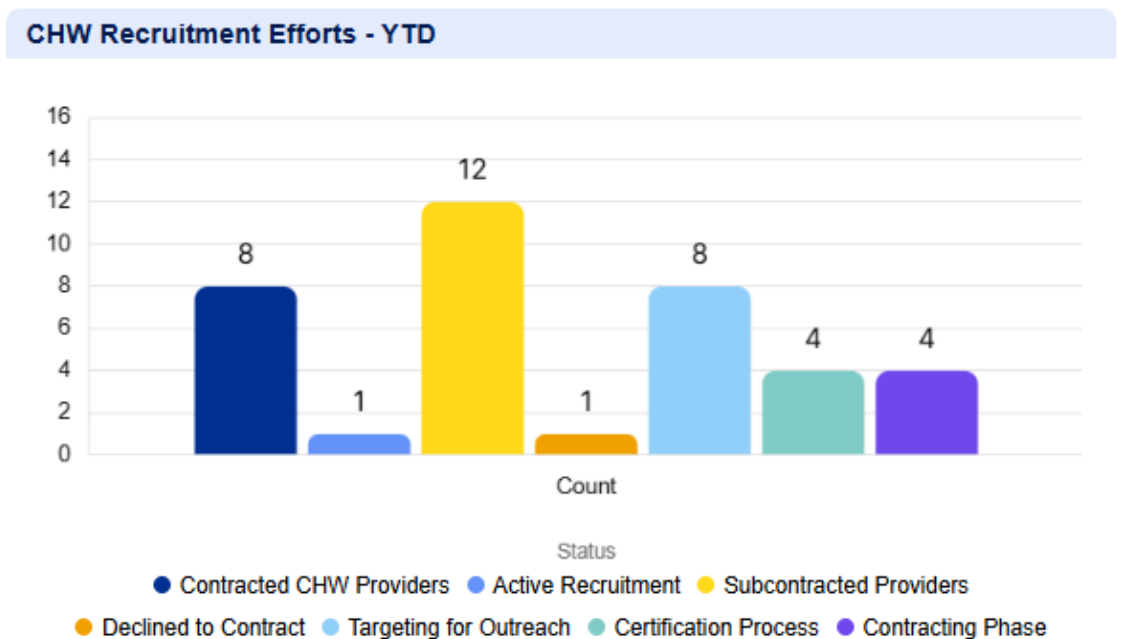
In addition to currently active providers, multiple organizations are engaged across early and mid-stage recruitment milestones, reflecting continued market interest in partnering with Alameda Alliance to advance equitable, community-rooted care. As illustrated in the Recruitment Pipeline Profile (March), organizations are distributed across outreach, active recruitment, certification, and onboarding stages, demonstrating sustained engagement while maintaining appropriate pacing and quality standards.

CHS team will focus on maximizing direct contract recruitment to strengthen programmatic oversight and monitoring of member outcomes.

Recruitment Pipeline Profile

- The recruitment pipeline reflects a balanced and intentional approach to network expansion:
- 8 organizations remain in the outreach phase, where Alliance has initiated early interest-building and informational communication.
- 1 organization is in active recruitment, having received program materials and assessing readiness to pursue certification and contracting.
- 4 organizations are currently engaged in the CHW certification process, actively progressing toward eligibility.
- 0 organizations are in the pre-contracting stage pending Senior Leadership Team (SLT) review and approval.
- 4 organizations have advanced to the contracting and onboarding stage.
- 20 providers are currently contracted and active, representing the core CHW delivery network.
- Year to date, one (1) organization has declined to proceed or been deemed ineligible, reflecting effective prescreening and strong alignment with program standards.

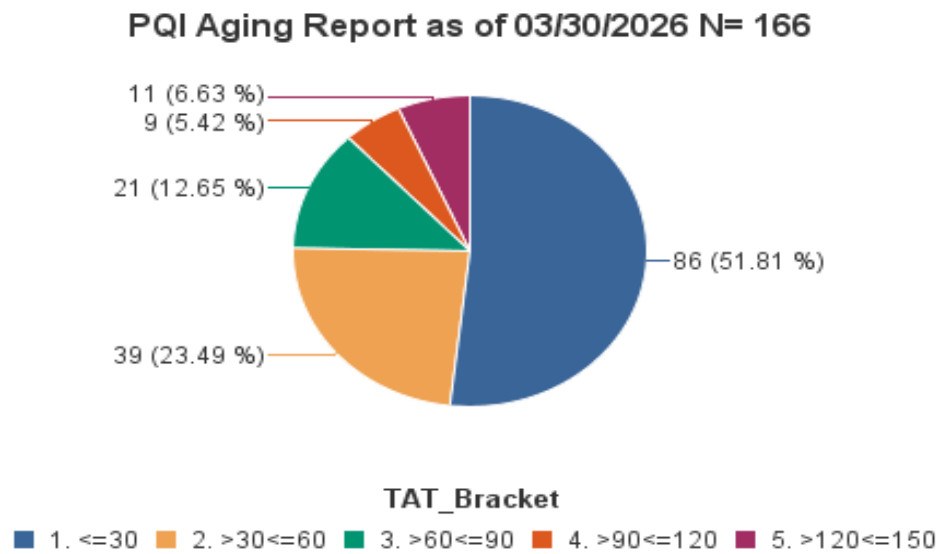
This pipeline structure demonstrates a thoughtful balance between program growth, quality assurance, and provider readiness.



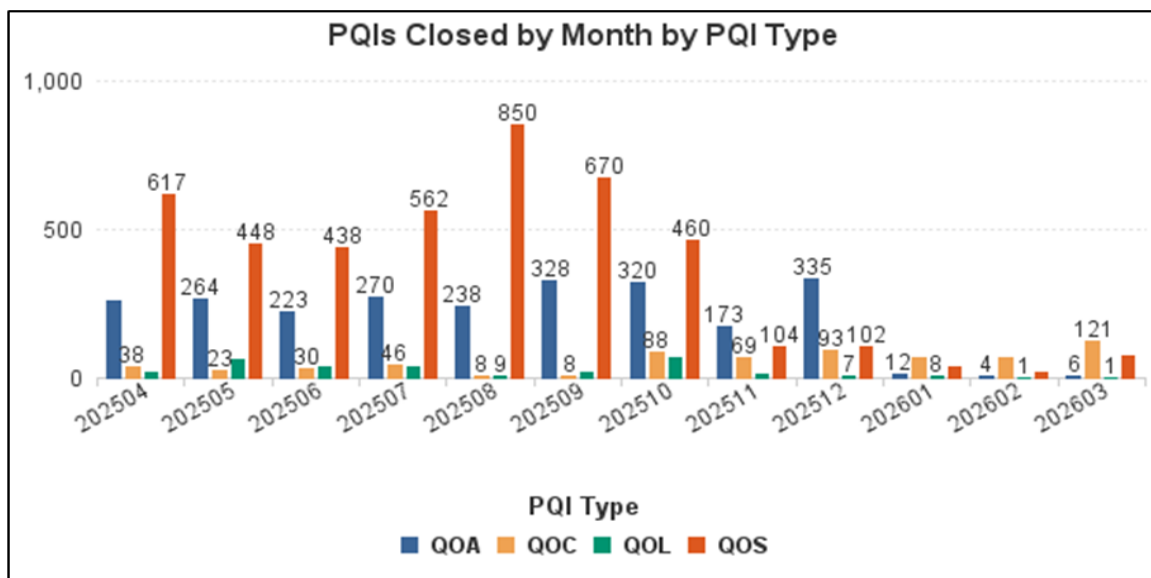
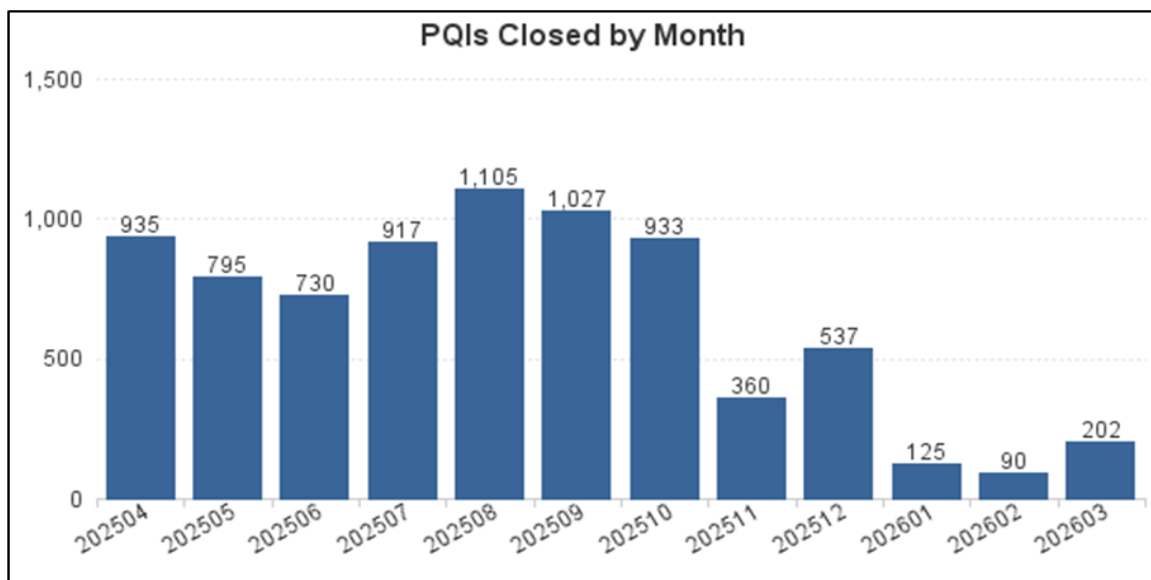
Quality

- As of March 30, 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 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 of process improvements for efficiency. The noted decline in cases were primarily Quality of Service as these were resolved upstream through the grievance process. There was a slight uptick in March 2026 for PQIs closed by month due to on-going efficiencies implemented by the QI Medical Director.
- The Department of Healthcare Services (DHCS) conducted the routine medical audit in March 2026. The interview sessions included questions related to processes, provider preventable conditions (PPCs), and case file reviews. For PPCs, it was emphasized that hospitals must report PPCs upon discovery to the DHCS as described here: [PPC Reporting](#). In the closing conference, there were no preliminary findings related to the PQI process.



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





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

Health Equity

Lao Paul Vang

To: Alameda Alliance for Health Board of Governors
From: Lao Paul Vang, Chief Health Equity Officer
Date: April 10th, 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**
 - As of August 2025, the Alliance is officially NCQA-accredited for Health Equity (HE) across both Medi-Cal and Group Care lines of business for a period of three years.
- **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.
- **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

- **Health & Human Resource Education Center (HHREC)**
 - Initiated discussion with the local community-based organization for collaborative education outreach for our faith-based organizations.
- **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.

Alliance Health Equity Strategic Roadmap Update

- 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. **California Healthcare Foundation (CHCF) grant-funded program to address HEDIS measures through the lens of Health Equity**

- 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.

B. Food-is-Medicine as the SDOH Mitigation Measure

- The Brown and Black communities suffer 2 to 3 times more food insecurity than the White community in Alameda County.
- Food insecurity is significantly associated with chronic diseases, and statistically, our membership data indicates that the chronic diseases, such as diabetes and hypertension, disproportionately affect our Brown and Black members. Therefore, food insecurity is 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 May. The 12-week program is based on well-established evidence-based FIM intervention and will be tested for its operational sustainability and effectiveness with regard to selected clinical and non-clinical outcomes.

C. Grant-funded California Improvement Network (CIN) Membership.

- 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.

D. SDOH Mitigation Exploration with Direct Engagement with Providers.

- 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

E. Community Connect:

- A new 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) Launched the inaugural Community Connect meeting series on 1-22-2026. b) 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. c) Direct Engagement with Provider's meetings, in partnership with QI team. d) Initiated potential providers' partnership in Food-Is-Medicine initiatives. e) 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. 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.
 - The next step is to train 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.

- Timeline and completion rate:
 - Dec 2024: confirmation of vendor.
 - Jan-Feb 2025: Implementation of training for all Alliance staff.
 - Feb 14: 97% of the Alliance staff completed the mandatory training. The 3% of non-completion represents staff who were on vacation or medical leave. Upon returning to the office, they will have up to 30 days to complete the training.
 - Feb 14, 2025: submission of documents per APL to the State, including evidence-based TGI training curriculum, updated online Providers Directory for gender-confirming services, G&A, and Policy and Procedures.
 - Feb 28, 2025: Attestation was submitted to DHCS.
 - June 2025 to date: HE Team is working with the TGI work group to implement phase 2 and phase 3 of the training, which is member-facing vendors, contractors, and downstream subcontractors.
 - October 7, 2025: Based on the current situation involving TGI and DEI, SLT decided to pause phase 3 of the TGI training. However, the TGI working group will continue to discuss and address specific issues that may impact DSNP's launch in January 2026.
 - December 12, 2025: SLT decided to pause the TGI training project until further notice by the state.
 - Jan 2026: The IPD team closed out 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 March 6th was canceled due to the 2026 DHCS Medical Routine Audit.
- The draft of the DEIB charter is under review and not ready for the committee's discussion.

VIA Committee Update

- The VIA Committee meeting on March 10th was canceled due to the 2026 DHCS Medical Routine Audit.
- The VIA charter is currently under review.

Calendar of Community Engagements

CBO/FBO/Providers		Services	Status
1	Coffee & Conversations: A	Joining the Alliance + CAC for a welcoming, in-person community	➤ Attending on April 11, 2026, to support the Alliance and our

	Community Chat with Alliance + CAC	conversation at our provider partner, Roots Community Health Center, Armstead Hall, 10:30AM - 11:30AM.	Community Advisory Committee (CAC).
2	Black Resilience, Kenyan Experience Event, HHREC	A powerful day celebrating Black culture, history, creativity, wellness, and community.	➤ March 18, 2026, in collaboration with our community partner, HHREC CHW, to build community, celebrate culture, and mental health wellness.
3	Black Joy Parade	The 9 th Annual Black Joy Parade, with the theme: "Black is the Blueprint".	➤ Feb 22, 2026, attended the 9 th 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.
4	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.	➤ Feb 5, 2026: in-person meeting in Oakland. ➤ Oct 9, 2026: in-person meeting in LA. ➤ July 9, 2025: Presented health equity best practices at the Affinity group virtual meeting. ➤ May 8, 2025: in-person meeting in Oakland.
5	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.
6	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.	○ Jan 2026: Initiated collaborative discussions with the president of BAMCA in Jan 2026. ○ Feb 4, 2026: Visited with the president of BAMCA in person. ○ Goal to co-develop a community health assessment for the Mongolian community in Alameda.
7	Health & Human Resource Education Center (HHREC)	Provider of education and training in health and wellness.	○ 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. ○ Feb 9, 2026: Visited with the CEO and her team at the office.
8	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.	➤ 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.
9	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."
10	Alameda Health System	One of the pediatricians works predominantly with Black mothers and children.	○ 10-21-2025: 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.
11	La-Clinica St Antonia Health Center	One of Alliance's contracted providers that serves our members.	○ 10-21-2025: Visited the on-site food pantry and reviewed the food-is-medicine services. ○ 9-12-2025: Initiated partnership meeting. ○ Potential collaboration: data-driven food-is-medicine targeting chronic diseases.
12	Oakland Black Cowboy Assoc., City of Oakland, Black Cowboy Parade & Heritage Festival	Local organization is celebrating its 51 st 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

13	Glad Tidings International Church of God	Established in 1978, the church serves over 1,000 members and is well known in the Hayward community.	○ 12-3-2025: visited with the church bishop and the executive director of the community outreach. ○ 10-21-2025: Visited the church food distribution. ○ 7-24-2025: Initiated meeting. ○ <i>Potential collaboration:</i> Promoting resources in health education, e.g., Doula services, diabetes, and other chronic diseases.
14	School-based Health Center in Madison Park Academy, Oakland	One of the eight school-based health centers operated by Native Americans.	○ July 8th, 2025: Visited the school clinic. ○ <i>Potential collaboration:</i> promote child health. ○ Collaborator: QI
15	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
16	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. ➤ <i>Potential collaboration:</i> Co-design community survey with the church to identify needs and SDOHs; support health education outreach to the congregation and community at large.
17	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. ➤ <i>Potential collaboration:</i> Co-design Parent Survey with OUSD to study food insecurity and SDOHs.
18	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
19	Oakland Catholic Workers	Provides transitional housing and resettlement resources to Central American refugees and immigrants.	➤ March 2025: initiated collaborative meetings. ➤ Resource sharing. ➤ Collaborator: PHM

20	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.



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

Information Technology

Sasikumar Karaiyan

To: Alameda Alliance for Health Board of Governors

From: Sasi Karaiyan, Chief Information & Security Officer

Date: April 10th, 2026

Subject: Information Technology Report

Encounter Data

- In the month of March 2026, the Alliance submitted 183 encounter files to the Department of Health Care Services (DHCS) with a total of 642,229.
- Alliance made its initial DSNP submission to CMS, achieving a 97% acceptance rate.

Enrollment

- The Medi-Cal Enrollment file for the month of March 2026 was received and loaded to HEALTHsuite.

Claims – HEALTHsuite Application

- The Alliance received 389,550 claims in the month of March 2026.
- A total of 383,530 claims were finalized during the month out of which 327,319 claims auto adjudicated. This sets the auto-adjudication rate for this period to 85.3%.
- HEALTHsuite 2026 Upgrade estimated to go-live in June 2026. Key system enhancements and bug fixes will become available with the upgrade.
- Proactively seeking AI-driven approaches to enhance auto-adjudication rates for claims and increase processing precision.

Quality Suite Application

- QS Automation Roadmap: This project targets faster application processing and better-quality metrics. Three key automations have been selected for rollout.
 - Automating the QA Process - This high-impact project aims to streamline the QA process by implementing an automated system to replace the existing manual workflow. Automating these tasks will help reduce repetitive work and enable the QA team to concentrate on maintaining high standards of quality. Additionally, this new approach will contribute to the coordinator scorecard used for performance evaluation.

- Letter Review Process Updates.
- Revise the existing dashboard and develop the reporting feature.

TruCare

- A total of 23,150 authorizations were received and processed in the TruCare application.
- TruCare Application Uptime – 99.9%.
- TruCare Upgrade:
 - Upgrade from 24.1.1 to 25.2.1.1.
 - The upgrade incorporates improvements to case management, program engagement, and split-screen functionality within the assessment, allowing users to view clinical data and complete documentation concurrently.
 - Planning to complete the upgrade by end May 2026.

Dev-Ops

- Data Warehouse Performance Optimization Initiative:
 - Conducted comprehensive end-to-end analysis of DWH batch processing to pinpoint performance bottlenecks and inefficiencies within existing load patterns.
 - Transitioned several processes from full loads to incremental loads, thereby reducing data volume and shortening execution time.
 - Applied targeted optimizations to critical jobs, including improved sequencing and enhanced dependency management to mitigate downstream delays.
 - As a result of these enhancements, DWH job completion times advanced substantially, now concluding by 4:30 AM PST rather than the previous 8:00 AM PST.
 - The accelerated completion window offers additional buffer for downstream consumers and enhances platform reliability and adherence to SLAs.
- DSNP Post-Production Enhancements:
 - An improvement to the Care Plan functionality allows provider

comments entered within the Care Plan section to be automatically transferred to TruCare.

- Implemented enhanced functionality for transmitting Encounters to CMS through Optum, supporting regulatory compliance and risk adjustment initiatives.
- Completion of CMS Enrollment and DTRR file loading to ODS

IT Security Program

- 2025 Security Risk Assessment:
 - The project is 78% complete and remains in progress. These findings ensure alignment with the NIST CSFv2 framework, which is recognized as an industry standard. Please note that, depending on the type of finding (such as technical or process and procedure), the complexity may be considerable and timelines may be extended.
- Operations:
 - Windows 10 virtual machines are being deprecated.
 - Efforts continue towards minimizing or eliminating the use of native Windows RDP.
 - Work is in progress to address the three remaining complex pen test findings.
 - Email authentication is preparing to enter the quarantine phase.
- Network micro-segmentation agent deployment to production system in early April.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of March 2026”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of March 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 March 2026

Month	Total MC ¹	MC ¹ - Add/ Reinstatements	MC ¹ - Terminated	Total GC ²	GC ² - Add/ Reinstatements	GC ² - Terminated	Alliance Wellness
March	386,382	2,802	5,769	6,241	123	105	212

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 March 2026

Auto-Assignments	Member Count
Auto-assignments MC	2,343
Auto-assignments Expansion	2,489
Auto-assignments GC	71
Auto-assignment AW	13
PCP Changes (PCP Change Tool) Total	4,916

TruCare Application

- See Table 2-1 “Summary of Intake Authorizations for the month of March 2026”.
- There were 23,150 intake authorizations for the Month of March 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 March 2026

Transaction Type	Total Auths Received
Provider Portal Requests (mPulse)	6,501
EDI (CHCN)	6,639
ADT	1,377
Behavioral Health COC Update - Online	92
Behavioral initial evaluation - Online	72
BHT/ABA Initial and Subsequent Treatment	76
Manual Entry	3,520
OCR	4,873
Total	23,150

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)

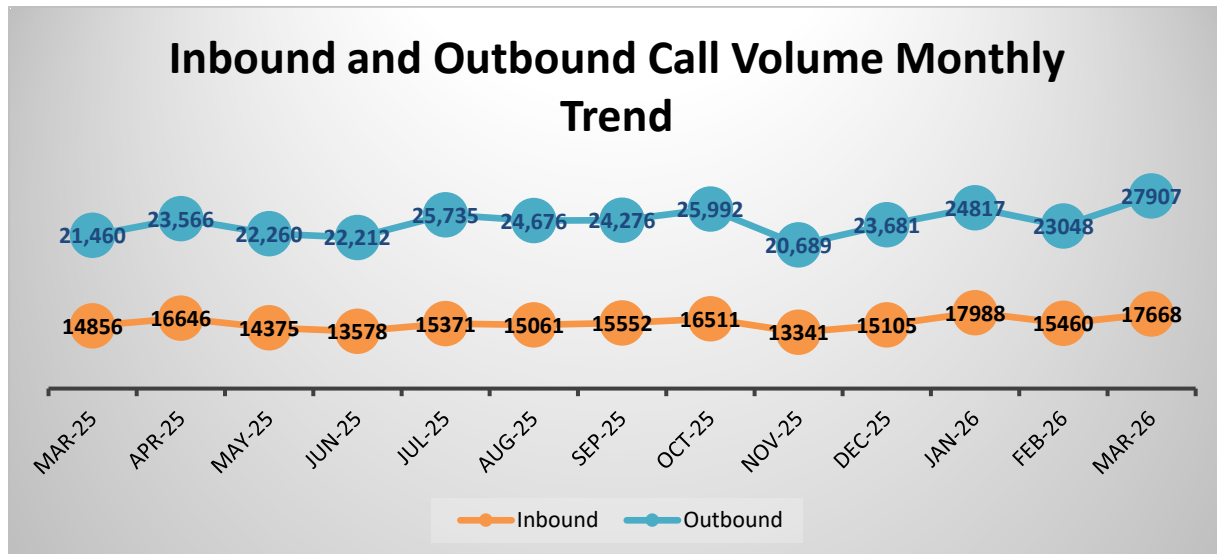
Table 3-1 Web Portal Usage for the Month of February 2025

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	11,621	6,869	507,015	855
MCAL	138,961	3,871	9,176	1,093
IHSS	4,333	74	774	39
Total	154,915	10,814	516,965	1,987

Table 3-2 Top Pages Viewed for the Month of February 2025

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1,664,301
Provider - Claims	Claim Status	247,939
Directory Config	Provider Directory	10,860
Provider - authorizations	Auth Search	10,422
Provider - authorizations	Auth Submit	7,433
Provider - Claims	Submit professional claims	6,357
Member My Care	Member Eligibility	3,377
Member Help Resources	Find a Doctor or Hospital	2,691
Member Help Resources	ID Card	2,490
Provider - eligibility/claim	Member Roster	2,279
Member My Care	My Benefits	2,270
Provider - Home	Behavior Health Forms SSO	1,922
Member Help Resources	Select or Change Your PCP	1,568
Provider - Home	Long Term Care Forms SSO	1,459
Member My Care	My Claims Services	1,418
Member Home	MC ID Card	1,364
Provider - Provider Directory	Provider Directory 2019	913
Member My Care	Authorization	826
Provider - Home	Forms	593
Provider - reports	Reports	580
Member My Care	VSP SSO	480
Member My Care	My Pharmacy Medication Benefits	435
Member Config	Provider Directory	402
Member Help Resources	Forms Resources	386

Call Center – Call Volume Overview:



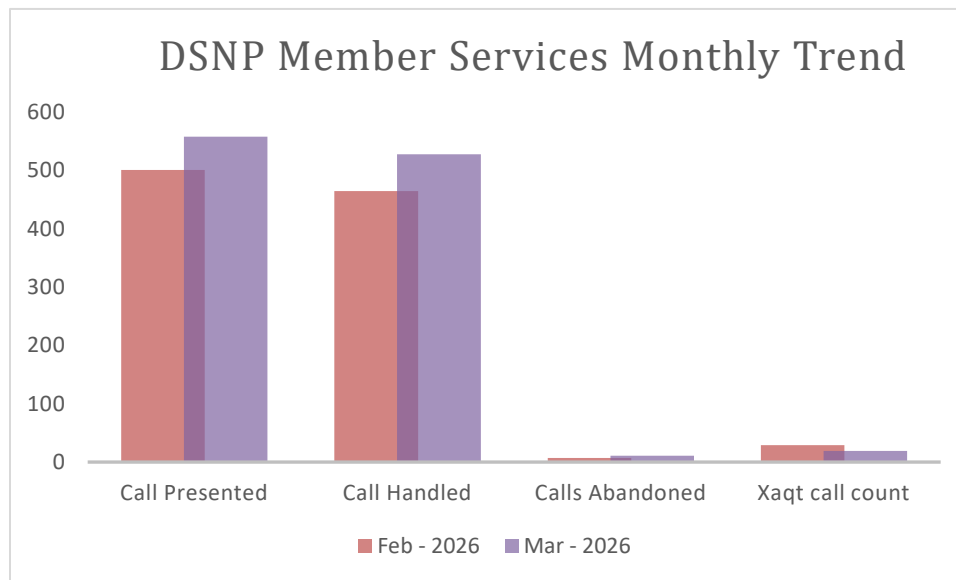
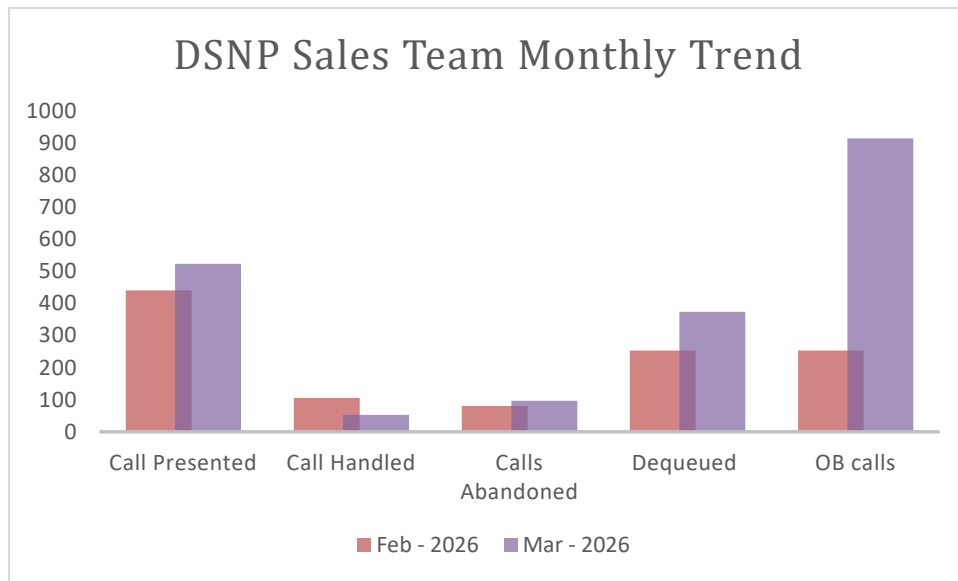
Members - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
October	14628	12104	705
November	11827	9662	515
December	13436	11549	594
January	15727	12696	731
February	13250	11092	592
March	15280	12079	782

Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
October	10884	8763	1592
November	8821	6474	1750
December	10851	7853	2251
January	13333	8809	3495
February	10591	8020	1942
March	10195	8332	1356

- 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:



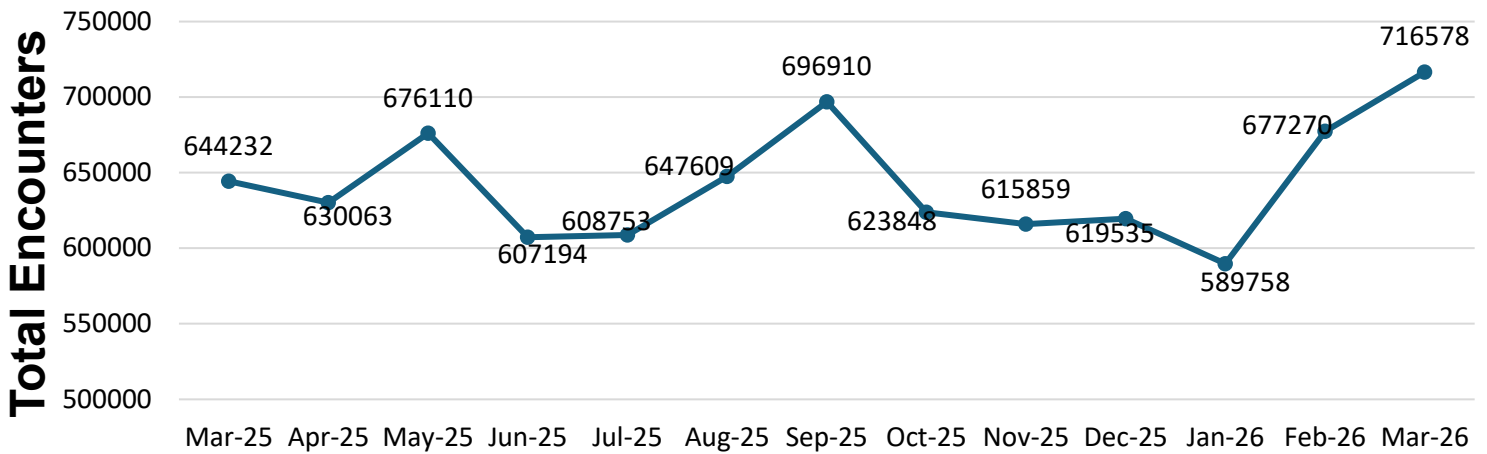
Encounter Data from Trading Partners 2026

- **AHS:** March monthly files (9,835 records) were received on time.
- **BACH:** March monthly files (0 records) were received on time.
- **BACS:** March monthly files (359 records) were received on time.
- **CHCN:** March monthly files (177,607 records) were received on time.
- **CHME:** March monthly files (7,129 records) were received on time.
- **CLAIMSNET:** March monthly files (17,563 records) were received on time.
- **Docustream:** March monthly files (1,292 records) were received on time.
- **EBI:** March monthly files (1,910 records) were received on time.
- **FULLCIR:** March monthly files (2,698 records) were received on time.
- **HCSA:** March monthly files (3,496 records) were received on time.
- **IOA:** March monthly files (1,660 records) were received on time.
- **LAFAM:** March monthly files (72 records) were received on time.
- **LIFE:** March monthly files (255 records) were received on time.
- **Logisticare:** March monthly files (62,637 records) were received on time.
- **Magellan:** March monthly files (567,339 records) were received on time.
- **March Vision:** March monthly files (2,702 records) were received on time.
- **MED:** March monthly files (912 records) were received on time.
- **PAIRTEAM:** March monthly files (14,368 records) were received on time.
- **Quest:** March monthly files (18,000 records) were received on time.
- **SENECA:** March monthly files (932 records) were received on time.
- **SERENE:** March monthly files (0 records) were received on time.
- **TITANIUM:** March monthly files (3,558 records) were received on time.
- **TVHC:** March monthly files (43 records) were received on time.

Trading Partner Encounter Inbound Submission History

Trading PartnerName	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
AHS	9273	8211	15875	7712	7880	10257	8455	9267	11333	8671	8345	10599	9835
BACH	291	131	0	296	172	172	180	181	0	0	0	0	0
BACS	81	72	88	128	81	82	100	102	114	109	196	140	359
CHCN	181049	117350	151416	170810	125697	132885	170744	152102	138524	153899	104101	193474	177607
CHME	6794	8293	9045	8638	8115	8368	8228	7938	9119	7579	8492	8597	7129
CLAIMSNET	21767	15856	21443	15710	13266	13336	20280	15705	20083	16647	10692	22313	17563
Docustream	767	890	1068	1052	1215	704	423	829	322	0	1568	852	1292
EBI	1390	2926	1457	1381	2946	1940	1800	1823	1922	1683	1856	1690	1910
FULLCIR	2099	2025	1479	1441	3266	3972	5006	2176	168	1358	462	3150	2698
HCSA	2118	2384	2628	2467	2671	2453	2930	172	2481	2876	2532	3008	3496
Health Suite	347469	372126	387564	340224	355255	389082	373025	372246	349052	320327	373154	378925	389550
IOA	736	0	2068	3083	1851	635	1377	1683	0	3095	1697	1672	1660
LAFAM	85	93	101	81	85	83	74	87	247	84	87	85	72
LIFE	431	317	1274	412	388	541	245	290	330	361	250	229	255
Logisticare	33754	55059	35875	15025	38834	34040	62760	15649	36206	59563	34215	16237	62637
March Vision	6985	6704	7929	8100	6914	7877	8374	9295	9338	7336	10116	2845	2702
MED	775	0	1581	958	2722	1246	1172	1468	1299	2894	1443	1434	912
PAIRTEAM	2055	16360	9244	7724	15956	14426	9446	9972	7871	10633	7419	5779	14368
Quest	22502	18003	22501	18000	18000	22500	18001	18001	22500	18004	18001	22499	18000
SENECA	129	108	109	160	76	0	188	66	0	123	360	206	932
SERENE	209	0	0	0	581	0	0	0	0	0	0	0	0
TITANIUM	2855	3039	2970	3792	2782	3010	4102	4796	4950	4244	4746	3536	3558
TVHC	618	116	395	0	0	0	0	0	0	49	26	0	43
TOTAL	644232	630063	676110	607194	608753	647609	696910	623848	615859	619535	589758	677270	716578

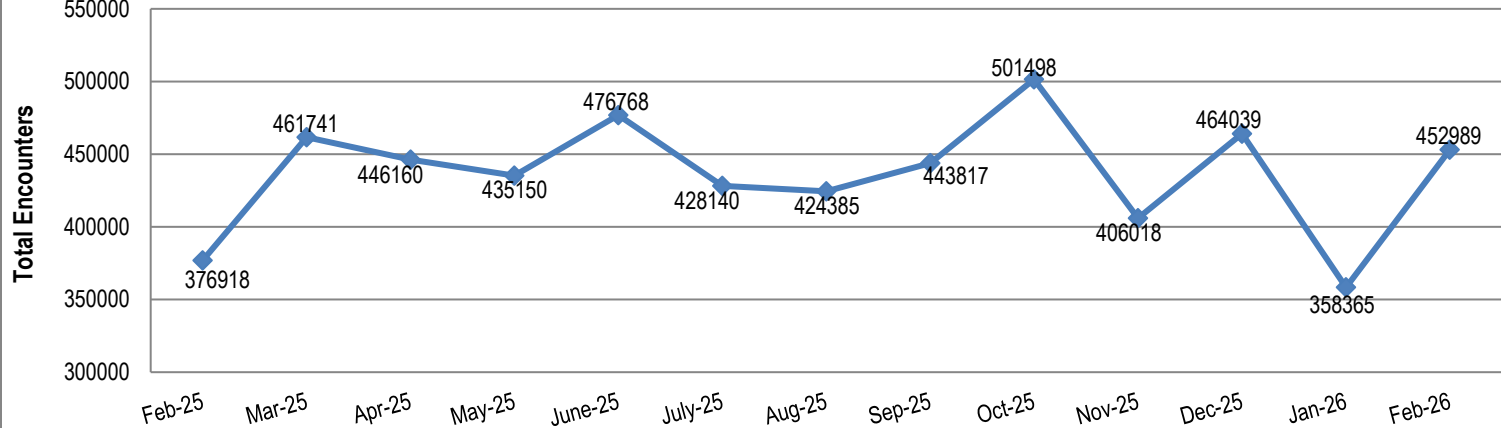
Total Encounters Received/Month



Outbound Encounter Submission

Trading PartnerName	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
AHS	7952	4510	9326	14010	7038	10166	8358	9125	11095	8218	8090	10555	9316
BACH	272	110	0	270	138	0	147	139	0	0	0	0	0
BACS	59	23	51	59	60	52	82	77	86	79	96	112	178
CHCN	95918	115571	106733	98329	106648	92163	89837	133350	93935	101887	69962	121092	119747
CHME	6682	8156	8914	8471	7991	8232	8090	7822	8407	7470	7697	8191	6682
CLAIMSNET	15008	11394	12430	13853	9238	9252	10764	11978	11518	13611	7425	13874	17300
Docustream	478	551	540	385	381	192	131	247	99	0	338	307	496
EBI	1308	1493	1346	1328	1885	1745	1634	1718	1834	1600	1770	1610	1869
FULLCIR	1823	1658	1155	1236	2889	3407	2713	1748	89	1081	165	2479	2226
HCSA	2103	2332	2603	2448	2637	2430	2871	149	2462	2840	2505	2979	3451
Health Suite	264948	210745	226401	274828	222783	228707	236163	253075	207026	228028	188845	245896	380981
IOA	626	0	48	1836	1732	551	1176	1304	0	2911	1617	1474	1108
LAFAM	80	84	90	67	80	76	69	84	93	83	87	82	64
LIFE	65	116	93	202	122	142	152	111	222	175	140	119	144
Logisticare	33656	54971	35829	15010	38763	33974	36968	41267	36150	59480	34166	16213	62539
March Vision	4354	3870	4591	4657	3888	4183	4724	5103	4847	3696	6051	1272	518
MED	731	0	595	553	2471	1124	974	1103	1160	1547	1360	1344	65
PAIRTEAM	1489	10873	4670	4549	9364	8386	8229	7901	5824	6500	6777	5157	11205
Quest	21048	16795	16853	21031	16774	16903	16855	20951	16810	20937	16905	16777	20859
SENECA	116	101	98	139	63	0	164	19	0	109	319	190	174
SERENE	20	0	0	0	569	0	0	0	0	0	0	0	0
TITANIUM	2551	2764	2714	3556	2577	2700	3746	4227	4361	3772	4039	3266	3293
TVHC	454	43	70	0	0	0	0	0	0	15	11	0	14
TOTAL	461741	446160	435150	466817	438091	424385	433847	501498	406018	464039	358365	452989	642229

Total Outbound Encounter/Month

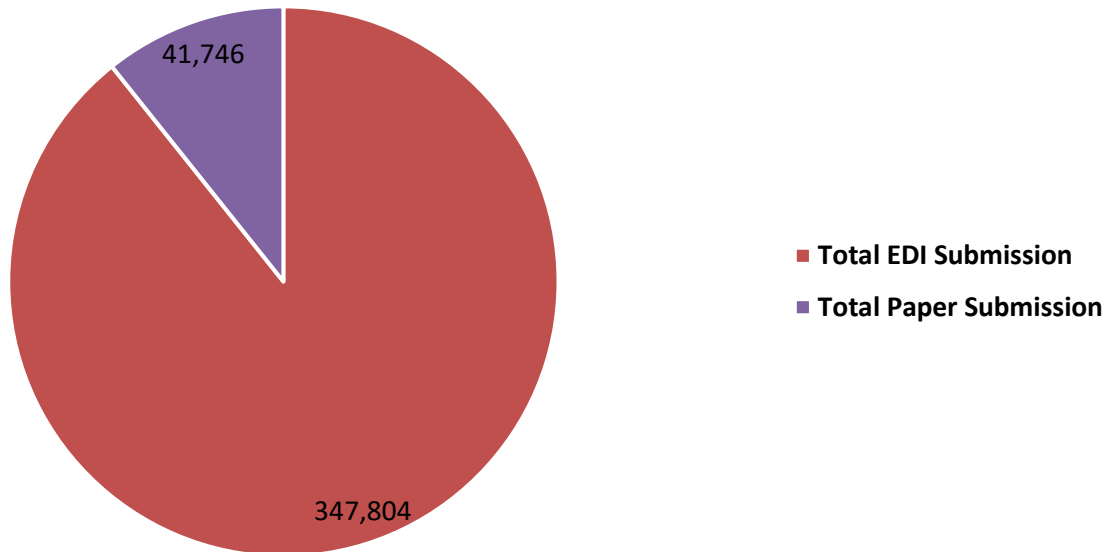


HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
26-Mar	347,804	41,746	389,550

Key: EDI – Electronic Data Interchange

EDI vs Paper Submission March 2026

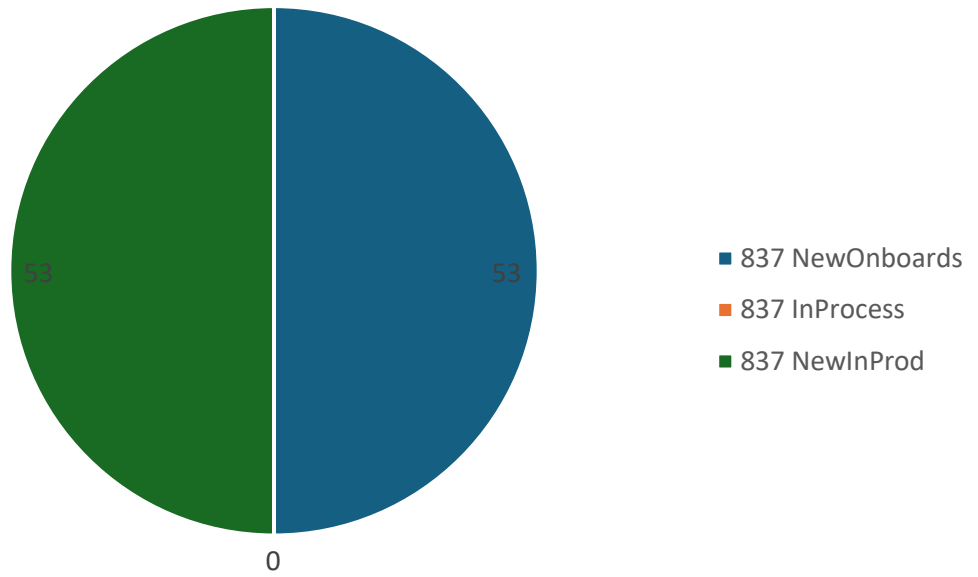


Onboarding EDI Providers – Updates

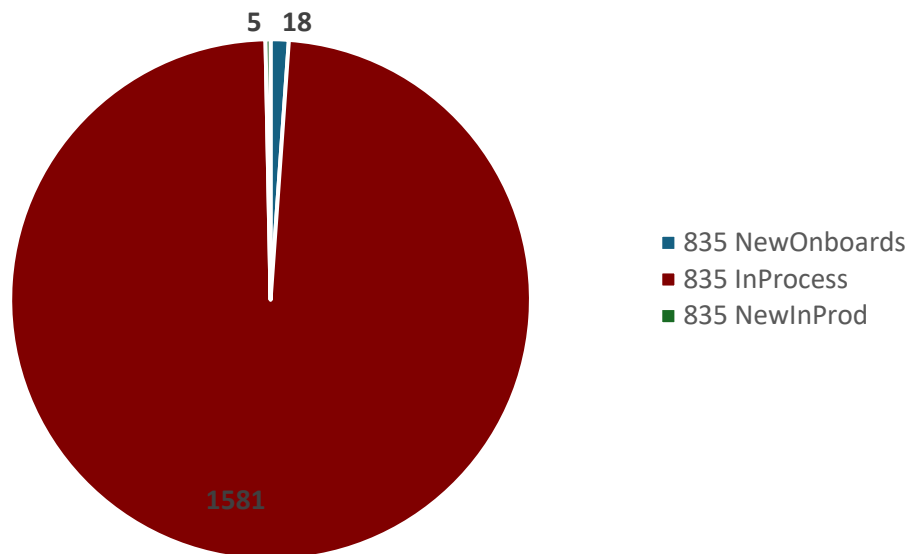
- March 2026 EDI Claims:
 - A total of 3,483 new EDI submitters has been added since October 2015, with 53 added in March 2026.
 - The total number of EDI submitters is 4,223 providers.
- March 2026 EDI Remittances (ERA):
 - A total of 1,612 new ERA receivers have been added since October 2015, with 5 added in March 2026.
 - The total number of ERA receivers is 1628 providers.

YearMonth	837	837	837	837	835	835	835	835
	NewOnboards	InProcess	NewInProd	TotalInProd	NewOnboards	InProcess	NewInProd	TotalInProd
Jan-25	61	8	53	3612	79	1234	22	1276
Feb-25	58	16	42	3654	83	1286	31	1307
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

837 EDI Submitters - March 2026



835 EDI Receivers - March 2026



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 **March 2026**.

File Type	TOTAL COUNT	YEAR MONTH
837 I Files	34	Mar-26
837 P Files	149	Mar-26
Total Files	183	

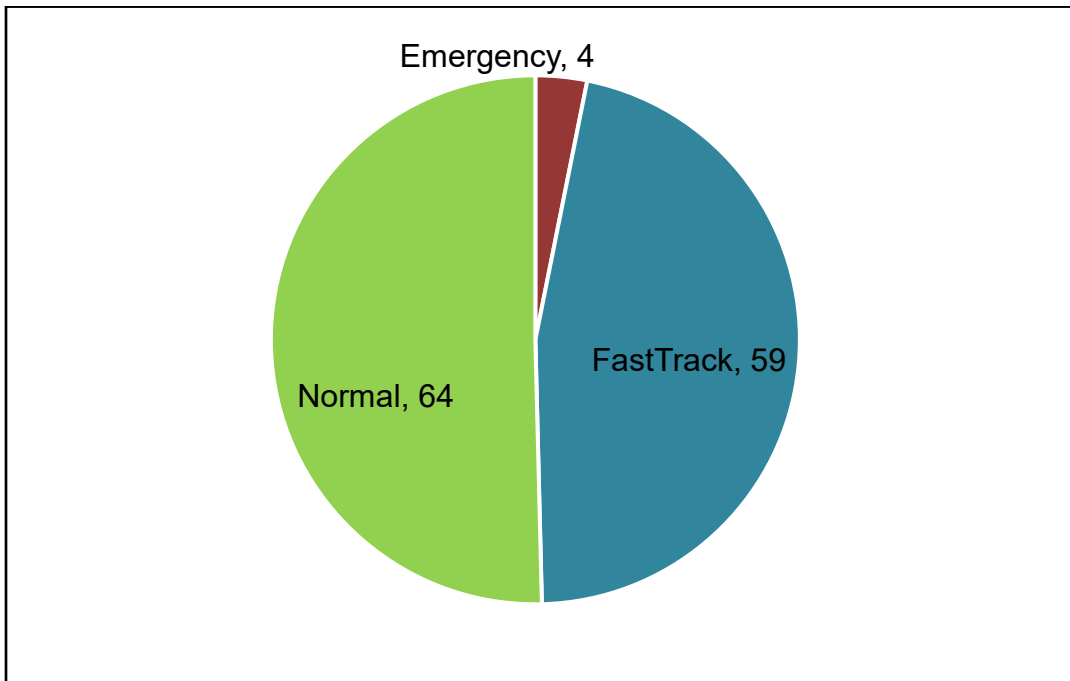
Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Feb-26	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	77%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	89%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	83%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	91%	80%

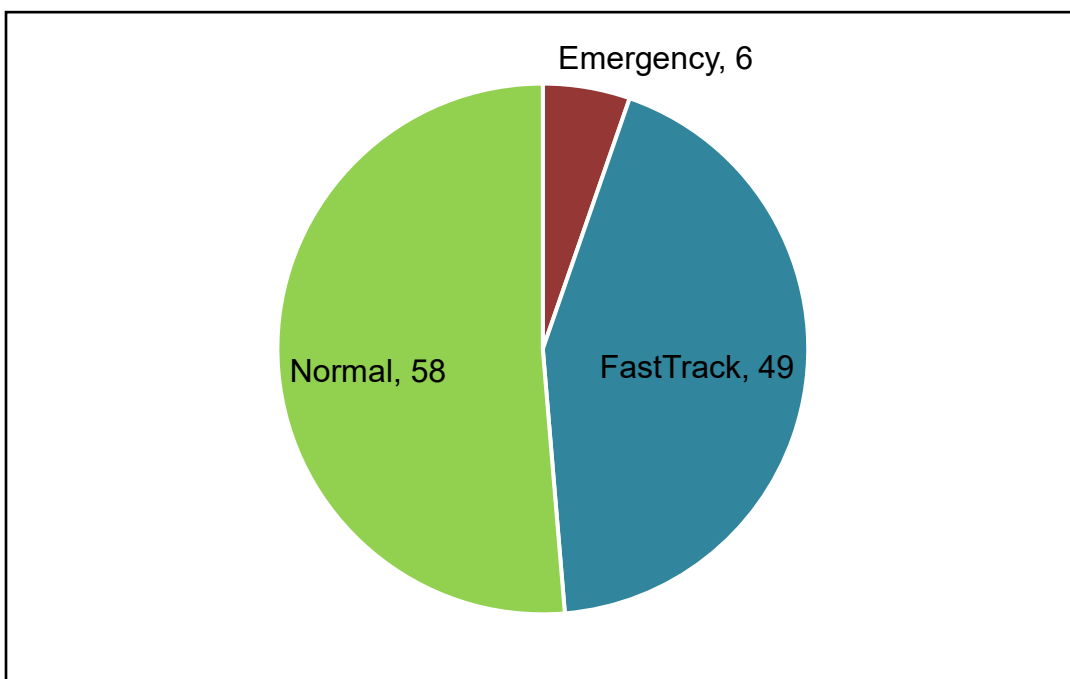
*Note, the Number of Encounters comes from: Total at bottom of this chart: **Outbound Encounter Submission**

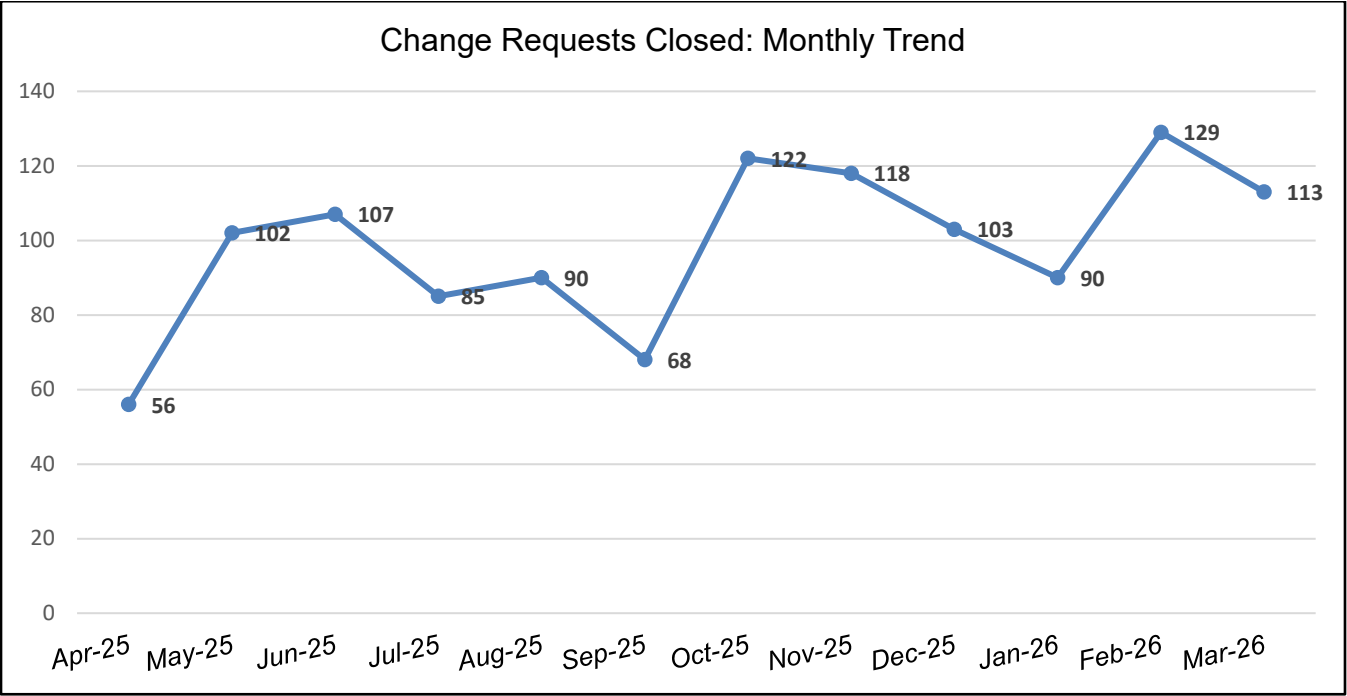
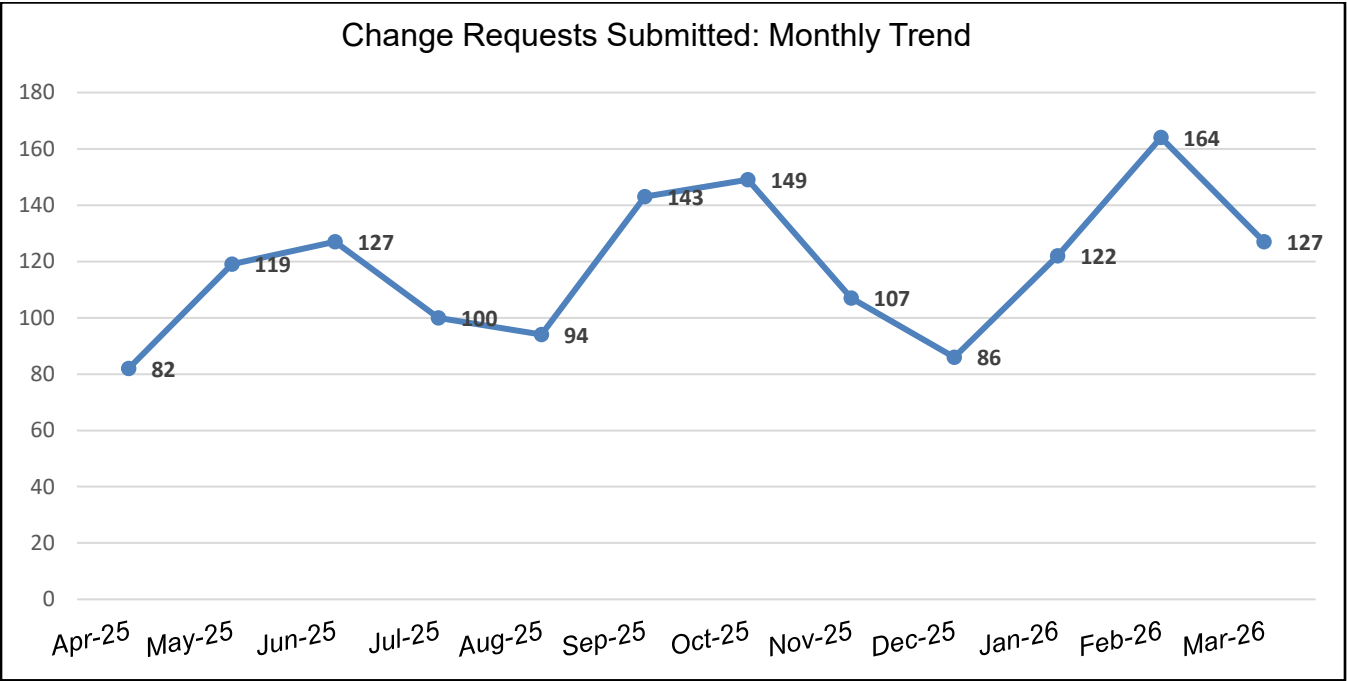
Change Management Key Performance Indicator (KPI)

- Change Request Overall Summary in the month of March 2026 KPI:
 - 127 Changes Submitted.
 - 113 Changes Completed and Closed.
 - 144 Active Change Requests in pipeline.
 - 30 Change Requests Cancelled or Rejected.
- 127 Change Requests Submitted in the month of March 2026



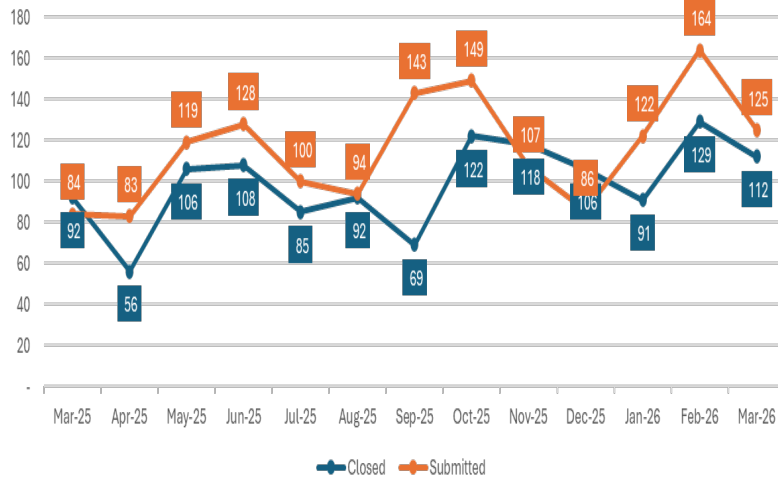
- 113 Change Requests Closed in the month of March 2026





Change Management Dashboard – MAR 2026

CLOSED & SUBMITTED - 13 MONTHS TREND

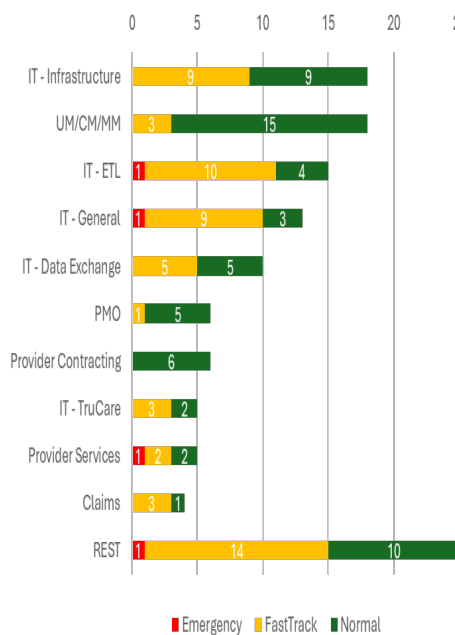


CLOSED & SUBMITTED BY TYPE



CRs Closed: 112
CRs Submitted: 125

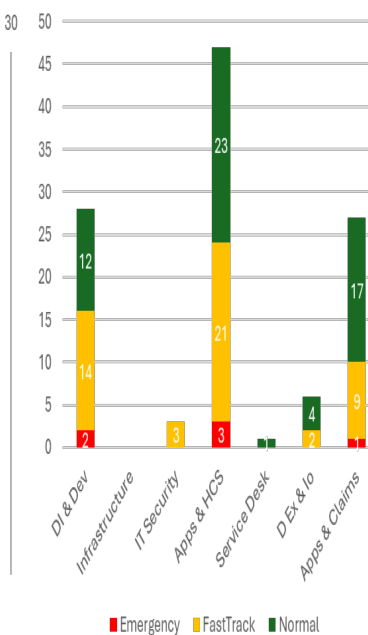
TOP 10 AREAS OF SUBMISSION



Active CRs - 139

CRs Open > 30 days - 65

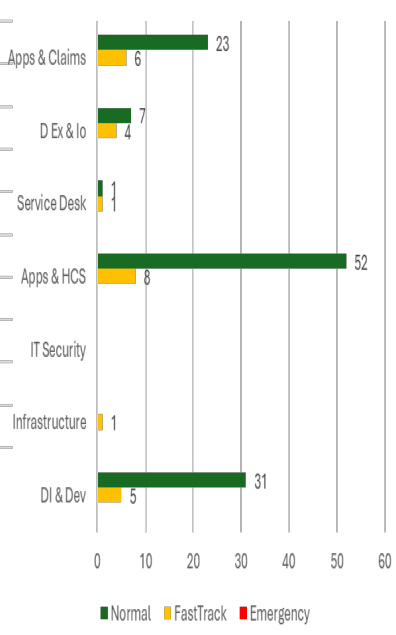
CRs CLOSED BY IT DEPARTMENT



CRs Open > 60 days - 37

CRs Open > 90 days - 22

ACTIVE CRs BY IT DEPARTMENT

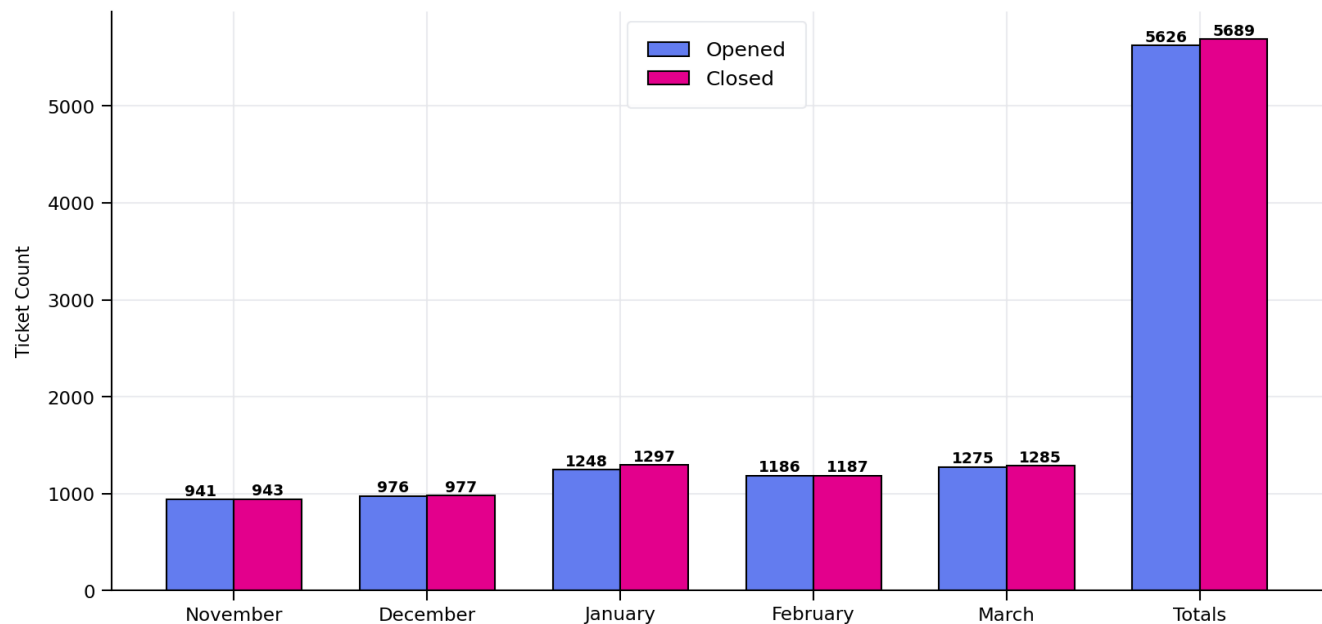


CRs Open > 1 year - 3

IT Stats: Service Desk

Month	Open Tickets	Closed Tickets
November	941	943
December	976	977
January	1248	1297
February	1186	1187
March	1275	1285

IT Service Tickets Opened and Closed



- 1,275 Service Desk tickets were opened in March 2026, which is 7.50% higher than the previous month (February: 1,186) and 17.21% higher than the previous 4-month average of 1,087.75 (November–February)
- 1,285 Service Desk tickets were closed in March 2026, which is 8.26% higher than the previous month (February: 1,187) and 16.71% higher than the previous 4-month average of 1,101 (November–February)

IT Stats: Security



Observations

Events parsed, enriched, and analyzed for security value.

279 M



Investigations

Number of potential incidents that were examined from your environment.

109



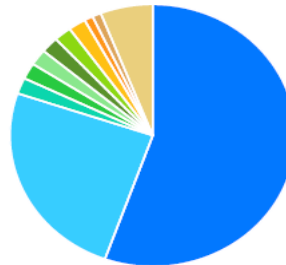
Reported Incidents

Security incidents that were brought to your attention.

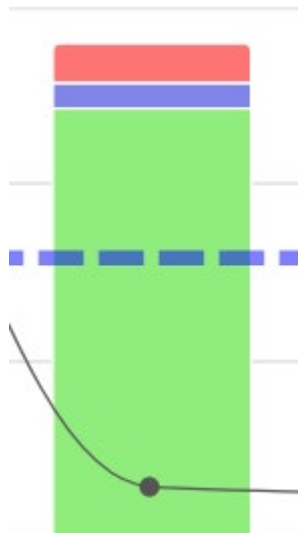
101



Reported Incident Breakdown



- March 2026 Arctic Wolf (Security Operations Center) stats
- No outstanding issues



OngoingPhishing
Monthly from categories: Sc
Started On: 03/02/2026
Groups: All Users
Emails Sent: 694
Bounced: 20
• Clicks: **23**
• Replies: **0**
• Attachments Opened: **14**
• Macro Enabled: **0**
• Data Entered: **1**
• QR Codes Scanned: **0**
• Callback: **0**
• Callback Data Entered: **0**
• Reported: **242**
• Phish-prone %: **5.5**

- **Timeframe:** March 2026
- **Left Bar:** Simulated phishing test results. Dotted blue line indicates industry baseline
- **Right Legend:** statistics breakout
- **Conclusion:** surpassing industry standards in reporting phishing and single digit phishing-prone %.



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

Analytics

Tiffany Cheang

To: Alameda Alliance for Health Board of Governors

From: Tiffany Cheang, Chief Analytics Officer

Date: April 10th, 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: Jan 2025 – Dec 2025 dates of service

Prior reporting period: Jan 2024 – Dec 2024 dates of service

(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 12.6% of members account for 89.7% of total costs.
- In comparison, the Prior reporting period was lower at 11.3% 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 decreased to account for 53.9% of the members, with SPD/LTCs accounting for 17.9% and ACA OE's at 36.0%.
- The percent of members with costs $\geq$ \$30K slightly increased from 3.0% to 3.2%.
- Of those members with costs $\geq$ \$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 29.6%.
- Demographics for member city and gender for members with costs $\geq$ \$30K follow the same distribution as the overall Alliance population.
- However, the age distribution of the top 12.6% 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

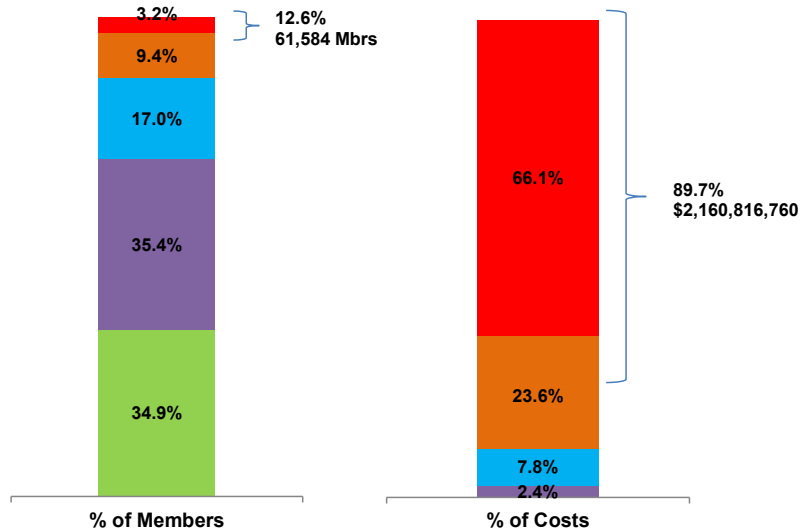
Lines of Business: MCAL, IHSS; Excludes Kaiser Members

Dates of Service: Jan 2025 - Dec 2025

Note: Data incomplete due to claims lag

Run Date: 03/27/2026

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
\$30K+	15,523	3.2%	\$ 1,592,991,322	66.1%
\$5K - \$30K	46,061	9.4%	\$ 567,825,438	23.6%
\$1K - \$5K	83,010	17.0%	\$ 188,855,232	7.8%
< \$1K	172,773	35.4%	\$ 58,929,145	2.4%
\$0	170,180	34.9%	\$ -	0.0%
Totals	487,547	100.0%	\$ 2,408,601,137	100.0%

Top 12.6% of Members = 89.7% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
\$100K+	5,046	1.0%	\$ 1,034,160,009	42.9%
\$75K to \$100K	1,802	0.4%	\$ 156,737,404	6.5%
\$50K to \$75K	3,017	0.6%	\$ 183,975,039	7.6%
\$40K to \$50K	2,221	0.5%	\$ 99,413,660	4.1%
\$30K to \$40K	3,437	0.7%	\$ 118,705,210	4.9%
SubTotal	15,523	3.2%	\$ 1,592,991,322	66.1%
\$20K to \$30K	6,570	1.3%	\$ 159,714,989	6.6%
\$10K to \$20K	17,963	3.7%	\$ 255,038,006	10.6%
\$5K to \$10K	21,528	4.4%	\$ 153,072,442	6.4%
SubTotal	46,061	9.4%	\$ 567,825,438	23.6%
Total	61,584	12.6%	\$ 2,160,816,760	89.7%

Enrollment Status	Members	Total Costs
Still Enrolled as of Dec 2025	404,468	\$ 2,165,009,713
Dis-Enrolled During Year	85,291	\$ 223,490,833
Totals	489,759	\$ 2,388,500,546

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

12.6% of Members = 89.7% of Costs

Lines of Business: MCAL, IHSS; Excludes Kaiser Members

Dates of Service: Jan 2025 - Dec 2025

Note: Data incomplete due to claims lag

Run Date: 03/27/2026

12.6% of Members = 89.7% of Costs

17.9% of members are SPD/LTCs and account for 24.6% of costs.

36.0% of members are ACA OE and account for 33.9% of costs.

8.2% of members disenrolled as of Dec 2025 and account for 9.6% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Members	% of Members
IHSS	IHSS	229	982	1,211	2.0%
MCAL	MCAL - ADULT	1,354	8,473	9,827	16.0%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	796	4,077	4,873	7.9%
	MCAL - ACA OE	5,153	16,996	22,149	36.0%
	MCAL - DUALS	-	-	-	0.0%
	MCAL - SPD-LTC	3,891	7,149	11,040	17.9%
	MCAL - SPD-LTC/Full Dual	2,546	4,901	7,447	12.1%
Not Eligible	Not Eligible	1,554	3,483	5,037	8.2%
Total		15,523	46,061	61,584	100.0%

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Costs	% of Costs
IHSS	IHSS	\$ 20,654,593	\$ 11,687,435	\$ 32,342,027	1.5%
MCAL	MCAL - ADULT	\$ 122,941,957	\$ 104,429,118	\$ 227,371,075	10.5%
	MCAL - BCCTP	\$ -	\$ -	\$ -	0.0%
	MCAL - CHILD	\$ 58,602,082	\$ 46,374,916	\$ 104,976,998	4.9%
	MCAL - ACA OE	\$ 521,518,822	\$ 212,020,961	\$ 733,539,783	33.9%
	MCAL - DUALS	\$ -	\$ -	\$ -	0.0%
	MCAL - SPD-LTC	\$ 437,885,915	\$ 93,109,122	\$ 530,995,037	24.6%
	MCAL - SPD-LTC/Full Dual	\$ 266,202,712	\$ 58,135,221	\$ 324,337,933	15.0%
Not Eligible	Not Eligible	\$ 165,185,241	\$ 42,068,665	\$ 207,253,906	9.6%
Total		\$ 1,592,991,322	\$ 567,825,438	\$ 2,160,816,760	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	5%	0%	2%
\$40K to \$50K	7%	0%	2%
\$30K to \$40K	9%	0%	3%
\$20K to \$30K	2%	1%	6%
\$10K to \$20K	0%	0%	10%
\$5K to \$10K	1%	0%	4%
Total	4%	0%	3%

Highest Cost Members: Cost Per Member >= \$100K

26.7% of members are SPD/LTCs and account for 29.2% of costs.

27.9% of members are ACA OE and account for 31.7% of costs.

8.9% of members disenrolled as of Dec 2025 and account for 9.9% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	49	1.0%
MCAL	MCAL - ADULT	295	5.8%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	92	1.8%
	MCAL - ACA OE	1,406	27.9%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,347	26.7%
	MCAL - SPD-LTC/Full Dual	1,408	27.9%
Not Eligible	Not Eligible	449	8.9%
Total		5,046	100.0%

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	\$ 11,469,626	1.1%
MCAL	MCAL - ADULT	\$ 70,047,510	6.8%
	MCAL - BCCTP	\$ -	0.0%
	MCAL - CHILD	\$ 25,518,949	2.5%
	MCAL - ACA OE	\$ 327,494,677	31.7%
	MCAL - DUALS	\$ -	0.0%
	MCAL - SPD-LTC	\$ 301,817,340	29.2%
	MCAL - SPD-LTC/Full Dual	\$ 195,462,965	18.9%
Not Eligible	Not Eligible	\$ 102,348,941	9.9%
Total		\$ 1,034,160,009	100.0%

Breakout by Service Type/Location

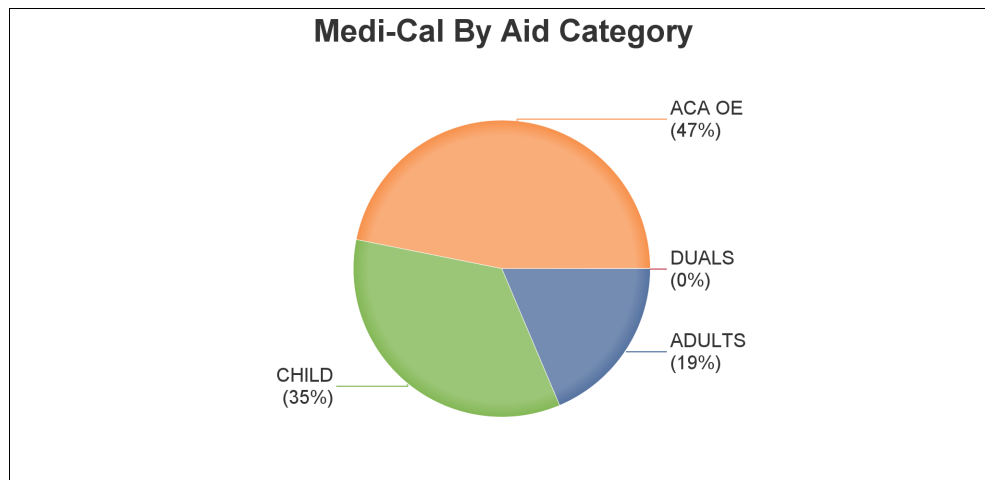
Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
15%	35%	1%	10%	3%	2%	34%
22%	23%	3%	5%	5%	4%	38%
28%	27%	5%	7%	7%	4%	24%
34%	24%	8%	6%	8%	1%	19%
33%	20%	12%	7%	9%	1%	19%
37%	20%	6%	9%	9%	1%	18%
38%	21%	6%	8%	10%	1%	15%
32%	10%	11%	13%	14%	1%	19%
24%	27%	4%	9%	6%	2%	27%

Notes:

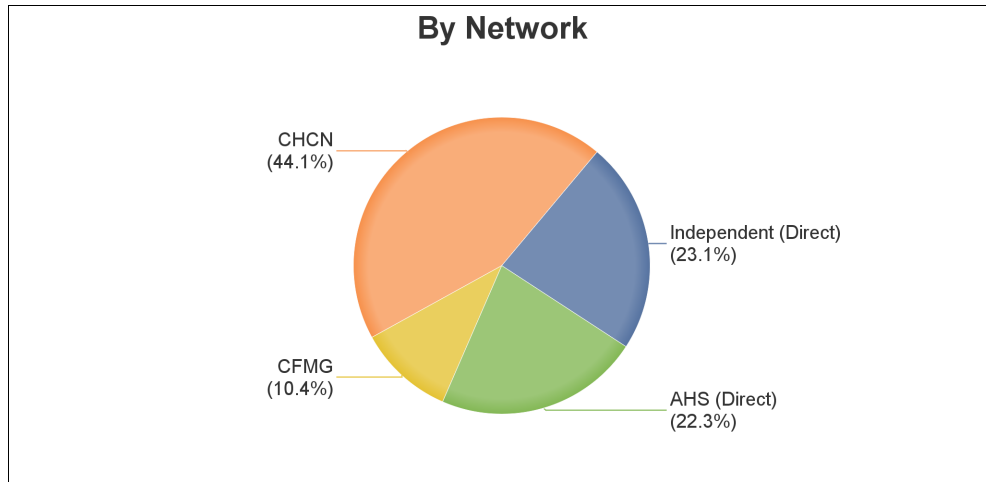
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend						
Category of Aid	Feb 2026	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	57,402	15%	11,799	14,217	0	31,386
CHILD	106,333	28%	9,894	13,808	37,900	44,731
SPD	0	0%	0	0	0	0
ACA OE	144,320	37%	26,690	49,338	1,510	66,782
DUALS	43	0%	40	3	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	28,815	7%	8,384	5,390	1,521	13,520
SPD-LTC/Full Dual	48,514	13%	31,329	3,513	0	13,672
Other	0		0	0	0	0
Medi-Cal	385,427		88,136	86,269	40,931	170,091
Group Care	6,207		2,224	1,233	0	2,750
D-SNP	193		67	17	0	109
Total	391,827	100%	90,427	87,519	40,931	172,950
Other %	0.0%		0.0%	0.0%	0.0%	0.0%
Medi-Cal %	98.4%		97.5%	98.6%	100.0%	98.3%
Group Care %	1.6%		2.5%	1.4%	0.0%	1.6%
D-SNP %	0.0%		0.1%	0.0%	0.0%	0.1%
Network Distribution			23.1%	22.3%	10.4%	44.1%
			% Direct:	45%	% Delegated:	55%

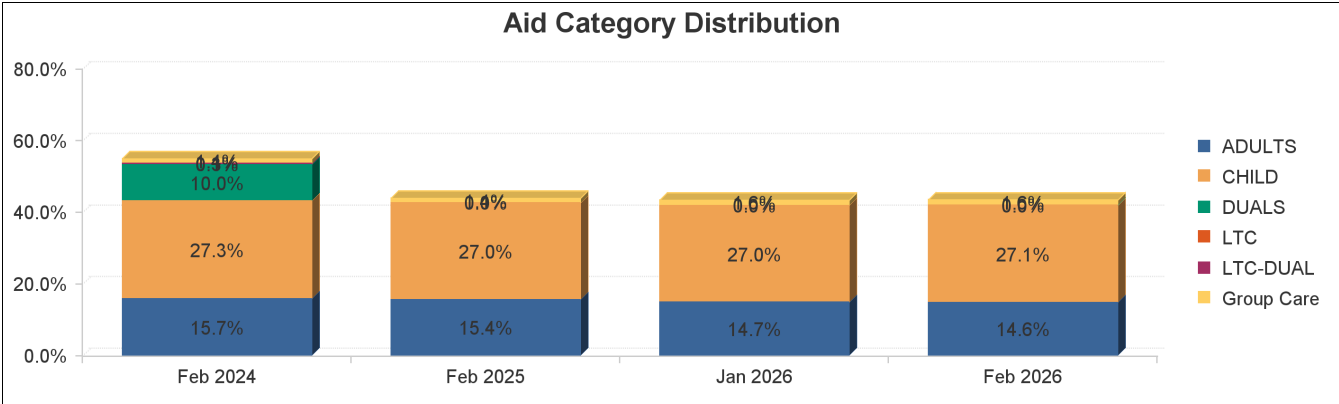


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

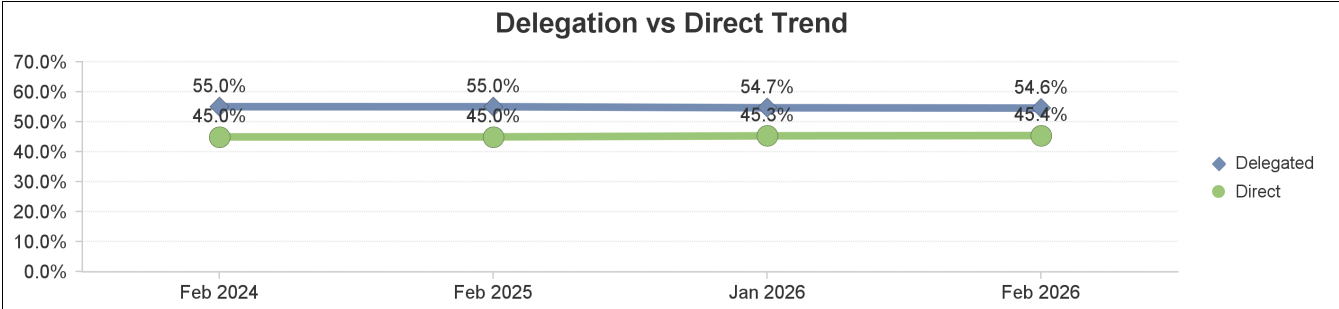


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend											
Category of Aid	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
ADULTS	63,130	63,758	58,220	57,402	15.7%	15.4%	14.7%	14.6%	1.0%	-11.1%	-1.4%
CHILD	109,957	111,576	106,746	106,333	27.3%	27.0%	27.0%	27.1%	1.5%	-4.9%	-0.4%
SPD	34,876	0	0	0	8.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ACA OE	146,758	154,609	146,364	144,320	36.5%	37.4%	37.0%	36.8%	5.1%	-7.1%	-1.4%
DUALS	40,403	2	41	43	10.0%	0.0%	0.0%	0.0%	#####	95.3%	4.7%
LTC	217	0	0	0	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LTC-DUAL	1,329	0	0	0	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SPD-LTC	0	29,497	29,119	28,815	0.0%	7.1%	7.4%	7.4%	100.0%	-2.4%	-1.1%
SPD-LTC/ Full Dual	0	48,100	48,675	48,514	0.0%	11.6%	12.3%	12.4%	100.0%	0.9%	-0.3%
Other	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medi-Cal	396,670	407,542	389,165	385,427	98.6%	98.6%	98.4%	98.4%	2.7%	-5.7%	-1.0%
Group Care	5,608	5,812	6,191	6,207	1.4%	1.4%	1.6%	1.6%	3.5%	6.4%	0.3%
D-SNP	0	0	170	193	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	402,278	413,354	395,526	391,827	100.0%	100.0%	100.0%	100.0%	2.7%	-5.5%	-1.0%

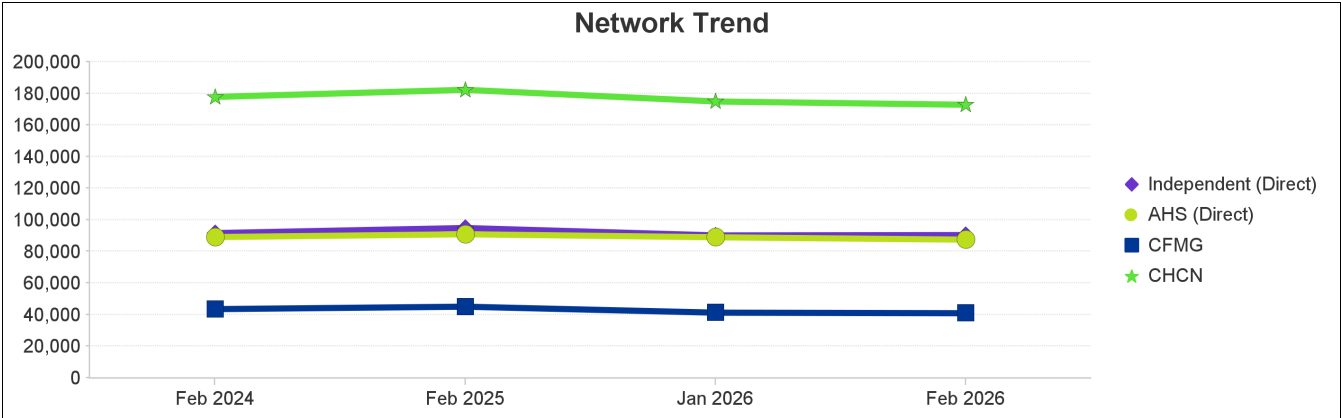


Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
Delegated	221,438	227,504	216,298	213,881	55.0%	55.0%	54.7%	54.6%	2.7%	-6.4%	-1.1%
Direct	180,840	185,850	179,228	177,946	45.0%	45.0%	45.3%	45.4%	2.7%	-4.5%	-0.7%
Total	402,278	413,354	395,526	391,827	100.0%	100.0%	100.0%	100.0%	2.7%	-5.5%	-1.0%



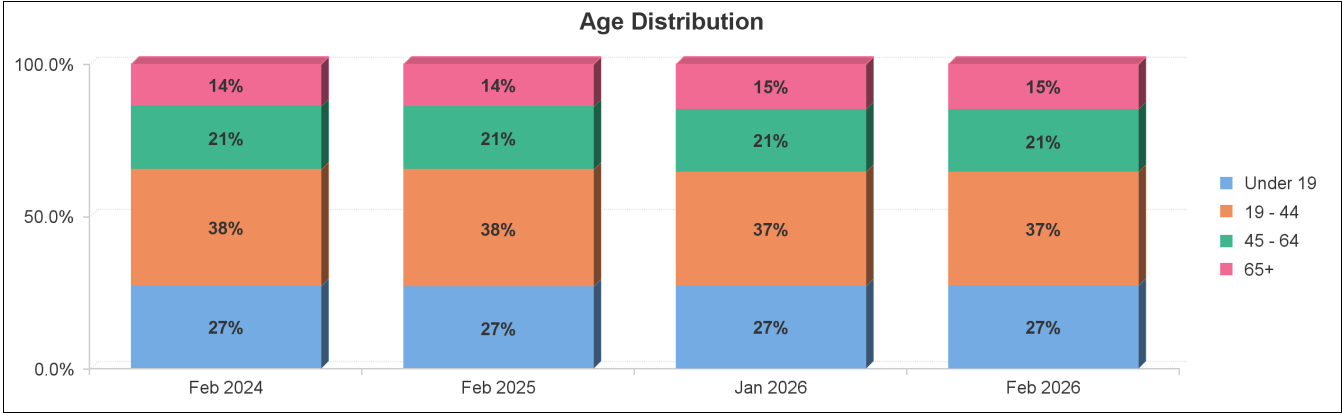
Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Network Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
Independent (Direct)	91,671	94,899	90,191	90,427	22.8%	23.0%	22.8%	23.1%	3.4%	-5.0%	0.3%
AHS (Direct)	89,169	90,951	89,037	87,519	22.2%	22.0%	22.5%	22.3%	2.0%	-3.9%	-1.7%
CFMG	43,528	45,079	41,278	40,931	10.8%	10.9%	10.4%	10.4%	3.4%	-10.1%	-0.8%
CHCN	177,910	182,425	175,020	172,950	44.2%	44.1%	44.2%	44.1%	2.5%	-5.5%	-1.2%
KAISER	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	402,278	413,354	395,526	391,827	100.0%	100.0%	100.0%	100.0%	2.7%	-5.5%	-1.0%

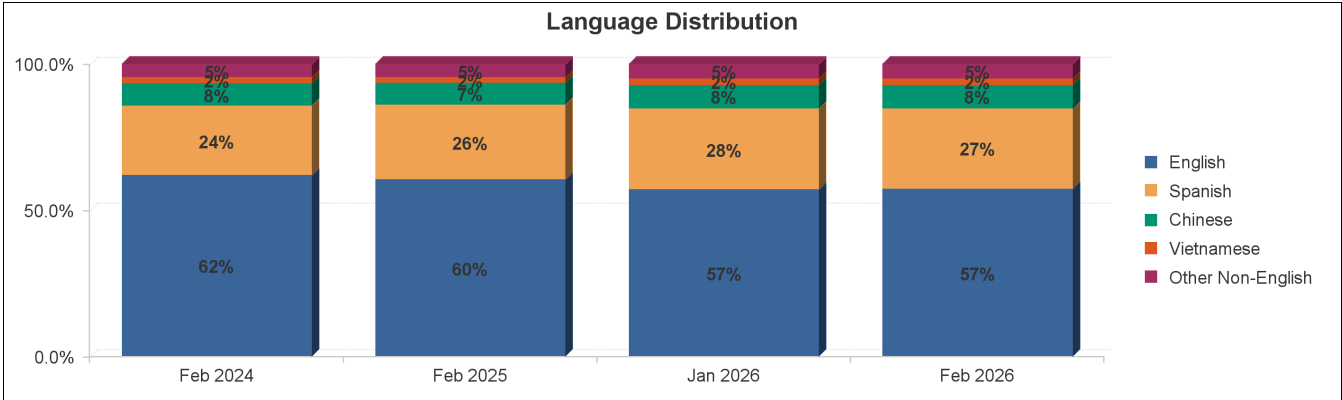


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Age Category Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
Under 19	108,207	110,599	106,640	106,246	27%	27%	27%	27%	2%	-4%	0%
19 - 44	154,277	159,068	147,945	145,855	38%	38%	37%	37%	3%	-9%	-1%
45 - 64	83,582	85,271	81,599	80,798	21%	21%	21%	21%	2%	-6%	-1%
65+	56,212	58,416	59,172	58,735	14%	14%	15%	15%	4%	1%	-1%
Total	402,278	413,354	395,356	391,634	100%	100%	100%	100%	3%	-6%	-1%

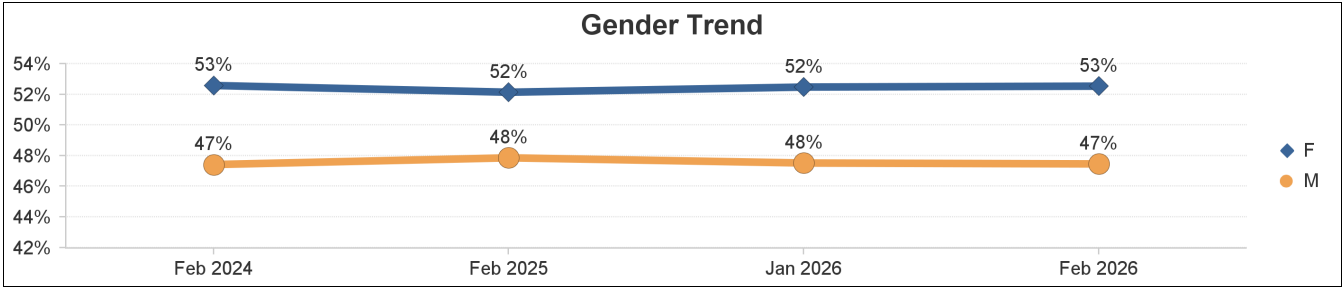


Language Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
English	248,268	248,996	224,692	223,411	62%	60%	57%	57%	0%	-11%	-1%
Spanish	95,947	105,721	109,447	107,488	24%	26%	28%	27%	9%	2%	-2%
Chinese	30,706	30,594	31,587	31,427	8%	7%	8%	8%	0%	3%	-1%
Vietnamese	8,516	8,238	8,924	8,864	2%	2%	2%	2%	-3%	7%	-1%
Other Non-English	18,841	19,805	20,706	20,444	5%	5%	5%	5%	5%	3%	-1%
Total	402,278	413,354	395,356	391,634	100%	100%	100%	100%	3%	-6%	-1%

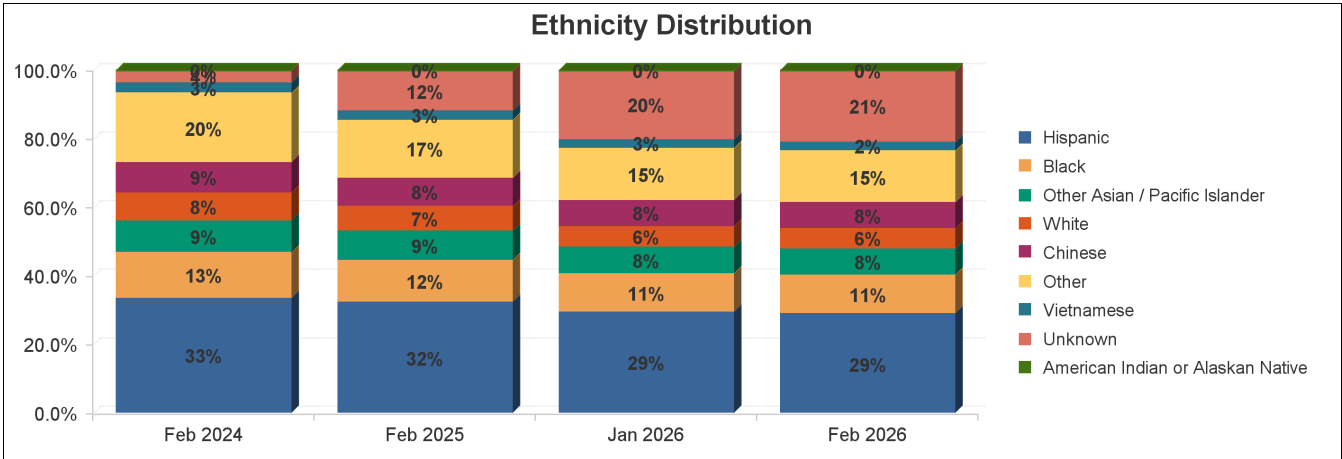


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Gender Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
F	211,525	215,525	207,573	205,863	53%	52%	52%	53%	2%	-5%	-1%
M	190,753	197,829	187,953	185,964	47%	48%	48%	47%	4%	-6%	-1%
Total	402,278	413,354	395,526	391,827	100%	100%	100%	100%	3%	-6%	-1%



Ethnicity Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024	Feb 2025	Jan 2026	Feb 2026	Feb 2024 to Feb 2025	Feb 2025 to Feb 2026	Jan 2026 to Feb 2026
Hispanic	134,527	133,402	116,069	113,383	33%	32%	29%	29%	-1%	-18%	-2%
Black	53,620	50,373	44,698	44,121	13%	12%	11%	11%	-6%	-14%	-1%
Other Asian / Pacific Islander	37,048	35,321	30,167	29,520	9%	9%	8%	8%	-5%	-20%	-2%
White	32,781	29,853	23,965	23,432	8%	7%	6%	6%	-10%	-28%	-2%
Chinese	35,685	33,774	30,204	29,804	9%	8%	8%	8%	-6%	-13%	-1%
Other	81,682	70,242	60,151	59,121	20%	17%	15%	15%	-16%	-19%	-2%
Vietnamese	12,017	11,084	9,894	9,776	3%	3%	3%	2%	-8%	-13%	-1%
Unknown	14,108	48,550	79,760	82,071	4%	12%	20%	21%	71%	41%	3%
American Indian or Alaskan Native	810	755	618	599	0%	0%	0%	0%	-7%	-26%	-3%
Total	402,278	413,354	395,526	391,827	100%	100%	100%	100%	3%	-6%	-1%



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

Medi-Cal By City						
City	Feb 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	153,040	40%	22,996	41,305	16,124	72,615
HAYWARD	49,846	13%	11,465	14,036	5,368	18,977
FREMONT	37,125	10%	15,466	6,432	2,025	13,202
SAN LEANDRO	24,217	6%	6,640	4,041	2,940	10,596
UNION CITY	13,881	4%	5,587	2,473	785	5,036
ALAMEDA	13,254	3%	3,330	2,502	2,011	5,411
BERKELEY	15,905	4%	3,608	2,624	1,681	7,992
LIVERMORE	12,553	3%	2,075	390	1,988	8,100
NEWARK	8,851	2%	2,683	3,667	467	2,034
CASTRO VALLEY	10,807	3%	3,231	1,662	1,662	4,252
SAN LORENZO	5,857	2%	1,218	1,384	671	2,584
PLEASANTON	7,740	2%	2,283	303	803	4,351
DUBLIN	7,560	2%	2,550	306	854	3,850
EMERYVILLE	2,981	1%	603	679	509	1,190
ALBANY	2,518	1%	536	293	550	1,139
PIEDMONT	466	0%	107	183	70	106
SUNOL	88	0%	31	9	7	41
ANTIOCH	31	0%	5	14	1	11
Other	18,707	5%	3,722	3,966	2,415	8,604
Total	385,427	100%	88,136	86,269	40,931	170,091

Group Care By City						
City	Feb 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,885	30%	342	451	0	1,092
HAYWARD	720	12%	316	206	0	198
FREMONT	697	11%	434	99	0	164
SAN LEANDRO	673	11%	268	116	0	289
UNION CITY	290	5%	171	58	0	61
ALAMEDA	314	5%	91	42	0	181
BERKELEY	158	3%	42	18	0	98
LIVERMORE	102	2%	31	1	0	70
NEWARK	150	2%	86	38	0	26
CASTRO VALLEY	226	4%	98	35	0	93
SAN LORENZO	164	3%	51	40	0	73
PLEASANTON	83	1%	31	4	0	48
DUBLIN	132	2%	50	9	0	73
EMERYVILLE	44	1%	12	8	0	24
ALBANY	22	0%	10	2	0	10
PIEDMONT	6	0%	0	3	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	26	0%	8	5	0	13
Other	514	8%	182	98	0	234
Total	6,207	100%	2,224	1,233	0	2,750

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

D-SNP By City						
City	Feb 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	74	38%	18	4	0	52
HAYWARD	23	12%	11	3	0	9
FREMONT	18	9%	6	0	0	12
SAN LEANDRO	12	6%	6	2	0	4
UNION CITY	2	1%	1	0	0	1
ALAMEDA	15	8%	5	4	0	6
BERKELEY	10	5%	0	2	0	8
LIVERMORE	9	5%	2	1	0	6
NEWARK	4	2%	4	0	0	0
CASTRO VALLEY	3	2%	2	0	0	1
SAN LORENZO	4	2%	3	0	0	1
PLEASANTON	6	3%	2	0	0	4
DUBLIN	3	2%	0	0	0	3
EMERYVILLE	1	1%	1	0	0	0
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	9	5%	6	1	0	2
Sum:			2,224	1,233	0	2,750

Total By City						
City	Feb 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	154,925	40%	23,338	41,756	16,124	73,707
HAYWARD	50,566	13%	11,781	14,242	5,368	19,175
FREMONT	37,822	10%	15,900	6,531	2,025	13,366
SAN LEANDRO	24,890	6%	6,908	4,157	2,940	10,885
UNION CITY	14,171	4%	5,758	2,531	785	5,097
ALAMEDA	13,568	3%	3,421	2,544	2,011	5,592
BERKELEY	16,063	4%	3,650	2,642	1,681	8,090
LIVERMORE	12,655	3%	2,106	391	1,988	8,170
NEWARK	9,001	2%	2,769	3,705	467	2,060
CASTRO VALLEY	11,033	3%	3,329	1,697	1,662	4,345
SAN LORENZO	6,021	2%	1,269	1,424	671	2,657
PLEASANTON	7,823	2%	2,314	307	803	4,399
DUBLIN	7,692	2%	2,600	315	854	3,923
EMERYVILLE	3,025	1%	615	687	509	1,214
ALBANY	2,540	1%	546	295	550	1,149
PIEDMONT	472	0%	107	186	70	109
SUNOL	89	0%	32	9	7	41

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

ANTIOCH	57	0%	13	19	1	24
Other	19,221	5%	3,904	4,064	2,415	8,838
Total	391,634	100%	90,360	87,502	40,931	172,841



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

Human Resources

Anastacia Swift

To: Alameda Alliance for Health Board of Governors

From: Anastacia Swift, Chief Human Resources Officer

Date: April 10th, 2026

Subject: Human Resources Report

Staffing

- As of April 1st, 2026, the Alliance had 674 full time employees and 1 part time employee.
- On April 1st, 2026, the Alliance had 21 open positions in which 2 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 19 positions open to date. The Alliance is actively recruiting for the remaining 19 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by division:

Division	Open Position April 1 st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	2	0	2
Operations	14	1	13
Healthcare Analytics	1	0	1
Information Technology	1	1	0
Finance	0	0	0
Compliance	0	0	0
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	21	2	19

- Our current recruitment rate is 3%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in March 2026 included:

5 years:

- Lori O (Integrated Planning)

6 years:

- Gabriela P (Marketing & Communications)
- Rosa C (Quality Management)
- Amani S (Health Plan Operations)

7 years:

- Catherine S (Case/Disease Management)
- Stephen W (Utilization Management)
- Gurjit S (Apps Management, IT Quality & Process Improvement)
- Tatyana N (Utilization Management)
- Timothy T (Pharmacy Services)
- Susan B (Long-Term Services and Support)

8 years:

- Anthony P (IT Infrastructure)
- Jayme M (Claims)
- Simin L (Financial Planning & Analysis)
- Carlos L (Member Service)

9 years:

- Sivilay S (Provider Services)
- Angelica G (HCS Behavioral Health)

10 years:

- Darryl C (Provider Services)
- Jamisha J (Quality Management)

11 years:

- Shiuwen F (IT Development)
- Dan P (IT Development)
- Ed F (IT Development)

12 years:

- Lisa C (Utilization Management)

14 years:

- Jeffrey M (IT Development)

21 years:

- Crista T (IT Quality & Process Improvement)

25 years:

- Anet Q (Claims)

30 years:

- Donna C (Credentialing)