



Board of Governors PACKET

AUGUST 14th, 2026

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, August 14th, 2026
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

PUBLIC COMMENTS: Public Comments can be submitted for any agendized item or for any item not listed on the agenda, by mailing your comment to: “Attn: Clerk of the Board,” 1240 S. Loop Road, Alameda, CA 94502 or by emailing the Clerk of the Board at bgonzalez@alamedaalliance.org. You may attend meetings in person or by computer by logging in to the following link: [Click here to join the meeting](#). You may also listen to the meeting by calling in to the following telephone number: [1-510-210-0967](tel:1-510-210-0967) [conference id 88758315#](#). If you use the link and participate via computer, you may use the chat function, and request an opportunity to speak on any agendized item, including general public comment. Your request to speak must be received before the item is called on the agenda. If you participate by telephone, please submit your comments to the Clerk of the Board at the email address listed above or by providing your comments during the meeting at the end of each agenda item. Oral comments to address the Board of Governors are limited to two (2) minutes per person. Whenever possible, the board would appreciate it if public comment communication was provided prior to the commencement of the meeting.

PLEASE NOTE: The Alameda Alliance for Health is making every effort to follow the spirit and intent of the Brown Act and other applicable laws regulating the conduct of public meetings.

1. CALL TO ORDER

(A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on August 14th, 2026, at 12:00 p.m. in Alameda County, California, by Andrea Schwab-Galindo, Presiding Officer. This meeting is to take place in person and by video conference call)

2. ROLL CALL

3. AGENDA APPROVAL

4. INTRODUCTIONS

5. CONSENT CALENDAR

(All matters listed on the Consent Calendar are to be approved with one motion unless a member of the Board of Governors removes an item for separate action. Any consent calendar item for which separate action is requested shall be heard as the next agenda item.)

a) JUNE 9th, 2026, FINANCE COMMITTEE MEETING MINUTES

b) JUNE 12th, 2026, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

c) JUNE 12th, 2026, BOARD OF GOVERNORS MEETING MINUTES

d) APPROVE RESOLUTION APPOINTING QIHE-UMC MEMBERS

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

b) FINANCE COMMITTEE

7. CEO UPDATE

8. BOARD BUSINESS

a) REVIEW AND APPROVE MAY AND JUNE 2026 MONTHLY FINANCIAL STATEMENTS

b) MEDICAL MANAGEMENT UPDATES & PROGRAMS

c) ENTERPRISE RISK MANAGEMENT – ONBOARDING PRESENTATION

9. STAFF UPDATES

10. UNFINISHED BUSINESS

11. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

12. PUBLIC COMMENT (NON-AGENDA ITEMS)

13. ADJOURNMENT

NOTICE TO THE PUBLIC

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

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

Additions and Deletions to the Agenda: Additions to the agenda are limited by California Government Code Section 54954.2 and confined to items that arise after the posting of the agenda and must be acted upon prior to the next Board meeting. For special meeting agendas, only those items listed on the published agenda may be discussed. The items on the agenda are arranged in three categories. **Consent Calendar:** These items are relatively minor in nature, do not have any outstanding issues or concerns, and do not require a public hearing. All consent calendar items are considered by the Board as one item and a single vote is taken for their approval, unless an item is pulled from the consent calendar for individual discussion. There is no public discussion of consent calendar items unless requested by the Board of Governors. **Public Hearings:** This category is for matters that require, by law, a hearing open to public comment because of the particular nature of the request. Public hearings are formally conducted, and public input/testimony is requested at a specific time. This is your opportunity to speak on the item(s) that concern you. If in the future, you wish to challenge in court any of the matters on this agenda for which a public hearing is to be conducted, you may be limited to raising only those issues which you (or someone else) raised orally at the public hearing or in written correspondence received by the Board at or before the hearing. **Board Business:** Items in this category are general in nature and may require Board action. Public input will be received on each item of Board Business.

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

Submittal of Information by Members of the Public for Dissemination or Presentation at Public Meetings (Written Materials/handouts): Any member of the public who desires to submit documentation in hard copy form may do so prior to the meeting by sending it to "Attn: Clerk of the Board", 1240 S. Loop Road, Alameda, CA 94502. This information will be disseminated to the Board at the time testimony is given.

Americans With Disabilities Act (ADA): It is the intention of the Alameda Alliance for Health to comply with the Americans with Disabilities Act (ADA) in all respects. If, as an attendee or participant at this meeting, you will need special assistance beyond what is normally provided, the Alameda Alliance for Health will attempt to accommodate you in every reasonable manner. Please contact the Clerk of the Board, Brenda Gonzalez, at (510) 995-1207 at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodations to attend or participate in meetings on a regular basis.

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org by August 11th, 2026, by 12:00 p.m.



Brenda Gonzalez, Clerk of the Board



EXECUTIVE SUMMARY APPENDIX

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

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FINANCE REPORT	Page 150
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SUPPORTING MATERIALS APPENDIX

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

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PRESENTATIONS

APPENDIX

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

MEDICAL MANAGEMENT UPDATE

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ENTERPRISE RISK MANAGEMENT PRESENTATION

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Consent Calendar



Finance Committee Meeting Minutes

**ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING**

**June 9th, 2026
8:00 am – 9:00 am**

SUMMARY OF PROCEEDINGS

Meeting conducted in person and by Teleconference.

Committee Members in-person: Dr. Rollington Ferguson, Yeon Park, Gil Riojas

Committee Members by Teleconference: Rebecca Gebhart, James Jackson

Committee Members Excused:

Board of Governors members in-person and on Conference Call: Andrea Schwab-Galindo

Alliance Staff in-person and on Conference Call: Matt Woodruff, Dr. Donna Carey, Tiffany Cheang, Lao Paul Vang, Pritika Dutt, Linda Ly, Brenda Gonzalez, Tome Meyers, Felix Rodriguez, Danube Serri, Anastasia Swift, Sasi Karaiyan, James Xu, Yen Ang

CALL TO ORDER

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

ROLL CALL

Roll call was conducted and confirmed.

INTRODUCTIONS

There were no introductions.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

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

COMMITTEE BUSINESS

a) CEO UPDATE

The CEO update discussed major upcoming changes to Medi-Cal eligibility, including a \$50 monthly premium for UIS members starting July 2027, loss of dental and enhanced care management benefits for UIS, and stricter medical management for community supports. Advocacy efforts are ongoing to keep UIS members in managed care, as fee-for-service would restrict provider access and impact FQHCs due to federal funding rules. Work requirements for satisfactory immigration status will begin next year, with details pending from the state.

Question: Ms. Gebhart asked why FQHCs cannot see UIS members under federal requirements, and if a UIS member does not pay the premium, are they eligible for indigent care? Mr. Woodruff said FQHCs receiving federal dollars cannot see undocumented members unless they operate a completely separate clinic. Immigration status is not included in eligibility files, so managed care keeps providers held harmless.

Question: Mr. Jackson asked what the operational implications are and how access for UIS members can be maintained without jeopardizing FQHCs. Mr. Woodruff explained that keeping UIS members in managed care is the cleanest solution, as providers would not know immigration status and would be held harmless. Fee-for-service introduces complexity and risk of denied claims and loss of RAP payments.

Question: Dr. Ferguson asked what the impact of legislative changes is on next year's budget and care services. Mr. Woodruff said the budget reflects a worst-case scenario with declining membership; changes may be incremental even if the state modifies its approach.

b) REVIEW AND APPROVE THE APRIL 2026 MONTHLY FINANCIAL STATEMENTS

APRIL 2026 Financial Statement Summary

Enrollment:

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

Net Income:

For the month ended April 30th, 2026, the Alliance reported a Net Income of \$388,000 (versus budgeted Net Income of \$1.9 million). For the year-to-date, the Alliance recorded a Net Income of \$67.0 million versus a budgeted Net Income of \$21.1 million.

Premium Revenue:

For the month ended April 30th, 2026, actual Revenue was \$188.1 million vs. our budgeted amount of \$183.1 million.

Medical Expense:

Actual Medical Expenses for the month were \$179.5 million, vs. budgeted amount of \$172.6 million. For the year-to-date, actual Medical Expenses were \$1.8 billion vs. budgeted Medical Expense of \$1.8 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 95.5%. The year-to-date MLR was 92.3%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending April 30th, 2026, were \$11.4 million vs. our budgeted amount of \$11.5 million. Our Administrative Loss Ratio (ALR) is 6.1% of our Revenue for the month, and 5.5% of Net Revenue for year-to-date.

Other Income / (Expense):

As of April 30th, 2026, our YTD interest income from investments show a gain of \$24.9 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending April 30th, 2026, we reported \$63.5 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of \$60.3 million. Our MCO Tax Expense was \$63.5 million vs. budgeted MCO Tax Expense of \$60.3 million.

Tangible Net Equity (TNE):

For April, the DMHC requires that we have \$79.8 million in TNE, and we reported \$236.3 million, leaving an excess of \$156.5 million. As a percentage we are at 296%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported \$577.3 million in cash; \$413.2 million is uncommitted. Our current ratio is above the minimum required at 1.23 compared to regulatory minimum of 1.0.

Capital Investments:

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

Motion: A motion was made by Yeon Park, and seconded by Dr. Rollington Ferguson, to accept and approve the April 2026 Financial Statements.

Motion Passed

No opposition or abstentions.

Question: Ms. Gebhart inquired whether there is a relationship between losses in duals with long-term care and growth in Medicare? Are duals dropping off, being converted, or going to Kaiser? Mr. Riojas replied that duals with long-term care have both Medi-Cal and Medicare coverage; as Medicare grows, duals may align, but the population is still new, and trends are being monitored.

Question: Ms. Gebhart asked what is going on with pharmacy and ancillary costs. Mr. Riojas explained that pharmacy costs are driven by physician-administered drugs and UCSF payment offsets; ancillary costs are higher due to community supports.

Question: Dr. Ferguson asked for an explanation of the risk corridor for UIS and how it works. Mr. Riojas replied that the risk corridor hedges costs for new programs: if expenses are below revenue, the state is repaid, and if expenses are above revenue, the state provides additional funding. Currently, \$2 million is being accrued, possibly up to \$8 million.

c) REVIEW AND APPROVE FY27 PRELIMINARY BUDGET

Highlights

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

- Clinical Department Expenses are \$2.5 million higher than FY 2026 3Q Forecast and comprise 2.1% of revenue.
- Medicare D-SNP program membership is expected to grow steadily over time.
- D-SNP Revenue risk scores are higher than bid assumptions leading to higher revenue.
- and expenses.
- Infertility services are now included under Group Care in accordance with regulatory.
- requirements.
- Transitional Rent is added to FY2027 Preliminary Budget projections.
- Transitional Care Management is starting July 2026.

Question: Dr. Ferguson asked where do you see the additional losses in membership coming from, and why is the trend continuing through 2027? Mr. Riojas said the largest loss is from the UIS population leaving, with about 67,000 members expected to decline and exit by January 2027. Additional losses are expected from the SIS population due to new work requirements starting in 2027.

Motion: A motion was made by Rebecca Gebhart, and seconded by James Jackson, to approve the FY27 Budget.

Motion Passed

No opposition or abstentions.

d) REVIEW ANNUAL ALLIANCE GRANTS REPORT

Grants Policy Summary

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

Question: Dr. Ferguson asked what institutions received the grants? Is the distribution equal or limited to single providers? Gil explained the detail exists and can be provided in future packets, showing by provider or facility type what was awarded. Anyone in the network could apply for provider recruitment grants, and the process was reviewed and vetted.

Informational Item Only.

e) MEMBER ACUITY ANALYSIS

Categories Defined:

- Stayers: Members who remain continuously enrolled.
- Leavers: Members who exit the plan.
- Joiners: New members joining the plan.

Cost Findings:

- Baseline (stayers) PMPM cost: ~\$340.
- Leavers PMPM cost: ~\$344, slightly higher than stayers, contrary to expectations.
- Joiners PMPM cost: ~\$411, significantly higher than both stayers and leavers.
- Net effect: Joiners' higher costs offset the expectation that leavers would be less costly.

Leavers Analysis:

- Higher costs among leavers are mainly in SPD and duals categories, likely due to end-of-life expenses rather than healthy disenrollment.

Joiners Analysis:

- Joiners are consistently more expensive, raising overall plan acuity and costs.

Optional Expansion and Child Categories:

- In these groups, leavers are less costly than stayers, confirming initial assumptions for these categories.

UIS Population:

- UIS members have 6.7% higher PMPM costs than baseline, especially in optional expansion adult and child categories.

Implications:

- Rising acuity among joiners may require adjustments to expense forecasts and outreach to the state for rate reconsideration.
- Care management programs will be critical for high-acuity joiners.
- If acuity trends shift downward, it would favorably impact rates and reserves, but current data shows rising acuity.

Next Steps:

- Analysis will be repeated twice a year.
- Targeted case management for high-acuity joiners.
- Actuarial review to ensure rates align with actual acuity.
- Ongoing communication with the state to advocate for rate adjustments based on real data.

Informational Item only.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 9:06 a.m.



Compliance Advisory Committee Meeting Minutes



COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes

June 12, 2026
10:30 a.m. – 11:30 a.m.

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

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

Remote: None

Committee Members Excused: None

1. CALL TO ORDER

The regular meeting of the Compliance Advisory Committee was officially called to order by Dr. Kelley Meade at approximately 10:31 a.m.

2. ROLL CALL

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

3. AGENDA APPROVAL OR MODIFICATIONS

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

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

No public comments were received.

5. CONSENT CALENDAR

a) May 8, 2026 Compliance Advisory Committee Meeting Minutes.

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

Second: Stephen Smythe.

Vote: All voting members present approved the motion.

6. COMPLIANCE MEMBER REPORTS

a) Compliance Activity Report:

i. Plan Audits and Regulatory Oversight:

1. 2025 DMHC Routine Full Medical Survey
 - Final findings received with two (2) responses due in July.
 - Working to remediate findings with DMHC.
2. 2026 DHCS Annual Routine Medical Survey
 - Waiting for the second exit interview, which was expected at the start of June; continuing to follow up with DHCS to get the exit interview scheduled.
 - No official preliminary audit findings until that interview is scheduled.
3. 2026 CMS NAV Audit
 - Federal Network Adequacy Audit.
 - This is the first CMS Network Validation for the Alliance.
 - This is a pass/fail audit; the Plan submits network to CMS.
 - Joint effort between the Analytics and Provider Contracting teams to gather data and prepare for the audit.
 - Required data was prepared and submitted at the opening of the submission window.
 - Initial formatting issue was corrected, and the upload was successfully completed.
 - We have a complete network thanks to the efforts of Provider Contracting to ensure 100% network accuracy.
 - Results are expected in Q3 2026.
4. 2026 HSAG NAV Audit
 - Annual audit coordinated by a third party for the State, Health Services Advisory Group (HSAG); same auditor as prior years.
 - This is a DHCS network adequacy audit.
 - On track for June 18th submission with 90% completion of period deliverables to date.
5. Encounter Validation Audit
 - Also performed by HSAG.

- Prior encounter validation audits have focused on medical records related to encounters, however this iteration is focusing on what makes an encounter/claim.
- Deep look into claims, including claims with our delegates.
- Currently we have requested materials from the delegates, and reviewing policies and procedures.
- Materials are due June 29th; currently on track to meet the deadline.

ii. Compliance Dashboard

- Dashboard totals
 - 250 total findings with 226 completed and 24 in progress.
 - Overall completion rate of 90.4%.
 - 214 are state audit findings, 198 are completed.
 - 36 are self-identified findings, 28 are completed.
- 2024 DHCS Annual Routine Medical Survey
 - All findings are fully closed.
 - Continuing to monitor findings that need oversight.
 - An internal audit validation was completed on findings related to the termination of suspended providers and consistent reporting to DHCS.
 - a. The corrective action plan (CAP) was closed on May 29th showing full remediation of this finding.
 - b. This CAP closure will be reported at the internal Administrative Oversight Committee (AOC).
- 2026 DHCS Annual Routine Medical Survey
 - a. Waiting for preliminary report.
 - b. Tracking two self-identified findings:
 - i. ECM Provider Directory did not show ECM providers for the

months of January – February
and July – December.

- ii. The Plan does not have an oversight mechanism in place for CPSP providers.
 - c. Self-identified findings are not necessarily indicative of future DHCS audit findings. Instead, they reflect areas that have been identified as potentially out of compliance or at risk of noncompliance, allowing corrective actions to be implemented proactively.
 - d. After each audit the Health Plan Audits team compiles a list of potential gaps to include as self-identified findings on the Compliance Dashboard. Once audit findings from the regulators come in, those findings are compared against the self-identified findings and reconciled so we can correct both the self-identified findings and the regulator identified findings.
- 2025 DMHC Routine Fiscal Examination
 - a. One finding undergoing validation related to follow up with capitated providers on claims forwarded to the Plan.
 - 2025 DMHC Routine Medical Audit
 - a. The final report was received May 19th
 - b. Four (4) of the sixteen (16) findings were corrected.
 - c. There are also six (6) self-identified findings.
 - d. The corrected items include:
 - i. updates to expedited grievance notice language,
 - ii. provider network capacity standards,
 - iii. behavioral health inter-rater reliability testing, and

- iv. use of approved medical necessity criteria.
 - e. There are two repeat findings:
 - i. Grievance and Appeals – Immediate notification to complainants of their right to contact the Department regarding an expedited grievance
 - 1. These notifications are done verbally, however the issue is the verbal notification is not always documented in the case file.
 - ii. Pharmacy – Published formulary did not meet regulatory requirements.
 - 1. The template has been updated and approved by DMHC, however there were missing items that need to be cross walked for DMHC to locate. The work is ongoing.
 - iii. Anti-Fraud Activity
 - Fraud, Waste, and Abuse Program
 - Fraud, Waste, and Abuse (FWA) remains a key compliance program integrity priority in 2026.
 - Approximately 130 potential FWA referrals have been received year-to-date through a combination of Compliance Hotline reports, member grievances, direct referrals, and vendor-generated referrals
 - Twenty six (26) referrals were determined to be potentially credible and were reported to DHCS for further investigation.
 - The Special Investigations Unit (SIU) continues to investigate credible allegations through claim reviews, medical record requests, and

collaboration with subject matter experts across operational departments.

- Monthly cross-functional FWA meetings support investigations, help identify emerging risk patterns, promote timely interventions, and facilitate process improvements related to FWA across the organization.
- Overall, the SIU is continuing to focus on investigative efforts to substantiate inappropriate billing and other FWA concerns, implement corrective actions when needed to ensure provider education, recovery of overpayments, and provider terminations or referral to outside agencies where appropriate,
- The SIU also continues to collaborate with external partners, including the Department of Justice (DOJ), to address emerging FWA trends and support investigations as warranted.
- Case Management Framework Enhancements
 - Efforts are ongoing to strengthen the SIU case management framework to support sustained investigation volume and maintain operational effectiveness.
 - Enhancements include continued refinement of risk-based case prioritization practices to focus resources on matters presenting the greatest financial exposure, compliance risk, and potential member impact,
- Process Improvements and DHCS Audit Alignment
 - Ongoing process enhancements were identified through the recent DHCS audit and internal continuous improvement efforts.
 - Efforts to strengthen verification of service (VOS) procedures, including the development of clearer documentation standards, greater consistency in application, and alignment with regulatory expectations.
 - SIU is partnering with Analytics to develop a periodic reporting and random claim sampling



process to proactively verify that billed services were received by members.

- Enhancements are intended to strengthen program integrity, improve oversight activities, and support ongoing audit readiness.

iv. Compliance Committee Overview

- Compliance Committee meets quarterly and serves as a key oversight forum for the Alliance Compliance Program. These meetings are now getting reported up through the Compliance Advisory Committee.
- Compliance Committee met on May 19, 2026 and continued its quarterly oversight of the Compliance Program, including regulatory reporting, policy implementation, regulatory audits, privacy, FWA, delegation oversight, and operational committee activities.
- There were no sanctions during the reporting period.
- Updates were reviewed on active compliance risks and issues, including grievance turnaround time requirements, Board Certified Behavior Analyst PAVE enrollment requirements, and claims processing timeliness.
- The annual Compliance Program, which included enhanced integration of Compliance, Enterprise Risk Management (ERM), and Internal Audit was reviewed and approved.
- Ongoing efforts to strengthen delegated entity oversight, audit monitoring processes, and training effectiveness were also discussed.
- ERM and operational oversight activities were presented and the foundation ERM governance components were approved.
- Results of the annual Compliance Program survey, which assessed program effectiveness across employee knowledge, communication, training, and organizational culture was presented.
 - Survey results reflected strong performance in compliance knowledge and leadership commitment.



- Opportunities for improvement were identified in communication, reporting, and training resources. These areas will be incorporated into future program enhancement efforts.

b) Medi-Cal and Medicare Program Updates

i. D-SNP Updates

- The D-SNP bid was completed timely and successfully.
- The MTM attestation was completed.
- The next big deadline is the State Medicaid Agency Contract (SMAC).
- Due the first Monday in July.

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a) Compliance Advisory Committee Charter Update

- Compliance has created an official charter for the Compliance Advisory Committee.
- The charter was reviewed with the committee and updates were made including emphasis and the Subcontractor and Delegation Oversight Committee reporting, FWA reporting, and sanctions and penalties.

b) Aligning Compliance Advisory Committee meetings with Board of Governors meetings

- Meeting cadence will match with Board of Governors, regarding in person verses remote meetings.

Motion: A motion to approve the Charter with the noted updates was made by Rebecca Gebhart.

Second: Byron Lopez.

Vote: All voting members present approved the motion.

8. STAFF UPDATES

- a) Sophia of the Compliance Audit team has left the Alliance.
- b) Vaneesha, of the Regulatory Affairs team will be leaving the Alliance as well.
- c) Staffing evaluations and repositing of these vacant positions are being coordinated with Human Resources and Executive Leadership.

9. UNFINISHED BUSINESS

a) None



10. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

a) Compliant Tracking Module (CTM)

- This is the federal version of grievances.
- Will be discussed at a future meeting.

11. ADJOURNMENT

- ### **a)**
- With no further business, the meeting was adjourned by Dr. Kelley Meade at 11:29 a.m.



Board of Governors Meeting Minutes

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

Video Conference Call and
1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

Board of Governors Present: Andrea Schwab-Galindo (Chair), Aaron Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Rebecca Gebhart, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam, Marcus Watkins, Natalie Williams

Board of Governors Remote: None

Board of Governors Excused: Dr. Noha Aboelata (Vice-Chair), Andrea Ford

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

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

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL

There were no modifications to the agenda.

4. INTRODUCTIONS

There were no introductions.

5. CONSENT CALENDAR

a) MAY 8th, 2026, BOARD OF GOVERNORS MEETING MINUTES

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

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

Motion: A motion was made by Natalie Williams and seconded by Jody Moore to approve the Consent Calendar.

Vote: The motion was passed unanimously.

Ayes: Aaron Basrai, Dr. Rollington Ferguson, Rebecca Gebhart, James Jackson, Byron Lopez, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam, Marcus Watkins, Natalie Williams, Chair Andrea Schwab-Galindo.

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

The Compliance Advisory Committee reported that audits for 2023 and 2024 have been fully closed, while the 2025 joint DMHC routine full medical survey is ongoing, with four out of sixteen items already closed and two repeat findings actively being remediated. For the 2026 survey, an exit conference has taken place, but the committee is still awaiting the preliminary report, with two self-identified items pending resolution. The committee also noted progress on network adequacy surveys, including a federal survey submitted early and expected to pass at 100%, and a similar state survey conducted by a third party. Members expressed satisfaction with the enterprise risk management process and anticipate further updates in future meetings. The committee reviewed and updated its charter, focusing on governance and its reporting relationship to the board, with input from Mr. Smith and his team. Additionally, the committee received a detailed report from the operational compliance committee, affirmed that the agenda aligned with the Board of Governors, and described the meeting as productive and positive, inviting questions from attendees.

b) FINANCE COMMITTEE

The Finance Committee met on June 9th and discussed four major items: April finances, the preliminary budget for fiscal year 2027, member activity analysis, and the annual grants program. The Alliance has awarded \$6.1 million in grants to date, with a detailed analysis of grant distribution forthcoming; however, the committee noted the absence of an institutional breakdown of grant recipients and requested further analysis. The preliminary budget for fiscal year 2027 anticipates a net loss of about \$23.7 million, with enrollment projected to decline to 263,000 members and medical expenses expected to decrease to \$1.8 billion, raising questions about the reasons for lower projected medical costs. April finances showed a monthly enrollment drop of approximately 5,500 members and a year-over-year decline of about 31,000, with medical expenses exceeding budget by \$5 million for the month but remaining on target year-to-date. Tangible net equity (TNE) has remained stable, and the medical loss ratio (MLR) rose slightly to 95.5% for the month, averaging 92% year-to-date. Overall, the committee reported positive financial trends and highlighted the need for further explanation of enrollment declines and medical expense projections.

c) COMMUNITY ADVISORY SELECTION COMMITTEE

The Community Advisory Committee (CAC) Selection Committee met in May, welcomed new members, and completed its annual charter review, recommending updates to align with current Brown Act requirements and clarifying participation expectations. The committee supported electronic voting for remote participants and reviewed membership attendance and engagement, discussing outreach strategies for inactive members. Recruitment efforts were updated to ensure the committee remains

diverse and representative of all members. The report emphasized ongoing efforts to maintain active engagement and inclusivity within the committee, and invited questions or comments from attendees.

7. CEO UPDATE

Mr. Woodruff presented the CEO report, noting that the Alliance once again failed to meet its grievance compliance targets. He attributed this shortfall to staffing shortages, with eight positions remaining vacant and recruitment efforts ongoing. The Board reviewed the Grievance and Appeals Report, which included the following information: member grievances had an 85% processing time for expedited grievances, falling short of the 95% compliance target. Additionally, the department achieved a 75% processing time for standard grievances, which also did not meet the 95% compliance standard. Furthermore, the Alliance's encounter data reporting was below the 65% and 80% standards, as the Alliance allowed providers to submit claims outside of the timely filing window due to the implementation of their new systems. He highlighted operational updates, including the need to reschedule the July board meeting due to anticipated absences, leading to a board vote to move it to August. Mr. Woodruff discussed upcoming board training requirements and introduced new live and digital options to ensure compliance and accommodate members' schedules. He reported 100% compliance for the Medicare network after signing a contract with Sutter and indicated plans to explore future compliance strategies. Legislative and budget updates were previewed, with Mr. Woodruff emphasizing the impact of state cuts to ECM and community supports and raising concerns about other health plans' leniency toward state guidelines. This prompted a board discussion about balancing operational flexibility with audit and financial risk, and Mr. Woodruff committed to providing a risk-benefit analysis and further data before any changes are made. He concluded by noting that additional strategic decisions will be required as the financial environment evolves and is committed to keeping the board informed and involved.

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Aaron Basrai to postpone the July 10, 2026, Board of Governors meeting to August 14, 2026.

Vote: The motion was passed unanimously.

Ayes: Aaron Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Rebecca Gebhart, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam, Marcus Watkins, Natalie Williams, Chair Andrea Schwab-Galindo.

No opposition or abstentions.

8. BOARD BUSINESS

a) LEGISLATIVE UPDATE

Highlights:

Budget Agreement & Timeline

- The Senate and Assembly reached a two-party budget agreement; bills are expected soon, and voting is scheduled for the following week. Ongoing negotiations with the governor's office are anticipated.

Medi-Cal Proposals

- Transition of UIS (Uninsured Immigrant Services) population to fee-for-service is still under negotiation; advocacy efforts continue to maintain managed care access for these members.

- Medi-Cal premiums delayed until July 2027; governor to set premium level between \$0 and \$50 by June 2027.
- Full-scope Medi-Cal for qualified non-citizens delayed to 2027-28, affecting about 9,000 Alameda County residents.
- Dental benefit cuts for adults with unsatisfactory immigration status are delayed by 12 months.
- Asset test for older adults and people with disabilities lowered to \$21,000 in 2027-28; adult acupuncture benefit retained.
- Medi-Cal loss remittances approved as budgeted; distressed hospitals to receive \$200M in forgivable loans and \$250M for public hospitals.

ECM & Community Supports

- The Senate and Assembly approved reductions in access to ECM (Enhanced Care Management) and community supports, with increased utilization management for ABA (Applied Behavioral Analysis) and transportation benefits.

HR1 Impacts

- HR1 provisions will cause 44,000 Medi-Cal members to lose coverage in 2026-27, with further losses projected by 2029.
- CMS released an interim final rule for work and community engagement requirements, with public comment due July 31. Medical frailty exclusions will require additional proof for exemption.

MCO Tax

- New MCO (Managed Care Organization) tax model proposed: \$8.85 per member per month for both Medi-Cal and non-Medi-Cal entities. Medi-Cal plans see a wash, but non-Medi-Cal plans face a net tax. Hospital payments are at risk if the tax is not approved.

UIS Transition Advocacy

- Local plans, including the Alliance, are actively advocating to keep the UIS population in managed care. Multiple meetings with legislators and local partners, including Assembly Member Bonta and Ortega.
- Alternative proposal developed: state-only contract for managed care plans to retain preventive services, with federally payable services (emergency, OB) carved out to fee-for-service. The proposal maintains two-thirds of the administration's savings and requests that the legislature fund the \$190M shortfall.
- Advocacy efforts are credited with keeping the issue alive in negotiations.

Implications & Next Steps

- If UIS members move to fee-for-service, providers will receive lower reimbursement rates; the proposal aims to maintain current capitation rates for managed care.
- Anticipated impacts on coverage, access, administrative burden, and financial stability for providers and the Alliance. Board to consider interventions and investments once more information is available.
- The health PAC program may see increased enrollment if UIS members lose managed care; current data shows only a small fraction of disenrolled Medi-Cal members joining Health PAC, likely due to deferred care.
- Emphasis on advocacy, data-driven decision-making, and proactive planning for health equity and financial sustainability.

Question: Ms. Gebhart asked if the MCO tax does not go through, will hospital payments be negatively impacted? Mr. Riojas confirmed that hospital payments would be negatively impacted, as the MCO tax funds various programs, including direct payments and intergovernmental transfers.

Question: Dr. Seevak asked for providers, if the plan is getting reduced rates for the UIS population, will that reduction be passed along to providers? Mr. Woodruff explained that if UIS members move to fee-for-service, providers will receive lower reimbursement rates (100% of Medi-Cal FFS). If the alternative proposal is accepted, the Alliance would pay providers at current capitation rates for managed care services.

Question: Mr. Basrai inquired whether programs like HealthPAC will be affected if UIS members lose managed care, and what the expected financial impact would be. Mr. Woodruff and Dr. Clanon responded that more UIS members would likely move into Health PAC, but current data show only a small fraction of disenrolled Medi-Cal members are joining Health PAC, likely due to deferred care. The full impact will depend on final budget decisions and further data analysis.

Informational Item Only.

b) FY26 GRANT UPDATES

Summary:

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

Question: Dr. Seevak asked if anyone has been looking closely at the grants and outcomes to see whether the investment has been worth it. Mr. Riojas responded that the Alliance is working to improve its process, analyzing data to evaluate grant effectiveness and determine future continuation. This includes collecting reports from providers and comparing outcome measures before and after grants.

Informational Item only.

c) MEMBER ACUITY ANALYSIS

Categories Defined:

- Stayers: Members who remain continuously enrolled.
- Leavers: Members who exit the plan.
- Joiners: New members joining the plan.

Cost Findings:

- Baseline (stayers) PMPM cost: ~\$340.
- Leavers PMPM cost: ~\$344, slightly higher than stayers, contrary to expectations.
- Joiners PMPM cost: ~\$411, significantly higher than both stayers and leavers.
- Net effect: Joiners' higher costs offset the expectation that leavers would be less costly.

Leavers Analysis:

- Higher costs among leavers are mainly in SPD and duals categories, likely due to end-of-life expenses rather than healthy disenrollment.

Joiners Analysis:

- Joiners are consistently more expensive, raising overall plan acuity and costs.

Optional Expansion and Child Categories:

- In these groups, leavers are less costly than stayers, confirming initial assumptions for these categories.

UIS Population:

- UIS members have 6.7% higher PMPM costs than baseline, especially in optional expansion adult and child categories.

Implications:

- Rising acuity among joiners may require adjustments to expense forecasts and outreach to the state for rate reconsideration.
- Care management programs will be critical for high-acuity joiners.
- If acuity trends shift downward, it would favorably impact rates and reserves, but current data show rising acuity.

Next Steps:

- Analysis will be repeated twice a year.
- Targeted case management for high-acuity joiners.
- Actuarial review to ensure rates align with actual acuity.
- Ongoing communication with the state to advocate for rate adjustments based on real data.

Question: Dr. Seevak asked what time frame is used to measure the cost of joiners? Mr. Riojas explained that the analysis looked at costs for joiners over a six-month period, acknowledging that costs are typically higher initially due to increased service use when members first join.

Informational Item only.

d) REVIEW AND APPROVE APRIL 2026 MONTHLY FINANCIAL STATEMENTS

APRIL 2026 Financial Statement Summary

Enrollment:

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

Net Income:

For the month ended April 30th, 2026, the Alliance reported a Net Income of \$388,000 (versus budgeted Net Income of \$1.9 million). For the year-to-date, the Alliance recorded a Net Income of \$67.0 million versus a budgeted Net Income of \$21.1 million.

Premium Revenue:

For the month ended April 30th, 2026, actual Revenue was \$188.1 million vs. our budgeted amount of \$183.1 million.

Medical Expense:

Actual Medical Expenses for the month were \$179.5 million, vs. budgeted amount of \$172.6 million. For the year-to-date, actual Medical Expenses were \$1.8 billion vs. budgeted Medical Expense of \$1.8 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 95.5%. The year-to-date MLR was 92.3%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending April 30th, 2026, were \$11.4 million vs. our budgeted amount of \$11.5 million. Our Administrative Loss Ratio (ALR) is 6.1% of our Revenue for the month, and 5.5% of Net Revenue for year-to-date.

Other Income / (Expense):

As of April 30th, 2026, our YTD interest income from investments shows a gain of \$24.9 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending April 30th, 2026, we reported \$63.5 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of \$60.3 million. Our MCO Tax Expense was \$63.5 million vs. budgeted MCO Tax Expense of \$60.3 million.

Tangible Net Equity (TNE):

For April, the DMHC requires that we have \$79.8 million in TNE, and we reported \$236.3 million, leaving an excess of \$156.5 million. As a percentage we are at 296%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported \$577.3 million in cash; \$413.2 million is uncommitted. Our current ratio is above the minimum required at 1.23 compared to regulatory minimum of 1.0.

Capital Investments:

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

Question: Mr. Watkins asked whether IHSS is included in the numbers and whether there is a way to see what is declining in IHSS versus traditional Medi-Cal? Mr. Riojas confirmed that IHSS is included, noted continued enrollment growth in IHSS (group care), and explained that declines are mainly in Medi-Cal categories, with IHSS offsetting some of the losses. Detailed breakdown is available.

Motion: A motion was made by Natalie Williams and seconded by Dr. Kelley Meade to approve the April 2026 Financial Statements.

Vote: The motion was passed unanimously.

Ayes: Aaron Basrai, Dr. Rollington Ferguson, Rebecca Gebhart, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam, Marcus Watkins, Natalie Williams, Chair Andrea Schwab-Galindo.

No opposition or abstentions.

e) REVIEW AND APPROVE FISCAL YEAR 2027 BUDGET

Highlights

- FY 2027 Projected Net Loss of \$23.7 million.
- Projected Tangible Net Equity (TNE) at year-end is 302% of required TNE.
- June 2027 projected enrollment is 263,000, down 106K from the prior year.
- Revenue is \$1.93 billion, \$338 million lower than FY 2026 3Q Forecast due to enrollment loss.
- Medical Expense totals \$1.8 billion in FY 2027, a decrease of \$236.5 million (-11.6%) from FY 2026 3Q Forecast.
- Administrative Department Expenses are \$3.8 million less than FY 2026 3Q Forecast, representing 6.4% of revenue.
- Clinical Department Expenses are \$2.5 million higher than FY 2026 3Q Forecast and comprise 2.1% of revenue.
- Medicare D-SNP program membership is expected to grow steadily over time.
- D-SNP Revenue risk scores are higher than bid assumptions, leading to higher revenue.
- and expenses.
- Infertility services are now included under Group Care in accordance with regulatory requirements.
- Transitional Rent is added to FY2027 Preliminary Budget projections.
- Transitional Care Management is starting in July 2026.

Question: Dr. Seevak inquired whether the assumption is that, if the UIS population stays with the Alliance, it would be a pass-through, and whether the Alliance would lose money on UIS patients? Is it possible that UIS members could continue to be administered through the Alliance even if their Medi-Cal status changes? Mr. Riojas clarified that the budget assumes the UIS population will not be in managed care and will move to fee-for-service, which is a major driver of revenue and expense decreases; Mr. Woodruff and Mr. Riojas explained that the state has not elaborated, but the budget conservatively assumes the population leaves managed care. If they move to fee-for-service, the state will administer, not the Alliance.

Question: Dr. Ferguson asked how and when the Alliance recover on group care, given that group care and D-SNP are showing increases in membership but also losses. Mr. Riojas stated that a new two-year contract with a rate increase was negotiated with the county, aiming for break-even or better, and noted the challenge of managing D-SNP due to fixed costs and slow enrollment growth.

Question: Mr. Basrai questioned how conservative the 106,000-member loss estimate is in the preliminary budget. Does it account for UIS, retroactive redeterminations, and work requirements from HR1? Mr. Riojas confirmed the estimate is conservative, assuming more members are disenrolled, and it accounts for all those factors.

Question: Dr. Ferguson asked when the Alliance will start being aggressive in enrolling D-SNP members to even out losses? Mr. Woodruff responded that aggressive marketing would begin in August, after a deliberate slow start to protect STARS ratings, with campaigns and co-branding planned with key partners.

Motion: A motion was made by Jody Moore and seconded by Natalie Williams to approve the Fiscal Year 2027 Budget.

Vote: The motion was passed unanimously.

Ayes: Aaron Basrai, Dr. Rollington Ferguson, Rebecca Gebhart, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam, Marcus Watkins, Natalie Williams, Chair Andrea Schwab-Galindo.

No opposition or abstentions.

9. STAFF UPDATES

There were no staff updates.

10. UNFINISHED BUSINESS

None.

11. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

12. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

13. ADJOURNMENT

Chair Schwab-Galindo adjourned the meeting at 1:53 p.m.



Resolution Appointing QIHE-UMC Members

RESOLUTION NO. 2026-XX

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH
APPOINTING ALLIANCE STAFF SHATAE JONES AND
ANDREA DEROCHI TO QUALITY IMPROVEMENT HEALTH
EQUITY & UTILIZATION MANAGEMENT COMMITTEE

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

WHEREAS, the Alliance Board of Governors (the “Board”) on September 8, 2023, passed Resolution 2023-07, creating the Quality Improvement and Health Equity Committee (the “QIHEC”) as a standing committee of the Board; and

WHEREAS, the QIHEC added Utilization Management to its name and oversight during a meeting in April 2026 to align with the Alliance’s D-SNP line of business requirements to become QIHE-UMC;

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

WHEREAS, the QIHE-UMC charter permits Alliance staff to participate as voting member(s);

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

SECTION 1. That the Alliance Board appoints the following individual(s) to serve as voting member(s) of the QIHE-UMC for two (2) year terms:

Shatae Jones – Director, Community Health Strategy

Andrea DeRochi – Behavioral Health Manager

PASSED AND ADOPTED by the Board at a meeting held on the 14th day of August 2026.

CHAIR, BOARD OF GOVERNORS

ATTEST:

Secretary



CEO Update

Matthew Woodruff

To: Alameda Alliance for Health Board of Governors
From: Matthew Woodruff, Chief Executive Officer
Date: August 14th, 2026
Subject: CEO Report

- **Financials:**

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

	<u>June</u>	<u>YTD</u>
Medi-Cal	(\$4.7M)	\$78.1M
Group Care	(\$527K)	(\$4.7M)
Medicare	(\$860K)	(\$11.1M)
Total	(\$6.1M)	\$62.4M

- **Revenue was \$190.6 million in June and \$2.3 billion Year-to-Date (YTD).**
 - Medical expenses were \$185.4 million in June and \$2.1 billion for the fiscal year-to-date; the medical loss ratio is 97.2% for the month and 92.8% for the fiscal year-to-date.
 - Administrative expenses were \$13.6 million in June and \$130.5 million for the fiscal year-to-date; the administrative loss ratio is 7.1% of net revenue for the month and 5.7% of net revenue year-to-date.
- **Tangible Net Equity (TNE):** Financial reserves are 291% of the required DMHC minimum, representing \$152.0 million in excess TNE.
- **Total enrollment in June was 370,073**, decreased by 4,860 Medi-Cal members compared to May 2026.

- **Alliance Compliance Update**

- **Key Performance Indicators – Grievances – MCAL & IHSS:**

- **Regulatory Metrics:**

- Standard grievances scored 94% processing time, which is below the 95% compliance mark.
- Exempt grievance and expedited grievance cases were resolved within the 95% of regulatory timeframes.
- Standard appeal and expedited appeal cases were resolved within the 95% of regulatory timeframes.
- There was a total of 2,249 unique grievance cases resolved during the reporting period, with a total of 2,389. Out of 2,609 cases, 37%

were related to Access to Care, 34% were related to Quality of Service, 19% were related to Coverage Dispute, 6% were related to “other” (enrollment and eligibility) and 4% were related to Quality of Care.

- For the month of June 2026, 75% of standard grievances were resolved in favor of members, 22% in favor of the Plan, and 3% were withdrawn by members; 77% of exempt grievance cases were resolved in favor of the members, and 23% were resolved in favor of the Plan.
- For the month of June 2026, there were a total of 1,800 unique exempt grievance cases resolved – of these cases, 34% were category “other,” 36% were Quality of Service, and 30% were Access to Care.
- Of the 92 appeals for the month of June 2026, 82% of cases were upheld/denied, 15% were overturned/approved, and 3% were partially upheld.
- **Non-Regulatory Metrics:**
 - All non-regulatory metrics were met for January.
- **Grievances – D-SNP:**
 - For the D-SNP line of business, there were 140 standard grievance and first call resolution cases resolved within the regulatory timeframes of 100% compliance rate. There was 1 appeal received in July. There were no expedited grievance cases or expedited appeal cases filed for D-SNP in the month of July 2026.
- **Legislative Updates:**
 - See Attachment
- **IT Workflow Automation – Next Update September 2026**
- **Alliance in the Community - Next Update September 2026**
- **Medicare Overview**
 - State Medicaid Agency Contract (SMAC) has been fully executed by the Alliance CEO and the State of California.
 - Collaborated with Legal and Compliance on filling out the Matrixes and attestation associated with the SMAC.
 - Documentation was submitted to CMS by the deadline of Monday, July 6th.

- Advancing Medicare sales and enrollment infrastructure to support future growth and operational excellence.
 - Continuing recruitment efforts for Medicare Field Sales and Community Agent positions to expand community outreach and enrollment capacity
 - Three (3) additional Medicare Field Sales & Community Agent positions have been approved and posted, which equates to a team of six (6) internal sales agents.
 - Deployment completed for individual D-SNP sales queues created within Finesse phone system for improved prospective member experience.
 - Medicare.gov and enrollment form via the Alliance public website is on track for deployment in August.
- The new PBM, MedImpact, is on track for deployment for CY2027. Contracting for the 65+ marketing campaign is complete, and work has officially begun with our marketing and sales vendor, Anderson.
 - The second contract for the age-in campaign is currently in progress.
- Progress continues on the D-SNP Centralized Website Initiative, a key component of the Medicare member acquisition and engagement strategy. Upcoming milestones include:
 - **August 2026:** Launch of shopping and enrollment functionality.
 - **October 2026:** Deployment of member resource content and Annual Enrollment Period (AEP) materials.
 - **January 2027:** Transition to CY2027 plan year content and retirement of CY2026 materials.
- Co-branding work underway with selected provider groups, and clinic leadership to establish visual co-branding identity, messaging, and patient-facing experience.
 - Co-branded marketing campaign targeted for Q1 2027 launch.
 - D-SNP branded materials and promotional assets are complete and ready for use at upcoming clinic sales events.
- Approved and posted a new position called Learning & Development Program Manager to support organizational D-SNP training.



Demographics

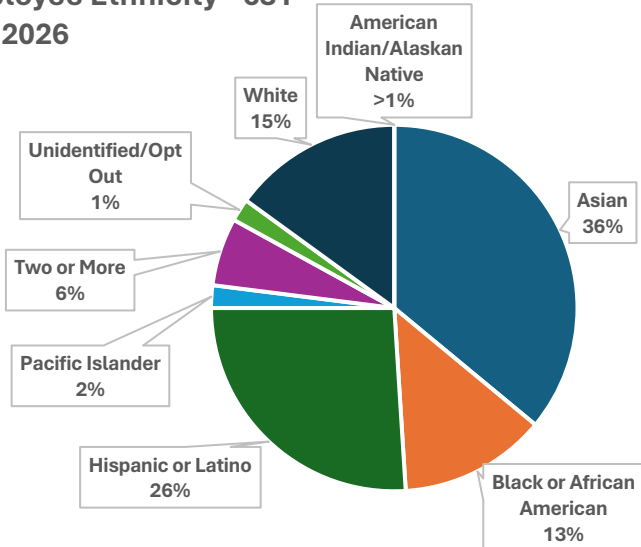
This report provides a comparative analysis of the demographic composition of Alameda Alliance for Health’s workforce in relation to the population profile of Alameda County. The evaluation focuses on key demographic indicators, including race/ethnicity, gender, and age distribution. The objective is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

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

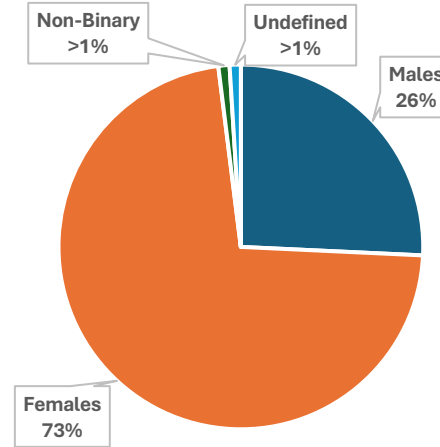
Category	Alameda Alliance for Health (Workforce information last updated July 2026)	Alameda County (Population information last updated in May 2026)
Population/Total Employees	631	1,647,132
Race & Ethnicity		
Asian	36%	35.62%
Hispanic	26%	23.53%
White	15%	24.90%
Black/African American	13%	8.82%
Native Hawaiian/Pacific Islander	2%	0.77%
American Indian/Alaskan Native	>1%	0.24%
Two or More Races	6%	5.51%
Unidentified/Opt Out	>1%	-
Gender		
Male	26%	49.57%
Female	73%	50.43%
Non-Binary	>1%	-
Undefined	>1%	-
Age Distribution		
Under 25	>1%	8.29%
25-34	18%	13.55%
35-44	37%	16.25%
45-54	29%	13.64%
55-Older	16%	29.35%

AAH Employee Demographics Data Report July 2026

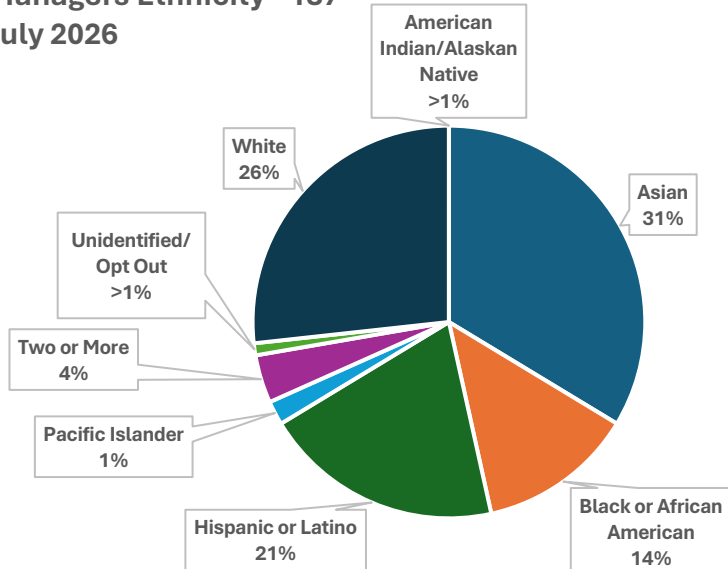
Employee Ethnicity - 631
July 2026



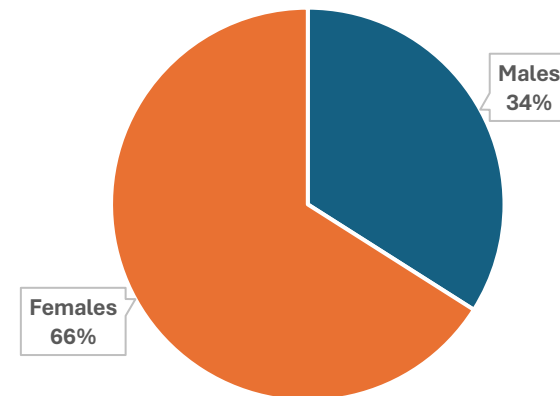
Employee Gender - 631
July 2026



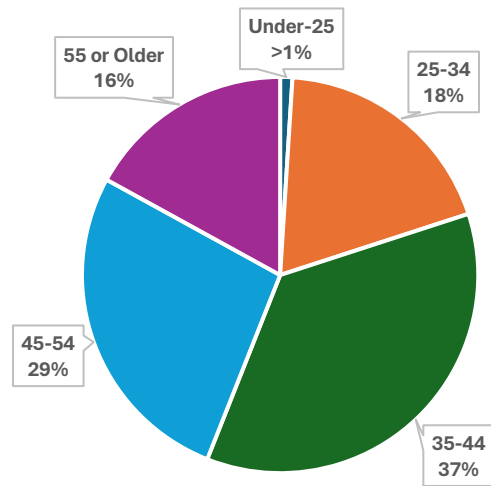
Managers Ethnicity - 137
July 2026



Managers Gender - 137
July 2026



Employee Age Demographics - 631
July 2026





Legislative Tracking



August 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

Federal scrutiny of fraud, waste, and abuse (FWA) in the Medicaid (Medi-Cal) program continues and on July 21, the U.S. Department of Health and Human Services (HHS) announced the deferral of \$867.5 million in federal Medicaid payments to California, following the \$1.2 billion deferral they had issued in May. According to the DHCS, the deferral is primarily tied to the IHSS program and administrative concerns within the Fee-For-Service (FFS) system and that there is little to no impact to the managed care delivery system.

This July, the federal government finalized the previously proposed public charge rule. The final regulation rescinds the 2022 final rule and will take effect 60 days after formal publication on the Federal Register. Additionally, the regulation will allow immigration officers to consider any case-specific factor, including use of any public benefit to determine an individual's inadmissibility – where previously only cash-assistance for income maintenance and long-term institutionalization assistance were considered for public charge purposes. Due to the final rule, the Department of Homeland Security (DHS) estimates that 1.2 million individuals are expected to disenroll from Medicaid, CHIP, SNAP, TANF and SSI.

Following the adoption of the state budget which approved MCO tax changes, including the administration's proposal to submit a new federally compliant tax model, California Republican Representatives sent a letter to Governor Newsom and State Medicaid Director Sandwith expressing their concerns that changes to the tax structures would increase costs on commercial health plans. They also stated their concerns over the tax being used to offset General Fund obligations, rather than working to make health care more affordable.

On June 1, CMS issued their interim final rule (IFR) on Medicaid community engagement and work requirements, which requires certain adults ages 19 through 64 to complete 80 hours per month of work, education or other community service to maintain their Medicaid coverage. The Alliance worked closely with their trade organizations, LHPC and ACAP to provide input on comment letters that were sent to CMS by the required deadline – July 31, 2026. The Alliance will monitor whether any new sub regulatory guidance is released now that the comment period has ended.

The Alliance continues to participate in coordinated multi-agency efforts to address Medi-Cal changes due to H.R. 1 and the state budget. Our work is focused on preserving coverage for



Medi-Cal beneficiaries. The Alliance continues to send out approximately 45,000 'Keep Your Coverage' postcards every month to Alliance members and maintains a comprehensive media campaign throughout Alameda County.

State Legislative Update

Despite our coordinated efforts with local and statewide partners, the final 2026-27 California state budget authorized the transition of Medi-Cal Members with unsatisfactory immigration status (UIS) from managed care to the fee-for-service (FFS) delivery system. This includes the transition of nearly 2 million Californians with UIS. It includes:

On July 31, 2026, DHCS released their draft policy guide for the UIS transition. The policy guide outlines how UIS Members will receive healthcare services through Medi-Cal FFS and that the state will pay providers directly for covered services beginning January 1, 2027. UIS Members will lose access to certain managed care services including enhanced care management and community supports. However, they will continue to receive behavioral health care services through county behavioral health plans (BHPs) as well as retain pharmacy benefits through Medi-Cal Rx.

The Alliance's trade association, the LHPC, is holding ongoing meetings with DHCS to determine the role of managed care plans in data-sharing, Member communications, and coordination with FFS providers to support a smooth transition for UIS Members. In addition, LHPC and Medi-Cal managed care plans are meeting biweekly to discuss feedback for DHCS and identify strategies to ensure UIS Members continue to access timely and quality services without disruption as they transition from managed care to FFS.

On the gubernatorial race to determine the successor to Governor Newsom, the two remaining contenders that will advance to the November 3 general election are Xavier Becerra (D) and Steve Hilton (R). Both candidates are in their final stretch of campaigning and Hilton has received endorsements from President Trump and the California Republican Party while Becerra has the backing of major Democratic leaders, including Governor Gavin Newsom and the state Democratic Party.

Our team will continue to track the Governor's race as well as attend relevant stakeholder meetings to ensure alignment with pending legislative and/or regulatory changes.

Priority Bill List

The final day for policy committees to meet and report bills is July 2, 2026. Below is a list of priority bills that our team is currently tracking. We will continue to update this list throughout the 2026-27 legislative cycle.

<i>Measure</i>	<i>Author</i>	<i>Topic</i>	<i>Summary</i>
AB 1126	Patterson	Medi-Cal Managed Care Plans: Enrollees with Other Health Care Coverage	This bill would require the department, in the case of a Medi-Cal managed care plan enrollee who also has other health care coverage and for whom the Medi-Cal program is a payer of last resort, to ensure that a provider that is not contracted with the plan and that is billing the plan for Medi-Cal allowable costs not paid by the other health care coverage does not face administrative requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system. Under the bill, in the case of an enrollee who meets those coverage criteria, except as specified, a Medi-Cal fee-for-service provider would not be required to contract as an in-network provider with the Medi-Cal managed care plan in order to bill the plan for Medi-Cal allowable costs for covered health care services. The bill would authorize a Medi-Cal managed care plan to require a letter of agreement, or a similar agreement, under specified circumstances, including if a covered service requires prior authorization, or if a service is not covered by the other health care coverage but is a covered service under the plan, as specified. The bill would require the department to take the actions that it deems necessary to provide clarification regarding the conditions for billing plans to providers that render services to enrollees who also have other health care coverage. The bill would specify the intent of the Legislature that the department offer educational resources to an enrollee who needs assistance with understanding continuity of care and coordinating Medi-Cal and their other health care coverage when requested by the enrollee.

AB 1648	Rodriguez	Public Health: California Epilepsy Program	This bill would require the State Department of Public Health to establish the California Epilepsy Program for the purposes of epidemiological assessments of the incidence and prevalence of epilepsy and seizures. The bill would require the department to convene an advisory panel comprised of specified individuals to provide support and advice for the implementation of the program. AB 1648 would authorize the department to seek private or public funding and to spend those funds for the purposes of the program, and would authorize the department to contract with various entities for the purposes of collecting and collating data. The bill would require the department to analyze available data, to prepare and publish reports on its internet website as necessary, and to publish on its internet website a listing of agencies that offer services to individuals affected by epilepsy, as specified.
AB 1670	Arambula	Medi-Cal: Dental Care	This bill would make behavior management and desensitization services without an accompanying dental procedure covered benefits under the Medi-Cal program, subject to utilization controls, when a patient's physical, behavioral, developmental, or emotional condition requires significant extra time, attention, or personnel, or requires such services preceding a dental visit, respectively, in order to safely deliver dental care. The bill would condition implementation of these provisions on the availability of federal financial participation and any necessary federal approvals having been obtained. The bill would, notwithstanding any other law, authorize the department to implement, interpret, or make specific provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions without taking any further regulatory action.

AB 1682	Hart	Health care Coverage: Scalp Cooling	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires coverage by health care service plans and health insurers for various screening and treatment services with respect to cancer. This bill would require a health care service plan contract or health insurance policy, except as specified, that is issued, amended, delivered, or renewed on or after January 1, 2027, to provide coverage for scalp cooling, as defined, as prescribed by a health care provider in connection with chemotherapy for people with cancer. Because a violation of these provisions with respect to a health care service plan would be a crime, this bill would impose a state-mandated local program.
AB 1672	Solache	Medi-Cal: Program of All- Inclusive Care for the Elderly: Rates	The bill would require the department, as part of this negotiation before submission for federal approval, to notify the PACE organization of the proposed rates at least 60 days prior to submission and to respond in writing to questions or feedback on the proposed rates submitted by the PACE organization by no later than 30 days prior to submission. The bill would authorize the department to define a reasonable date by which the PACE organization must submit those questions or feedback. The bill would require the department to provide the rationale for any assumptions or calculations concerning the proposed rates upon request and to make a good faith effort to reach agreement with the contracting PACE organization on capitation rates.

AB 1561	Krell	Medi-Cal: Complex Rehabilitation Technology	This bill would prohibit the department from requiring prior authorization for the repair of a CRT-powered wheelchair if the cost of the repair does not exceed \$1,250. Under the bill, a treatment authorization request for repair or replacement of a CRT-powered wheelchair would not require an individual prescription or documentation of medical necessity from the treating practitioner if the CRT-powered wheelchair has already been approved for use by the patient. For repair of a CRT-powered wheelchair, the bill would require the supplier to document and maintain records of the items being repaired, the reason for the repair, and the labor details, as specified, with the information being subject to a post-payment audit by the department. The bill would set forth other recording requirements for the supplier.
AB 1366	Flora	Reimbursement for Pharmacist Services	This bill would require the rate of reimbursement for advanced practice pharmacist services to be the same as the fee schedule for physician services, including MTM pharmacist services. The bill would require the department to implement an MTM reimbursement methodology relating to the use of drugs to ensure that Medi-Cal payments are only made to eligible advanced practice pharmacists or pharmacies for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories.
AB 1629	Haney	Dental Coverage	This bill would require a plan or insurer, including a specialized plan or insurer, covering dental services, upon written and dated consent of the enrollee or insured, to pay a noncontracting dental provider directly for covered services rendered to the enrollee or insured in accordance with the benefit provided in the contract or policy. The bill would prohibit a noncontracting dental provider accepting assignment of benefits from charging an enrollee or insured, prior to the plan payment, more than an estimate of the enrollee's

			or the insured's cost sharing for the treatment or a deposit that approximates that cost share. The bill would require a noncontracting dental provider to make specified disclosures to an enrollee or insured before accepting an assignment of benefits. Because a willful violation of these provisions relative to health care service plans would be a crime, this bill would impose a state-mandated local program.
<u>AB 1649</u>	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.
<u>AB 1717</u>	Castillo	Medi-Cal Dental Reimbursement: House/Extended Care Facility Call	Under the Medi-Cal Dental Provider Handbook, the maximum allowance for a house/extended care facility call under a specified billing code is \$20. This bill would require the department to increase the Medi-Cal reimbursement base rate for a house/extended care facility call in order to reflect the reasonable travel costs for purposes of delivering dental services in the patient's private residence or applicable facility instead of the location of the dental provider.
<u>AB 1773</u>	Blanca Rubio	Pharmacy Benefit Managers	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the

			Department of Insurance. Existing law requires a pharmacy benefit manager contracting with a health care service plan or health insurer to secure a license from the Department of Managed Health Care on or after January 1, 2027, or the date on which the department has established the licensure process, whichever is later. This bill would require the department to maintain a public internet website displaying specified information for each licensed pharmacy benefit manager, including, among other things, the legal name, license number, and license expiration date.
AB 1887	Zbur	Prescription Drug Coverage for Rare Diseases	This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to require a health care service plan or health insurer to complete prior authorization or other utilization review within 30 days upon initial request, as specified, 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. The 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 step therapy for these drugs.
AB 1949	Lee	Medi-Cal: Acupuncture Treatments	This bill would state the intent of the Legislature to enact legislation that allows more flexibility in Medi-Cal coverage for acupuncture treatments. require the Medi-Cal program to cover up to 24 acupuncture visits per beneficiary per calendar year and would state that additional visits per calendar year may be authorized based on medical necessity and the extent of federal funding.
AB 1970	Harabedian	Health Care Coverage:	This bill would prohibit a health care service plan contract or a health insurance policy that is issued,

		Mental Health or Substance Use Disorders	amended, or renewed on or after January 1, 2027, from imposing step therapy as a prerequisite to authorizing coverage of any prescription drug used for the treatment of a serious mental illness or substance use disorder, as those terms are defined. The bill would specify that the prohibition on step therapy does not apply when the United States Food and Drug Administration-labeled indications and usage of a drug indicate that some prior medication must be taken.
AB 1979	Bonta	Health Care Services: Artificial Intelligence	This bill would require a health facility, clinic, physician's office, or office or a group practice to ensure that no clinical decision, as specified, is based solely on the output of a clinical decision support system, as defined, and that a licensed health care professional exercises independent professional judgment when reviewing and approving a clinical decision that is based on the output of a clinical decision support system. The bill would authorize the appropriate professional licensing board to pursue an injunction or restraining order to enforce these provisions to the extent that a violation constitutes the practice of a health care profession without a license. The bill would specify that these provisions do not prohibit the use of artificial intelligence for documentation and communication that does not involve the application of professional judgment, including automated messages to inform patients of updates to their health records. By placing new requirements on health facilities and clinics, this bill would expand the scope of a crime and would impose a state-mandated local program
AB 2036	Patel	Medi-Cal: Federally Qualified Health Centers and Rural Health Clinics	Under existing law, to the extent that federal financial participation is available, federally qualified health center (FQHC) services and rural health clinic (RHC) services are covered Medi-Cal benefits. Under existing law, FQHCs and RHCs receive a per-visit prospective payment system (PPS) rate for each visit. Existing law provides different methods by which an FQHC or RHC may

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

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

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

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

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

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

			whether the reimbursement rates for those services are sufficient to ensure that all authorized hours are able to be provided. The bill would require the department to prepare and submit a report to the Legislature on the findings of the assessment by no later than March 1, 2027.
AB 2268	Schiavo	In-Home Supportive Services Program	Existing law establishes the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, and disabled persons are provided with services to permit them to remain in their own homes. This bill would state the intent of the Legislature to enact legislation relating to the In-Home Supportive Services program.
AB 2278	Ávila Farías	In-home Supportive Services: Community First Choice Option Program: Noncompliance Penalties	Existing federal law, the Community First Choice Option (CFCO) program, authorizes states to provide home- and community-based attendant services and supports to eligible Medicaid enrollees, as specified. Existing federal law provides federal financial participation for a state that provides services under the CFCO program. Existing state law establishes the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, and disabled persons are provided with services in order to permit them to remain in their own homes. Existing law requires the state and counties to share the annual cost of providing IHSS pursuant to a specified cost ratio. Existing law requires all counties to have a rebased County IHSS Maintenance of Effort (MOE) and requires the rebased MOE to be adjusted for the annualized cost of increases in provider wages, health benefits, or other benefits, as prescribed. Existing law commencing July 1, 2026, requires a county to pay, separate from the rebased County IHSS MOE payment, a 100% share of the enhanced federal financial participation that would have been

			received if the state ceases to receive that funding for the provision of services due to noncompliance of timely case reassessment for the federal CFCO program. This bill would require the department to, on or before July 1, 2029, prepare and submit to the Legislature a report on the amount of the above-described payments made by counties due to noncompliance of timely case reassessment for the federal CFCO program.
<u>AB 2327</u>	Lowenthal	Medi-Cal: Subcontractors: Rates	This bill would authorize a subcontracting plan subject to the above-described agreement to request a review of the Medi-Cal managed care rates paid by the primary plan for a particular rating period, as specified. The bill would require the department to direct an independent, qualified actuarial consultant to review those rates upon a showing by the subcontracting plan that certain conditions have occurred or are likely to occur, including, among others, a medical loss ratio in excess of 93% for the preceding 12-month period. If the department determines that the rates paid by the primary plan to the subcontracting plan for a particular rating period are not actuarially sound, the bill will require the department to order a revision of those rates, as specified. The bill would make any failure by the department to comply with these provisions reviewable and subject to appeal at the request of the subcontracting plan through a notice of dispute pursuant to the terms of the Medi-Cal managed care contract. The bill would require these disputes to be concluded and resolved within 120 calendar days of the initial request. The bill would authorize the department to implement, interpret, or make specific provisions through the use of all-county letters, plan letters, plan bulletins, amendments to the state Medi-Cal managed care contract, or similar instructions without taking any further regulatory action.

AB 2348	Bonta	Medi-Cal: Community Supports	This bill would require the department, by July 1, 2027, to produce model managed care coverage standards and policy, reflecting best practices, for each community support provided for plan years beginning on January 1, 2028. If a managed care plan deviates from the standards and policy, the bill would require the plan to provide the department a specific explanation and justification for that deviation. The bill would require the department to provide ongoing technical assistance to managed care plans and to require the plans to continue to provide technical assistance to providers of community supports. The bill would require the department to publicly post any policy changes for stakeholder input, and to publicly release written updates to the department's policy guidance, as specified. The bill would require a managed care plan to track and report to the department certain quantitative data regarding nonprofit community providers, as defined, and would require the department to publish a report on this data not less than annually. The bill would modify a requirement for the department to publish a public report on ECM and community supports utilization data, populations served, and demographic data, from annual to quarterly publications instead. The bill would require the department, by March 31, 2029, to provide the legislative committees' information necessary to inform legislative consideration of transitioning community supports to benefits that are required to be covered under the Medi-Cal program. The bill would require the department, until January 1, 2032, to continue to convene the CalAIM Implementation Advisory Group that is in effect on January 1, 2026, and as most recently updated. For purposes of the above-described provisions on ECM and community supports coverage, the bill would remove references to their
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			implementation in accordance with CalAIM Terms and Conditions.
<u>AB 2352</u>	Valencia	Medi-Cal Providers: Nonprofit Public Benefit Corporations	Existing law sets forth various procedures, including the submission of an application package, for provider enrollment, continuing enrollment, or enrollment at a new location or a change in location under the Medi-Cal program. Existing law requires an applicant or provider who is a natural person and is licensed or certificated under provisions relating to healing arts, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or is a professional corporation, to comply with the above-described procedures and to be enrolled in the Medi-Cal program as either an individual provider or as a rendering provider in a provider group for each application package that is submitted and approved. This bill would also apply the above-described provision to a nonprofit public benefit corporation that has been granted tax-exempt status and through which licensed providers enumerated in the Medicaid state plan provide non-specialty mental health services, as specified.
<u>AB 2355</u>	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.
<u>AB 2359</u>	Ta	Medi-Cal	Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care

			services. Pursuant to existing law, health care granted under the Medi-Cal program is subject to laws amending, repealing, or supplementing provisions affecting the Medi-Cal program, and subject to the rules and regulations of the department. Existing law provides that an individual receiving health care from the Medi-Cal program does not have a claim for compensation or otherwise because their service is affected by those changes. This bill would make technical, non-substantive changes to that provision.
AB 2431	Patel	Downcoding Medical Claims	This bill would require a determination to downcode a claim, which is the unilateral alteration by a payer of the service or procedure code submitted on a claim resulting in a lower payment, to include a documented review of the clinical information supporting the billed service. The bill would set forth requirements for and limitations of downcoding decisions, and, if a claim is downcoded, would require a plan or insurer to provide a billing provider with specified information and a clear and accessible process for disputing downcoded claims. The bill would prohibit a plan or insurer from using downcoding practices in a targeted or discriminatory manner against physicians or other health care providers who routinely treat patients with high acuity, complex, or chronic conditions, and would authorize the departments to take action against a plan or insurer that engages in a pattern or practice of discriminatory downcoding or that otherwise violates these provisions. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would require the departments to collect data on coding and claims adjustment practices, evaluate the information, and submit a report with specified information to the Legislature.

AB 2448	Bauer-Kahan	Medical Information: Confidentiality	Existing law, the Confidentiality of Medical Information Act (CMIA), generally prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information regarding a patient, enrollee, or subscriber without first obtaining an authorization, unless a specified exception applies. Existing law makes a violation of the CMIA that results in economic loss or personal injury to a patient punishable as a misdemeanor. Existing law requires specified businesses that electronically store or maintain medical information on the provision of sensitive services on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer to develop capabilities, policies, and procedures, on or before July 1, 2024, to enable certain security features, including limiting user access privileges and segregating medical information related to gender affirming care, abortion and abortion-related services, and contraception, as specified. This bill would also require those specified businesses to enable the above-specified capabilities, policies, and procedures for those security features, as specified. Because the bill would expand the scope of an existing crime, it would impose a state-mandated local program
AB 2457	Connolly	Health Care Provider Credentialing	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires a full-service health care service plan, excluding a Medi-Cal managed care plan, or its delegate, to subscribe to and use the Council for Affordable Quality Healthcare credentialing form on and after January 1, 2028. On and after January 1, 2027, existing law requires a health care service plan, excluding a Medi-Cal managed care plan, or its delegate, that credentials health care providers for its networks to decide regarding the credentials of a provider within 90 days after

			receiving a completed provider credentialing application. This bill would extend the application of the above-described requirements to Medi-Cal managed care plans. Because a willful violation of these requirements by a Medi-Cal managed care plan would be a crime, the bill would impose a state-mandated local program.
AB 2511	Ahrens	Behavioral Health Provider Comparable Worth Study	This bill would require the department, in consultation with the Department of Managed Health Care, the Department of Insurance, the Department of Health Care Access and Information, and the Office of Health Care Affordability, to conduct a comparable worth study to examine and compare compensation and reimbursement for behavioral health providers with compensation and reimbursement for similarly situated medical-surgical providers. The bill would require a health care service plan or health insurer to report certain data to the department with respect to payments made directly to providers and payments made to intermediaries and health systems. The bill would also require specified intermediaries and health systems to report certain data to the department relating to payments received and payments made. The bill would make an entity that fails to comply with the reporting requirements subject to civil penalty, as prescribed.

<u>AB 2565</u>	Wallis	Medi-Cal: Pharmacist Services: Reporting	This bill would require the department to issue guidance clarifying Medi-Cal managed care plan obligations to cover pharmacist services, as specified. The bill would require the department to update its model evidence of coverage to explicitly include coverage of pharmacist services. The bill would also require the department to take appropriate corrective action for failure to comply with existing provisions of law relating to Medi-Cal coverage of pharmacist services or the issued guidance. The bill would authorize the department to implement, interpret, or make specific provisions by means of all-plan letters, plan letters, or other similar instructions, without taking any further regulatory action.
<u>AB 2571</u>	Flora	Reimbursement for Pharmacist Services	This bill would require the rate of reimbursement for advanced practice pharmacist services to be no less than 85% of the fee schedule for physician services, including MTM pharmacist services. The bill would require the department to implement an MTM reimbursement methodology relating to the use of drugs to ensure that Medi-Cal payments are only made to eligible advanced practice pharmacists or pharmacies including those operating at federally qualified health centers or rural health clinics, for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories. This bill would require those health care service plans and disability insurers to pay or reimburse the cost of the service performed by a pharmacist enrolled as a provider with the plan or insurer. The bill would specify for these purposes that a pharmacist includes pharmacists who provide services at a federally qualified health center or a rural health clinic.

AB 2575	Ortega	Health Care Services: Artificial Intelligence	This bill would require a health facility, clinic, physician's office, or office of a group practice that uses or deploys a clinical decision support system, as defined, for patient care, on or before July 1, 2027, to make available, upon request from a licensed health care professional or other person using a clinical decision support system or viewing outputs from a clinical decision support system, an inventory of all clinical decision support systems currently in use or deployed for patient care. The bill would require a health facility, clinic, physician's office, or office of a group practice that uses a clinical decision support system for patient care to make specified information about the clinical decision support system upon request from a licensed health care professional or other person using a clinical decision support system or viewing outputs from a clinic decision support system, including, among other things, a summary of how the clinical decision support system generates outputs. The bill would also require a health facility, clinic, physician's office, or office of a group practice subject to these provisions to notify a licensed health care professional or other person whose duties include using a clinical decision support system or viewing outputs from a clinical decision support system upon being hired and annually of their right to request the above-described information.
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.

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

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

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

			department has sufficient evidence to substantiate the allegation. This bill would require the department, if it acts against a recovery residence pursuant to that provision, to conduct a site visit of a certified program or licensed facility that has disclosed the specified interest in the recovery residence. The bill would also require, no later than July 15, 2026, and by July 15 each year thereafter, that all programs certified or facilities licensed by the department submit to the department a report of all money transfers between the program or facility and a recovery residence during the previous fiscal year, in order to detect patient brokering, illicit kickbacks, or unethical inducements that harm patients. The bill would require the department to analyze that data and develop guidelines for permissible and impermissible transfers.
<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, among other topics, clinical guidelines for the provision of BHT services, treatment plan requirements, requirements for the provision of center-based services compared to services provided elsewhere, and supervision of unlicensed and uncertified professionals, as specified. The bill would require the department, on or before January 1, 2028, to release and maintain clear clinical guidance for the provision of the BHT benefit, as specified. The bill would require the department, on or before January 1, 2029, to report to the legislature on the utilization of the BHT benefit, a synopsis of changes made as a result of the stakeholder workgroup, and

recommendations for actions necessary to ensure Medi-Cal reimbursement practices align with federal Medicaid program integrity requirements.

<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 specify that any participation by the State Department of Public Health does not change the State Department of Health Care Services' authority to implement comprehensive community-based perinatal services for purposes of the Medi-Cal program. By January 1, 2028, the bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health, to clarify each department's roles and responsibilities regarding comprehensive perinatal services by regulation. The bill would, among other things, require the State Department of Health Care Services to develop informational and educational materials on comprehensive perinatal services by January 1, 2028, and require all Medi-Cal managed care plans to disseminate the materials, as specified. The bill would require the State Department of Health Care Services, no later than July 15, 2027, to submit to the Assembly Committee on Health and the Senate Committee on Health, and post on its internet website, a report that identifies the number of pregnant and postpartum individuals that received comprehensive perinatal services from January 1, 2022, to January 1, 2025, inclusive. The bill would also require the State Department of Health Care Services, commencing
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July 15, 2028, and every 3 years thereafter, to submit to those committees, and post on its internet website, a report that identify the number of pregnant and postpartum individuals that received and were offered comprehensive perinatal services during the previous 3 calendar years.

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

			service plan would be a crime, this bill would impose a state-mandated local program.
<u>SB 1089</u>	Richardson	Preventive Treatment Health Care Act	Existing law requires the California Health and Human Services Agency (CHHSA) to enter into partnerships resulting in the production of generic prescription drugs, including at least one form of insulin made available at production and dispensing costs, if one does not already exist in the market. Existing law additionally authorizes CHHSA to enter into partnerships to increase competition, lower prices, and address supply shortages for generic or brand name drugs to address emerging health concerns. This bill would specify that the above-described authorized partnerships include those for at least one glucagon-like peptide-1 (GLP-1) approved by the United States Food and Drug Administration (FDA).
<u>SB 1037</u>	Weber Pierson	Health Care Coverage: Rate Review	This bill would instead define “unreasonable rate increase,” for the above-described purposes, to mean a rate increase that the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, determines is excessive, unjustified, unfairly discriminatory, or otherwise unreasonable. This bill would instead require a health care service plan or health insurer to demonstrate the impact of health care cost targets on rate development, including medical trends, medical inflation, and medical administrative costs. If a plan or insurer asserts that aging, high-cost drugs, or other cost drivers explain a rate increase, the bill would require the plan or insurer to explain how it reconciles this information with analysis published by the Office of Health Care Affordability. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

			This bill would require, in determining whether a rate increase is unreasonable, the director to consider whether the plan, and the commissioner to consider whether the insurer has sufficient or excessive financial capacity for the past 3 years using specified measures. The bill would require the Department of Managed Health Care and the Department of Insurance, in collaboration with the Office of Health Care Affordability, as part of the existing rate review process, to each conduct an enhanced rate review to determine if health care premiums are affordable, as defined, for individual and group purchasers. The bill would require the review to include the annual change in premiums and cost sharing for the prior 5 years, including deductibles, copayments, coinsurance, and any other cost sharing that impact actuarial value.
<u>SB 1199</u>	Weber Pierson	Prescription Drug Cost Sharing	This bill would require a health care service plan or health insurer, when calculating an enrollee's or insured's overall contribution to an out-of-pocket maximum or cost sharing requirement under the plan contract or insurance policy, to count any amount paid by the enrollee or insured or on behalf of the enrollee or insured toward the enrollee's or insured's cost sharing, including any form of direct support offered by drug manufacturers that is permitted, except as provided. The bill would prescribe an administrative penalty for each violation by a health insurer that is enforceable by the Insurance Commissioner after appropriate notice and opportunity for hearing. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.
<u>SB 1202</u>	Weber Pierson	Medi-Cal: Dashboard and Outreach	This bill would require the department to establish a data dashboard that provides data on applications, enrollment, redeterminations, disenrollments, and terminations, with certain objectives in consideration, related to the impact of the above-described federal law on Medi-Cal

eligibility and enrollment, as specified. The bill would require the dashboard to track and report on the specific data for work or community engagement requirements and exemptions.

The bill would require the department to undertake efforts to conduct outreach about work or community engagement requirements, more frequent redetermination, and changes to retroactive eligibility to impacted Medi-Cal beneficiaries, and to conduct listening sessions, as specified. Under the bill, beneficiary outreach and education would be coordinated across public social services programs to help minimize barriers to administrative disenrollments.

The bill would require a Medi-Cal managed care plan to establish and conduct an outreach and education plan for its enrollees about the work or community engagement guidelines set forth in federal law based on guidance provided by the department. The bill would require the plan to address certain information on Medi-Cal eligibility, the right to appeal or reinstate Medi-Cal coverage, and resources, and to meet certain cultural and linguistic appropriateness standards.

This bill would remove the requirement for the managed care plan to ask the beneficiary for approval for purposes of providing contact information to the county. The bill would remove the requirement for the county to make the verification attempt and would remove a related provision on the method of contact. The bill would require the department to share, or require each county to share, beneficiary redetermination data with applicable managed care plans to aid in managed care plans' efforts to assist beneficiaries with retaining Medi-Cal coverage, as specified. To the extent the bill creates new duties for counties relating to the sharing of Medi-Cal redetermination data, it would impose a state-mandated local program.

SB 1242	Choi	Community Assistance, Recovery, and Empowerment (CARE) Court Program	This bill would authorize the original petitioner to provide specified information regarding the respondent, including the respondent's condition, treatment history, and housing status. The bill would require the CARE team to review specified parts of the provided information, including that relevant to the respondent's care and treatment, and would authorize the court to consider that information in evaluating the respondent's progress and compliance, among other things. The bill would specify that the respondent's consent is not required to receive this information from the original petitioner and that submission of this information does not confer party status on the original petitioner or create a right to direct treatment decisions, obtain discovery, access confidential records, receive protected health information, attend confidential proceedings, or otherwise participate in the proceedings without the respondent's consent, except as expressly provided by law.
SB 1244	Allen	Public Agency Benefits Intermediary Compensation Disclosure Act	This bill, the Public Agency Benefits Intermediary Compensation Disclosure Act, would require a covered service provider, defined to mean a broker, agent, consultant, or advisor that meets specified criteria, to disclose to a public agency or its group health plan the direct and indirect compensation it expects to receive for providing brokerage or consulting services, among other information, before it enters into, extends, renews, or materially amends a contract or arrangement for brokerage services or consulting services with the public agency or its plan. The bill would also require a covered service provider to disclose compensation and material financial interests related to a covered health care benefits arrangement that the covered service provider recommends, places, renews, services, or materially influences for the public agency or its group health plan. Disclosure would be required under these provisions if the covered service

			provider reasonably expected it would receive \$1,000 or more in compensation during the term of the contract or arrangement. The bill would require these disclosures at specified times. This bill would prohibit a covered service provider from requesting, accepting, or receiving direct or indirect compensation in connection with brokerage services or consulting services provided to a public agency or its plan unless the compensation is disclosed, and would prohibit evasion of disclosure requirements.
SB 1252	Durazo	California Resident Taxpayer Health Care Coverage	This bill would state that every person who is a resident subject to a tax and whose income is at or below 138% of the federal poverty level using the modified adjusted gross income methodology, as specified, is entitled to access to the public health care coverage their tax dollars support. The bill would require the State Department of Health Care Services to ensure that these individuals have access to public health care coverage through programs it administers, including Medi-Cal. To the extent that these provisions would alter the population of beneficiaries for Medi-Cal, the bill would impose a state-mandated local program. The bill would make related findings and declarations.
SB 1221	Stern	Lanterman-Petris-Short Act: Conservatorships	This bill would authorize the district attorney to review all filed documents regarding the investigation, initiation, termination, or modification of, and to be present and represent public safety interests at all hearings that consider, a conservatorship of a person who is gravely disabled, as defined by being found mentally incompetent and meeting the above-described conditions, to provide input to the court about appropriate placement or interim placement by the public conservator. The bill would require a copy of the conservatorship investigation report to be transmitted to the district attorney if the investigation was initiated as part of a

determination of mental competence for trial. The bill would authorize the district attorney, if the individual has been appointed a conservator under specified provisions, to challenge the recommendation of the public conservator after the conservatorship investigation for an abuse of discretion in a contested hearing before a judge. The bill would prohibit the district attorney from using the information contained in these reports in subsequent criminal proceedings, except as specified. To the extent the bill imposes a higher level of service on county agencies that prepare and transmit conservatorship investigation reports and on a district attorney to receive those reports, the bill would impose a state-mandated local program.

This bill would authorize a county with a population size of 750,000 or greater to consider prioritizing the placement of specified conservatees in a state hospital run by the State Department of State Hospitals if at least 40 of those conservatees are waiting for placement in a state hospital. The bill would also authorize the placement to be on an interim basis at a county detention facility pending acceptance into a facility that achieves the purposes of treatment of the conservatee and protection of the public. The bill would require the conservatee to receive treatment services in accordance with the conservatorship plan within the detention facility pending permanent placement and would require the court to review the conservator's placement efforts every 60 calendar days.

SB 1261	Laird	Aging and Disability Resource Connection Program	Existing law establishes an Aging and Disability Resource Connection (ADRC) program, administered by the California Department of Aging, to provide information to consumers and their families on available long-term services and supports (LTSS) programs and to assist older adults, caregivers, and persons with disabilities in accessing LTSS programs at the local level.
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			This bill would prohibit the California Department of Aging from revoking the designation of an ADRC program solely due to the revocation or voluntary termination of a designation, suspension, or temporary inability of either the area agency on aging or the independent living center partner to serve in its operator role, and would authorize the remaining partner to continue to operate the ADRC independently during a transition period, as specified.
SB 1280	Valladares	Health Care Coverage For Mental Health and Substance Use Disorders	This bill would require a health care service plan or disability insurer to reimburse a noncontracting individual health professional the greater of the average contracted rate or 125% of the amount Medicare reimburses for similar services, as specified, for out-of-network services that are provided as described above. The bill would prohibit an enrollee or insured from owing the health professional more than the in-network cost-sharing amount, and would prohibit the health professional from billing or collecting an amount from the enrollee or insured that is more than that amount. The bill would require any communication from the health professional to an enrollee or insured, before the receipt of information about the amount the individual owes for services provided, to include a notice informing the individual that it is not a bill and not to pay until they are informed by their plan or insurer of any applicable cost sharing. The bill would require a plan or insurer to inform an enrollee or insured and the noncontracting individual health professional of the in-network cost-sharing amount owed by the individual at the time of payment by the plan or insurer to the health professional. Under the bill, the payments made by the plan or insurer and enrollee or insured pursuant to these provisions would constitute full payment. Because a willful violation of these provisions by a health care service plan would be

			a crime, the bill would impose a state-mandated local program.
<u>SB 1284</u>	Smallwood-Cuevas	Medi-Cal Benefits: Employer Reports	This bill would require the State Department of Health Care Services, after obtaining specified information from the Employment Development Department (EDD), to prepare a report that includes information regarding employers in California that employ 100 or more employees and have any employees who receive benefits from the Medi-Cal program, including, among other things, the estimated total annual cost of Medi-Cal services provided to employees, and the dependents of those employees, of each employer, and submit that report to the Legislature no later than September 1, 2027, and annually thereafter. The bill would provide individually identifiable information about employees or Medi-Cal enrollees contained in the report is exempt from disclosure under the California Public Records Act, and would authorize the department and EDD to enter into data-sharing agreements, as provided. The bill would also repeal an obsolete reporting requirement. This bill would additionally prohibit an employer from discharging or in any manner discriminating or retaliating against an employee who applies for, or is enrolled in, the Medi-Cal program. The bill would also prohibit an employer from refusing to hire a person because that person is enrolled in the Medi-Cal program.
<u>SB 1309</u>	Rubio	Health Care Coverage: Lung Cancer	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 provide coverage for follow-up screening or diagnostic services for lung cancer, as specified. The bill would prohibit a contract or policy from imposing a copayment, coinsurance, deductible, or any other form of cost sharing for this coverage. If a health care service plan contract or health

			insurance policy is a high-deductible health plan, the bill would prohibit the contract from imposing a deductible, coinsurance, or any other cost sharing on this coverage unless not imposing the deductible, coinsurance, or cost sharing would conflict with the federal requirements for high-deductible health plans.
SB 1377	Jones	Immunizations: Medical Exemptions	This bill would exempt a child from immunization requirements if the parent or guardian files with the governing authority a written statement, as described above. The bill would prohibit the department, a local health department, or a third-party review panel from revoking, invalidating, or conditioning a medical exemption duly issued by a licensed physician and surgeon, except by final order of a court upon clear and convincing evidence of fraud. The bill would prohibit the department and local health departments from auditing, disciplining, or referring a physician and surgeon to the Medical Board of California or Osteopathic Medical Board of California based solely on the number of medical exemptions issued. This bill would prohibit a physician and surgeon from being investigated, disciplined, or otherwise acted against by any state department or board based on their issuance of medical exemptions unless the medical exemption is found to be fraudulent or otherwise invalid. The bill would prohibit a medical exemption from being considered in any investigation or action against a physician and surgeon that is otherwise unrelated to medical exemptions. This bill would prohibit a health care service plan or health insurer from denying coverage, imposing higher premiums, canceling a policy, or otherwise penalizing an enrollee or insured because a covered minor holds a medical exemption.

SB 1422	Durazo	Medi-Cal: Eligibility: Immigration Status	This bill would require the Director of the Department of Finance to determine and report to the Legislature and the Governor the cost of implementing eligibility for the full scope of Medi-Cal benefits for individuals who do not have satisfactory immigration status if they are otherwise eligible, and whether including those costs the General Fund would be in a deficit, as defined. The bill would then, on January 1 of the year following such a determination, end the above-described limitations on services for those who apply for Medi-Cal after January 1, 2026, or who lose eligibility for the full-scope of Medi-Cal benefits on or after January 1, 2026, thereby making an individual who is 19 years of age or older, who does not have satisfactory immigration status, eligible for the full scope of Medi-Cal benefits subject to certain limitations, such as the payment of premiums and certain dental benefits. The bill would require that the implementation of eligibility for the full-scope of Medi-Cal benefits be done by groups categorized by age, beginning with individuals over 49 years of age.
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Executive Dashboard

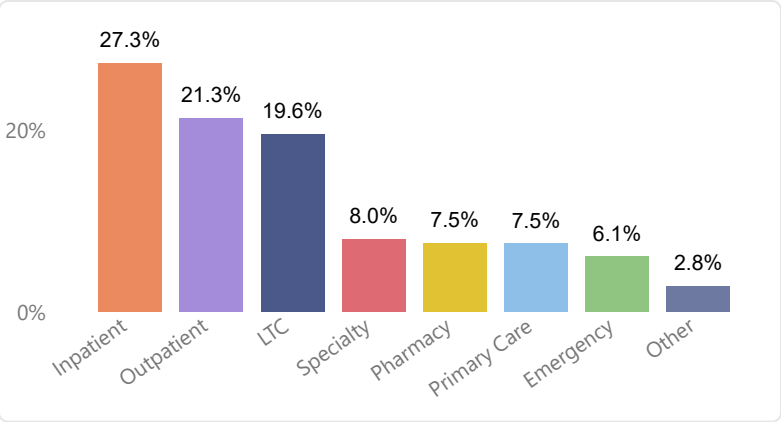
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Financials

Income & Expenses

	JUNE 2026	FISCAL YTD
REVENUE	\$ 252.7 M	\$ 3.0 B
MEDICAL EXPENSE	\$ (185.4) M	\$ (2.1) B
ADMIN EXPENSE	\$ (13.6) M	\$ (130.5) M
OTHER/TAX	\$ (59.8) M	\$ (741.3) M
NET INCOME	\$ (6.1) M	\$ 62.4 M
Medical Loss % (Fiscal YTD)		
92.8%		

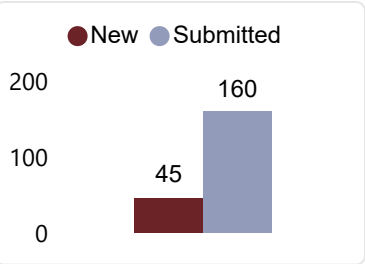
Medical Expenses



Liquid Reserves

TNE %	290.7%
TNE \$	\$231.7M

Reinsurance Cases

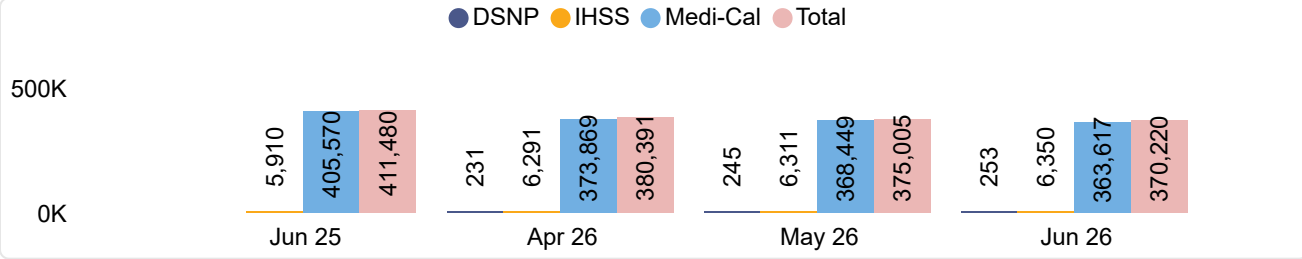


Balance Sheet

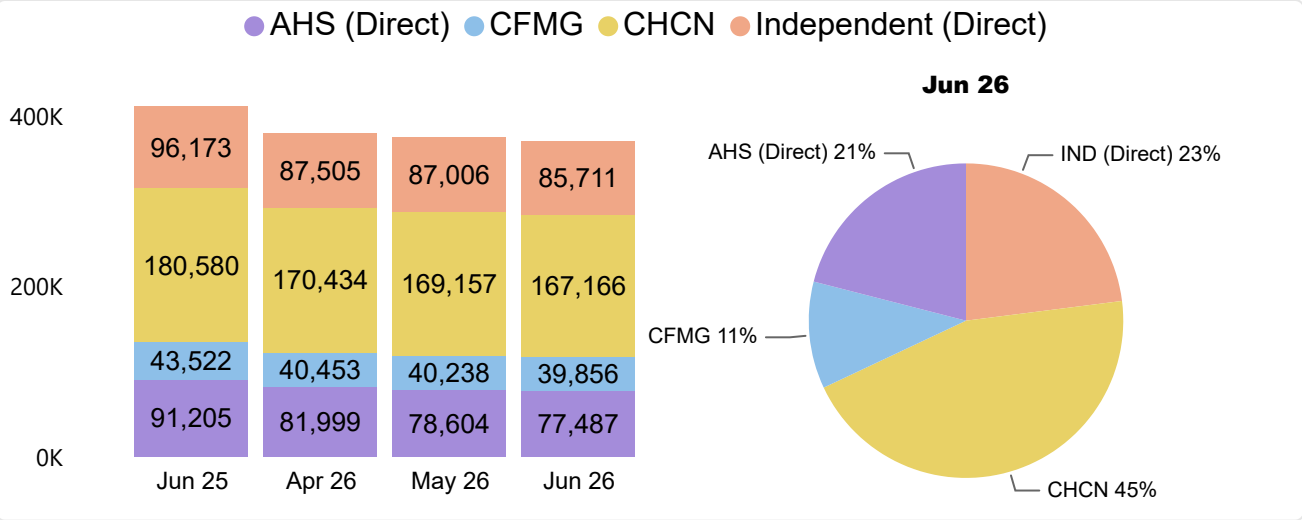
Cash Equivalents	\$704.6M	Current Ratio 1.14
Pass-Through Liabilities	\$562.0M	
Uncommitted Cash	\$142.6M	
Working Capital	\$183.9M	

Membership

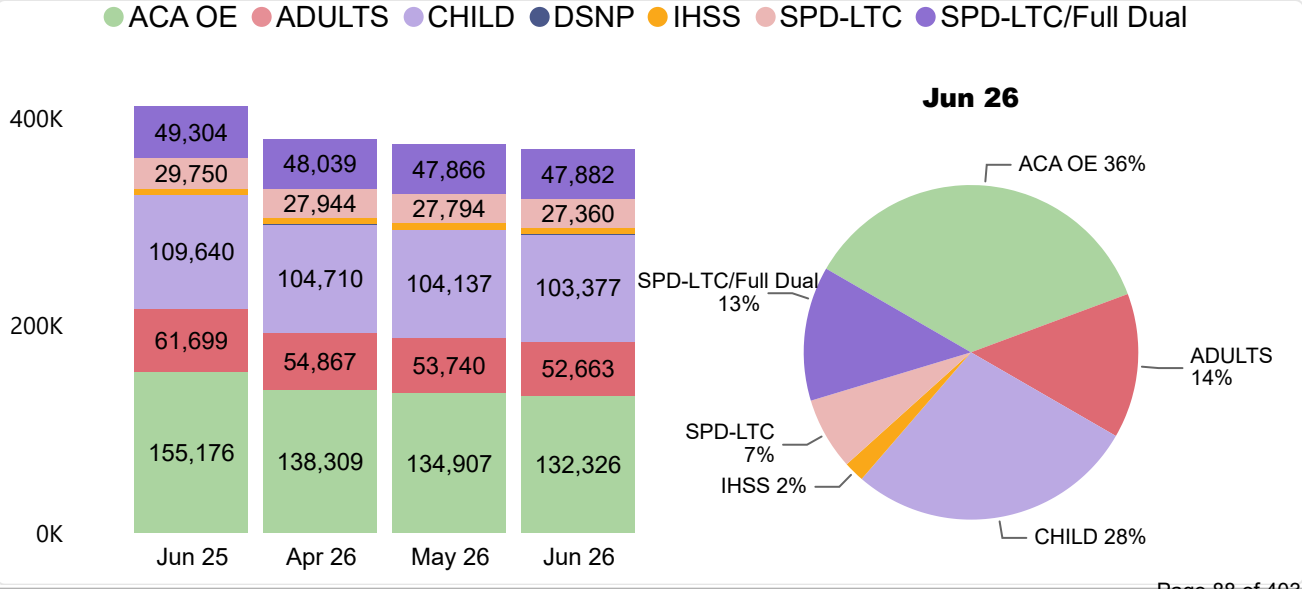
By Plan



By Network

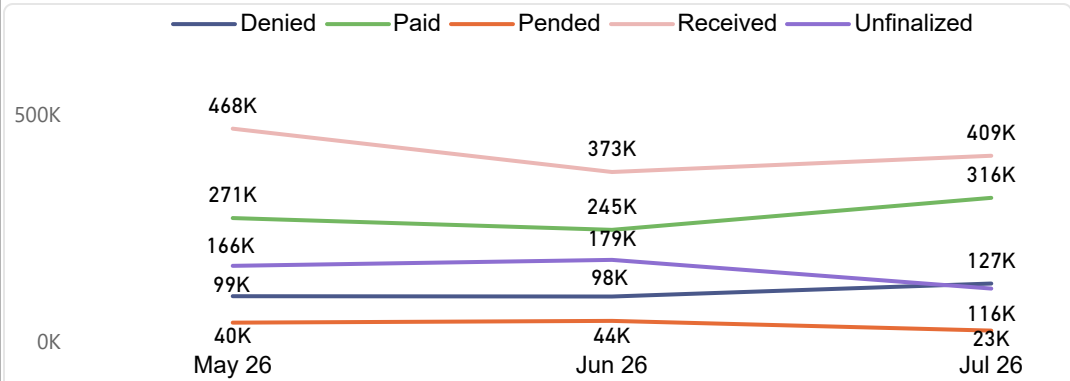


By Category



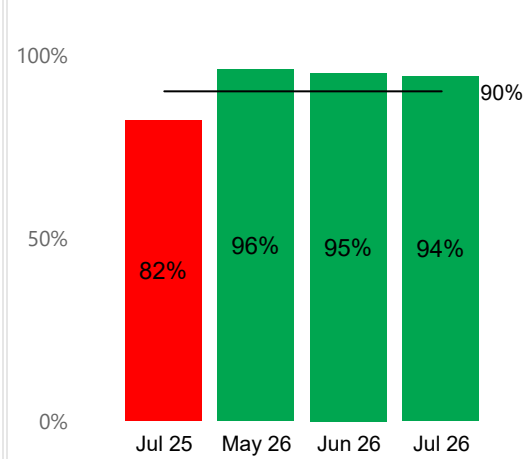
Claims

Claims Processing



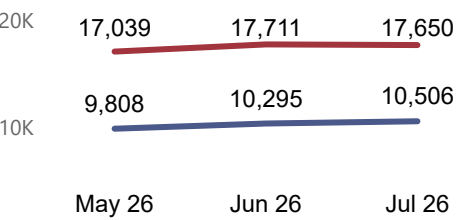
Claims Compliance

Processed 30 Cal Days (%)

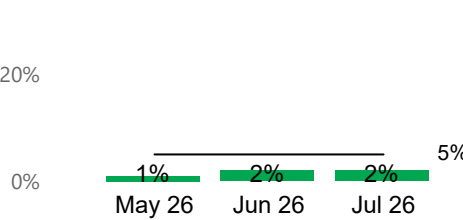


Member Services

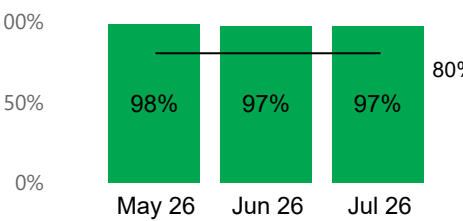
Inbound Calls Outbound Calls



Abandoned Call Rate (%)

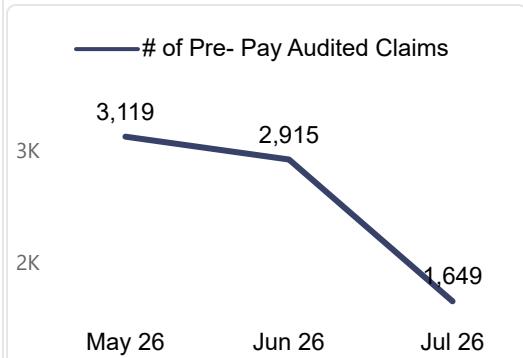


Calls Answered in 30 Seconds (%)

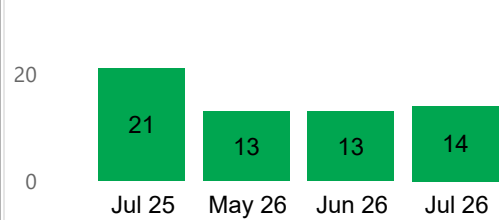


Average Call Times	May 26	Jun 26	Jul 26
Wait Time	00:06	00:08	00:07
Call Duration	07:18	07:34	07:31

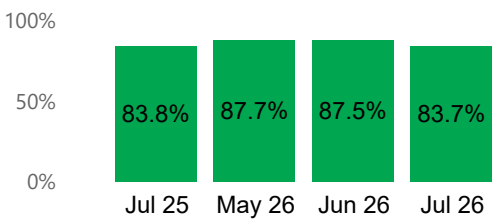
Claims Auditing



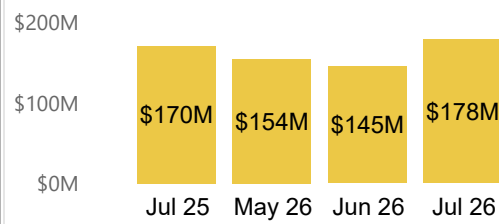
Average Payment TAT (Days)



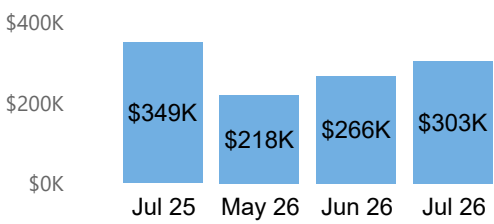
Auto Adjudication Rate (%)



Claims Paid (\$)

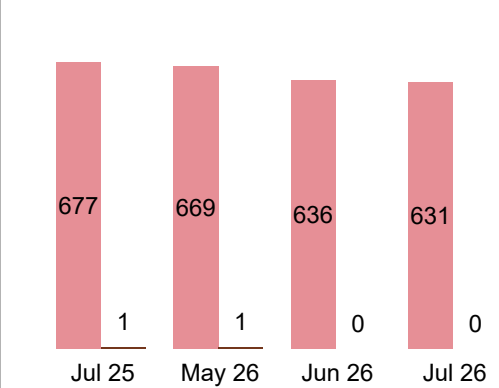


Interest Paid (\$)



Human Resources

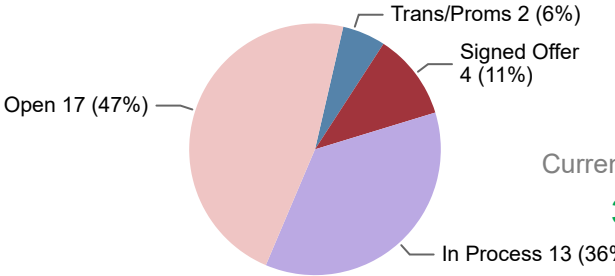
Full Time Part Time



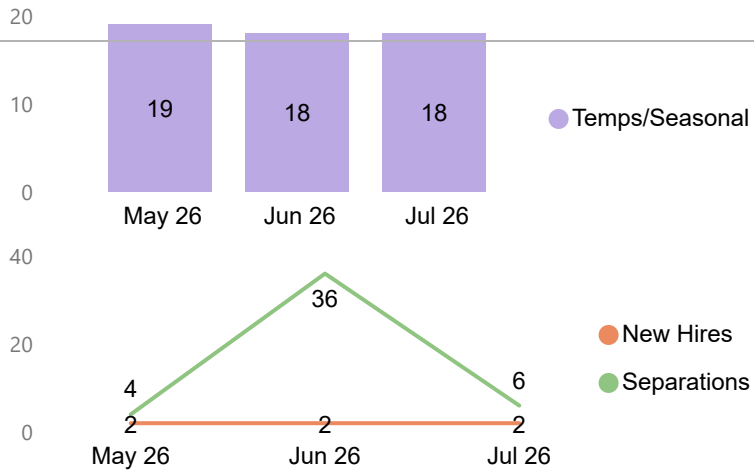
Recruiting Status

Jul 26

Trans/Proms Signed Offer In Process Open



Current Vacancy
3%



Provider Services

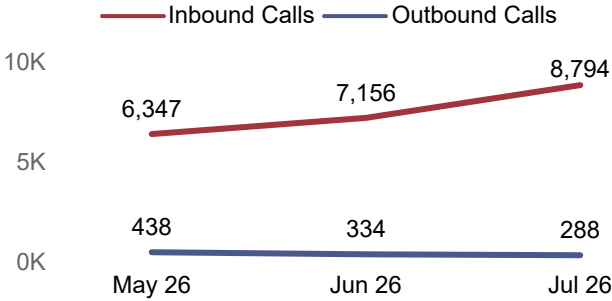
Provider Network

Hospital	17
Specialist	12,446
Primary Care Physician	708
Skilled Nursing Facility	107
Urgent Care	12
Health Centers (FQHCs and Non-FQHCs)	87
TOTAL	13,377

Provider Credentialing

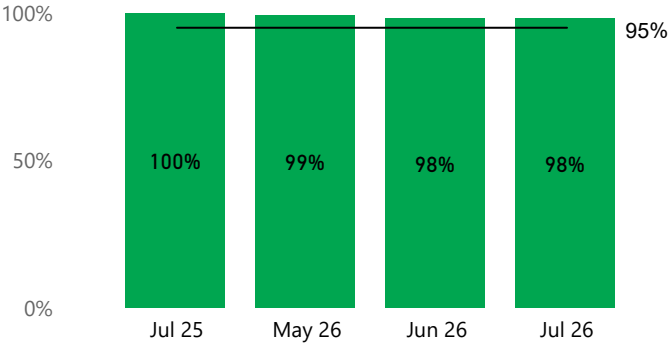
6,066

Provider Call Center



Provider Disputes & Resolutions

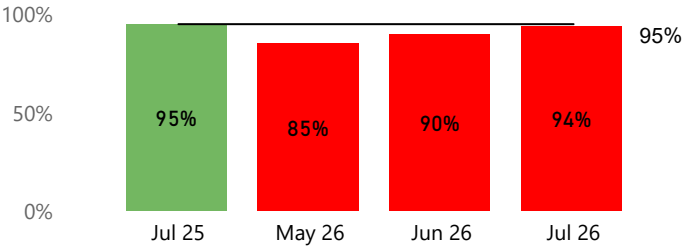
Turnaround Compliance (45 business days)



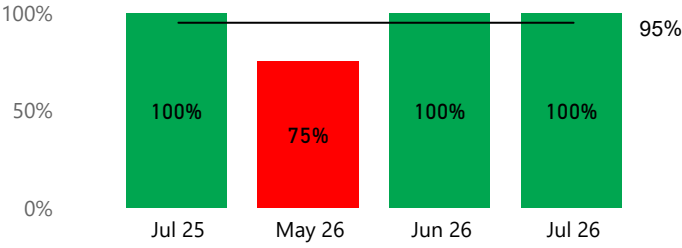
Compliance

Member Grievances

Standard (30 calendar days)

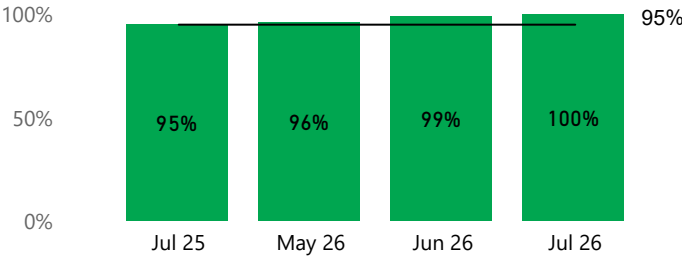


Expedited (3 calendar days)

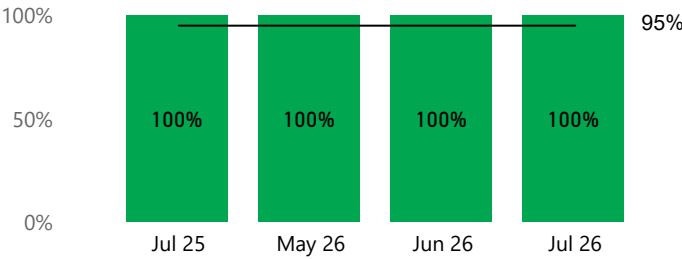


Member Appeals

Standard (30 calendar days)

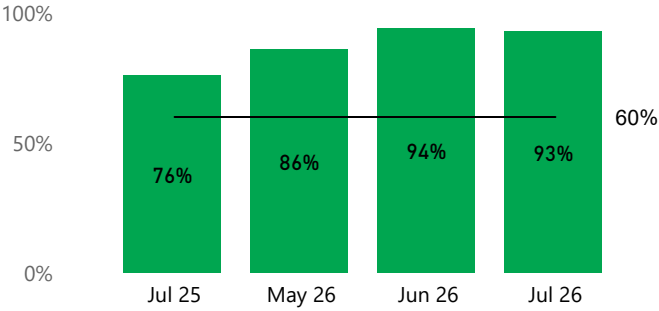


Expedited (3 calendar days)

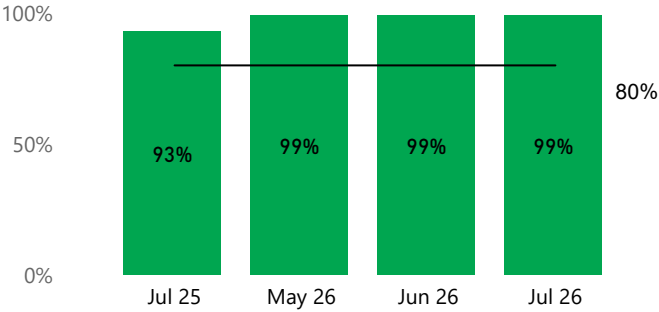


Encounter Data

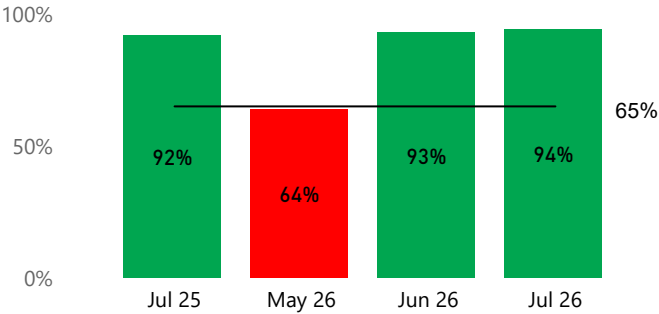
Institutional 0-90 days



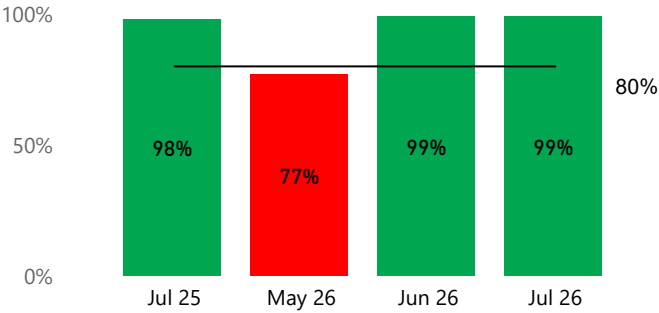
Institutional 0-180 days



Professional 0-90 days



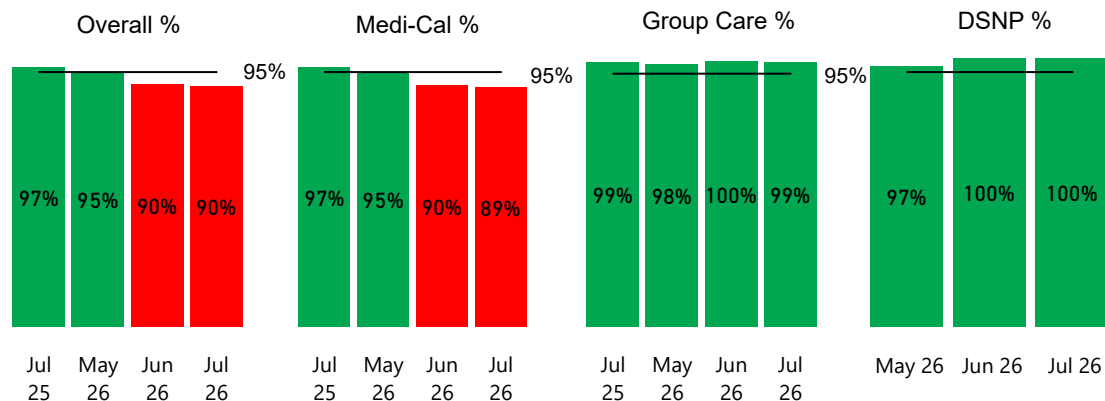
Professional 0-180 days



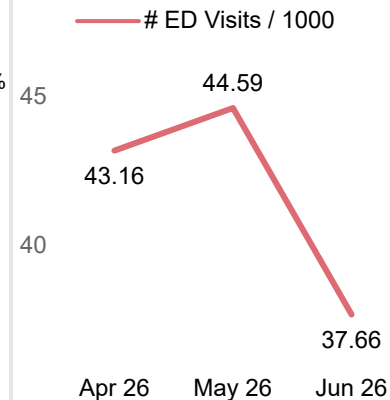
8/5/2026 8:03:12 AM

Health Care Services

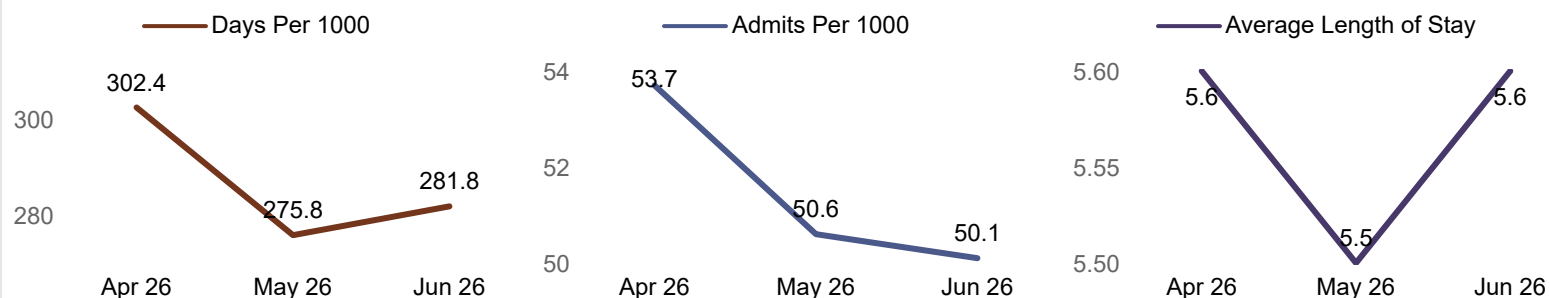
Authorization Turnaround



ED Utilization



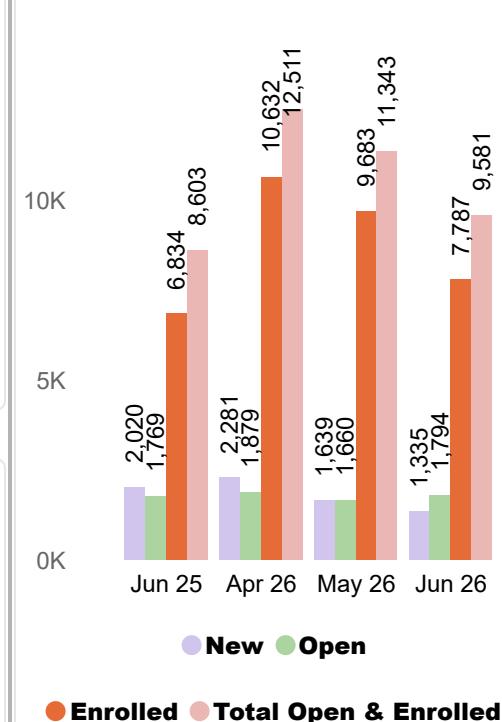
Inpatient Utilization



Case Management

Total Cases^

^ ECM Metrics since 2022

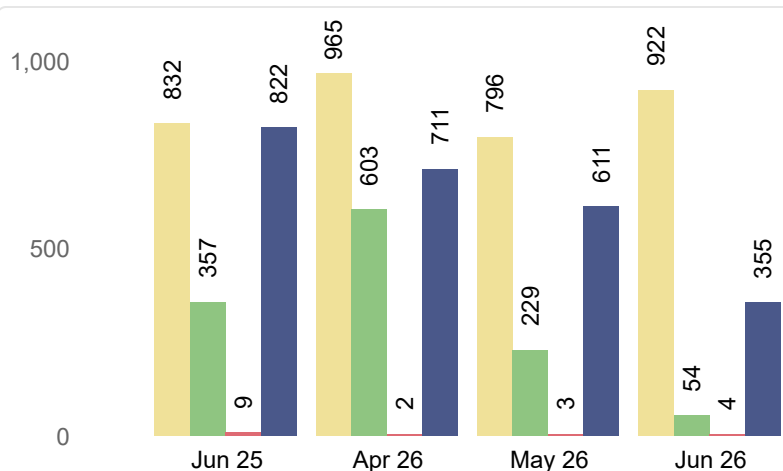


Case Management^

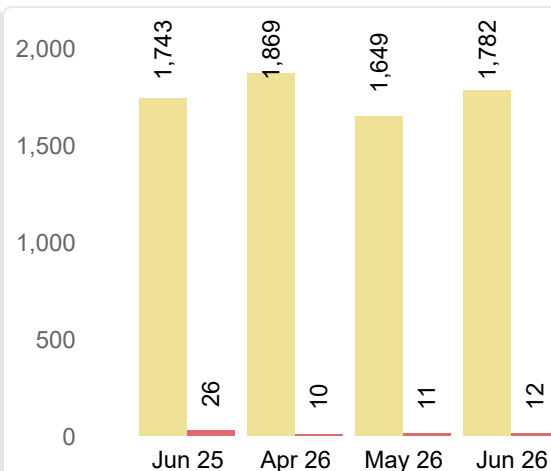
● Care Coordination ● Community Supports ● Complex Cases ● Enhanced Case Management

^ ECM Metrics since 2022

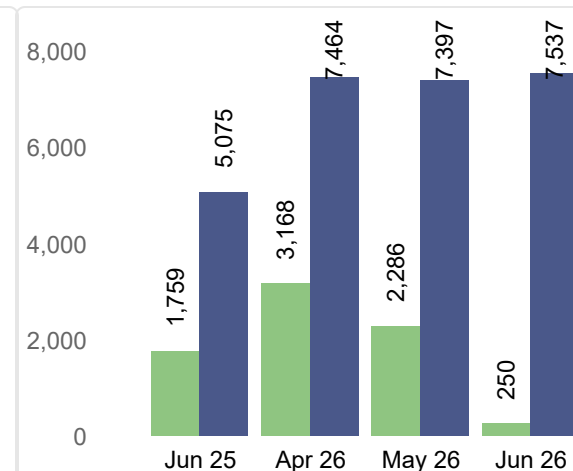
New Cases



Open Cases



Enrolled Cases



Technology (Business Availability)

Applications ▲	Jul 25	May 26	Jun 26	Jul 26
HEALTHsuite System	100.0%	99.5%	100.0%	99.9%
Other Applications	100.0%	99.9%	99.5%	99.9%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Jul 25	May 26	Jun 26	Jul 26
Denial Rate Excluding Partial Denials (%)	4.1%	5.2%	5.6%	4.9%
Overall Denial Rate (%)	4.7%	5.5%	5.9%	5.3%
Partial Denial Rate (%)	0.7%	0.4%	0.3%	0.4%

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

Pharmacy Authorizations

Authorizations ▲	Jul 25	May 26	Jun 26	Jul 26
Approved Prior Authorizations	43	57	59	43
Closed Prior Authorizations	9	19	24	24
Denied Prior Authorizations	90	89	91	100
Total Prior Authorizations	142	165	174	167



Board Business



Medical Management

Healthcare Services - Medical Management BOG Presentation

Donna C. Carey, MD,MS
Chief Medical Officer
8.14.26

Introduction to Health Care Services (HCS) Division

HCS Division

- ▷ 6 major Departments
- ▷ 4 Medical Directors
- ▷ 214 staff members
- ▷ 7 Directors
 - ▶ 1 Executive Director
 - ▶ 2 Sr Directors
 - ▶ 4 Directors
- ▷ Utilization Management
- ▷ Case & Disease Management
- ▷ Long Term Support Services (LTSS)
- ▷ Pharmacy Services
- ▷ Quality & Health Equity (HE)
- ▷ Behavioral Health

HCS Leadership Team

- ▶ Dr. Donna C. Carey – CMO/CHEO
- ▶ Allison Lam – Executive Director
- ▶ Michelle Stott- Sr Director of Quality & HE
- ▶ Luke Lim – Sr Director of Pharmacy Services
- ▶ Lily Hunter – Director, SDOH
- ▶ Michelle Findlater – Director, UM
- ▶ Linda Ayala – Director, PHM & Equity
- ▶ Shatae Jones – Director, CH Strategy
- ▶ Dr. Stephanie Brown – Medical Director, QI & HE
- ▶ Dr. Beverly Juan – Medical Director, CM/CHS
- ▶ Dr. Daphne Lo – Medical Director, LTSS
- ▶ Dr. Parag Sharma – Medical Director, UM

HCS is a Dept that works as a transdisciplinary team to be good partners internally and externally. We lead with the value of trust and assume positive intent from our colleagues, for the benefit of serving our members and helping them reach their “optimal health and well being at every stage of life.”



T

rust

E

fficiency

A

daptability

M

Members

Wellness / Work life balance

O

perations

R

Resilience

K

ommunication / Kollaboration / Kindness

Quality & Health Equity

Quality Improvement & Health Equity

Program Components



**Member Experience &
Access to Care**

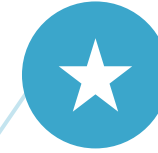


Safe care

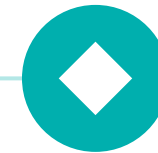


**Community Health
Strategy**

Community Health
Workers as trusted
connectors

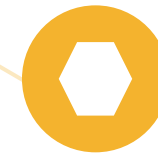


Quality Performance
Top quality scores



**Population Health &
Equity**

Address Social Drivers of
Health and reduce
disparities in health
outcomes



NCQA Accreditation
Achieve high standards
and excellence

Quality Improvement & Health Equity

Overall Objectives



Advance Health Equity

Everyone gets fair, equal access to quality care



Support Communities

Address social factors that affect health



Whole-Person Care

Treat the full person — body, mind, and social needs



Track Quality

Measure and improve how care is delivered



Close the Gaps

Reduce differences in health outcomes across all populations

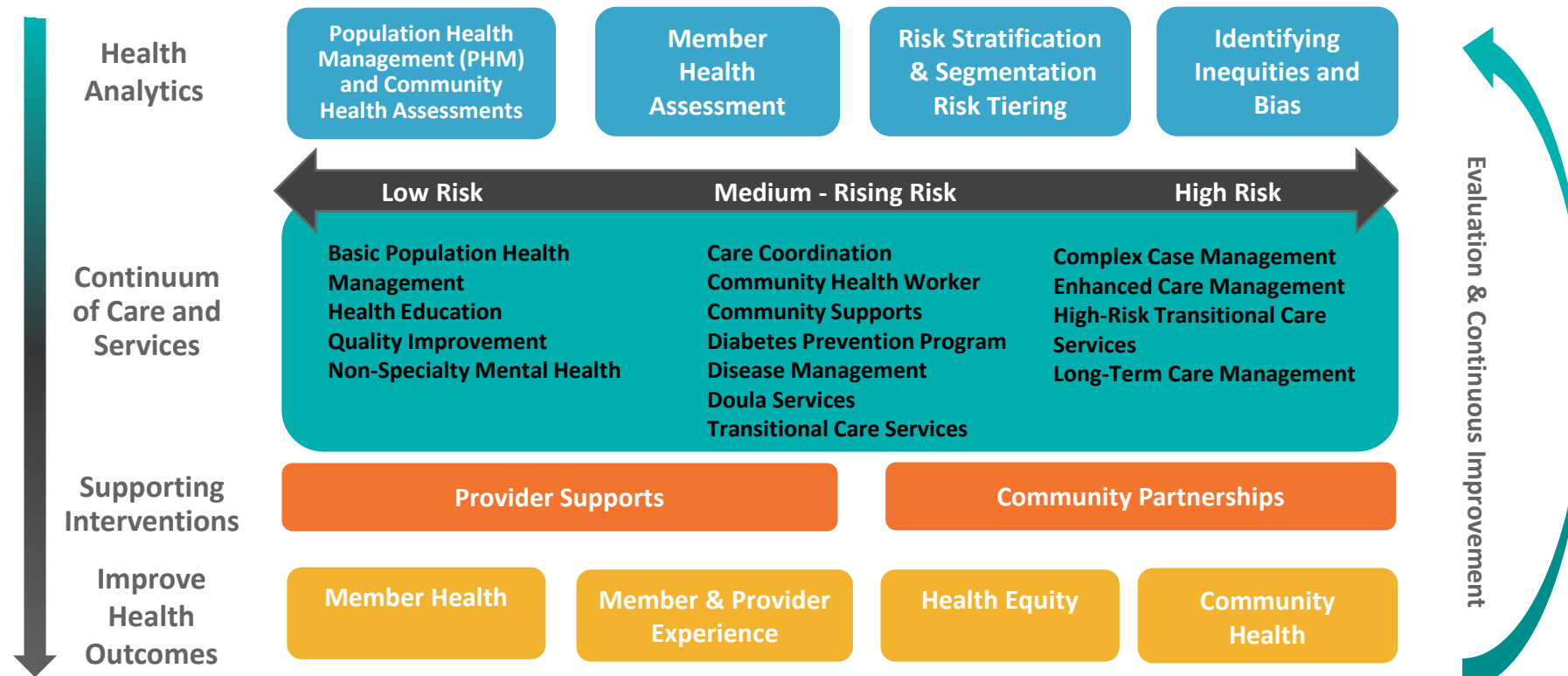


Keep Improving

Use continuous quality improvement to raise standards over time

Population Health Management (PHM)

Alliance Population Health Management Framework



Addressing social determinants of health to promote health equity.



PHM 2026 Strategy Highlights



Improving Chronic Conditions

Goal: Increase member's confidence in ability to manage their health conditions

- Outreach to CCM-eligible members
- Offer member incentive for disease management health coaching



Achieving Women's Health Equity

Goals: Connect members to doula and perinatal mental health services; address cancer screening gaps

- Promote member use of doula services and care coordination of doula referrals
- Promote maternal mental health care
- Share CCS best practices with providers
- Host mobile mammography; focus: ages 40-49



Ensuring Members receive needed Behavioral Health Care

Goals: Address disparity gaps and increase timely care after ED visits

- Focus NSMHS outreach and education for members with limited English proficiency
- Engage members when at the ED, through text messaging, and ECM outreach



Connecting Children to Well Care

Goals: Address well child visit disparities and build on 2025 topical fluoride improvements.

- Fund Beloved Babies Centering group visits at AHS
- Topical fluoride member outreach calls & texts
- First 5 outreach calls



Birth Equity Initiatives



Doula Workforce: 759% growth from 17 → 146
Doula Services: 403% growth from 63 → 317 served



Group visits: Equity effort to improve outcomes - sponsor Beloved Black baby at AHS



Maternal Mental Health Program

- Member outreach: Birthwise Wellbeing
- Online provider Screening Guidelines & Resources
- Our Roots: CHW



DHCS Medi-Cal Connect: July 2026

- Prenatal/Postpartum TCS
- Birthing checklist



FY27 HCS Goal: Create Alliance Maternal Health Equity Program



Doula Scholarship Program

Doulas who received scholarships represent nearly one-quarter of the network while serving one-third of unique members.

-  **Doula Network:** 146 contracted doulas as of June 2026
-  **Scholarship Reach:** 33 scholarship doulas (23% of contracted and credentialed doulas)*
-  **Member Reach:** 99 unique members served by scholarship awardees (31% of unique members served)*

*FY 2024-25 and FY 2025-26

Funding FY 2025 – 2026

Amount Allocated: \$18,750.00

Amount Awarded: \$18,750.00

Amount Per Scholarship: **\$1,250.00**

FY 2026 – 2027

\$38,250 allocated to support doula workforce investment and access for members.



Doula Scholarship Impact

Feedback on member's experience with doula services was collected from August 2025 – March 2026.

18 out of 19 members found working with a doula “Incredibly Helpful”



Support: *[I am] very happy that doula services is a covered benefit. [I] wouldn't have had a smooth overall experience without the doula's help.*



Respect: *[My doula] did a great job. She helped with everything and respected how I think especially during pregnancy.*

A Doula Story

Felicity* is a domestic violence survivor. Her ex-husband left her on the street with her two kids (3 years old and 5 years old) with only \$100 in her pocket. Because of the Alliance Doula Scholarship, Felicity was able to complete her doula training, enroll in PAVE, and become a contracted provider with the Alliance. She feels like she is thriving now and wants to pay it forward and support others by being a part of the doula community.

*Name changed in the source slide to protect provider privacy.



[I am] so incredibly grateful for the scholarship. It's made such an impact on my life.

Community Health Strategy (CHS)

- ❑ CHS integrates population health analytics, clinical and non-clinical care delivery, quality infrastructure, and community partnerships to:
 - ✓ Deliver culturally responsive, person-centered interventions
 - ✓ Address social drivers of health
 - ✓ Reduce disparities and improve measurable outcomes for Medi-Cal and Medicare members through CHW-Led intervention

COMMUNITY HEALTH STRATEGY (CHS)

How Alameda Alliance Operationalizes Health Equity

CHS is the operational bridge between enterprise priorities and community-based care, mobilizing partners, empowering CHWs, and improving outcomes for every member in every community.



CHW Provider Network – Across HEDIS Domains

26

CHW Contracted Providers

- 12 direct contractors in our provider network
- 14 subcontractors in our provider network

Directly Contracted Providers

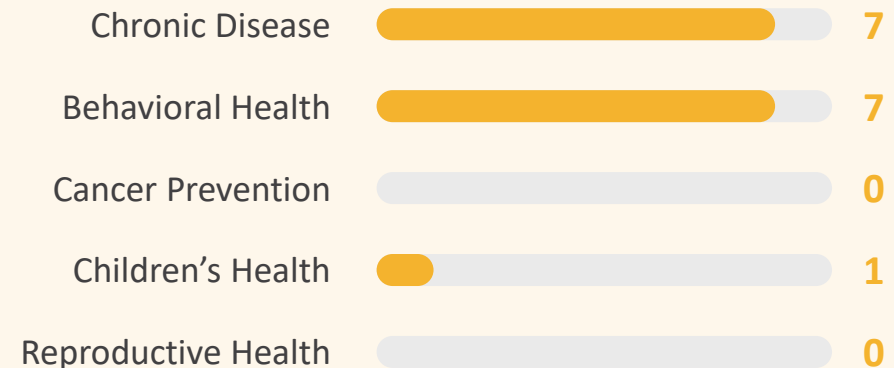


140

Community Health Workers

- Collectively speak 25 languages
(English, Cantonese, Spanish, Tagalog, Korean, Hindi, Japanese, Mandarin, Russian, Tigrinya)

Subcontracted Providers



CHW-LED INTERVENTION PILOT PORTFOLIO

12 STRATEGIC INITIATIVES. STRONGER COMMUNITIES. BETTER HEALTH OUTCOMES.

1



Chronic Disease Management

CHW outreach targeting blood pressure control and A1C reduction

2



Hospital-Based Interventions

SDOH screening and support to reduce IP/ED visits & readmissions

3



Asthma Education

CHW-led education to improve self-management and reduce exacerbations

4



Quality Outreach Campaigns

Targeted outreach to improve care gaps, HEDIS® and MCAS performance

5



Parental Depression Screening & New Coaching

Early identification and peer support to strengthen behavioral health outcomes

6



Pharmacy Outreach & Medication Adherence

CHW-supported engagement to improve medication adherence and continuity of care

7



Fatty Liver Education & Self-Management

Patient education to support healthy lifestyle change and risk management

8



CHW Capacity Building & Clinic Integration

Strengthening CHW workforce integration within clinics and workflows

9



W15 / W30 Well-Child Visit Performance Initiative (First 5/Clarity Pediatrics)

Targeted outreach and navigation to improve well-child visits (0–15 months and 15–30 months)

10



Food Access & Health Navigation Pilot

CHW-led screening, food resource connection, and navigation to improve whole-person health

11



Housing as Health Pilot

CHW roving team to support housing instability and care coordination to reduce hospitalizations and increase housing stability

12



Aging with Dignity Initiative

CHW senior navigation & connection to address isolation, unmet needs, functional decline risks and early ECM needs



Collectively Advancing:



Improving Outcomes



Advancing Equity



Enhancing Member Experience



Reducing Avoidable Utilization



Stronger Communities, Healthier Lives, Together

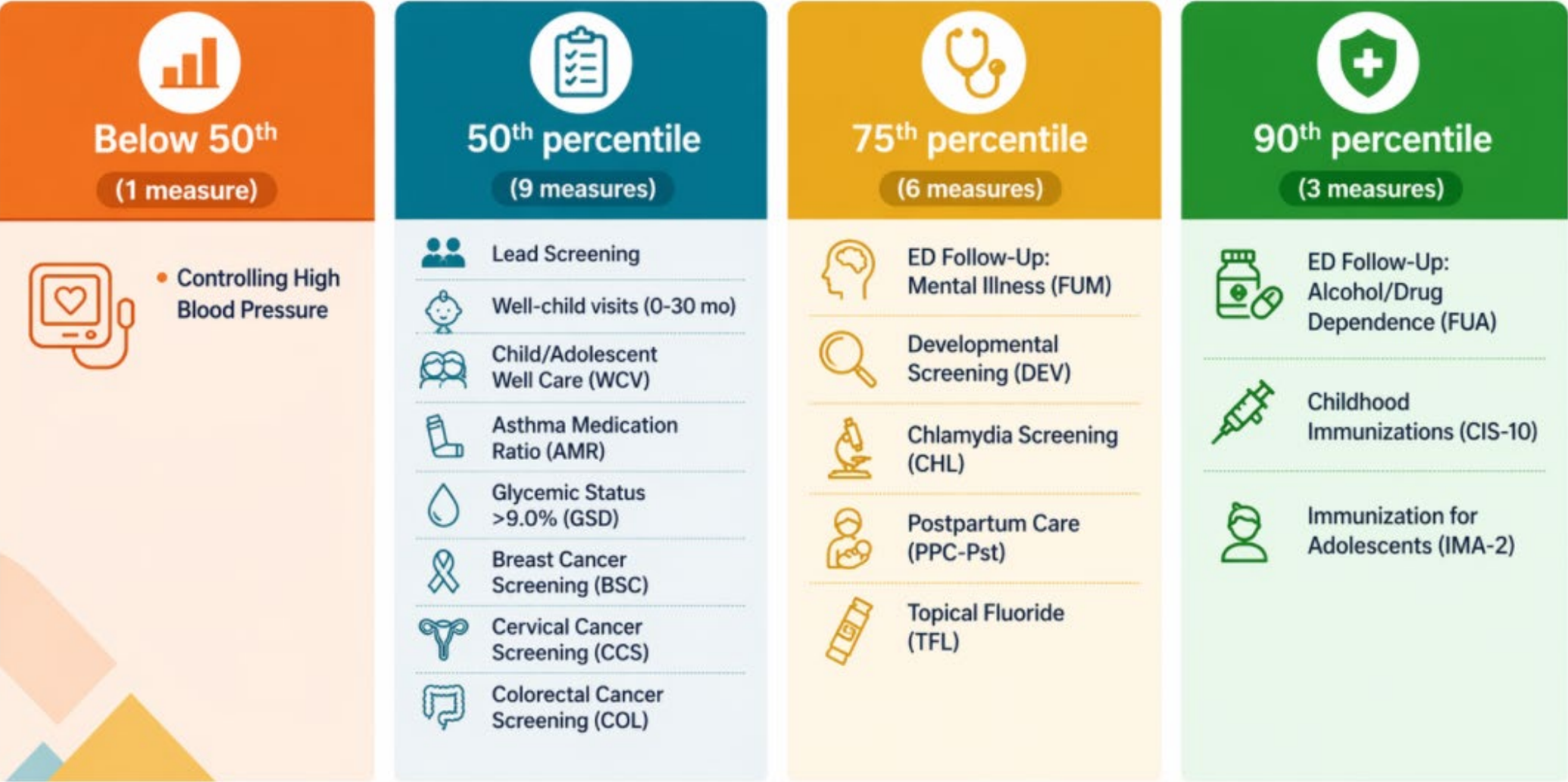
Member Impact

Member Engagement

- ▶ Alliance QI Member Outreach Calls
 - ▶ 8,996 unique members received at least one call
 - ▶ 4,314 successful calls (spoke to member/left voicemail)
 - ▶ 30% or 1,295 members completed a visit or preventative screening
- ▶ Alliance Mailers (birthday cards / flyers) – 5,285
 - ▶ Mailers only - 4,452
 - ▶ Mailer + outcall or text – 833
- ▶ First 5 Member Outreach Calls (0-5 years)
 - ▶ 4,942 unique members received at least one call
 - ▶ 20% or 1,010 members with completed well visits facilitated by First 5
- ▶ Alliance CM Member Outreach Calls
 - ▶ Between January 1, 2026 and June 30, 2026, 5,627 unique members received at least one call
 - ▶ 75% successful calls (spoke to member)

Managed Care Accountability Set (MCAS)

✓ Quality Measures: 17 out of 18 above the 50th percentile



Our Commitment:

Driving high-quality care and better health outcomes for our members.



Member Experience (CAHPS)

Activities:

- ▶ Communicate and review comparative CAHPS health care performance results and member feedback throughout QI/Provider meetings and on-site visits.

Next Steps:

- ▶ Correlate with grievance data and access PQI complaint data to share with providers.
- ▶ Member-facing document outlining alternative access options (e.g., urgent care, telehealth, nurse advice line, after hour/weekend clinics).

Summary Rate Scores: Medi-Cal Child			
	RY 2025	RY 2026	Previous Yr Comparison
Getting Needed Care (% Always or Usually)	78.0%	80.6%	↑
Getting Care Quickly (% Always or Usually)	76.1%	81.6%	↑
Coordination of Care (% Always or Usually)	81.4%	87.5%	↑
Rating of Health Plan (% 9 or 10)	69.3%	74.0%	↑
Summary Rate Scores: Medi-Cal Adult			
	RY 2025	RY 2026	Previous Yr Comparison
Getting Needed Care (% Always or Usually)	73.6%	77.2%	↑
Getting Care Quickly (% Always or Usually)	68.0%	76.9%	↑
Coordination of Care (% Always or Usually)	80.0%	89.3%	↑
Rating of Health Plan (% 9 or 10)	60.0%	63.4%	↑

ECM Member Story

- ▶ Fred Finch under Full Circle was working with a 7 year old who was temporarily placed in foster care after mom was in a motor vehicle accident resulting in a TBI
 - ▶ The child was eventually placed with the maternal grandfather who was also acting as the caregiver for child's mother
 - ▶ Grandfather was overwhelmed with this responsibility

- ▶ The Lead Care Manager (LCM) :
 - ▶ referred the grandfather and mom to ECM (with other providers to help address their own needs)
 - ▶ Grandfather was connected to Bananas for childcare benefit/subsidy
 - ▶ Mom was approved for IHSS hours
 - ▶ Mom and child were connected to PCP and BH services
 - ▶ Forged a working relationship with the child's school and connected all parties together (child care providers, IHSS providers, school teachers, grandfather)
 - ▶ Found a summer program subsidized that the child was interested in, enrolled and arranged transportation for the child
 - ▶ Assisted with finding a bigger apartment closer to the child's school with lower rent

- ▶ Today:
 - ▶ Child and mother are now established with a PCP, dental and BH providers
 - ▶ The family has successfully moved to more affordable housing
 - ▶ IHSS support is in place
 - ▶ Preparing to graduate from ECM

Goal is to increase ECM Enrollment

- ▶ Enrollment into ECM has increased because:
 - ▶ Prioritization of members on the MIF (Member Information File)
 - ▶ Appropriate transitions to other levels of care management/care coordination
 - IDT Rounds
 - Ad hoc Meetings
 - Monthly Clinical Ops Meetings
 - ▶ Community Based Organizations (non-contracted ECM providers) increase in referrals into the Alliance for ECM as more CBOs become familiar with ECM

- ▶ ECM Enrollment Trends
 - ▶ Adults
 - Continued increase in ECM enrollment across all Populations of Focus
 - Sharpest increase with Homelessness, High Utilizers and members at Risk for LTC Institutionalization populations

 - ▶ Children
 - Continued increase in ECM enrollment across all Populations of Focus
 - Sharpest increase with High Utilizer, Homelessness and children with SMI/SUD populations

We are seeing a lot of unhoused families enroll in ECM. We are attempting to work closely with our Community Supports partners to connect the assigned Housing Navigators to the ECM Lead Care Managers

ECM Providers by Population of Focus		Providers		
1a	Individuals Experiencing Homeless: Adults without Dependent Children/Youth Living with Them Experiencing Homelessness	AHS BACS CCC CHCN	EBI IOA MedZed	Roots Pair Team Star Nursing Titanium
1b	Individuals Experience Homelessness: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	CHCN Full Circle La Familia	MedZed Pair Team	Star Nursing Titanium UCSF
2	Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly “High Utilizers”)	AHS BACS CCC CCS CHCN EBI	Full Circle IOA La Familia MedZed Roots Pair Team	Seneca Family Services Star Nursing Titanium UCSF
3	Individuals with Serious Mental Health and/or SUD Needs	ACBH AHS BACS CHCN	Full Circle IOA La Familia MedZed Roots	Pair Team Seneca Family Services Star Nursing Titanium
4	Individuals Transitioning from Incarceration	BACS CHCN Full Circle	La Familia Roots	Pair Team UCSF
5	Adults Living in the Community and At Risk for LTC Institutionalization	CHCN EBI	IOA Pair Team	Star Nursing Titanium
6	Adult Nursing Facility Residents Transitioning to the Community	CHCN EBI	IOA Pair Team	Star Nursing Titanium
7	Children and Youth Enrolled in California Children’s Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition	CCS CHCN	Full Circle MedZed	Pair Team Titanium

ECM Process Improvements

▶ Provider Portal

- ▶ ECM eligibility and enrollment status - *complete*
- ▶ Assigned ECM provider - *complete*

▶ Authorization Process

- ▶ Automatic authorization creation for single referrals through the Provider Portal – *complete*
 - All authorizations were created manually prior to this automated process
- ▶ Batch authorization creation through the Return Transmission File (RTF) - in process

▶ Billing/Data Exchange

- ▶ Re-evaluating Encounter and RTF submission process - in process

▶ **GOAL:** Decrease provider administrative burden related to authorization submission, data reconciliation, and reimbursement procedures

- ▶ Timely notification of authorization decisions
- ▶ Timely and accurate reimbursement
- ▶ Provider data integrity for regulatory reporting
- ▶ Increase visibility to ECM eligibility & enrollment status to decrease duplication of services across systems

NOTE: further expansion of ECM Provider network has been paused until process improvements are complete

Transitional Rent Success Story

▶ ***Victor*, age 73, Fremont***

- ▶ Victor, a UC Berkeley graduate, had his own business for decades. But as he retired and he grew older, he became too frail to work again. With no income, he eventually had to move out of his home and was soon experiencing homelessness. He lived for several months in an East Bay shelter run by a church.
- ▶ Then, he got connected to Transitional Rent through Alameda County's Flex Pool program, with Abode Services as the servicing provider. With their help, he found an apartment at an affordable housing complex in Fremont. Abode staff provided him furniture, kitchenware, and other essential household items that helped Victor make his apartment a home. He said he is able to make meals for himself again, cooking nutritional food in his own kitchen – which has allowed him to gain back some of the weight he lost while he experienced housing insecurity.
- ▶ ***"I call Abode by a different name – "Adore" – because I adore them for what they've done for me," Victor said. "I'm so grateful to the county, too. I'm just so grateful to have a place of my own again."***

○ **Victor is a pseudonym used to protect this participant's personal information.*

Transitional Rent Community Support

- ▶ Transitional Rent is the newest addition to the suite of Community Supports
- ▶ First **mandatory** community support (as of 1/1/2026), as well as a **benefit**
- ▶ Transitional Rent provides up to **six months** of rental assistance in interim and permanent settings to Members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care).
- ▶ Transitional rent requires that members have a permanent housing solution identified, so the biggest challenge with Transitional Rent is identifying long-term rental subsidies for our members once the six months are up
 - To address this, AAH has partnered with the **Alameda County Flexible Housing Subsidy Pool**, to connect Alliance members to permanent long-term rental subsidies and housing solutions

Transitional Rent Highlights

- ▶ AAH has received **55** Transitional Rent authorization requests
- ▶ Transitional Rent has **successfully housed 39** members and their families
- ▶ Projected to serve **250** households in the first year
- ▶ Members are connected to the full suite of housing community supports (Housing Navigation, Housing Deposits, and Housing Tenancy Sustaining Services) and Enhanced Care Management (ECM)
- ▶ Members also receive a **permanent** rental housing subsidy at the conclusion of Transitional Rent through the Alameda County Flexible Housing Subsidy Pool, which only requires them to pay a max of 30% of their income towards rent (if members have no income, they do not pay any rent)

Behavioral Health Success Stories

"It was so nice speaking to you yesterday. You made me feel so much better. I was going through a lot and I needed those words. Thank you so much. You are doing God's Work."

Mother of a child with ASD provided with ABA and parenting support resources.

"I have been on both sides of the [healthcare system], but as I am aging I am more on the receiving end. I have never felt more care in my entire life since becoming a member of Alameda Alliance. "

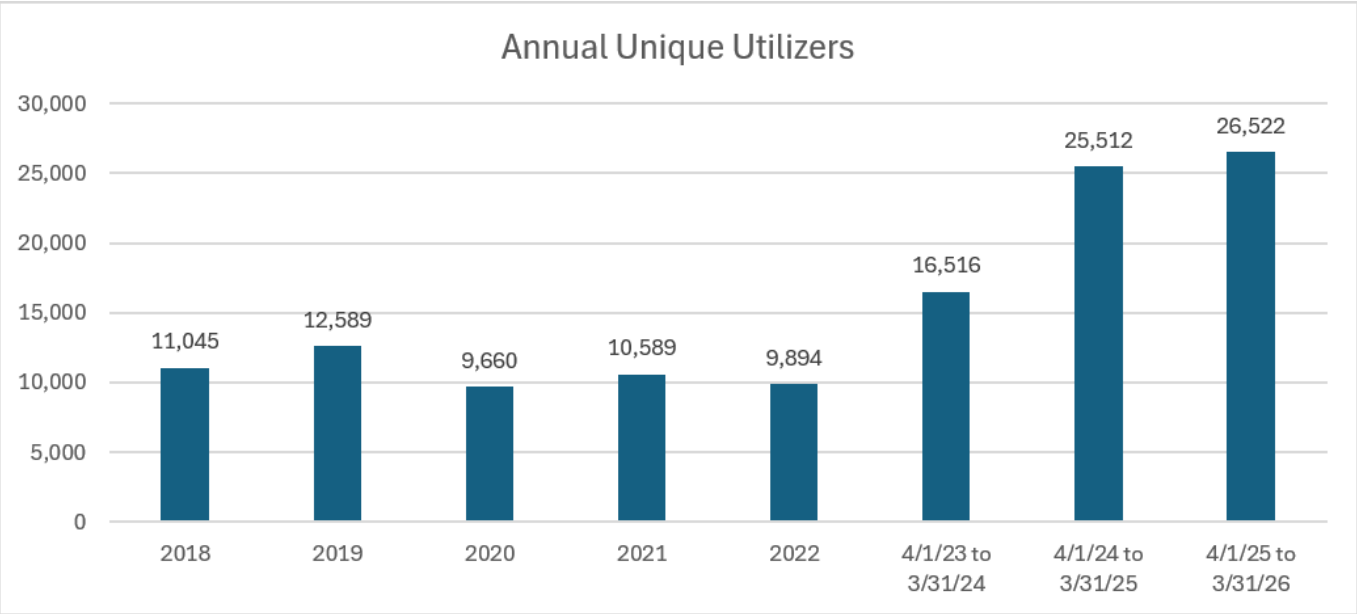
DSNP Member connected with MH care

How did we get there?

- ▶ Organizational commitment to behavioral health across departments
- ▶ Expansion of the network to meet demand
- ▶ Created relationships with local BH network providers who are invested in Alameda County residents
- ▶ Developed referral pathways to decrease barriers to care
- ▶ Increased outreach and communication to members about BH services

Increasing Access

- ▶ Our departmental success is best reflected in the numbers of members who utilize care since insourcing on 4/1/23.
- ▶ Mental Health Utilization has increased by 168% since insourcing in 2023.

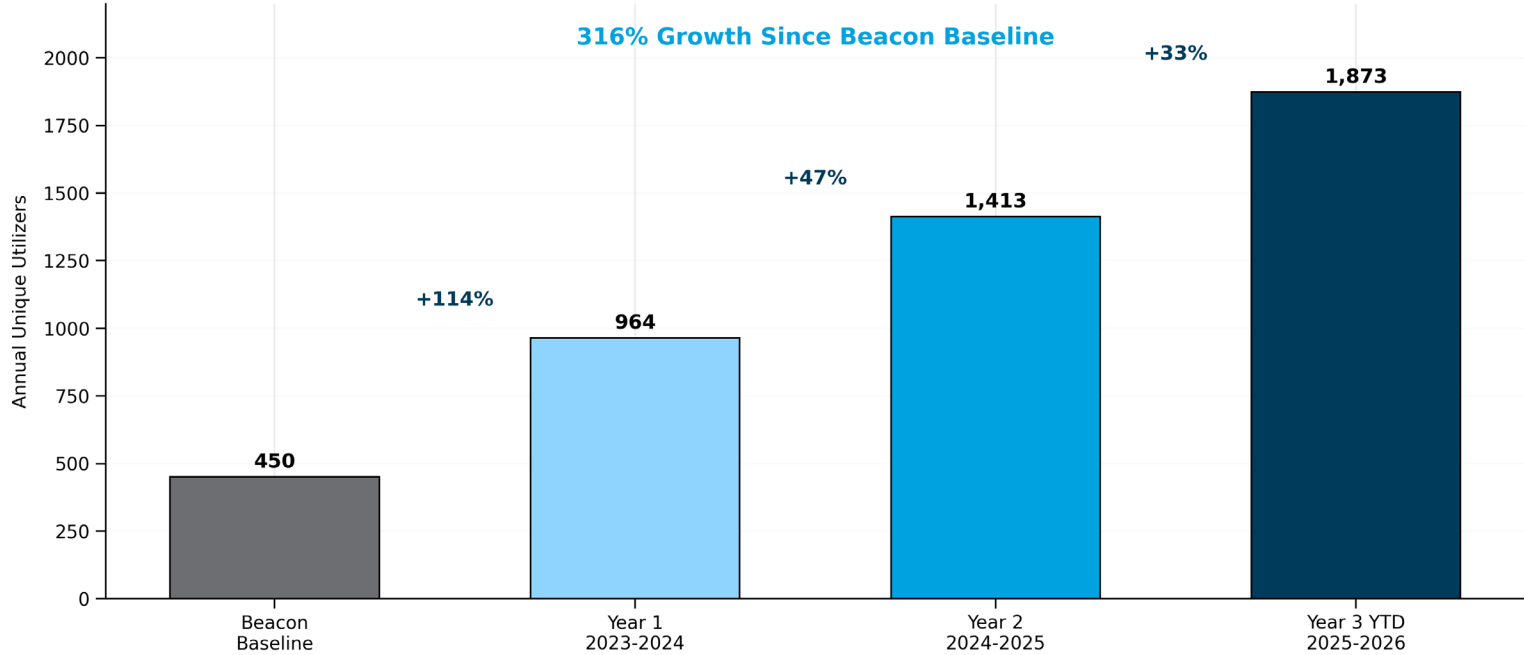


Mental Health Unique Utilizers

ABA/BHT Unique Utilizers

The number of children utilizing ABA/BHT services since insourcing has increased by 316%.

BHT Program Growth Since Transition From Beacon



Period	Unique Utilizers
Beacon Baseline	450
Year 1 (4/1/23-3/31/24)	964
Year 2 (4/1/24-3/31/25)	1,413
Year 3 YTD (4/1/25-3/26/26)	1,873

Pharmacy Transition of Care services

- ▶ The Pharmacy Transitional Care Services (TCS) program advances health of members
- ▶ Referrals come in from CM/DM team and Washington, Sutter, and Highland ADT feeds.
 - ▶ Pharmacy technician reviews ADT feeds for recently discharged members with Alliance primary coverage that meet certain diagnostic criteria: heart failure, sepsis, ESRD.
 - ▶ Pharmacy Tech reconciles discharge meds against pharmacy claims then refer to Pharmacist.
 - ▶ Pharmacist reviews drug list, medical notes, charts to identify any potential drug-related barriers to care.
 - ▶ Pharmacist attempts to outreach to member twice.
 - ▶ If contacted, Pharmacist explains medication regimen, answers member questions, triages issues requiring prescriber follow-up, and documents activities for CM.

Inpatient Coordination of Care

- ▶ **Onsite Nurse at Washington Hospital** – stationed in the ED and on inpatient floors
 - ▶ Strengthened real-time collaboration and care coordination with hospital Case Managers and Social Workers
 - ▶ On-site authorizations for SNF/home health/transportation to support timely discharge
 - ▶ Connection with members at bedside to educate on available resources post-discharge (ie: Advice Nurse line, Case Management)

CASE EXAMPLE: IP Onsite nurse met with member with multiple CHF readmissions (6 in 2026) and member's daughter at the bedside, providing an AAH AOR form after she was identified as his primary caregiver – to allow for her to be involved in medical-decision making. Acting as a key point of contact, and liaison between patient, family, Washington Hospital, member and family received support with transportation resources, member services information, the advice nurse line, and urgent care resources. The member has not been re-hospitalized since.

- ▶ **Transitional Care Services** – Partnership with Upward Health
 - ▶ Supporting members who are transitioning from one level of care to another (hospital to home, hospital to SNF to home) by helping coordinate care for post-discharge follow up, DME and home health orders, as well as patient education to help decrease readmissions
 - ▶ High Risk Members are helped by Upward Health who are providing in-person visits, in the hospital, and post-discharge (at home)
 - ▶ Low Risk Members are supported by the internal CM team to help link the members to the PCP for post-discharge follow up appointments

▶ @Luke – impact of med rec/pharmacy services on hospitalized members?

Long-Term Care Highlights

Strengthened partnerships with facilities & external systems:

- ▶ April 2026: LTSS Liaison Quarterly Provider Office Hours with long term care facilities
 - ▶ Educational focus & reach: 40 long term care facilities and 6 ICF-DD providers
 - ▶ July 2026 sessions scheduled
- ▶ Leadership on-site visits with LTSS Liaison – increased understanding of facility operations
- ▶ Engagement with community partners – exploring opportunities with CHWs, housing supports, Alameda County Behavioral Health, Alameda County Public Guardian Office, IHSS

Expanded care coordination and care management processes to ensure members receive care in the most appropriate setting

- ▶ Re-evaluating process for identifying members who would benefit most from LTC Social Worker onsite visits (based on facility feedback and using data-driven approach)
 - ▶ Frequent inpatient admissions and/or readmissions, frequent ER visits, members who have longer lengths of stay when admitted, members who are ready to transition to home/community-based setting
- ▶ Rounds between inpatient SNF and LTC teams to support early identification of transitional care needs, while members are still receiving skilled level of care

Community Supports Success Story

- ▶ Member was admitted to BACS Medical Respite due to severe, debilitating back pain that left him unable to perform basic ADLs and IADLs, including dressing himself.
- ▶ Initial Medical Respite authorization was approved from **September 16, 2026, through November 11, 2026** to address his acute medical needs and stabilize his condition.
- ▶ **Collaboration** revealed that the member had been unable to participate in physical and occupational therapy until receiving a steroid injection and achieving partial pain control.
- ▶ When an additional **60-day authorization** was requested, the Alameda Alliance Community Supports RN proactively contacted the Medical Respite team to better understand the member's progress, barriers, and long-term discharge plan.
- ▶ Despite limited housing options due to his reliance on **General Assistance (GA)** income, the care team worked together to identify potential housing pathways while supporting his continued recovery.
- ▶ The authorization was approved, providing the member with critical time to heal, engage in therapy, and regain independence.
- ▶ The member experienced a remarkable recovery, progressing from dependence in ADLs and IADLs at admission to **complete independence** at discharge.
- ▶ Through strong collaboration and person-centered care planning, the member successfully transitioned to **Medically Frail Housing** and moved into his own apartment without requiring assistance.
- ▶ What began as a period of severe pain and uncertainty became a success story of recovery, housing stability, and restored independence.

Community Support Services

- Asthma Remediation
- Medically Tailored Meals/Medically Supportive Foods
- Community or Home Transition Services
- Assisted Living Transition Services
- Personal Care and Homemaker Services
- Respite (Caregiver respite)
- Recuperative Care (Medical respite)
- Home Modifications
- Housing Bundle
 - Housing Deposits
 - Housing Navigations Services
 - Housing Tenancy Sustaining Service

NCQA Accreditation



Health Plan

- ▶ Status: **Accredited**
- ▶ Line of Business:
 - Commercial
 - Medi-Cal
 - (Corrective Action Plan CLOSED – UM 9B: Timeliness of Appeals)
- ▶ Accreditation Period:
 - September 23, 2025 to September 23, 2028

Health Outcomes (formerly Health Equity)

- ▶ Status: **Accredited**
- ▶ Line of Business:
 - Commercial
 - Medi-Cal
- ▶ Accreditation Period:
 - August 13, 2025 to August 13, 2028

Universal Design

Solving for the unique needs of those who have been left behind improves outcomes for all

Shoveling the stairs first limits access to the door for those who use a wheelchair, creating a disparity in outcomes.

Shoveling the ramp first allows everyone to safely access the door (equal outcomes).



CLEARING A PATH
FOR PEOPLE WITH SPECIAL NEEDS
CLEARS THE PATH FOR EVERYONE!

Thank you!

Questions?
dcarey@alamedaalliance.org



Enterprise Risk Management

Enterprise Risk Management (ERM)

Board – Onboarding Session
August 2026

Purpose & Agenda

Purpose

Establish a common understanding of ERM and the Alliance's approach to identifying, assessing, and managing risks that could impact strategy, operations, compliance, finances, and member outcomes.

Agenda

Foundation: What Is ERM and Risk?

- Why is the Alliance embarking in this journey?
- Governance: 3LOD & COSO
- Risk Categories
- Risk Methodology

Future State: End-to-End Process

Foundation: What is ERM? What is risk?

Enterprise Risk Management (ERM) is:

A structured approach used across the organization to **identify, assess, prioritize, and manage risks** that could impact achieving goals—so leadership can make informed decisions and improve outcomes.

It helps us:

- Understand what **could** go wrong (or opportunities)
- Prioritize what matters most
- Take action before issues become problems
- Provide transparency to the various risks across the Alliance

- ▷ **Risk is something that could happen that might cause harm or problems.**
 - ▷ It is not certain—it's a possibility we need to watch and manage.
- ▷ **Risk is about two things:**
 - ▷ How likely it is to happen
 - ▷ How big the impact could be if it does happen
- ▷ **Risk is the chance that something could go wrong and affect our Members, operations, or results.**

Why is the Alliance embarking on this ERM journey?

Do the right thing for our Members.

We find and fix risks early so people get safe, high-quality care and a better experience.

Catch problems before they happen.

We move from reacting to issues to preventing them, so we can act early and avoid bigger problems later.

Use our time and resources wisely.

We focus on the most important risks, reduce repeat work, and improve how we deliver services.

Give leaders a clear, full picture.

We provide simple, clear insight into risks and performance so leaders can make better decisions.

Meet requirements and build them into daily work.

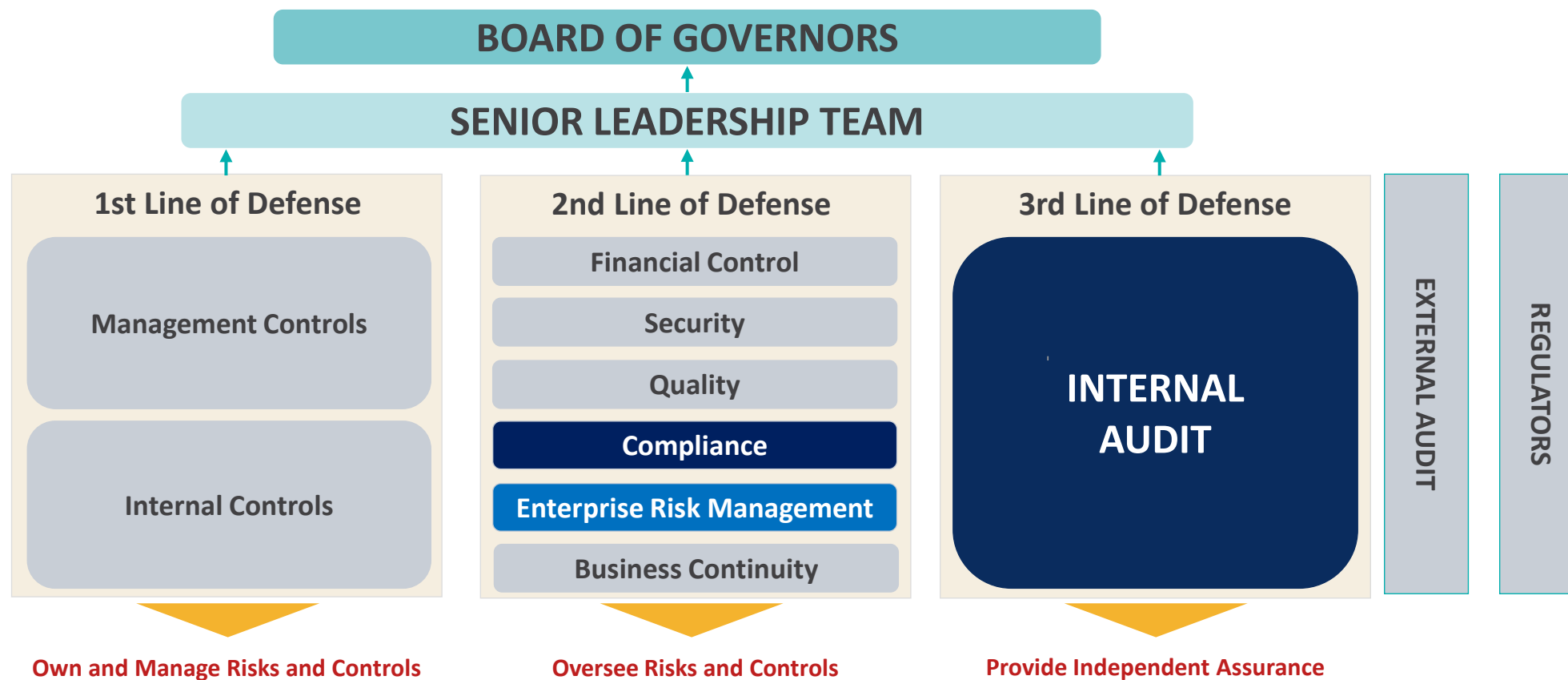
We follow CMS rules by preventing, finding, and fixing issues as part of how we work every day—not as a separate activity.

Why is the Alliance embarking on this ERM journey?

Regulator	What They Expect	ERM Role	Monitoring Role	Internal Audit Role	Board/Committee Oversight
OIG (HHS Office of Inspector General)	Effective compliance program with ongoing risk assessment, monitoring, auditing, corrective action, and compliance oversight. OIG's 2023 Guidance emphasizes annual risk assessments and continuous monitoring.	Identify and prioritize compliance, FWA, operational, and strategic risks.	Routine compliance monitoring to detect issues early.	Independent auditing is one of OIG's Seven Elements of an Effective Compliance Program.	<u>Governing body should oversee compliance program effectiveness.</u> [crowell.com]
DOJ (Department of Justice)	Organizations should maintain an effective compliance program supported by risk assessments, internal controls, data analytics, and testing. DOJ evaluates whether compliance programs are well-designed and working in practice.	Enterprise risk assessments drive resource allocation and control design.	Ongoing testing and monitoring demonstrate compliance effectiveness.	<u>Independent testing validates controls and program effectiveness.</u> [justice.gov]	Leadership and Boards are expected to exercise active oversight of compliance and risk management.
CMS (Medicare Advantage, Part D, Medicaid)	Requires systems for routine monitoring and identification of compliance risks, internal audits, corrective actions, and compliance program effectiveness. 42 CFR 422.503 and 423.504 expressly require monitoring and auditing.	Enterprise-wide identification and prioritization of compliance and operational risks.	Continuous monitoring of operations, delegated entities, claims, grievances, appeals, care management, etc.	Independent audits of high-risk areas and compliance program effectiveness.	Compliance Committee and Governing Body oversight expected.
DHCS (Medi-Cal Oversight)	Ongoing oversight of managed care plans, routine audits, corrective action plans, quality monitoring, and operational compliance.	Risk assessment supports prioritization of Medi-Cal compliance risks.	Monitoring of quality, access, grievances, utilization management, and contract compliance.	<u>Audits validate compliance with contract, regulatory, and quality requirements.</u>	<u>Leadership oversight of remediation and CAPs is expected.</u>
DMHC (Knox-Keene Regulator)	<u>Requires demonstration of effective oversight of quality, access, grievances, utilization management, and health plan performance through regular surveys and reviews.</u>	Enterprise view of emerging member access, quality, operational, and regulatory risks.	Continuous monitoring of regulatory performance indicators.	<u>Audits confirm compliance with Knox-Keene and regulatory requirements.</u>	<u>Board and executive accountability for health plan performance and corrective actions.</u>

Regulatory Expectations → ERM (Identify Risk) → Monitoring (Manage Risk) → Internal Audit (Validate Risk) → Board Oversight (Governance)

Governance: Three Lines of Defense (3LOD) Framework



Sources: Protiviti, Institute of Internal Auditors (IIA), and Information Systems Audit and Control Association (ISACA)

Governance: Committee of Sponsoring Organizations of Treadway Commission (COSO) Framework

► Includes (5) interrelated components –

- Control Environment
- Risk Assessment
- Control Activities
- Information and Communication
- Monitoring



Risk Categories: Levels

- ▶ **Level 1** – Strategic Risk Categories
Broad, enterprise-wide risk domains representing major areas of exposure. These align directly with Board of Governors (BOG) and CEO strategic objectives.
- ▶ **Level 2** – Tactical Risk Themes
Sub-categories and operational themes that define specific areas for mitigation, monitoring, and control within each Level 1 category.
- ▶ **Level 3** – Issue-Level Risks
Individual risk events or issues that may accumulate into significant exposure. Each instance maps to corresponding Level 1 and Level 2 categories for traceability and escalation.



Risk Methodology: Likelihood Criteria Table

▶ **Likelihood** – reflects the probability that a risk event will occur within the planning or reporting period

Likelihood Rating	Definition	Description
Critical	Almost Certain	The risk is expected to occur frequently or is already occurring; ≥90% probability or recurring events with limited control effectiveness.
High	Likely	The risk is likely to occur under current conditions; historical occurrence or strong indicators of recurrence (≈60–89%).
Medium	Possible	The risk may occur at some point; limited history or emerging indicators (≈30–59%).
Low	Unlikely	The risk is unlikely to occur; strong controls in place and little or no prior occurrence (<30%).

Risk Methodology: Consequence (Impact) Criteria Table



▶ **Consequence** – reflects the severity of impact to members, with secondary consideration to regulatory, financial, and reputational effects

Consequence Rating	Member Harm Impact	Organizational / Regulatory Impact
Critical	Severe or widespread member harm; significant disruption to care, safety, privacy, access, or rights	Immediate regulatory action, material sanctions, sustained reputational damage, executive/AOC intervention required
High	Significant member harm affecting access, quality, or timeliness of care, or rights	Reportable regulatory issues, financial penalties, heightened oversight
Medium	Moderate member impact; service delays, increased grievances or appeals	Operational disruption, corrective actions required, potential regulator attention
Low	Minimal or isolated member impact; inconvenience without care disruption	Minor operational impact; managed within routine processes



Future State: End-to-End Process



Q&A



Finance

Gil Riojas

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

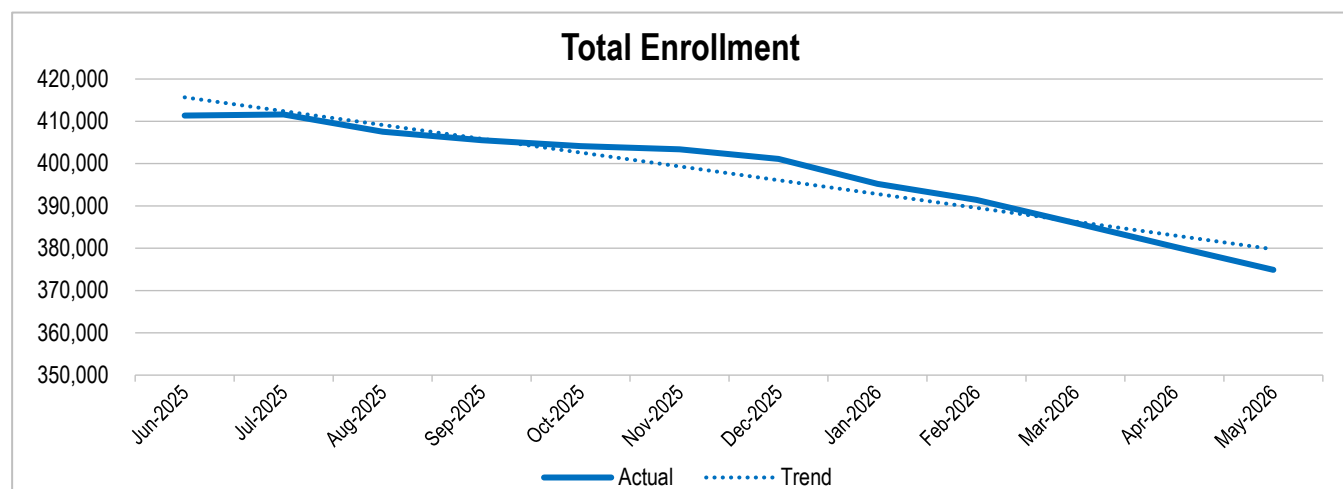
Date: August 14th, 2026

Subject: Finance Report – May 2026 Financials

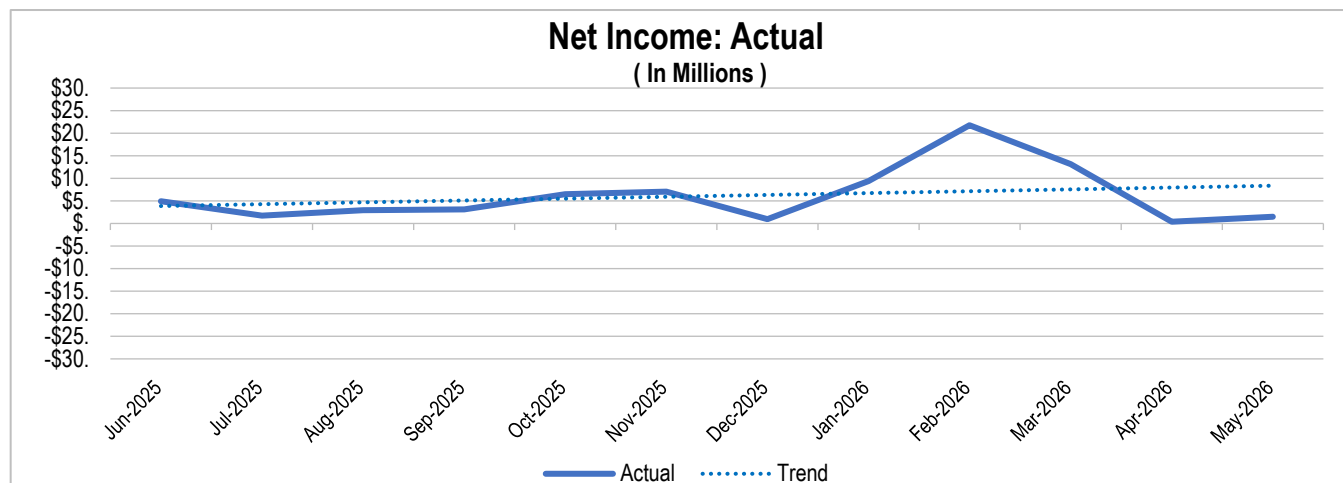
Executive Summary

For the month of May, the Alliance decreased in enrollment, down to 374,886 members. Net Income of \$1.5 million was reported, and the Plan's Medical Expenses represented 93.7% of Premium Revenue. Alliance reserves increased to 301% of required and continue to remain above minimum requirements.

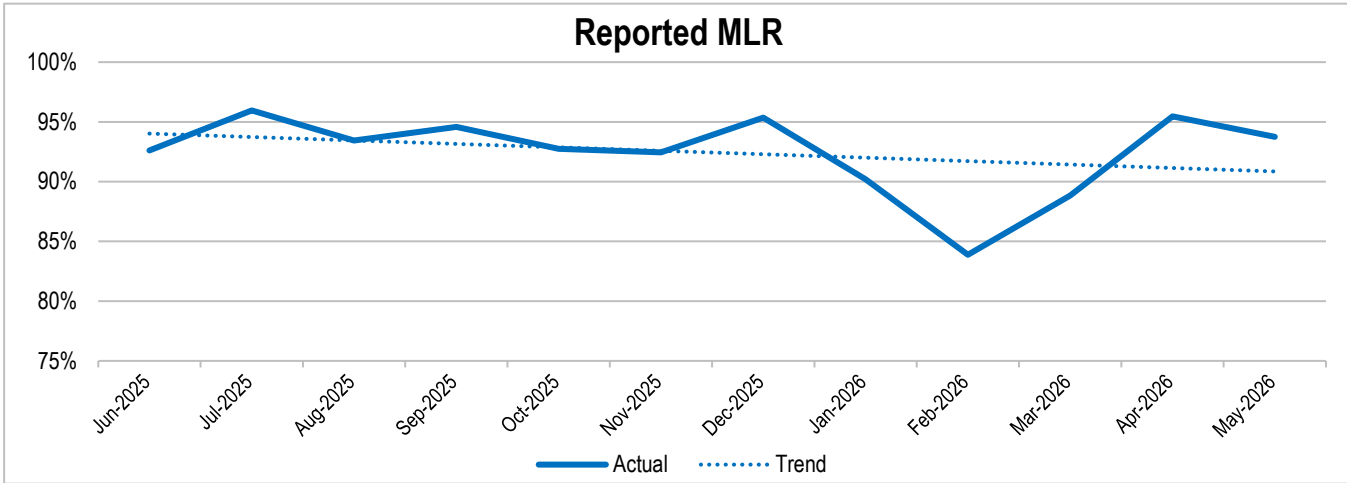
Enrollment – In May, Enrollment decreased by 5,467 members.



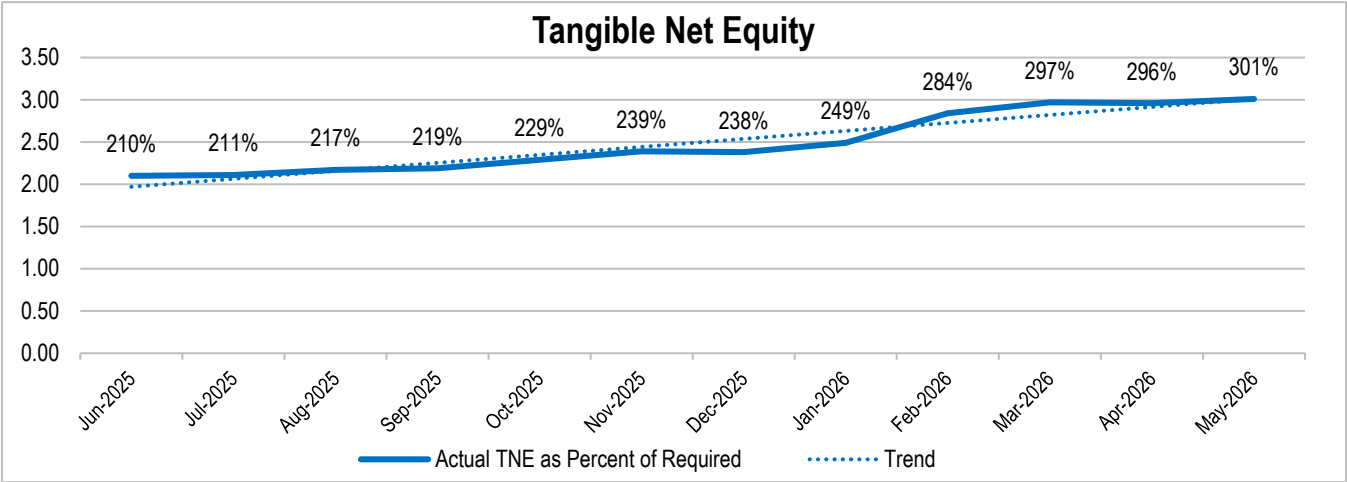
Net Income – For the month ended May, actual Net Income was \$1.5 million vs. budgeted Net Loss of \$1.0 million. For the fiscal YTD, actual Net Income was \$68.5 million vs. budgeted Net Income of \$20.1 million. For the month, Premium Revenue was favorable to budget, actual Revenue was \$184.5 million vs. budgeted Revenue of \$181.0 million. Premium Revenue favorable variance of \$3.5 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 93.7% for the month, and 92.4% for fiscal YTD.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required \$78.9 million in reserves, we reported \$237.8 million. Our overall TNE remains above DMHC requirements at 301%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, investments show a gain of \$27.3 million and capital assets acquired are \$51,000.

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: August 14, 2026

Subject: Finance Report – May 2026

Executive Summary

- For the month ended May 31st, 2026, the Alliance had enrollment of 374,886 members, a Net Income of \$1.5 million and 301% of required Tangible Net Equity (TNE).

<u>Overall Results: (in Thousands)</u>		
	Month	YTD
Revenue	\$246,687	\$2,793,389
Medical Expense	172,951	1,926,412
Admin. Expense	12,374	116,986
MCO Tax Expense	62,201	708,722
Other Inc. / (Exp.)	2,312	27,208
Net Income	\$1,474	\$68,477

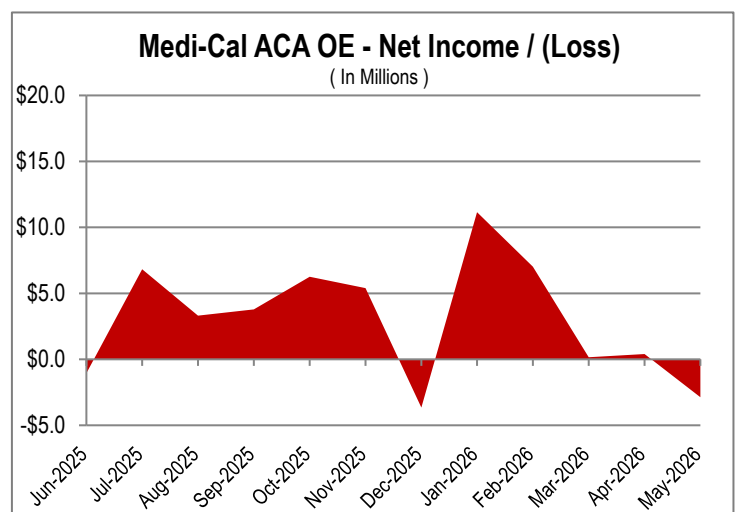
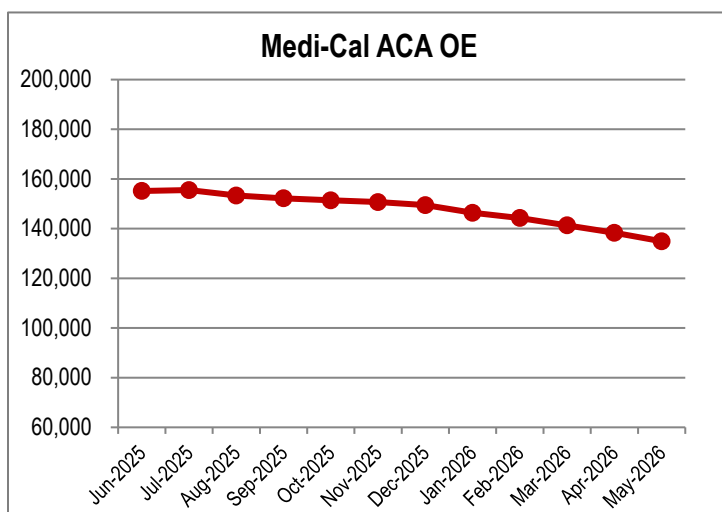
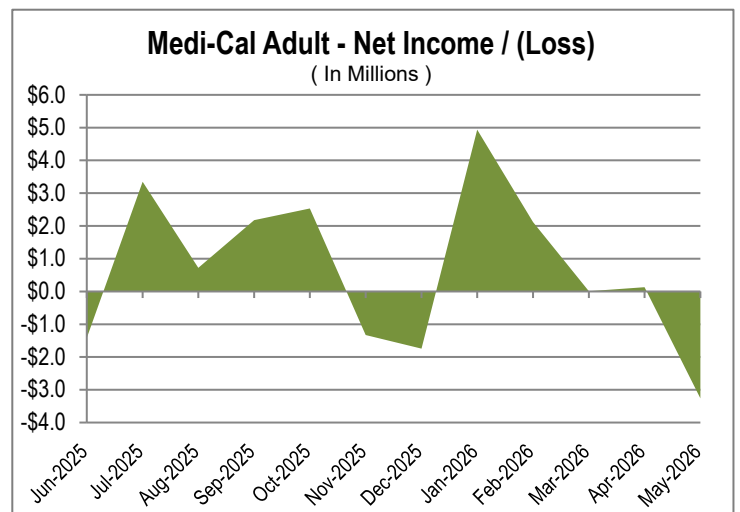
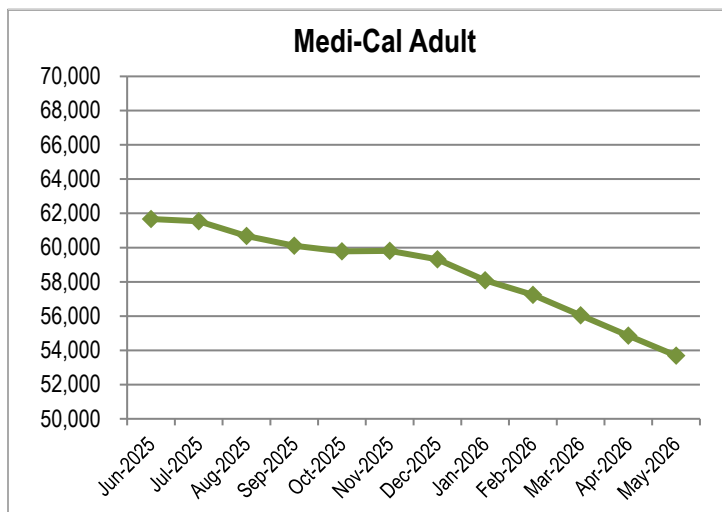
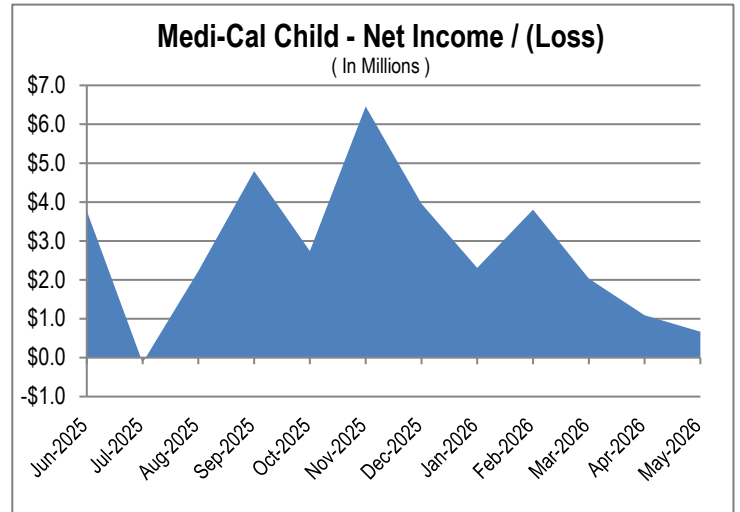
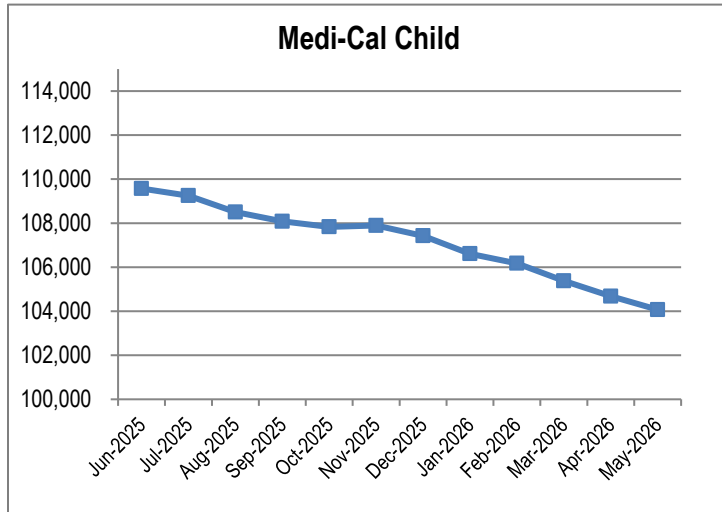
<u>Net Income by Program: (in Thousands)</u>		
	Month	YTD
Medi-Cal	\$3,658	\$82,800
Group Care	(1,250)	(4,127)
Medicare	(935)	(10,196)
	\$1,474	\$68,477

Enrollment

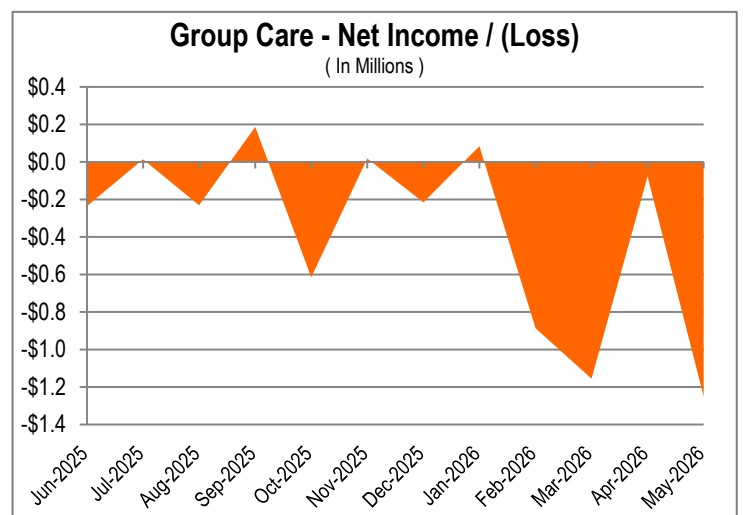
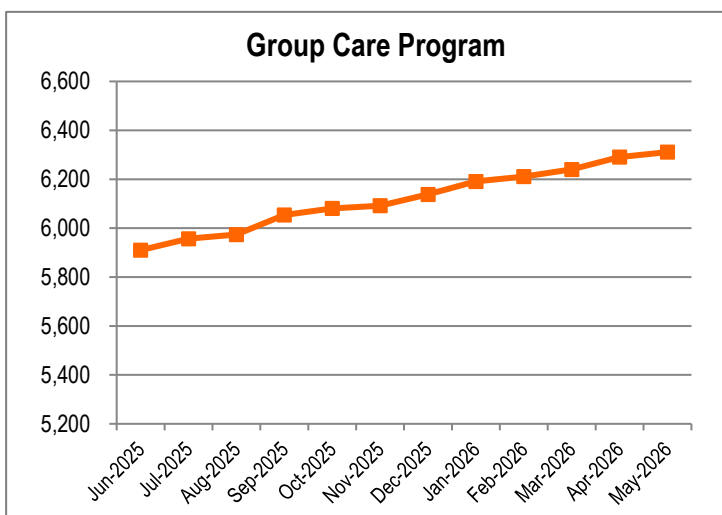
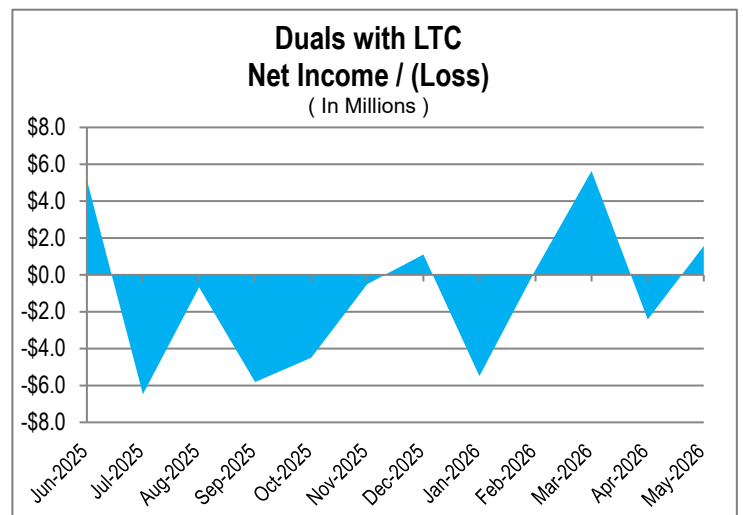
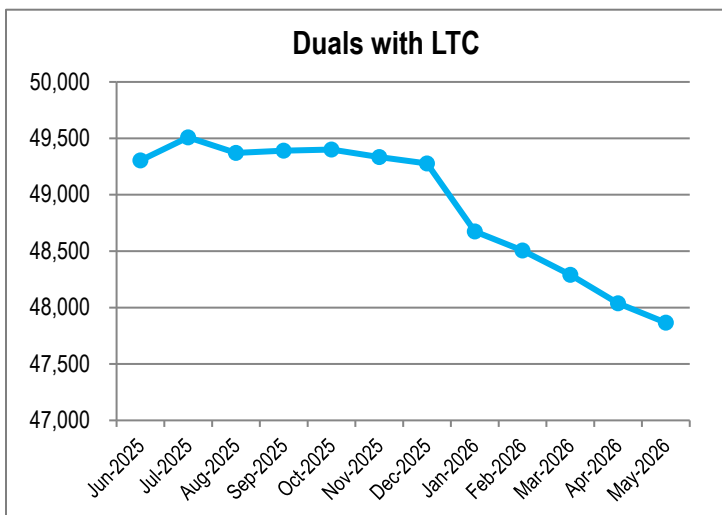
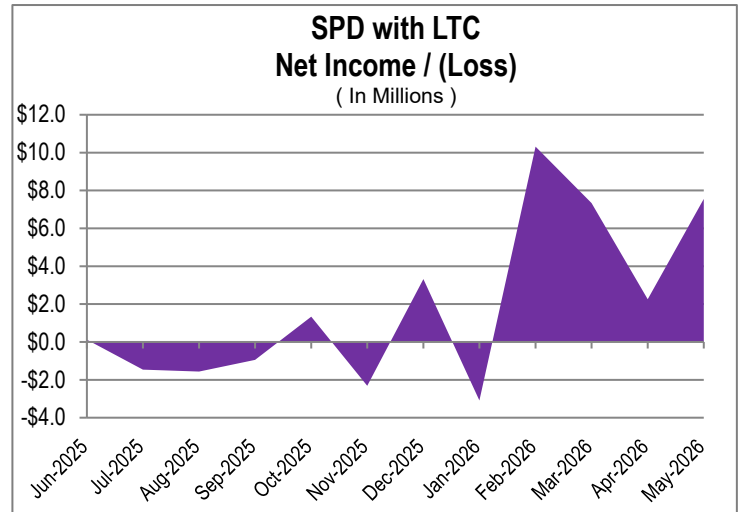
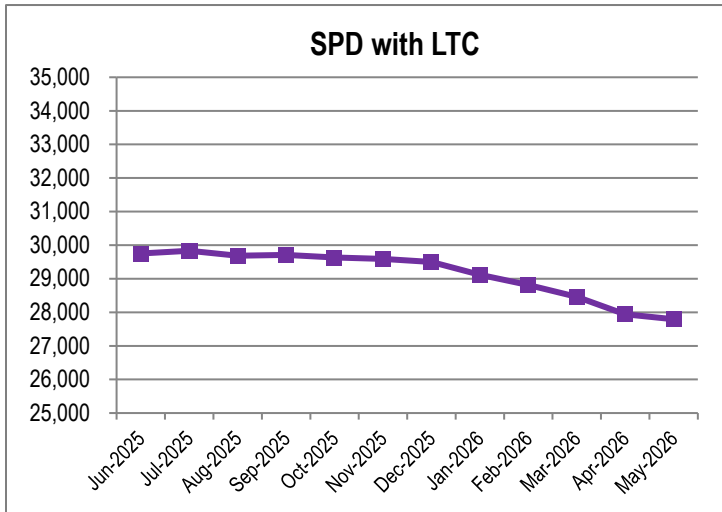
- Total enrollment decreased by 5,467 members since April 2026.
- Total enrollment decreased by 36,497 members since June 2025.

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 %
104,072	104,025	47	0.0%		Child	1,175,908	1,174,369	1,539
53,691	54,907	(1,216)	(2.2%)	Adult	641,136	642,347	(1,211)	(0.2%)
134,907	132,040	2,867	2.2%	ACA OE	1,617,813	1,606,512	11,301	0.7%
27,794	21,241	6,553	30.9%	SPD with LTC	320,079	285,513	34,566	12.1%
47,866	55,973	(8,107)	(14.5%)	Duals with LTC	537,657	577,040	(39,383)	(6.8%)
368,330	368,186	144	0.0%	Medi-Cal Total	4,292,593	4,285,781	6,812	0.2%
6,311	6,103	208	3.4%	Group Care	67,540	66,685	855	1.3%
245	722	(477)	(66.1%)	Medicare	1,049	2,450	(1,401)	(57.2%)
374,886	375,011	(125)	(0.0%)	Total	4,361,182	4,354,916	6,266	0.1%

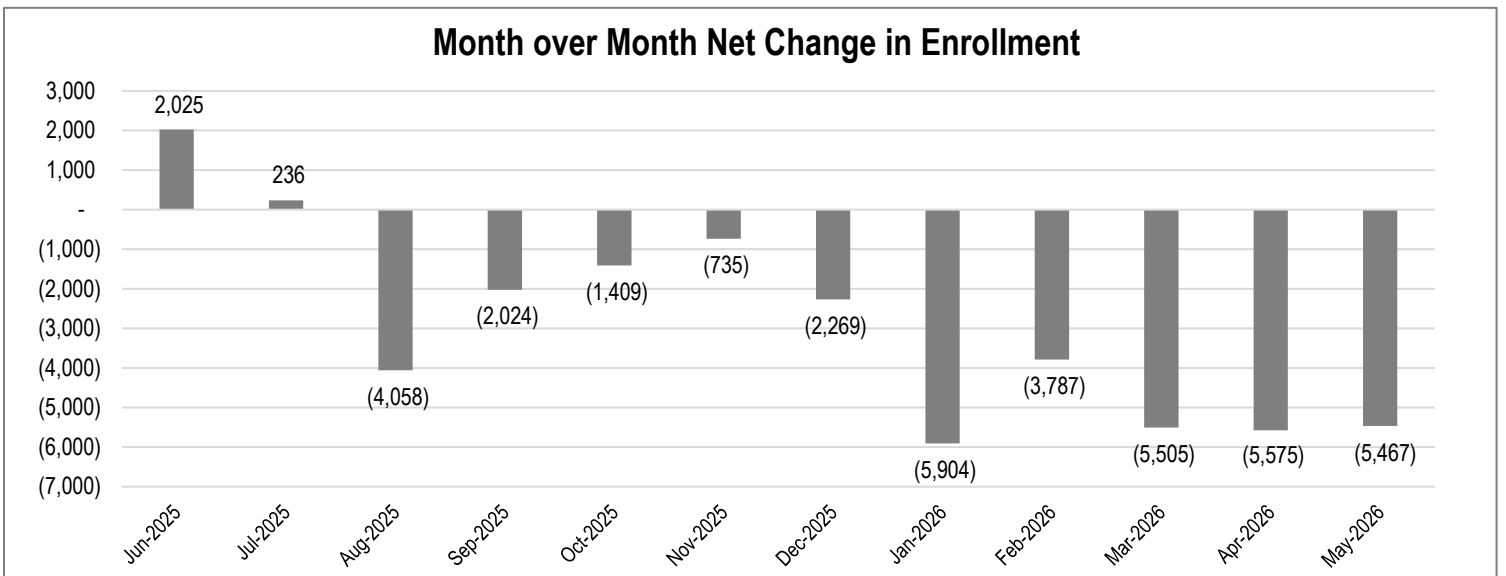
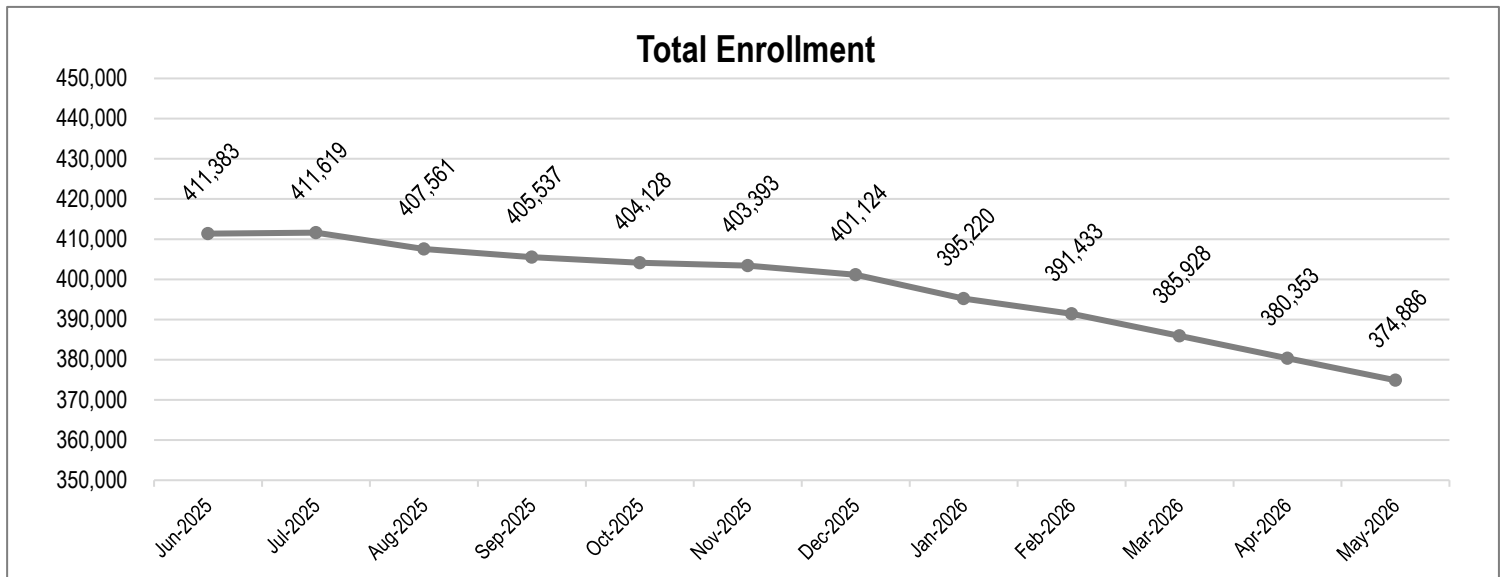
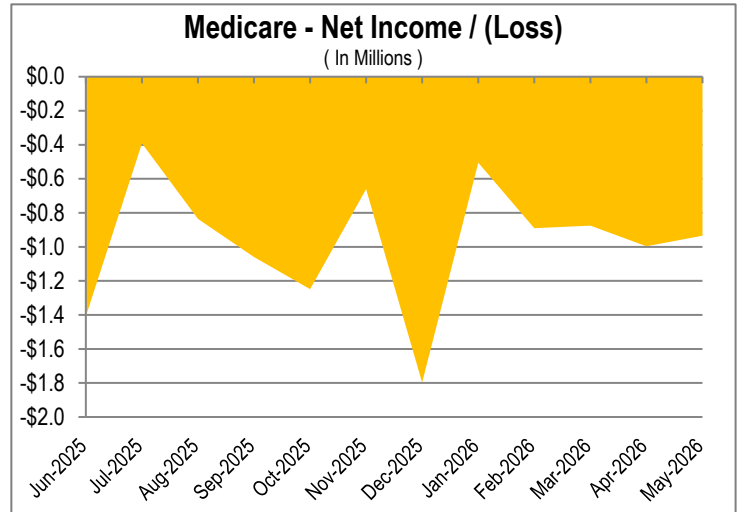
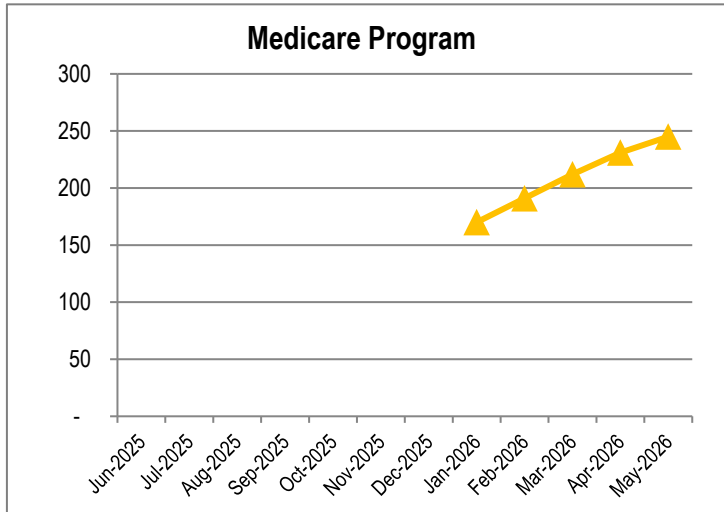
Enrollment and Profitability by Program and Category of Aid



Enrollment and Profitability by Program and Category of Aid

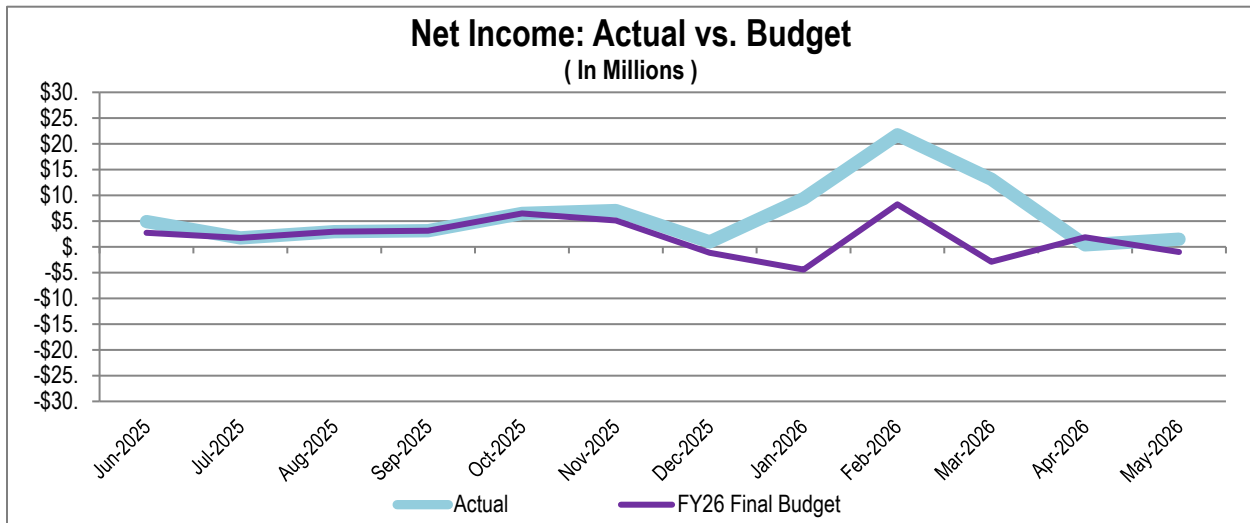


Enrollment and Profitability by Program and Category of Aid



Net Income

- For the month ended May 31st, 2026:
 - Actual Net Income: \$1.5 million.
 - Budgeted Net Loss: \$1.0 million.
- For the fiscal YTD ended May 31st, 2026:
 - Actual Net Income \$68.5 million.
 - Budgeted Net Income \$20.1 million.

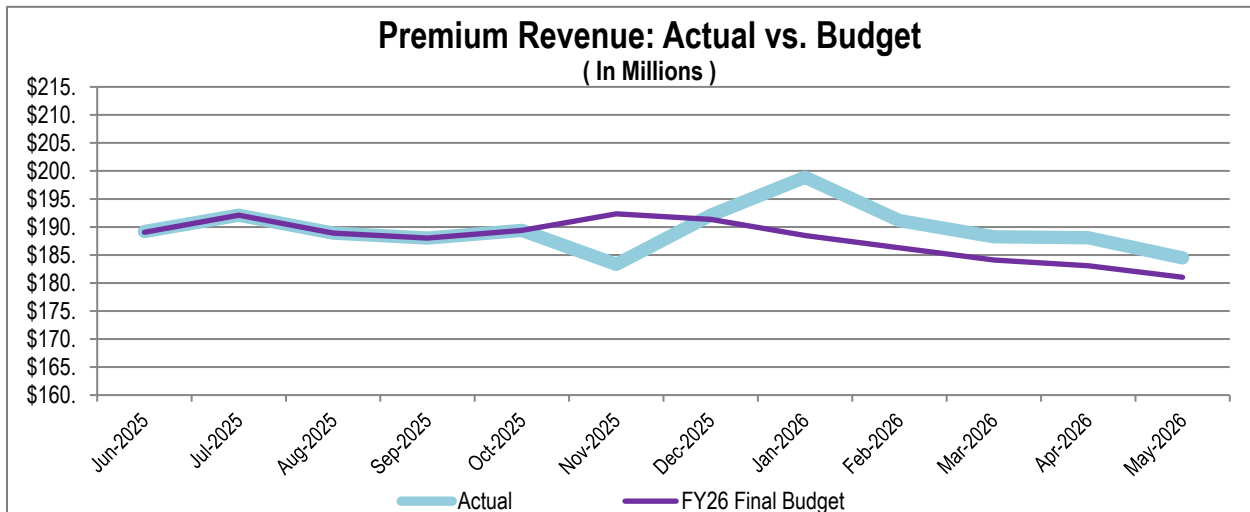


The favorable variance of \$2.5 million in the current month is primarily due to:

- Favorable \$3.5 million higher than anticipated Premium Revenue.
- Favorable \$2.0 million lower than anticipated Medical Expense.
- Unfavorable \$2.3 million higher than anticipated Administrative Expense.

Premium Revenue

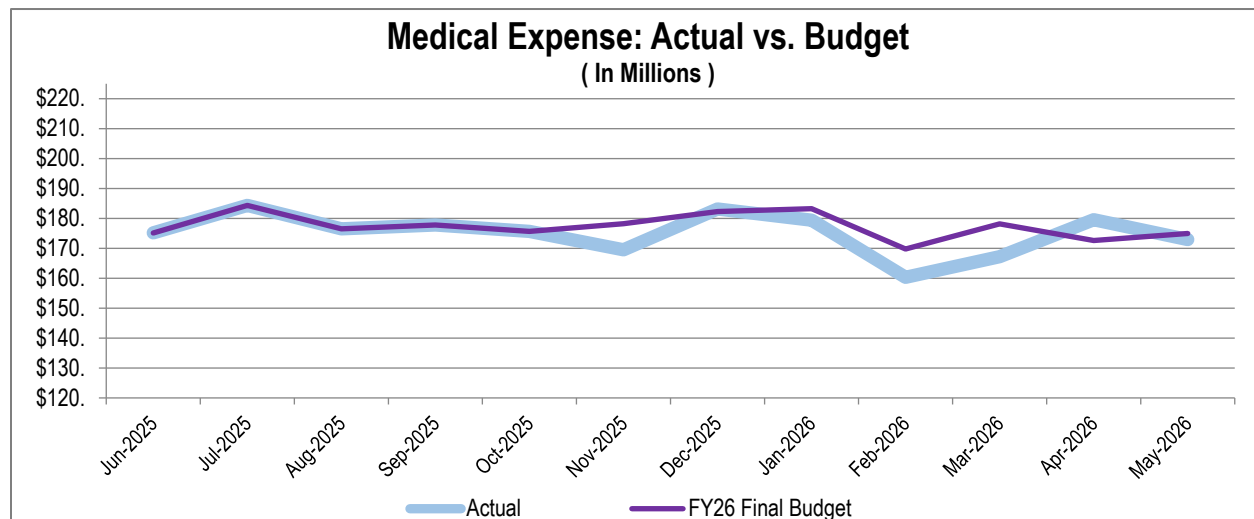
- For the month ended May 31st, 2026:
 - Actual Revenue: \$184.5 million.
 - Budgeted Revenue: \$181.0 million.
- For the fiscal YTD ended May 31st, 2026:
 - Actual Revenue: \$2.1 billion.
 - Budgeted Revenue: \$2.1 billion.



- For the month ended May 31st, 2026, the favorable Premium Revenue variance of \$3.5 million is primarily due to favorable \$5.6 million Medi-Cal and IHSS volume variance for May 2026 which includes favorable \$6.2 million budgeted Medicare Part A “buy-in” for May 2026 that did not occur, and favorable \$2.5 million retroactive membership for April 2025 through March 2026. This was partially offset by an unfavorable \$1.4 million Death Audit for 2018 until the current year, and \$1.0 million each for both the April 2026 True-up and the current month rate variances.

Medical Expense

- For the month ended May 31st, 2026:
 - Actual Medical Expense: \$173.0 million.
 - Budgeted Medical Expense: \$174.9 million.
- For the fiscal YTD ended May 31st, 2026:
 - Actual Medical Expense: \$1.9 billion.
 - Budgeted Medical Expense: \$2.0 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 May, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by \$2.7 million. Year to date, the estimate for prior years decreased by \$12.6 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)						
Adjusted to Eliminate the Impact of Prior Period IBNP Estimates						
	Actual			Budget	Variance: Actual Adjusted vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical Expense	\$194,229,743	\$0	\$194,229,743	\$190,770,530	(\$3,459,213)	(1.8%)
Primary Care FFS	\$38,268,244	\$11,466,072	\$49,734,316	\$53,359,933	\$15,091,689	28.3%
Specialty Care FFS	\$90,439,417	\$2,048,495	\$92,487,912	\$93,193,609	\$2,754,192	3.0%
Outpatient FFS	\$139,770,345	(\$97,713)	\$139,672,632	\$142,858,997	\$3,088,652	2.2%
Ancillary FFS	\$235,934,840	\$2,843,097	\$238,777,937	\$222,607,262	(\$13,327,578)	(6.0%)
Pharmacy FFS	\$146,902,495	(\$6,712,015)	\$140,190,480	\$121,875,770	(\$25,026,725)	(20.5%)
ER Services FFS	\$117,478,328	\$275,995	\$117,754,322	\$113,243,475	(\$4,234,853)	(3.7%)
Inpatient Hospital FFS	\$532,801,995	(\$13,102,311)	\$519,699,685	\$533,958,845	\$1,156,850	0.2%
Long Term Care & SNF FFS	\$389,116,772	(\$9,306,090)	\$379,810,682	\$421,661,490	\$32,544,718	7.7%
Other Benefits & Services	\$43,193,504	\$0	\$43,193,504	\$49,285,875	\$6,092,371	12.4%
Net Reinsurance	\$251,310	\$0	\$251,310	\$3,251,004	\$2,999,694	92.3%
Provider Incentive	\$10,609,099	\$0	\$10,609,099	\$7,569,099	(\$3,040,000)	(40.2%)
	\$1,938,996,093	(\$12,584,470)	\$1,926,411,623	\$1,953,635,890	\$14,639,797	0.70%

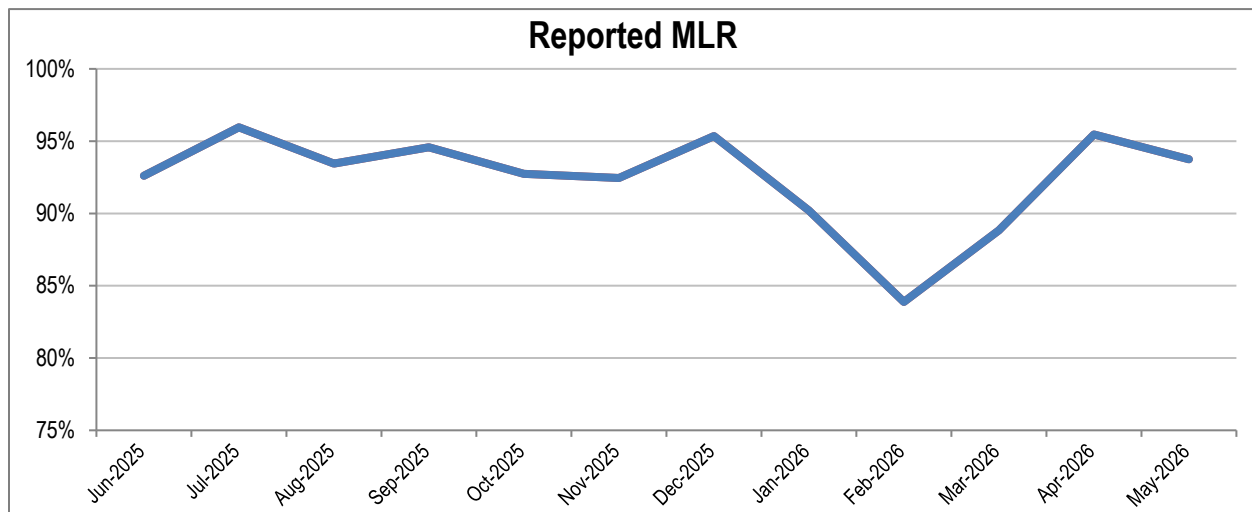
Medical Expense - Actual vs. Budget (Per Member Per Month)						
Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance: Actual Adjusted vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical Expense	\$44.54	\$0.00	\$44.54	\$43.81	(\$0.73)	(1.7%)
Primary Care FFS	\$8.77	\$2.63	\$11.40	\$12.25	\$3.48	28.4%
Specialty Care FFS	\$20.74	\$0.47	\$21.21	\$21.40	\$0.66	3.1%
Outpatient FFS	\$32.05	(\$0.02)	\$32.03	\$32.80	\$0.76	2.3%
Ancillary FFS	\$54.10	\$0.65	\$54.75	\$51.12	(\$2.98)	(5.8%)
Pharmacy FFS	\$33.68	(\$1.54)	\$32.15	\$27.99	(\$5.70)	(20.4%)
ER Services FFS	\$26.94	\$0.06	\$27.00	\$26.00	(\$0.93)	(3.6%)
Inpatient Hospital & SNF FFS	\$122.17	(\$3.00)	\$119.16	\$122.61	\$0.44	0.4%
Long Term Care & SNF FFS	\$89.22	(\$2.13)	\$87.09	\$96.82	\$7.60	7.9%
Other Benefits & Services	\$9.90	\$0.00	\$9.90	\$11.32	\$1.41	12.5%
Net Reinsurance	\$0.06	\$0.00	\$0.06	\$0.75	\$0.69	92.3%
Provider Incentive	\$2.43	\$0.00	\$2.43	\$1.74	(\$0.69)	(40.0%)
	\$444.60	(\$2.89)	\$441.72	\$448.60	\$4.00	0.9%

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is \$14.6 million favorable to budget. On a PMPM basis, medical expense is 0.9% favorable to budget. For per-member-per-month expense:
 - Capitated Expense is over budget, primarily driven by unfavorable member mix in PCP Capitation FQHC expense.
 - Primary Care Expense is under budget, due to TRI reclassifications across all populations except for Group Care and Medicare.

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

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported Medical Expense divided by Premium Revenue) was 93.7% for the month and 92.4% for the fiscal year-to-date.



Administrative Expense

- For the month ended May 31st, 2026:
 - Actual Administrative Expense: \$12.4 million.
 - Budgeted Administrative Expense: \$10.1 million.
- For the fiscal YTD ended May 31st, 2026:
 - Actual Administrative Expense: \$117.0 million.
 - Budgeted Administrative Expense: \$121.7 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 %	
\$9,360,131	\$6,177,102	(\$3,183,029)	(51.5%)		Personnel Expense	\$75,152,575	\$74,405,786	(\$746,788)	(1.0%)
92,225	93,846	1,621	1.7%		Medical Benefits Admin Expense	832,218	1,041,755	209,538	20.1%
2,049,832	2,320,431	270,598	11.7%		Purchased & Professional Services	23,637,769	27,008,239	3,370,470	12.5%
871,717	1,460,677	588,960	40.3%	Other Admin Expense	17,363,321	19,214,992	1,851,671	9.6%	
\$12,373,905	\$10,052,056	(\$2,321,850)	(23.1%)	Total Administrative Expense	\$116,985,882	\$121,670,773	\$4,684,890	3.9%	

The year-to-date variances include:

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

The Administrative Loss Ratio (ALR) is 6.7% of net revenue for the month and 5.6% of revenue year-to-date. Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is \$2.4 million.

Other Income / (Expense)

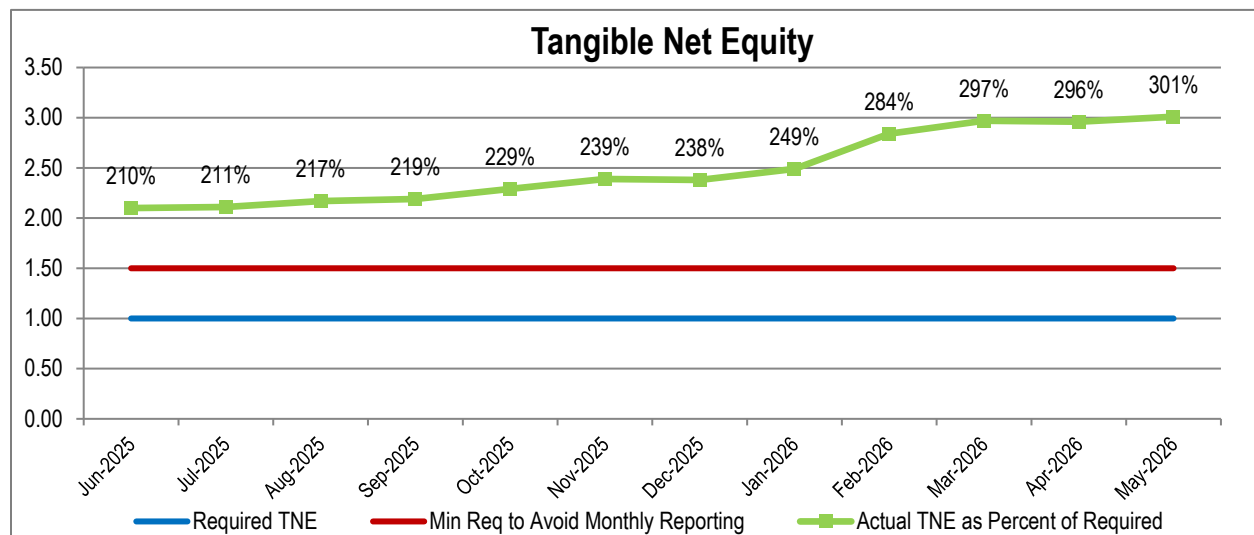
Other Income & Expense is comprised primarily of investment income. Fiscal year-to-date net investments show a gain of \$27.2 million.

Managed Care Organization (MCO) Provider Tax

- Revenue:
 - For the month ended May 31st, 2026:
 - Actual: \$62.2 million.
 - Budgeted: \$59.5 million.
 - For the fiscal YTD ended May 31st, 2026:
 - Actual: \$708.7 million.
 - Budgeted: \$692.9 million.
- Expense:
 - For the month ended May 31st, 2026:
 - Actual: \$62.2 million.
 - Budgeted: \$59.5 million.
 - For the fiscal YTD ended May 31st, 2026:
 - Actual: \$708.7 million.
 - Budgeted: \$692.9 million.

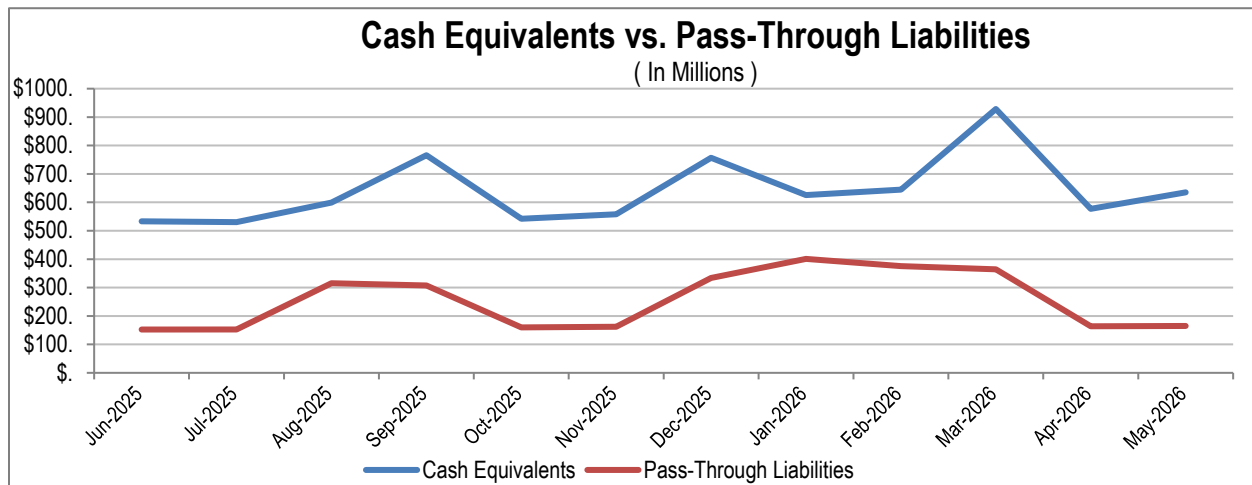
Tangible Net Equity (TNE)

- 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 \$78.9 million
 - Actual TNE \$237.8 million
 - Excess TNE \$158.8 million
 - TNE % of Required TNE 301%



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

- Key Metrics:
 - Cash & Cash Equivalents \$635.1 million
 - Pass-Through Liabilities \$165.0 million



- Uncommitted Cash \$470.2 million
- Working Capital \$184.4 million
- Current Ratio 1.22 (regulatory minimum is 1.00)

Capital Investment

- Fiscal year-to-date capital assets acquired: \$51,000.
- Annual capital budget: \$1.4 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

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

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED 31 MAY, 2026

CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance	% Variance	Account Description	Actual	Budget	\$ Variance	% Variance
		(Unfavorable)	(Unfavorable)				(Unfavorable)	(Unfavorable)
MEMBERSHIP								
368,330	368,186	144	0.0%	1. Medi-Cal	4,292,593	4,285,781	6,812	0.2%
6,311	6,103	208	3.4%	2. GroupCare	67,540	66,685	855	1.3%
245	722	(477)	(66.1%)	3. Medicare SNP	1,049	2,450	(1,401)	(57.2%)
374,886	375,011	(125)	(0.0%)	3. TOTAL MEMBER MONTHS	4,361,182	4,354,916	6,266	0.1%
REVENUE								
\$184,486,175	\$181,029,964	\$3,456,211	1.9%	4. Premium Revenue	\$2,084,666,214	\$2,065,131,481	\$19,534,733	0.9%
\$62,200,708	\$59,484,130	\$2,716,578	4.6%	5. MCO Tax Revenue AB119	\$708,722,293	\$692,938,585	\$15,783,708	2.3%
\$246,686,884	\$240,514,094	\$6,172,790	2.6%	6. TOTAL REVENUE	\$2,793,388,507	\$2,758,070,066	\$35,318,441	1.3%
MEDICAL EXPENSES								
Capitated Medical Expenses								
\$16,371,543	\$15,315,087	(\$1,056,456)	(6.9%)	7. Capitated Medical Expense	\$194,229,743	\$190,770,530	(\$3,459,213)	(1.8%)
Fee for Service Medical Expenses								
\$46,191,095	\$48,439,505	\$2,248,410	4.6%	8. Inpatient Hospital Expense	\$519,699,685	\$533,958,846	\$14,259,161	2.7%
\$6,410,615	\$4,366,891	(\$2,043,724)	(46.8%)	9. Primary Care Physician Expense	\$49,734,316	\$53,359,933	\$3,625,618	6.8%
\$9,007,894	\$7,896,256	(\$1,111,638)	(14.1%)	10. Specialty Care Physician Expense	\$92,487,912	\$93,193,609	\$705,697	0.8%
\$19,324,342	\$20,481,382	\$1,157,040	5.6%	11. Ancillary Medical Expense	\$238,777,937	\$222,607,262	(\$16,170,676)	(7.3%)
\$11,599,497	\$11,785,044	\$185,546	1.6%	12. Outpatient Medical Expense	\$139,672,632	\$142,858,997	\$3,186,365	2.2%
\$12,235,514	\$10,126,219	(\$2,109,295)	(20.8%)	13. Emergency Expense	\$117,754,322	\$113,243,475	(\$4,510,847)	(4.0%)
\$16,458,189	\$12,069,337	(\$4,388,852)	(36.4%)	14. Pharmacy Expense	\$140,190,480	\$121,875,770	(\$18,314,711)	(15.0%)
\$31,119,683	\$39,222,209	\$8,102,525	20.7%	15. Long Term Care Expense	\$379,810,682	\$421,661,490	\$41,850,808	9.9%
\$152,346,829	\$154,386,842	\$2,040,012	1.3%	16. Total Fee for Service Expense	\$1,678,127,967	\$1,702,759,382	\$24,631,415	1.4%
\$4,007,564	\$4,423,446	\$415,882	9.4%	17. Other Benefits & Services	\$43,193,504	\$49,285,875	\$6,092,371	12.4%
(\$64,890)	\$529,636	\$594,527	112.3%	18. Reinsurance Expense	\$251,310	\$3,251,004	\$2,999,694	92.3%
\$290,000	\$290,000	\$0	0.0%	19. Risk Pool Distribution	\$10,609,099	\$7,569,099	(\$3,040,000)	(40.2%)
\$172,951,045	\$174,945,010	\$1,993,965	1.1%	20. TOTAL MEDICAL EXPENSES	\$1,926,411,623	\$1,953,635,890	\$27,224,267	1.4%
\$73,735,838	\$65,569,084	\$8,166,755	12.5%	21. GROSS MARGIN	\$866,976,884	\$804,434,176	\$62,542,708	7.8%
ADMINISTRATIVE EXPENSES								
\$9,360,131	\$6,177,102	(\$3,183,029)	(51.5%)	22. Personnel Expense	\$75,152,575	\$74,405,786	(\$746,788)	(1.0%)
\$92,225	\$93,846	\$1,621	1.7%	23. Benefits Administration Expense	\$832,218	\$1,041,755	\$209,538	20.1%
\$2,049,832	\$2,320,431	\$270,598	11.7%	24. Purchased & Professional Services	\$23,637,769	\$27,008,239	\$3,370,470	12.5%
\$871,717	\$1,460,677	\$588,960	40.3%	25. Other Administrative Expense	\$17,363,321	\$19,214,992	\$1,851,671	9.6%
\$12,373,905	\$10,052,056	(\$2,321,850)	(23.1%)	26. TOTAL ADMINISTRATIVE EXPENSES	\$116,985,882	\$121,670,773	\$4,684,890	3.9%
\$62,200,708	\$59,484,130	(\$2,716,578)	(4.6%)	27. MCO TAX EXPENSES	\$708,722,293	\$692,938,585	(\$15,783,708)	(2.3%)
(\$838,775)	(\$3,967,102)	\$3,128,327	78.9%	28. NET OPERATING INCOME / (LOSS)	\$41,268,709	(\$10,175,182)	\$51,443,890	505.6%
OTHER INCOME / EXPENSES								
\$2,312,333	\$2,957,980	(\$645,646)	(21.8%)	29. TOTAL OTHER INCOME / (EXPENSES)	\$27,207,858	\$30,277,651	(\$3,069,793)	(10.1%)
\$1,473,558	(\$1,009,123)	\$2,482,681	246.0%	30. NET SURPLUS (DEFICIT)	\$68,476,567	\$20,102,469	\$48,374,097	240.6%
93.7%	96.6%	2.9%	3.0%	31. Medical Loss Ratio	92.4%	94.6%	2.2%	2.3%
6.7%	5.6%	(1.1%)	(19.6%)	32. Administrative Expense Ratio	5.6%	5.9%	0.3%	5.1%
0.6%	(0.4%)	1.0%	250.0%	33. Net Surplus (Deficit) Ratio	2.5%	0.7%	1.8%	257.1%

**ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED 31 MAY, 2026**

	5/31/2026	4/30/2026	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	\$25,186,278	\$38,803,262	(\$13,616,984)	(35.1%)
CNB Short-Term Investment	609,884,182	538,461,270	71,422,913	13.3%
Interest Receivable	3,304,671	2,567,688	736,983	28.7%
Premium Receivables	363,006,778	369,828,884	(6,822,105)	(1.8%)
Reinsurance Recovery Receivable	14,290,310	15,427,507	(1,137,197)	(7.4%)
Other Receivables	2,380,452	1,819,688	560,764	30.8%
Prepaid Expenses	716,683	784,800	(68,117)	(8.7%)
TOTAL CURRENT ASSETS	1,018,769,354	967,693,099	51,076,256	5.3%
OTHER ASSETS				
CNB Long-Term Investment	37,486,717	37,458,394	28,323	0.1%
CalPERS Net Pension Asset	(6,465,233)	(6,465,233)	0	0.0%
Deferred Outflow	15,271,214	15,271,214	0	0.0%
Restricted Asset-Bank Note	364,852	363,852	1,001	0.3%
GASB 87-Lease Assets (Net)	42,575	45,850	(3,275)	(7.1%)
GASB 96-SBITA Assets (Net)	7,306,844	7,552,000	(245,156)	(3.2%)
TOTAL OTHER ASSETS	54,006,969	54,226,076	(219,107)	(0.4%)
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,893,508	9,893,508	0	0.0%
Furniture And Equipment	13,400,309	13,400,309	0	0.0%
Leasehold Improvement	902,447	902,447	0	0.0%
Internally Developed Software	14,824,002	14,824,002	0	0.0%
Fixed Assets at Cost	39,020,265	39,020,265	0	0.0%
Less: Accumulated Depreciation	(34,077,836)	(34,015,137)	(62,699)	0.2%
PROPERTY AND EQUIPMENT (NET)	4,942,429	5,005,128	(62,699)	(1.3%)
TOTAL ASSETS	1,077,718,752	1,026,924,303	50,794,449	4.9%
CURRENT LIABILITIES				
Trade Accounts Payable	11,663,872	11,973,779	(309,907)	(2.6%)
Incurred But Not Reported Claims	310,505,030	324,464,820	(13,959,790)	(4.3%)
Other Medical Liabilities	151,725,198	150,744,348	980,850	0.7%
Pass-Through Liabilities	164,834,303	164,043,127	791,176	0.5%
MCO Tax Liabilities	181,015,941	118,815,233	62,200,708	52.4%
GASB 87 and 96 ST Liabilities	3,041,162	2,941,215	99,946	3.4%
Payroll Liabilities	11,533,934	12,012,751	(478,817)	(4.0%)
TOTAL CURRENT LIABILITIES	834,319,439	784,995,272	49,324,166	6.3%
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	2,403,081	2,406,356	(3,275)	(0.1%)
Deferred Inflow	3,240,306	3,240,306	0	0.0%
TOTAL LONG TERM LIABILITIES	5,643,386	5,646,661	(3,275)	(0.1%)
TOTAL LIABILITIES	839,962,825	790,641,934	49,320,891	6.2%
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)	68,476,567	67,003,009	1,473,558	2.2%
TOTAL NET WORTH	237,755,927	236,282,369	1,473,558	0.6%
TOTAL LIABILITIES AND NET WORTH	1,077,718,752	1,026,924,303	50,794,449	4.9%
Additional Information				
Cash Equivalents	635,070,460	577,264,531	57,805,929	10.0%
Pass-Through	164,834,303	164,043,127	791,176	0.5%
Uncommitted Cash	470,236,158	413,221,405	57,014,753	13.8%
Working Capital	184,449,916	182,697,826	1,752,089	1.0%
Current Ratio	122.1%	123.3%	(1.2%)	(1.0%)

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

May 31, 2026

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	\$3,445,303	\$10,293,268	\$20,411,438	\$36,888,976
GroupCare Receivable	3,432,313	9,849	2,590	480
Total	6,877,616	10,303,117	20,414,028	36,889,456
Medicare Premiums				
Medicare Premiums	292,583	1,240,041	2,022,941	2,022,941
Deferred Premium Revenue	0	(405,514)	0	0
Medicare Receivable	(18,822)	(18,858)	(18,858)	(18,858)
Total	273,761	815,669	2,004,083	2,004,083
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	242,948,997	738,822,684	1,505,188,553	2,754,476,589
Premium Receivable	3,408,613	238,682,721	190,691,096	135,284,271
Total	246,357,610	977,505,405	1,695,879,649	2,889,760,860
Investment & Other Income Cash Flows				
Other Revenues	122,683	(187,659)	687,079	665,628
Interest Income	2,205,353	9,184,979	14,573,747	26,658,130
Interest Receivable	(736,983)	(823,560)	758,745	282,287
Total	1,591,053	8,173,760	16,019,571	27,606,045
Medical & Hospital Cash Flows				
Total Medical Expenses	(172,951,047)	(519,725,414)	(1,042,596,065)	(1,926,411,623)
Other Health Care Receivables	578,970	(715,846)	(226,672)	(6,485,758)
Capitation Payable	-	-	-	-
IBNP Payable	(13,959,790)	(56,881,344)	(73,963,930)	(101,612,265)
Other Medical Payable	1,482,025	(205,317,321)	16,735,637	40,155,937
Risk Share Payable	290,000	870,000	4,950,000	6,000,856
New Health Program Payable	-	-	-	-
Total	(184,559,842)	(781,769,925)	(1,095,101,030)	(1,988,352,853)
Administrative Cash Flows				
Total Administrative Expenses	(12,389,609)	(35,093,585)	(68,463,692)	(117,101,780)
Prepaid Expenses	68,116	371,869	407,479	1,128
Other Receivables	(2,536)	6,622	3,987	(3,878)
CalPERS Pension	-	-	-	-
Trade Accounts Payable	(309,908)	(302,045)	899,827	146,948
Payroll Liabilities	(478,818)	2,190,938	3,721,515	2,170,019
GASB Assets and Liabilities	345,102	767,986	(232,522)	166,974
Depreciation Expense	62,699	188,351	375,313	685,242
Total	(12,704,954)	(31,869,864)	(63,288,093)	(113,935,347)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(62,200,708)	(189,537,561)	(384,713,432)	(708,722,293)
MCO Tax Liabilities	62,200,708	1,162,561	(117,619,901)	(44,802,462)
Total	0	(188,375,000)	(502,333,333)	(753,524,755)
Net Cash Flows from Operating Activities	57,835,244	(5,216,838)	73,594,875	100,447,489

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

May 31, 2026

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(28,314)	(4,203,675)	3,323,430	1,668,646
Total	(28,314)	(4,203,675)	3,323,430	1,668,646
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(1,001)	(2,960)	(5,995)	(10,986)
Total	(1,001)	(2,960)	(5,995)	(10,986)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	(15,230)	(26,407)	(50,860)
Depreciation expense				
Change in A/D				
Purchases of Property and Equipment	-	(15,230)	(26,407)	(50,860)
Net Cash Flows from Investing Activities	(29,315)	(4,221,865)	3,291,028	1,606,800
Financing Cash Flows				
Subordinated Debt Proceeds	-	-	-	-
Net Change in Cash	57,805,929	(9,438,703)	76,885,903	102,054,289
Rounding	-	-	-	-
Cash @ Beginning of Period	577,264,530	644,509,162	558,184,556	533,016,170
Cash @ End of Period	\$635,070,459	\$635,070,459	\$635,070,459	\$635,070,459
Variance	-	-	-	-

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

May 31, 2026

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	\$1,473,555	\$14,996,753	\$47,110,569	\$68,476,568
Add back: Depreciation & Amortization	62,699	188,351	375,313	685,242
Receivables				
Premiums Receivable	3,389,791	238,663,863	190,672,238	135,265,413
Interest Receivable	(736,983)	(823,560)	758,745	282,287
Other Health Care Receivables	578,970	(715,846)	(226,672)	(6,485,758)
Other Receivables	(2,536)	6,622	3,987	(3,878)
GroupCare Receivable	3,432,313	9,849	2,590	480
Total	6,661,555	237,140,928	191,210,888	129,058,544
Prepaid Expenses	68,116	371,869	407,479	1,128
Trade Payables	(309,908)	(302,045)	899,827	146,948
Claims Payable and Shared Risk Pool				
IBNP Payable	(13,959,790)	(56,881,344)	(73,963,930)	(101,612,265)
Capitation Payable & Other Medical Payable	1,482,025	(205,317,321)	16,735,637	40,155,937
Risk Share Payable	290,000.00	870,000.00	4,950,000	6,000,856
Claims Payable				
Total	(12,187,765)	(261,328,665)	(52,278,293)	(55,455,472)
Unearned Revenue				
Deferred Premium Revenue				
Deferred Revenue - IHSS				
Deferred Revenue - Medicare (DSNP)	0	(405,514)	0	0
Total	-	(405,514.00)	-	-
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	(478,818)	2,190,938	3,721,515	2,170,019
GASB Assets and Liabilities	345,102	767,986	(232,522)	166,974
New Health Program	-	-	-	-
MCO Tax Liabilities	62,200,708	1,162,561	(117,619,901)	(44,802,462)
Total	62,066,992	4,121,485	(114,130,908)	(42,465,469)
Rounding	-	-	-	-
Cash Flows from Operating Activities	57,835,244	(5,216,838)	73,594,875	100,447,489
Variance	-	-	-	-

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

May 31, 2026

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	\$246,357,610	\$977,505,405	\$1,695,879,649	\$2,889,760,860
Medicare Revenue	\$273,761	\$815,669	\$2,004,083	\$2,004,083
GroupCare Premium Revenue	6,877,616	10,303,117	20,414,028	36,889,456
Other Income	122,683	(187,659)	687,079	665,628
Interest Income	1,468,370	8,361,419	15,332,492	26,940,417
Less Cash Paid				
Medical Expenses	(184,559,842)	(781,769,925)	(1,095,101,030)	(1,988,352,853)
Vendor & Employee Expenses	(12,704,954)	(31,869,864)	(63,288,093)	(113,935,347)
MCO Tax Expense AB119	0	(188,375,000)	(502,333,333)	(753,524,755)
Net Cash Flows from Operating Activities	57,835,244	(5,216,838)	73,594,875	100,447,489
Cash Flows from Investing Activities:				
Long Term Investments	(28,314)	(4,203,675)	3,323,430	1,668,646
Restricted Assets-Treasury Account	(1,001)	(2,960)	(5,995)	(10,986)
Purchases of Property and Equipment	0	(15,230)	(26,407)	(50,860)
Net Cash Flows from Investing Activities	(29,315)	(4,221,865)	3,291,028	1,606,800
Net Change in Cash	57,805,929	(9,438,703)	76,885,903	102,054,289
Rounding	-	-	-	-
Cash @ Beginning of Period	577,264,530	644,509,162	558,184,556	533,016,170
Cash @ End of Period	\$635,070,459	\$635,070,459	\$635,070,459	\$635,070,459
Variance	\$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	\$1,473,555	\$14,996,754	\$47,110,568	\$68,476,568
Add Back: Depreciation	62,699	188,351	375,313	685,242
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	6,661,555	237,140,928	191,210,888	129,058,544
Prepaid Expenses	68,116	371,868	407,480	1,128
Trade Payables	(309,908)	(302,045)	899,827	146,948
Claims Payable, IBNP and Risk Sharing	(12,187,765)	(261,328,665)	(52,278,293)	(55,455,472)
Deferred Revenue- Medicare (DSNP)	0	(405,514)	0	0
Other Liabilities	62,066,992	4,121,485	(114,130,908)	(42,465,469)
Total	57,835,244	(5,216,838)	73,594,875	100,447,489
Rounding	-	-	-	-
Cash Flows from Operating Activities	\$57,835,244	(\$5,216,838)	\$73,594,875	\$100,447,489
Variance	\$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF APRIL 2026

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

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE APRIL 2026

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

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 May, 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)								
\$9,360,131	\$6,177,102	(\$3,183,029)	(51.5%)	Personnel Expenses	\$75,152,575	\$74,405,786	(\$746,788)	(1.0%)
\$92,225	\$93,846	\$1,621	1.7%	Benefits Administration Expense	\$832,218	\$1,041,755	\$209,538	20.1%
\$2,049,832	\$2,320,431	\$270,598	11.7%	Purchased & Professional Services	\$23,637,769	\$27,008,239	\$3,370,470	12.5%
\$505,054	\$492,256	(\$12,799)	(2.6%)	Occupancy	\$5,526,677	\$5,360,232	(\$166,445)	(3.1%)
\$318,765	\$205,327	(\$113,438)	(55.2%)	Printing Postage & Promotion	\$3,583,228	(\$195,043)	(\$3,778,271)	1,937.1%
(\$368,602)	\$205,818	\$574,420	279.1%	Licenses Insurance & Fees	\$2,801,676	\$5,247,005	\$2,445,329	46.6%
\$416,500	\$557,276	\$140,776	25.3%	Other Administrative Expense	\$5,451,740	\$8,802,797	\$3,351,057	38.1%
\$3,013,774	\$3,874,954	\$861,180	22.2%	Total Other Administrative Expenses (excludes Personnel Expenses)	\$41,833,308	\$47,264,986	\$5,431,679	11.5%
\$12,373,905	\$10,052,056	(\$2,321,850)	(23.1%)	Total Administrative Expenses	\$116,985,882	\$121,670,773	\$4,684,890	3.9%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 May, 2026

CURRENT MONTH									FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)				
6,601,984	2,929,140	(3,672,844)	(125.4%)	Salaries & Wages	49,586,166	46,712,410	(2,873,756)	(6.2%)				
285,568	556,132	270,564	48.7%	Paid Time Off	4,569,836	4,605,836	36,001	0.8%				
100	55,759	55,659	99.8%	Compensated Incentives	7,951	314,324	306,374	97.5%				
431,031	0	(431,031)	0.0%	Severance	431,031	400,000	(31,031)	(7.8%)				
72,864	92,750	19,887	21.4%	Payroll Taxes	912,405	1,044,654	132,249	12.7%				
74,775	47,845	(26,930)	(56.3%)	Overtime	708,275	650,755	(57,520)	(8.8%)				
(29,499)	0	29,499	0.0%	Commission Pay	23,745	0	(23,745)	0.0%				
364,004	483,618	119,614	24.7%	CalPERS ER Match	3,988,969	3,888,818	(100,151)	(2.6%)				
1,309,346	1,406,874	97,528	6.9%	Employee Benefits	12,748,396	13,285,526	537,129	4.0%				
(16,004)	0	16,004	0.0%	Personal Floating Holiday	211,491	218,795	7,304	3.3%				
23,185	72,750	49,565	68.1%	Language Pay	243,791	406,022	162,231	40.0%				
(1,240)	0	1,240	0.0%	Med Ins Opted Out Stipend	35,500	12,100	(23,400)	(193.4%)				
126,365	0	(126,365)	0.0%	Sick Leave	800,495	77,895	(722,600)	(927.7%)				
5	24,392	24,387	100.0%	Compensated Employee Relations	(47)	232,831	232,877	100.0%				
21,560	26,240	4,680	17.8%	Work from Home Stipend	242,790	261,760	18,970	7.2%				
3,606	4,172	566	13.6%	Mileage, Parking & Local Travel	15,468	35,752	20,283	56.7%				
6,933	8,887	1,954	22.0%	Travel & Lodging	40,474	217,029	176,554	81.4%				
76,415	126,296	49,881	39.5%	Temporary Help Services	382,346	1,066,575	684,228	64.2%				
8,333	53,180	44,847	84.3%	Staff Development/Training	150,330	435,898	285,568	65.5%				
801	289,067	288,266	99.7%	Staff Recruitment/Advertisement	53,163	538,807	485,645	90.1%				
9,360,131	6,177,102	(3,183,029)	(51.5%)	Personnel Expense	75,152,575	74,405,786	(746,788)	(1.0%)				
41,319	34,755	(6,564)	(18.9%)	Pharmacy Administrative Fees	359,575	320,545	(39,030)	(12.2%)				
0	0	0	0.0%	Behavioral Hlth Administration	(236,422)	0	236,422	0.0%				
0	10,000	10,000	100.0%	M3P Admin Fees	115,000	155,000	40,000	25.8%				
2,462	433	(2,029)	(468.4%)	OTC Administrative	29,795	1,470	(28,325)	(1,926.9%)				
139	0	(139)	0.0%	Capitation Admin Fees	455	0	(455)	0.0%				
48,304	48,658	353	0.7%	Telemedicine Admin. Fees	563,816	564,741	925	0.2%				
92,225	93,846	1,621	1.7%	Benefits Administration Expense	832,218	1,041,755	209,538	20.1%				
454,015	667,670	213,655	32.0%	Consultant Fees - Non Medical	6,030,726	7,921,483	1,890,756	23.9%				
315,689	398,129	82,441	20.7%	Computer Support Services	4,397,300	4,937,554	540,254	10.9%				
(40,324)	11,750	52,074	443.2%	Audit Fees	98,046	148,705	50,659	34.1%				
0	0	0	0.0%	Consultant Fees - Medical	17,593	117,593	100,000	85.0%				
303,211	349,941	46,729	13.4%	Other Purchased Services	2,982,339	3,302,732	320,393	9.7%				
0	1,879	1,879	100.0%	Maint.&Repair-Office Equipment	0	13,153	13,153	100.0%				
44,558	62,267	17,709	28.4%	Legal Fees	470,721	634,840	164,119	25.9%				
0	0	0	0.0%	Member Health Education	(25)	(17)	8	(50.0%)				
38,229	26,000	(12,229)	(47.0%)	Translation Services	576,878	429,523	(147,356)	(34.3%)				
0	151,900	151,900	100.0%	Medical Refund Recovery Fees	1,977,680	1,889,450	(88,230)	(4.7%)				
853,788	513,758	(340,029)	(66.2%)	Software - IT Licenses & Subsc	6,184,619	6,492,746	308,127	4.7%				
9,184	76,737	67,553	88.0%	Hardware (Non-Capital)	301,359	680,744	379,386	55.7%				
71,483	60,400	(11,083)	(18.3%)	Provider Credentialing	600,532	439,733	(160,800)	(36.6%)				
2,049,832	2,320,431	270,598	11.7%	Purchased & Professional Services	23,637,769	27,008,239	3,370,470	12.5%				
62,699	84,460	21,761	25.8%	Depreciation	685,242	761,431	76,188	10.0%				
(5,008)	9,235	14,243	154.2%	Lease Rented Office Equipment	54,253	103,295	49,042	47.5%				
14,276	19,715	5,439	27.6%	Utilities	194,244	205,798	11,554	5.6%				
90,478	108,156	17,678	16.3%	Telephone	983,255	1,133,108	149,853	13.2%				
23,100	20,690	(2,410)	(11.6%)	Building Maintenance	214,316	280,447	66,131	23.6%				

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 May, 2026

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
319,510	250,000	(69,510)	(27.8%)	GASB96 SBITA Amort. Expense	3,395,366	2,876,154	(519,212)	(18.1%)
505,054	492,256	(12,799)	(2.6%)	Occupancy	5,526,677	5,360,232	(166,445)	(3.1%)
64,872	42,535	(22,337)	(52.5%)	Postage	1,016,807	1,023,602	6,795	0.7%
9,444	30,700	21,257	69.2%	Design & Layout	91,271	84,442	(6,830)	(8.1%)
169,790	48,793	(120,997)	(248.0%)	Printing Services	1,854,111	1,519,623	(334,488)	(22.0%)
22,459	15,600	(6,859)	(44.0%)	Mailing Services	302,628	122,665	(179,963)	(146.7%)
8,939	19,204	10,265	53.5%	Courier/Delivery Service	76,755	129,585	52,831	40.8%
(452)	2,345	2,797	119.3%	Pre-Printed Materials & Public	1,470	10,415	8,945	85.9%
(162)	0	162	0.0%	Promotional Products	34,683	35,000	317	0.9%
0	150	150	100.0%	Promotional Services	358	6,408	6,050	94.4%
43,875	46,000	2,125	4.6%	Community Relations	205,146	(3,126,782)	(3,331,928)	106.6%
318,765	205,327	(113,438)	(55.2%)	Printing Postage & Promotion	3,583,228	(195,043)	(3,778,271)	1,937.1%
0	0	0	0.0%	Regulatory Penalties	0	225,000	225,000	100.0%
51,615	45,500	(6,115)	(13.4%)	Bank Fees	430,039	487,138	57,099	11.7%
0	200	200	100.0%	Insurance Premium	1,143,841	1,139,979	(3,862)	(0.3%)
(435,297)	143,333	578,630	403.7%	License,Permits, & Fee - NonIT	613,667	2,510,126	1,896,459	75.6%
15,080	16,785	1,705	10.2%	Subscriptions and Dues - NonIT	614,128	884,762	270,634	30.6%
(368,602)	205,818	574,420	279.1%	License Insurance & Fees	2,801,676	5,247,005	2,445,329	46.6%
4,613	5,885	1,272	21.6%	Office and Other Supplies	42,365	54,146	11,781	21.8%
0	1,000	1,000	100.0%	Furniture & Equipment	0	6,000	6,000	100.0%
2,418	34,740	32,322	93.0%	Ergonomic Supplies	93,778	254,199	160,421	63.1%
11,469	14,760	3,291	22.3%	Meals and Entertainment	153,429	188,952	35,523	18.8%
0	0	0	0.0%	Miscellaneous	(865,606)	(245,248)	620,358	(253.0%)
2,350	3,125	775	24.8%	Member Incentive	3,750	21,875	18,125	82.9%
218,483	164,432	(54,051)	(32.9%)	Provider Interest (All Depts)	2,422,687	2,086,281	(336,406)	(16.1%)
177,167	333,334	156,167	46.9%	Community Reinvestment Expense	3,601,337	6,436,593	2,835,256	44.0%
416,500	557,276	140,776	25.3%	Other Administrative Expense	5,451,740	8,802,797	3,351,057	38.1%
3,013,774	3,874,954	861,180	22.2%	Total Other Administrative ExpenseS (excludes Personnel Expenses)	41,833,308	47,264,986	5,431,679	11.5%
12,373,905	10,052,056	(2,321,850)	(23.1%)	TOTAL ADMINISTRATIVE EXPENSES	116,985,882	121,670,773	4,684,890	3.9%

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

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	\$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Routers	IT-FY26-01	\$ -	\$ -	\$ -	\$ 45,000	\$ 45,000
	Firewall AAH Location	IT-FY26-02	\$ -	\$ -	\$ -	\$ 110,000	\$ 110,000
	Firewall Roseville Location	IT-FY26-03	\$ -	\$ -	\$ -	\$ 110,000	\$ 110,000
	VPN Device	IT-FY26-04	\$ -	\$ -	\$ -	\$ 115,000	\$ 115,000
	CISCO UCS Blades	IT-FY26-05	\$ -	\$ -	\$ -	\$ 300,000	\$ 300,000
	CISCO UCS Blades	IT-FY26-05	\$ -	\$ -	\$ -	\$ 275,000	\$ 275,000
	Pure Storage	IT-FY26-06	\$ -	\$ -	\$ -	\$ 150,000	\$ 150,000
	Teams Meeting Hardware	IT-FY26-07	\$ -	\$ -	\$ -	\$ 100,000	\$ 100,000
	Network Cabeling and WIFI Access	IT-FY26-08	\$ -	\$ -	\$ -	\$ 40,000	\$ 40,000
Hardware Subtotal			\$ -	\$ -	\$ -	\$ 1,245,000	\$ 1,245,000
3. Building Improvement:							
	1240 Exterior lighting update	FA-FY26-01	\$ -	\$ -	\$ -	\$ 30,000	\$ 30,000
	1240 Secured Fencing for Warehouse	FA-FY26-02	\$ 19,727	\$ -	\$ 19,727	\$ 30,000	\$ 10,273
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	\$ -	\$ -	\$ -	\$ 10,000	\$ 10,000
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	\$ -	\$ -	\$ -	\$ 5,000	\$ 5,000
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	\$ -	\$ -	\$ -	\$ 10,000	\$ 10,000
	1240 Exterior Landscaping	FA-FY26-04	\$ 1,133	\$ -	\$ 1,133	\$ 6,500	\$ 5,367
	1240 Exterior Landscaping	FA-FY26-04	\$ 15,000	\$ -	\$ 15,000	\$ 15,000	\$ -
	1240 Exterior Landscaping	FA-FY26-04	\$ 15,000	\$ -	\$ 15,000	\$ 15,000	\$ -
Building Improvement Subtotal			\$ 50,860	\$ -	\$ 50,860	\$ 121,500	\$ 70,640
GRAND TOTAL			\$ 50,860	\$ -	\$ 50,860	\$ 1,366,500	\$ 1,315,640
6. Reconciliation to Balance Sheet:							
	Fixed Assets @ Cost - 5/31/26				\$ 39,020,265		
	Fixed Assets @ Cost - 6/30/25				\$ 38,969,405		
	Fixed Assets Acquired YTD				\$ 50,860		

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
FOR THE MONTH AND FISCAL YTD ENDED MAY 31, 2026

TANGIBLE NET EQUITY (TNE)

	QRT. END Jun-25	Jul-25	Aug-25	QRT. END Sep-25	Oct-25	Nov-25	QRT. END Dec-25	Jan-26	Feb-26	QRT. END Mar-26	Apr-26	May-26
Current Month Net Income / (Loss)	\$ 4,912,222	\$ 1,727,933	\$ 2,950,359	\$ 3,127,768	\$ 6,501,450	\$ 7,058,478	\$ 967,656	\$ 9,388,630	\$ 21,757,529	\$ 13,135,534	\$ 387,650	\$ 1,473,555
YTD Net Income / (Loss)	\$ (86,095,783)	\$ 1,727,938	\$ 4,678,300	\$ 7,806,066	\$ 14,307,514	\$ 21,365,998	\$ 22,333,655	\$ 31,722,281	\$ 53,479,813	\$ 66,615,357	\$ 67,003,009	\$ 68,476,567
Net Assets	\$ 169,279,360	\$ 171,007,298	\$ 173,957,660	\$ 177,085,426	\$ 183,586,874	\$ 190,645,358	\$ 191,613,015	\$ 201,001,641	\$ 222,759,173	\$ 235,894,717	\$ 236,282,369	\$ 237,755,927
Subordinated Debt & Interest	-	-	-	-	-	-	-	-	-	-	-	-
Total Actual TNE	\$ 169,279,360	\$ 171,007,298	\$ 173,957,660	\$ 177,085,426	\$ 183,586,874	\$ 190,645,358	\$ 191,613,015	\$ 201,001,641	\$ 222,759,173	\$ 235,894,717	\$ 236,282,369	\$ 237,755,927
Increase/(Decrease) in Actual TNE	\$ 4,912,222	\$ 1,727,933	\$ 2,950,359	\$ 3,127,768	\$ 6,501,450	\$ 7,058,478	\$ 967,656	\$ 9,388,630	\$ 21,757,529	\$ 13,135,534	\$ 387,650	\$ 1,473,555
Required TNE ⁽¹⁾	\$ 80,653,661	\$ 81,235,858	\$ 80,224,390	\$ 80,693,435	\$ 80,147,121	\$ 79,750,550	\$ 80,436,968	\$ 80,592,303	\$ 78,360,003	\$ 79,446,994	\$ 79,829,374	\$ 78,913,801
Min. Req'd to Avoid Monthly Reporting at 150% of Required TNE	\$ 120,980,491	\$ 121,853,786	\$ 120,336,585	\$ 121,040,152	\$ 120,220,681	\$ 119,625,824	\$ 120,655,452	\$ 120,888,454	\$ 117,540,005	\$ 119,170,490	\$ 119,744,061	\$ 118,370,702
TNE Excess / (Deficiency)	\$ 88,625,699	\$ 89,771,440	\$ 93,733,270	\$ 96,391,991	\$ 103,439,753	\$ 110,894,808	\$ 111,176,047	\$ 120,409,338	\$ 144,399,170	\$ 156,447,723	\$ 156,452,995	\$ 158,842,126
Actual TNE as a Multiple of Required	2.10	2.11	2.17	2.19	2.29	2.39	2.38	2.49	2.84	2.97	2.96	3.01

LIQUID TANGIBLE NET EQUITY

Net Assets	\$ 169,279,360	\$ 171,007,298	\$ 173,957,660	\$ 177,085,426	\$ 183,586,874	\$ 190,645,358	\$ 191,613,015	\$ 201,001,641	\$ 222,759,173	\$ 235,894,717	\$ 236,282,369	\$ 237,755,927
Less: Fixed Assets at Net Book Value	(5,576,811)	(5,514,960)	(5,453,108)	(5,391,257)	(5,329,406)	(5,291,335)	(5,229,076)	(5,166,817)	(5,115,549)	(5,067,826)	(5,005,127)	(4,942,428)
Net Lease Assets	(2,072,151)	(1,979,137)	(1,678,452)	(1,751,482)	(1,932,587)	(1,672,654)	(1,426,385)	(3,031,854)	(2,673,163)	(2,245,863)	(2,250,278)	(1,905,177)
CD Pledged to DMHC	(353,866)	(354,839)	(355,847)	(356,859)	(357,840)	(358,857)	(359,844)	(360,866)	(361,892)	(362,821)	(363,852)	(364,852)
Liquid TNE (Liquid Reserves)	\$ 161,276,532	\$ 163,158,362	\$ 166,470,253	\$ 169,585,828	\$ 175,967,041	\$ 183,322,512	\$ 184,597,710	\$ 192,442,104	\$ 214,608,569	\$ 228,218,207	\$ 228,663,112	\$ 230,543,470
Liquid TNE as Multiple of Required	2.00	2.01	2.08	2.10	2.20	2.30	2.29	2.39	2.74	2.87	2.86	2.92

**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
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,251	108,503	108,083	107,831	107,894	107,424	106,611	106,175	105,381	104,683	104,072		1,175,908
Adult	61,536	60,679	60,106	59,780	59,806	59,312	58,090	57,240	56,039	54,857	53,691		641,136
ACA OE	155,533	153,348	152,196	151,404	150,677	149,473	146,364	144,297	141,305	138,309	134,907		1,617,813
SPD with LTC	29,833	29,686	29,708	29,631	29,590	29,500	29,119	28,813	28,461	27,944	27,794		320,079
Duals with LTC	49,509	49,371	49,390	49,401	49,334	49,277	48,675	48,506	48,290	48,038	47,866		537,657
Medi-Cal Program	405,662	401,587	399,483	398,047	397,301	394,986	388,859	385,031	379,476	373,831	368,330		4,292,593
Group Care Program	5,957	5,974	6,054	6,081	6,092	6,138	6,191	6,211	6,240	6,291	6,311		67,540
Medicare Program	0	0	0	0	0	0	170	191	212	231	245		1,049
Total	411,619	407,561	405,537	404,128	403,393	401,124	395,220	391,433	385,928	380,353	374,886		4,361,182

Month Over Month Enrollment Change:

Medi-Cal Monthly Change:													
Child	(323)	(748)	(420)	(252)	63	(470)	(813)	(436)	(794)	(698)	(611)		(5,502)
Adult	(133)	(857)	(573)	(326)	26	(494)	(1,222)	(850)	(1,201)	(1,182)	(1,166)		(7,978)
ACA OE	357	(2,185)	(1,152)	(792)	(727)	(1,204)	(3,109)	(2,067)	(2,992)	(2,996)	(3,402)		(20,269)
SPD with LTC	83	(147)	22	(77)	(41)	(90)	(381)	(306)	(352)	(517)	(150)		(1,956)
Duals with LTC	205	(138)	19	11	(67)	(57)	(602)	(169)	(216)	(252)	(172)		(1,438)
Medi-Cal Program	189	(4,075)	(2,104)	(1,436)	(746)	(2,315)	(6,127)	(3,828)	(5,555)	(5,645)	(5,501)		(37,143)
Group Care Program	47	17	80	27	11	46	53	20	29	51	20		401
Medicare Program	0	0	0	0	0	0	170	21	21	19	14		245
Total	236	(4,058)	(2,024)	(1,409)	(735)	(2,269)	(5,904)	(3,787)	(5,505)	(5,575)	(5,467)		(36,497)

Enrollment Percentages:

Medi-Cal Program % of Total:													
Child % of Medi-Cal	26.9%	27.0%	27.1%	27.1%	27.2%	27.2%	27.4%	27.6%	27.8%	28.0%	28.3%		27.4%
Adult % of Medi-Cal	15.2%	15.1%	15.0%	15.0%	15.1%	15.0%	14.9%	14.9%	14.8%	14.7%	14.6%		14.9%
ACA OE % of Medi-Cal	38.3%	38.2%	38.1%	38.0%	37.9%	37.8%	37.6%	37.5%	37.2%	37.0%	36.6%		37.7%
SPD with LTC % of Medi-Cal	7.4%	7.4%	7.4%	7.4%	7.4%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%		7.5%
Duals with LTC % of Medi-Cal	12.2%	12.3%	12.4%	12.4%	12.4%	12.5%	12.5%	12.6%	12.7%	12.9%	13.0%		12.5%
Medi-Cal Program % of Total	98.6%	98.5%	98.5%	98.5%	98.5%	98.5%	98.4%	98.4%	98.3%	98.3%	98.3%		98.4%
Group Care Program % of Total	1.4%	1.5%	1.5%	1.5%	1.5%	1.5%	1.6%	1.6%	1.6%	1.7%	1.7%		1.5%
Medicare Program % of Total	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%		0.0%
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%

**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	87,617	87,480	86,918		1,000,628
Alameda Health System	92,861	91,758	91,032	91,084	90,621	90,714	88,985	87,443	86,119	81,995	78,601		971,213
Directly-Contracted Subtotal	186,794	185,026	184,631	183,754	184,036	182,180	179,024	177,666	173,736	169,475	165,519		1,971,841
Delegated:													
CFMG	43,381	42,852	42,253	42,053	41,790	41,683	41,247	40,893	40,565	40,449	40,233		457,399
CHCN	181,444	179,683	178,653	178,321	177,567	177,261	174,949	172,874	171,627	170,429	169,134		1,931,942
Delegated Subtotal	224,825	222,535	220,906	220,374	219,357	218,944	216,196	213,767	212,192	210,878	209,367		2,389,341
Total	411,619	407,561	405,537	404,128	403,393	401,124	395,220	391,433	385,928	380,353	374,886		4,361,182
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(518)	(1,768)	(395)	(877)	282	(1,856)	(3,156)	(1,358)	(3,930)	(4,261)	(3,956)		(21,793)
Delegated:													
CFMG	(128)	(529)	(599)	(200)	(263)	(107)	(436)	(354)	(328)	(116)	(216)		(3,276)
CHCN	882	(1,761)	(1,030)	(332)	(754)	(306)	(2,312)	(2,075)	(1,247)	(1,198)	(1,295)		(11,428)
Delegated Subtotal	754	(2,290)	(1,629)	(532)	(1,017)	(413)	(2,748)	(2,429)	(1,575)	(1,314)	(1,511)		(14,704)
Total	236	(4,058)	(2,024)	(1,409)	(735)	(2,269)	(5,904)	(3,787)	(5,505)	(5,575)	(5,467)		(36,497)
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	45.4%	45.4%	45.5%	45.5%	45.6%	45.4%	45.3%	45.4%	45.0%	44.6%	44.2%		45.2%
Delegated:													
CFMG	10.5%	10.5%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	10.5%	10.6%	10.7%		10.5%
CHCN	44.1%	44.1%	44.1%	44.1%	44.0%	44.2%	44.3%	44.2%	44.5%	44.8%	45.1%		44.3%
Delegated Subtotal	54.6%	54.6%	54.5%	54.5%	54.4%	54.6%	54.7%	54.6%	55.0%	55.4%	55.8%		54.8%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%

**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
TRENDING ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2026

	Variance Jul-25	Variance Aug-25	Variance Sep-25	Variance Oct-25	Variance Nov-25	Variance Dec-25	Variance Jan-26	Variance Feb-26	Variance Mar-26	Variance Apr-26	Variance May-26	Variance Jun-26	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	271	410	203	369	171	68	47		1,539
Adult	0	0	0	0	505	534	108	43	(383)	(802)	(1,216)		(1,211)
ACA OE	0	0	0	0	216	(9)	572	2,092	2,586	2,977	2,867		11,301
Total	0	0	0	0	16	44	7,308	7,147	6,936	6,562	6,553		34,566
Duals with LTC*	0	0	0	0	139	205	(7,794)	(7,838)	(7,930)	(8,058)	(8,107)		(39,383)
Medi-Cal Program	0	0	0	0	1,147	1,184	397	1,813	1,380	747	144		6,812
Group Care Program	0	0	0	0	13	53	112	126	149	194	208		855
Medicare Program	0	0	0	0	0	0	(96)	(179)	(261)	(388)	(477)		(1,401)
Total	0	0	0	0	1,160	1,237	413	1,760	1,268	553	(125)		6,266
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	5	(1,480)	(4,741)	(3,585)	(5,243)	(4,482)	(4,140)		(23,666)
Alameda Health System	0	0	0	0	296	961	1,564	1,544	1,705	(974)	(2,957)		2,139
Directly-Contracted Subtotal	0	0	0	0	301	(519)	(3,177)	(2,041)	(3,538)	(5,456)	(7,097)		(21,527)
Delegated:													
CFMG	0	0	0	0	117	236	534	437	362	498	532		2,716
CHCN	0	0	0	0	742	1,520	3,056	3,364	4,444	5,511	6,440		25,077
Delegated Subtotal	0	0	0	0	859	1,756	3,590	3,801	4,806	6,009	6,972		27,793
Total	0	0	0	0	1,160	1,237	413	1,760	1,268	553	(125)		6,266

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

MEDICARE SUPPLEMENT

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Current Direct/Provider Network Enrollment:													
Directly-Contracted:													
Directly Contracted (DCP)	0	0	0	0	0	0	74	67	59	68	77		345
Alameda Health System	0	0	0	0	0	0	15	16	25	27	24		107
Directly-Contracted Subtotal	0	0	0	0	0	0	89	83	84	95	101		452
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0		0
CHCN	0	0	0	0	0	0	81	108	128	136	144		597
Provider Network Subtotal	0	0	0	0	0	0	81	108	128	136	144		597
Total	0	0	0	0	0	0	170	191	212	231	245		1,049

Direct/Provider Network Month Over Month Enrollment Change:													
Directly-Contracted	0	0	0	0	0	0	89	(6)	1	11	6		101
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0		0
CHCN	0	0	0	0	0	0	81	27	20	8	8		144
Provider Network Subtotal	0	0	0	0	0	0	81	27	20	8	8		144
Total	0	0	0	0	0	0	170	21	21	19	14		245

Direct/Provider Network Enrollment Percentages:													
Directly-Contracted	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	52.4%	43.5%	39.6%	41.1%	41.2%		43.1%
Provider Network:													
CFMG	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%
CHCN	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	47.6%	56.5%	60.4%	58.9%	58.8%		56.9%
Provider Network Subtotal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	47.6%	56.5%	60.4%	58.9%	58.8%		56.9%
Total	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%

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

Direct/Provider Network Month Over Month Enrollment Change:													
Directly-Contracted	0	0	0	0	0	0	191	75	74	105	74	74	593
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	0	0	0	0	0	0	75	29	29	41	29	29	232
Provider Network Subtotal	0	0	0	0	0	0	75	29	29	41	29	29	232
Total	0	0	0	0	0	0	266	104	103	146	103	103	825

Direct/Provider Network Enrollment Percentages:													
Directly-Contracted	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	71.8%	71.9%	71.9%	71.9%	71.9%	71.9%	71.9%
Provider Network:													
CFMG	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CHCN	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	28.2%	28.1%	28.1%	28.1%	28.1%	28.1%	28.1%
Provider Network Subtotal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	28.2%	28.1%	28.1%	28.1%	28.1%	28.1%	28.1%
Total	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Variance Jul-25	Variance Aug-25	Variance Sep-25	Variance Oct-25	Variance Nov-25	Variance Dec-25	Variance Jan-26	Variance Feb-26	Variance Mar-26	Variance Apr-26	Variance May-26	Variance Jun-26	YTD Member Variance
Current Direct/Provider Network Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted:													
Directly Contracted (DCP)	0	0	0	0	0	0	(98)	(173)	(248)	(334)	(392)		(1,245)
Alameda Health System	0	0	0	0	0	0	(4)	(10)	(8)	(16)	(26)		(64)
Directly-Contracted Subtotal	0	0	0	0	0	0	(102)	(183)	(256)	(350)	(418)		(1,309)
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0		0
CHCN	0	0	0	0	0	0	6	4	(5)	(38)	(59)		(92)
Provider Network Subtotal	0	0	0	0	0	0	6	4	(5)	(38)	(59)		(92)
Total	0	0	0	0	0	0	(96)	(179)	(261)	(388)	(477)		(1,401)

**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 MAY, 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>				
\$1,508,951	\$1,476,436	(\$32,515)	(2.2%)	PCP Capitation	\$21,737,462	\$21,509,428	(\$228,035)	(1.1%)
5,918,073	5,706,302	(211,771)	(3.7%)	PCP Capitation FQHC	76,199,184	74,209,221	(1,989,963)	(2.7%)
444,855	435,461	(9,395)	(2.2%)	Specialty Capitation	5,069,232	5,004,402	(64,830)	(1.3%)
5,567,805	4,898,799	(669,006)	(13.7%)	Specialty Capitation FQHC	57,002,134	56,657,469	(344,665)	(0.6%)
752,231	701,542	(50,689)	(7.2%)	Laboratory Capitation	8,593,674	8,282,430	(311,245)	(3.8%)
322,414	315,551	(6,863)	(2.2%)	Vision Capitation	3,699,590	3,641,824	(57,766)	(1.6%)
101,180	99,045	(2,135)	(2.2%)	CFMG Capitation	1,152,991	1,138,252	(14,739)	(1.3%)
786,421	757,614	(28,807)	(3.8%)	ANC IPA Admin Capitation FQHC	9,614,586	9,473,256	(141,330)	(1.5%)
(4,877)	0	4,877	0.0%	Kaiser Capitation	(21,749)	(12,511)	9,238	(73.8%)
973,825	922,229	(51,597)	(5.6%)	DME Capitation	11,179,642	10,859,606	(320,036)	(2.9%)
663	2,108	1,445	68.6%	Dental Capitation	2,996	7,154	4,158	58.1%
16,371,543	15,315,087	(1,056,456)	(6.9%)	7. TOTAL CAPITATED EXPENSES	194,229,743	190,770,530	(3,459,213)	(1.8%)
				<u>FEE FOR SERVICE MEDICAL EXPENSES</u>				
(2,778,959)	0	2,778,959	0.0%	IBNR Inpatient Services	(44,862,897)	(20,241,559)	24,621,338	(121.6%)
(83,368)	0	83,368	0.0%	IBNR Settlement (IP)	(1,345,888)	(607,245)	738,643	(121.6%)
(222,316)	0	222,316	0.0%	IBNR Claims Fluctuation (IP)	(3,589,032)	(1,619,325)	1,969,707	(121.6%)
44,246,902	43,648,265	(598,636)	(1.4%)	Inpatient Hospitalization FFS	514,203,951	501,866,589	(12,337,361)	(2.5%)
3,662,341	3,317,945	(344,396)	(10.4%)	IP OB - Mom & NB	37,405,055	37,496,313	91,258	0.2%
260,141	138,594	(121,547)	(87.7%)	IP Behavioral Health	2,810,101	1,910,800	(899,301)	(47.1%)
1,106,355	1,334,701	228,346	17.1%	Inpatient Facility Rehab FFS	15,078,395	15,153,272	74,877	0.5%
46,191,095	48,439,505	2,248,410	4.6%	8. Inpatient Hospital Expense	519,699,685	533,958,846	14,259,161	2.7%
1,657,023	0	(1,657,023)	0.0%	IBNR PCP	2,843,685	3,433,331	589,646	17.2%
49,711	0	(49,711)	0.0%	IBNR Settlement (PCP)	85,310	103,000	17,690	17.2%
132,562	0	(132,562)	0.0%	IBNR Claims Fluctuation (PCP)	227,494	274,669	47,175	17.2%
3,245,989	3,095,184	(150,805)	(4.9%)	PCP FFS	31,576,974	35,551,373	3,974,399	11.2%
0	0	0	0.0%	Special Needs Medical Expense	278	278	0	0.0%
492,159	394,674	(97,485)	(24.7%)	PCP FQHC FFS	5,636,927	4,633,559	(1,003,368)	(21.7%)
0	0	0	0.0%	Prop 56 Physician Pmt	(3,778)	(3,778)	0	0.0%
20,556	0	(20,556)	0.0%	Prop 56 Hyde	202,315	64,417	(137,898)	(214.1%)
104,686	0	(104,686)	0.0%	Prop 56 Trauma Screening	975,287	303,469	(671,818)	(221.4%)
114,545	0	(114,545)	0.0%	Prop 56 Developmentl Screening	1,092,241	361,844	(730,397)	(201.9%)
593,384	877,032	283,648	32.3%	Prop 56 Family Planning	7,097,842	8,638,031	1,540,189	17.8%
0	0	0	0.0%	Prop 56 VBP	(259)	(259)	0	0.0%
6,410,615	4,366,891	(2,043,724)	(46.8%)	9. Primary Care Physician Expense	49,734,316	53,359,933	3,625,618	6.8%
(376,663)	0	376,663	0.0%	IBNR Specialist	(1,958,352)	(334,249)	1,624,103	(485.9%)
(11,299)	0	11,299	0.0%	IBNR Settlement (SCP)	(58,750)	(10,026)	48,724	(486.0%)
(30,134)	0	30,134	0.0%	IBNR Claims Fluctuation (SCP)	(156,672)	(26,743)	129,929	(485.8%)
912,581	8,856	(903,725)	(10,204.4%)	Psychiatrist FFS	7,553,855	2,769,685	(4,784,170)	(172.7%)
4,086,786	7,759,746	3,672,960	47.3%	Specialty Care FFS	38,706,843	71,282,415	32,575,572	45.7%
232,346	0	(232,346)	0.0%	Specialty Anesthesiology	3,244,285	1,349,666	(1,894,618)	(140.4%)
1,884,419	0	(1,884,419)	0.0%	Specialty Imaging FFS	19,629,504	6,999,284	(12,630,220)	(180.5%)
31,447	0	(31,447)	0.0%	Obstetrics FFS	509,916	236,824	(273,092)	(115.3%)
415,048	0	(415,048)	0.0%	Specialty IP Surgery FFS	4,798,350	1,954,243	(2,844,107)	(145.5%)
1,025,469	0	(1,025,469)	0.0%	Specialty OP Surgery FFS	11,285,416	4,456,894	(6,828,522)	(153.2%)
650,193	0	(650,193)	0.0%	Specialty IP Physician	7,054,199	2,930,480	(4,123,719)	(140.7%)
187,702	127,653	(60,049)	(47.0%)	Specialist FQHC FFS	1,879,317	1,585,136	(294,182)	(18.6%)
9,007,894	7,896,256	(1,111,638)	(14.1%)	10. Specialty Care Physician Expense	92,487,912	93,193,609	705,697	0.8%
(1,755,509)	0	1,755,509	0.0%	IBNR Ancillary (ANC)	(3,155,642)	(3,205,959)	(50,317)	1.6%
(52,667)	0	52,667	0.0%	IBNR Settlement (ANC)	(94,674)	(96,181)	(1,507)	1.6%

**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 MAY, 2026**

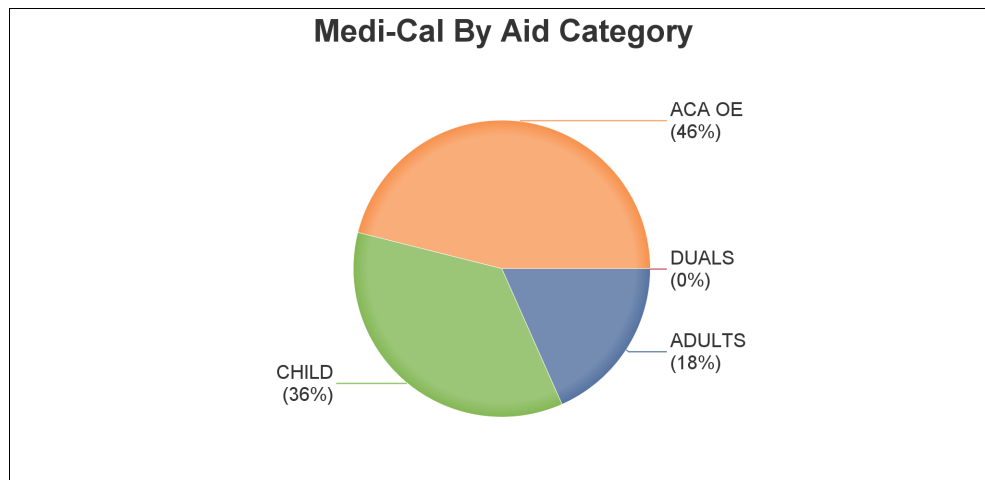
CURRENT MONTH				FISCAL YEAR TO DATE				
		\$ Variance	% Variance				\$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
(140,442)	0	140,442	0.0%	IBNR Claims Fluctuation (ANC)	(252,453)	(256,479)	(4,026)	1.6%
(91,811)	0	91,811	0.0%	IBNR Transportation FFS	424,268	(320,108)	(744,376)	232.5%
3,133,835	2,490,269	(643,567)	(25.8%)	Behavioral Health Therapy FFS	34,886,152	30,442,833	(4,443,319)	(14.6%)
3,823,277	0	(3,823,277)	0.0%	Psychologist & Other MH Prof	31,544,243	10,562,380	(20,981,863)	(198.6%)
737,720	0	(737,720)	0.0%	Other Medical Professional	8,149,787	2,326,374	(5,823,413)	(250.3%)
172,051	2,238	(169,813)	(7,587.0%)	Hearing Devices	1,854,479	690,872	(1,163,608)	(168.4%)
19,261	0	(19,261)	0.0%	ANC Imaging	307,352	138,286	(169,066)	(122.3%)
582	0	(582)	0.0%	Vision FFS	526,240	330,028	(196,211)	(59.5%)
0	0	0	0.0%	Family Planning	5	5	0	0.0%
1,034,023	812,319	(221,704)	(27.3%)	Laboratory FFS	8,913,432	8,665,290	(248,142)	(2.9%)
218,622	0	(218,622)	0.0%	ANC Therapist	1,982,956	667,783	(1,315,172)	(196.9%)
0	21,660	21,660	100.0%	OTC Card	10,756	73,500	62,744	85.4%
1,878,910	1,645,883	(233,027)	(14.2%)	Transp/Ambulance FFS	19,920,763	19,046,363	(874,400)	(4.6%)
0	90	90	100.0%	Worldwide Emergency Benefit	0	306	306	100.0%
3,138,587	2,723,133	(415,454)	(15.3%)	Non-ER Transportation FFS	31,420,908	28,461,113	(2,959,794)	(10.4%)
270,896	2,172,582	1,301,686	59.9%	Hospice FFS	19,267,936	22,170,406	2,902,470	13.1%
2,399,262	3,263,690	864,428	26.5%	Home Health Services	28,821,631	32,909,928	4,088,297	12.4%
4,900	89,704	84,804	94.5%	Other Medical FFS	9,800	306,849	297,049	96.8%
(466,867)	0	466,867	0.0%	Medical Refunds through HMS	(1,947,791)	(883,969)	1,063,821	(120.3%)
24,924	1,858,703	1,833,779	98.7%	DME & Medical Supplies FFS	288,769	13,337,674	13,048,905	97.8%
3,419,246	3,275,242	(144,004)	(4.4%)	ECM Base/Outreach FFS ANC	32,828,760	31,705,261	(1,123,498)	(3.5%)
160,561	180,388	19,827	11.0%	CS Housing Deposits FFS ANC	1,734,213	1,925,704	191,491	9.9%
(50,310)	714,357	764,667	107.0%	CS Housing Tenancy FFS ANC	5,949,822	8,585,852	2,636,030	30.7%
(20,538)	429,092	449,630	104.8%	CS Housing Navi Servc FFS ANC	3,837,049	5,302,307	1,465,258	27.6%
140,432	382,892	242,461	63.3%	CS Medical Respite FFS ANC	3,253,852	3,949,508	695,656	17.6%
260,880	277,162	16,282	5.9%	CS Med. Tailored Meals FFS ANC	2,460,074	2,782,544	322,470	11.6%
7,358	11,662	4,304	36.9%	CS Asthma Remediation FFS ANC	196,166	229,491	33,325	14.5%
0	0	0	0.0%	MOT Wrap Around (Non Med MOT)	6,868	6,868	0	0.0%
1,661	2,617	957	36.5%	CS Home Modifications FFS ANC	6,743	18,159	11,415	62.9%
35,842	104,066	68,223	65.6%	CS P.Care & Hmker Svcs FFS ANC	562,579	960,807	398,228	41.4%
0	6,771	6,771	100.0%	CS Cgiver Respite Svcs FFS ANC	25,156	53,229	28,073	52.7%
0	22	22	100.0%	CS ST PostHospital Housing FFS	0	(6)	(6)	100.0%
1,670	1,006	(664)	(66.0%)	CS Housing Outreach	8,320	8,165	(155)	(1.9%)
416,455	0	(416,455)	0.0%	CommunityBased Adult Svc(CBAS)	4,874,073	1,519,540	(3,354,533)	(220.8%)
1,529	10,831	9,302	85.9%	CS LTC to ALF Transition FFS ANC	136,481	139,665	3,184	2.3%
0	5,003	5,003	100.0%	CS LTC to Home Transition FFS ANC	18,866	52,874	34,008	64.3%
19,324,342	20,481,382	1,157,040	5.6%	11. Ancillary Medical Expense	238,777,937	222,607,262	(16,170,676)	(7.3%)
(1,039,011)	0	1,039,011	0.0%	IBNR Outpatient	(5,055,727)	1,452,995	6,508,722	448.0%
(31,171)	0	31,171	0.0%	IBNR Settlement (OP)	(151,675)	43,588	195,263	448.0%
(83,121)	0	83,121	0.0%	IBNR Claims Fluctuation (OP)	(404,456)	116,241	520,697	447.9%
3,309,273	5,525,047	2,215,774	40.1%	Outpatient FFS	34,727,867	51,953,026	17,225,159	33.2%
3,161,622	150,155	(3,011,467)	(2,005.6%)	OP Ambul Surgery FFS	34,377,560	14,101,361	(20,276,199)	(143.8%)
2,071,441	3,305,817	1,234,376	37.3%	Imaging Services FFS	29,575,348	36,224,014	6,648,666	18.4%
103,130	0	(103,130)	0.0%	Behavioral Health FFS	1,333,617	493,539	(840,078)	(170.2%)
903,524	0	(903,524)	0.0%	Outpatient Facility Lab FFS	9,689,176	3,448,349	(6,240,827)	(181.0%)
271,058	0	(271,058)	0.0%	Outpatient Facility Cardio FFS	2,776,769	1,028,586	(1,748,183)	(170.0%)
147,289	0	(147,289)	0.0%	OP Facility PT/OT/ST FFS	1,382,697	461,172	(921,525)	(199.8%)
2,785,464	2,804,024	18,560	0.7%	OP Facility Dialysis Ctr FFS	31,421,456	33,536,125	2,114,670	6.3%
11,599,497	11,785,044	185,546	1.6%	12. Outpatient Medical Expense	139,672,632	142,858,997	3,186,365	2.2%
1,135,421	0	(1,135,421)	0.0%	IBNR Emergency	(2,970,977)	(2,513,669)	457,308	(18.2%)
34,063	0	(34,063)	0.0%	IBNR Settlement (ER)	(89,124)	(75,408)	13,716	(18.2%)
90,835	0	(90,835)	0.0%	IBNR Claims Fluctuation (ER)	(237,676)	(201,094)	36,582	(18.2%)
9,729,602	10,126,219	396,617	3.9%	ER Facility	107,359,934	111,081,867	3,721,933	3.4%
1,245,593	0	(1,245,593)	0.0%	Specialty ER Physician FFS	13,692,165	4,951,779	(8,740,386)	(176.5%)
12,235,514	10,126,219	(2,109,295)	(20.8%)	13. Emergency Expense	117,754,322	113,243,475	(4,510,847)	(4.0%)

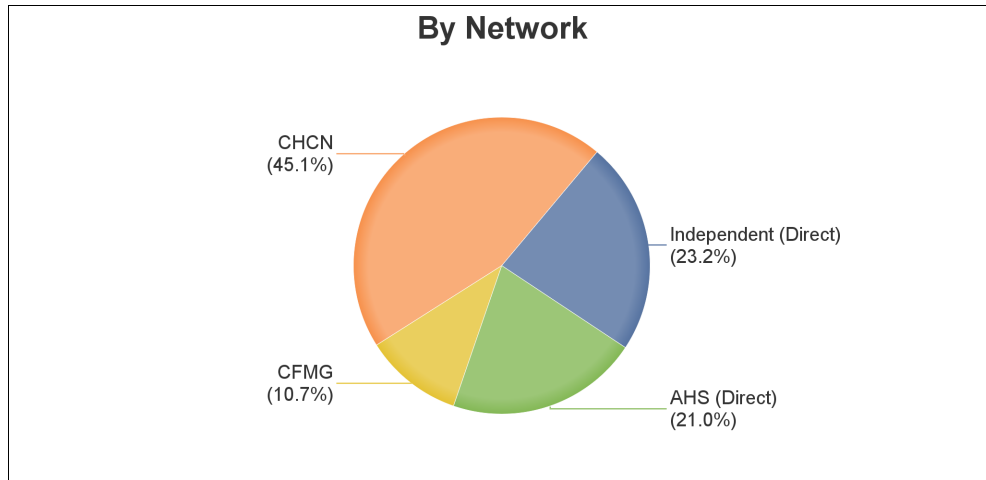
**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 MAY, 2026**

CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
869,899	0	(869,899)	0.0%	IBNR Pharmacy (OP)	(1,886,745)	(2,257,911)	(371,166)	16.4%
26,096	0	(26,096)	0.0%	IBNR Settlement Rx (OP)	(56,599)	(67,734)	(11,135)	16.4%
69,590	0	(69,590)	0.0%	IBNR Claims Fluctuation Rx(OP)	(150,940)	(180,633)	(29,693)	16.4%
798,823	1,063,754	264,931	24.9%	Pharmacy FFS (OP)	8,446,390	9,416,713	970,323	10.3%
124,110	0	(124,110)	0.0%	Pharmacy Non PBM FFS Other-ANC	1,667,221	479,027	(1,188,194)	(248.0%)
9,982,838	11,094,825	1,111,987	10.0%	Pharmacy Non PBM FFS OP-FAC	89,815,188	102,257,604	12,442,416	12.2%
683,886	0	(683,886)	0.0%	Pharmacy Non PBM FFS PCP	4,396,441	1,140,883	(3,255,558)	(285.4%)
3,830,531	0	(3,830,531)	0.0%	Pharmacy Non PBM FFS SCP	37,816,945	11,779,726	(26,037,219)	(221.0%)
101,569	0	(101,569)	0.0%	Pharmacy Non PBM FFS FQHC	821,887	165,336	(656,551)	(397.1%)
10,848	0	(10,848)	0.0%	Pharmacy Non PBM FFS HH	161,273	78,426	(82,847)	(105.6%)
(40,000)	(89,243)	(49,243)	55.2%	Medical Expenses Pharm Rebate	(840,581)	(935,667)	(95,087)	10.2%
16,458,189	12,069,337	(4,388,852)	(36.4%)	14. Pharmacy Expense	140,190,480	121,875,770	(18,314,711)	(15.0%)
(4,141,208)	0	4,141,208	0.0%	IBNR LTC	(21,381,187)	(5,530,063)	15,851,124	(286.6%)
(124,236)	0	124,236	0.0%	IBNR Settlement (LTC)	(641,437)	(165,902)	475,535	(286.6%)
(331,297)	0	331,297	0.0%	IBNR Claims Fluctuation (LTC)	(1,710,499)	(442,407)	1,268,092	(286.6%)
1,906,934	1,974,311	67,377	3.4%	LTC - ICF/DD	20,212,697	21,460,197	1,247,500	5.8%
24,851,852	29,348,392	4,496,540	15.3%	LTC Custodial Care	287,629,770	314,507,379	26,877,609	8.5%
8,957,638	7,899,505	(1,058,133)	(13.4%)	LTC SNF	95,701,338	91,832,286	(3,869,052)	(4.2%)
31,119,683	39,222,209	8,102,525	20.7%	15. Long Term Care Expense	379,810,682	421,661,490	41,850,808	9.9%
152,346,829	154,386,842	2,040,012	1.3%	16. TOTAL FFS MEDICAL EXPENSES	1,678,127,967	1,702,759,382	24,631,415	1.4%
0	(2,289,437)	(2,289,437)	100.0%	Clinical Vacancy #102	0	(2,759,705)	(2,759,705)	100.0%
105,658	313,751	208,093	66.3%	Quality Analytics #123	2,111,164	2,994,945	883,781	29.5%
356,554	544,804	188,250	34.6%	LongTerm Services and Support #139	4,265,149	4,521,220	256,071	5.7%
880,369	1,462,470	582,101	39.8%	Utilization Management #140	10,225,871	11,461,602	1,235,731	10.8%
200,461	1,191,471	991,011	83.2%	Case & Disease Management #185	7,517,178	9,459,428	1,942,250	20.5%
513,318	469,175	(44,143)	(9.4%)	Medical Management #230	345,129	682,509	337,380	49.4%
1,444,938	1,791,044	346,106	19.3%	Quality Improvement #235	12,877,667	15,546,895	2,669,227	17.2%
398,014	609,278	211,264	34.7%	HCS Behavioral Health #238	4,393,558	4,906,183	512,625	10.4%
108,253	330,889	222,636	67.3%	Pharmacy Services #245	1,461,815	2,478,088	1,016,273	41.0%
0	0	0	0.0%	Regulatory Readiness #268	(4,027)	(5,289)	(1,262)	23.9%
4,007,564	4,423,446	415,882	9.4%	17. Other Benefits & Services	43,193,504	49,285,875	6,092,371	12.4%
(2,315,821)	(1,588,909)	726,912	(45.7%)	Reinsurance Recoveries	(26,109,107)	(22,420,193)	3,688,915	(16.5%)
2,250,931	2,118,546	(132,385)	(6.2%)	Reinsurance Premium	26,360,418	25,671,197	(689,221)	(2.7%)
(64,890)	529,636	594,527	112.3%	18. Reinsurance (Net)	251,310	3,251,004	2,999,694	92.3%
290,000	290,000	0	0.0%	P4P Risk Pool Provider Incenti	10,609,099	7,569,099	(3,040,000)	(40.2%)
290,000	290,000	0	0.0%	19. Risk Pool Distribution	10,609,099	7,569,099	(3,040,000)	(40.2%)
172,951,045	174,945,010	1,993,965	1.1%	20. TOTAL MEDICAL EXPENSES	1,926,411,623	1,953,635,890	27,224,267	1.4%

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

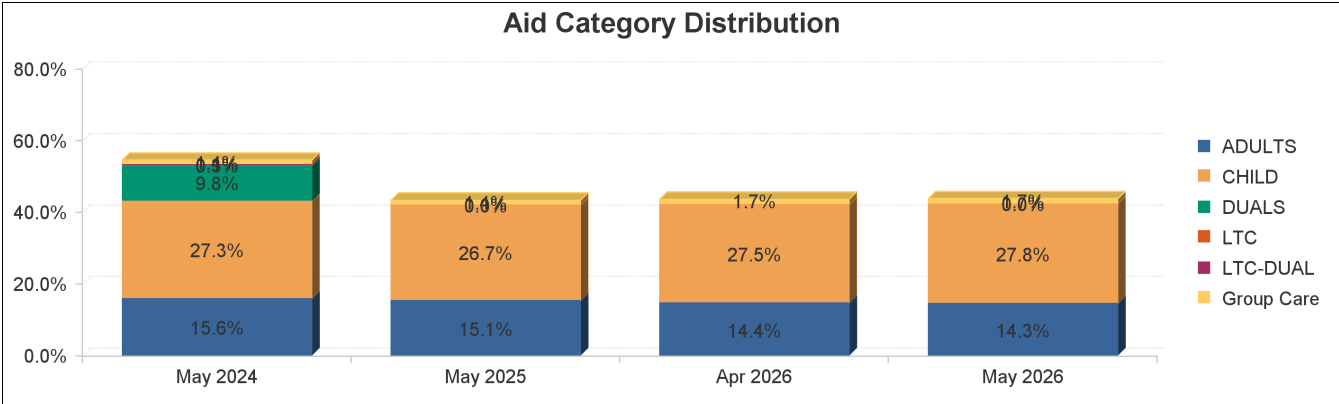
Category of Aid Trend						
Category of Aid	May 2026	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	53,740	15%	11,078	12,643	2	30,017
CHILD	104,137	28%	9,527	13,697	37,295	43,618
SPD	0	0%	0	0	0	0
ACA OE	134,907	37%	25,147	42,728	1,426	65,606
DUALS	5	0%	5	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	27,794	8%	8,015	4,978	1,515	13,286
SPD-LTC/Full Dual	47,866	13%	30,880	3,390	0	13,596
Other	0		0	0	0	0
Medi-Cal	368,449		84,652	77,436	40,238	166,123
Group Care	6,311		2,277	1,144	0	2,890
D-SNP	245		77	24	0	144
Total	375,005	100%	87,006	78,604	40,238	169,157
Other %	0.0%		0.0%	0.0%	0.0%	0.0%
Medi-Cal %	98.3%		97.3%	98.5%	100.0%	98.2%
Group Care %	1.7%		2.6%	1.5%	0.0%	1.7%
D-SNP %	0.1%		0.1%	0.0%	0.0%	0.1%
Network Distribution			23.2%	21.0%	10.7%	45.1%
			% Direct:	44%	% Delegated:	56%



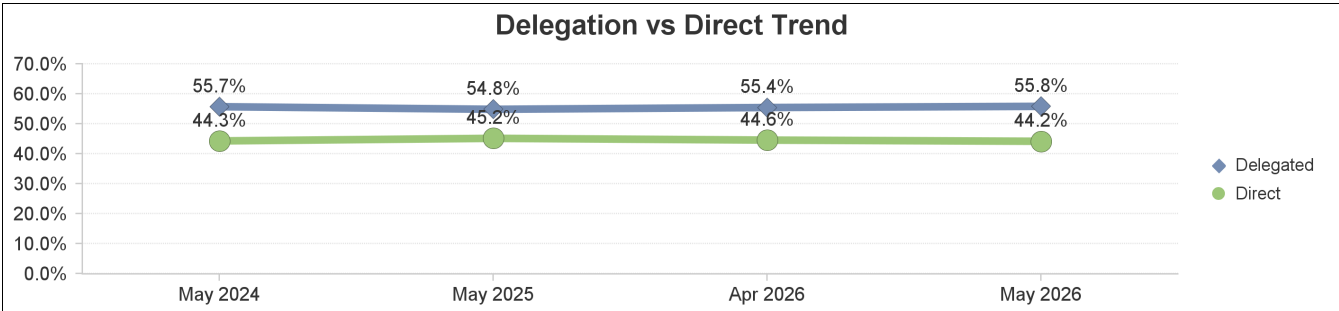


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend											
Category of Aid	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2024	May 2025	Apr 2026	May 2026	May 2024	May 2025	Apr 2026	May 2026	May 2024 to May 2025	May 2025 to May 2026	Apr 2026 to May 2026
ADULTS	63,405	61,851	54,867	53,740	15.6%	15.1%	14.4%	14.3%	-2.5%	-15.1%	-2.1%
CHILD	110,561	109,496	104,710	104,137	27.3%	26.7%	27.5%	27.8%	-1.0%	-5.1%	-0.6%
SPD	34,965	0	0	0	8.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ACA OE	149,427	153,782	138,309	134,907	36.9%	37.6%	36.4%	36.0%	2.8%	-14.0%	-2.5%
DUALS	39,842	1	0	5	9.8%	0.0%	0.0%	0.0%	#####	80.0%	100.0%
LTC	220	0	0	0	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LTC-DUAL	1,283	0	0	0	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SPD-LTC	0	29,455	27,944	27,794	0.0%	7.2%	7.3%	7.4%	100.0%	-6.0%	-0.5%
SPD-LTC/ Full Dual	0	48,957	48,039	47,866	0.0%	12.0%	12.6%	12.8%	100.0%	-2.3%	-0.4%
Other	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medi-Cal	399,703	403,542	373,869	368,449	98.6%	98.6%	98.3%	98.3%	1.0%	-9.5%	-1.5%
Group Care	5,640	5,887	6,291	6,311	1.4%	1.4%	1.7%	1.7%	4.2%	6.7%	0.3%
D-SNP	0	0	231	245	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
Total	405,343	409,429	380,391	375,005	100.0%	100.0%	100.0%	100.0%	1.0%	-9.3%	-1.4%

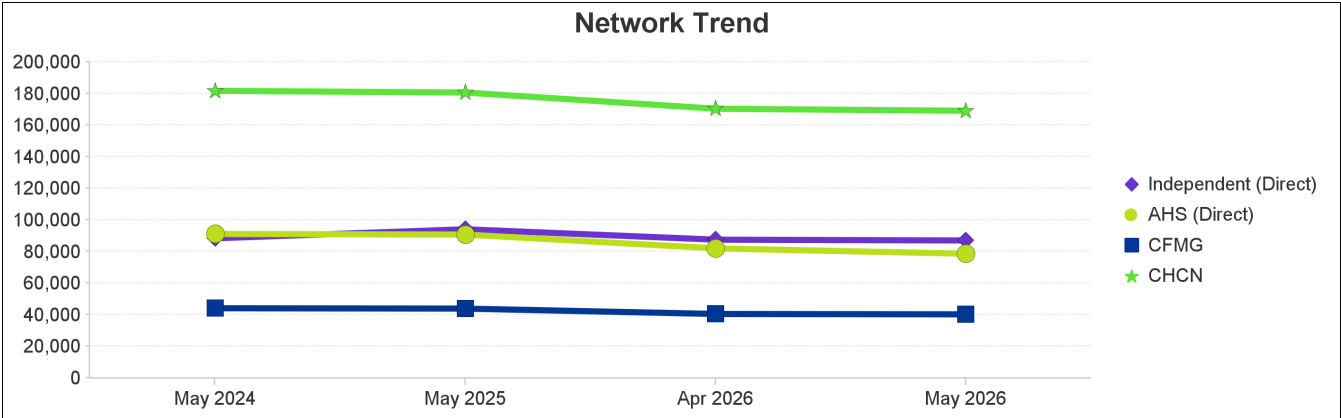


Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2024	May 2025	Apr 2026	May 2026	May 2024	May 2025	Apr 2026	May 2026	May 2024 to May 2025	May 2025 to May 2026	Apr 2026 to May 2026
Delegated	225,844	224,566	210,887	209,395	55.7%	54.8%	55.4%	55.8%	-0.6%	-7.3%	-0.7%
Direct	179,499	184,863	169,504	165,610	44.3%	45.2%	44.6%	44.2%	2.9%	-11.7%	-2.4%
Total	405,343	409,429	380,391	375,005	100.0%	100.0%	100.0%	100.0%	1.0%	-9.3%	-1.4%



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

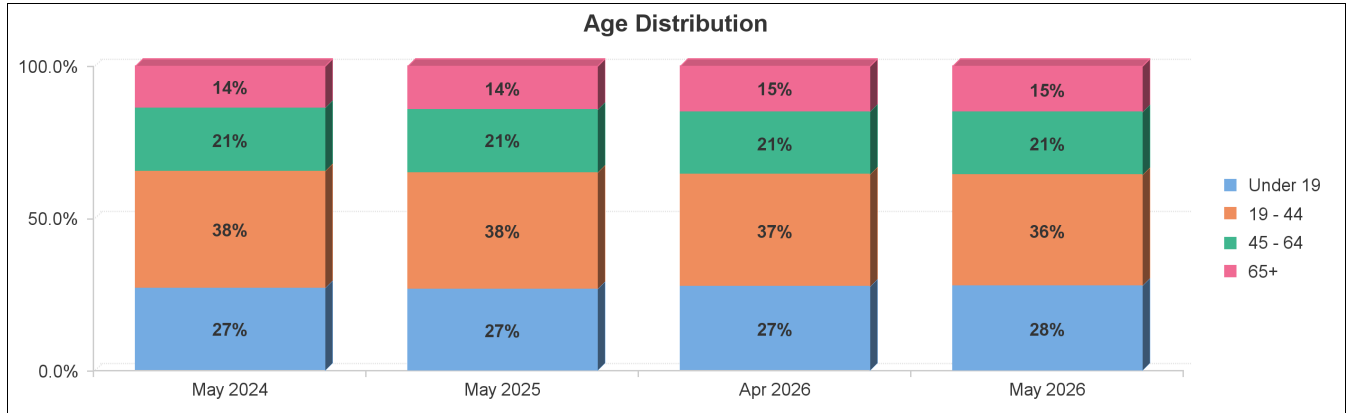
Network Trend											
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2024	May 2025	Apr 2026	May 2026	May 2024	May 2025	Apr 2026	May 2026	May 2024 to May 2025	May 2025 to May 2026	Apr 2026 to May 2026
Independent (Direct)	88,381	94,112	87,505	87,006	21.8%	23.0%	23.0%	23.2%	6.1%	-8.3%	-0.6%
AHS (Direct)	91,118	90,751	81,999	78,604	22.5%	22.2%	21.6%	21.0%	-0.4%	-15.5%	-4.3%
CFMG	44,083	43,866	40,453	40,238	10.9%	10.7%	10.6%	10.7%	-0.5%	-9.0%	-0.5%
CHCN	181,761	180,700	170,434	169,157	44.8%	44.1%	44.8%	45.1%	-0.6%	-6.9%	-0.8%
KAISER	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	405,343	409,429	380,391	375,005	100.0%	100.0%	100.0%	100.0%	1.0%	-9.3%	-1.4%



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

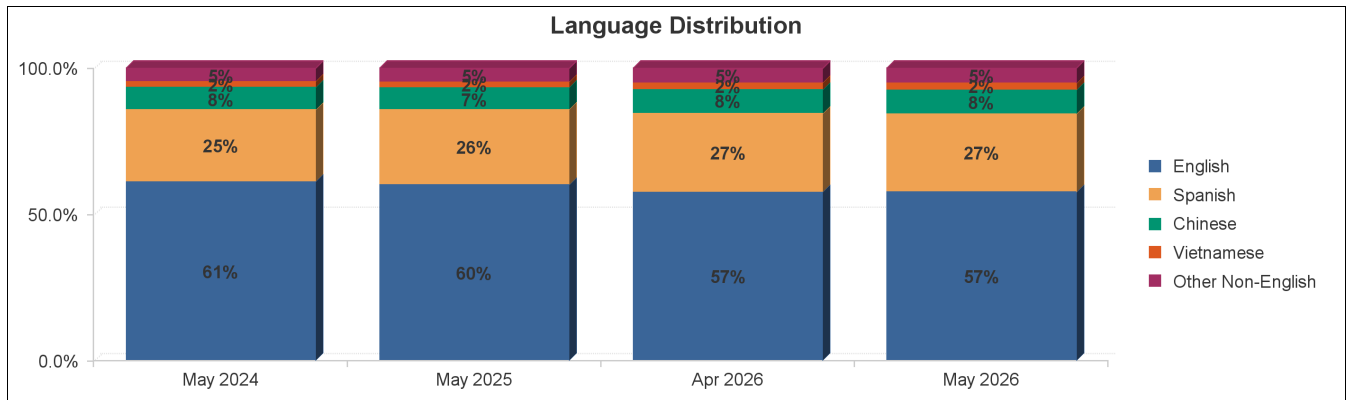
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	May 2024	May 2025	Apr 2026	May 2026	May 2024	May 2025	Apr 2026	May 2026	May 2024 to May 2025	May 2025 to May 2026	Apr 2026 to May 2026
Under 19	108,994	109,093	104,534	103,989	27%	27%	27%	28%	0%	-5%	-1%
19 - 44	155,914	156,608	139,860	136,512	38%	38%	37%	36%	0%	-15%	-2%
45 - 64	84,121	84,588	78,293	77,090	21%	21%	21%	21%	1%	-10%	-2%
65+	56,314	59,140	57,473	57,169	14%	14%	15%	15%	5%	-3%	-1%
Total	405,343	409,429	380,160	374,760	100%	100%	100%	100%	1%	-9%	-1%



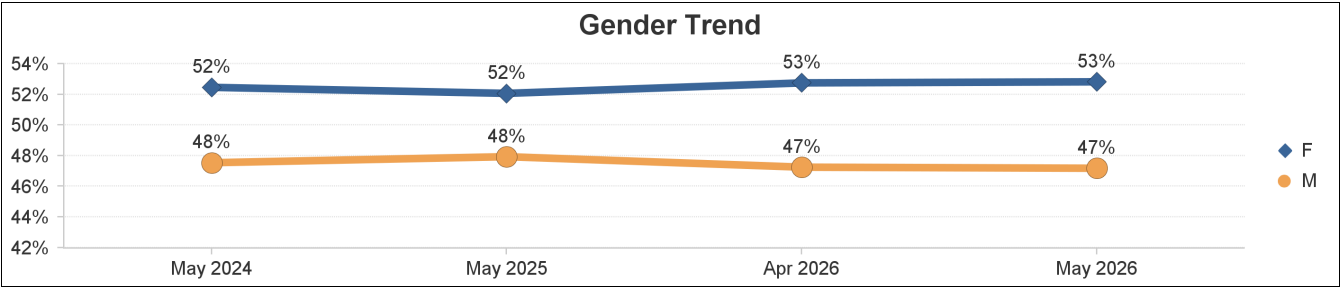
Language Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	May 2024	May 2025	Apr 2026	May 2026	May 2024	May 2025	Apr 2026	May 2026	May 2024 to May 2025	May 2025 to May 2026	Apr 2026 to May 2026
English	247,134	245,363	218,138	215,572	61%	60%	57%	57%	-1%	-14%	-1%
Spanish	99,964	105,584	102,453	100,122	25%	26%	27%	27%	5%	-5%	-2%
Chinese	30,741	30,483	30,854	30,532	8%	7%	8%	8%	-1%	0%	-1%
Vietnamese	8,461	8,131	8,730	8,689	2%	2%	2%	2%	-4%	6%	0%
Other Non-English	19,043	19,868	19,985	19,845	5%	5%	5%	5%	4%	0%	-1%
Total	405,343	409,429	380,160	374,760	100%	100%	100%	100%	1%	-9%	-1%

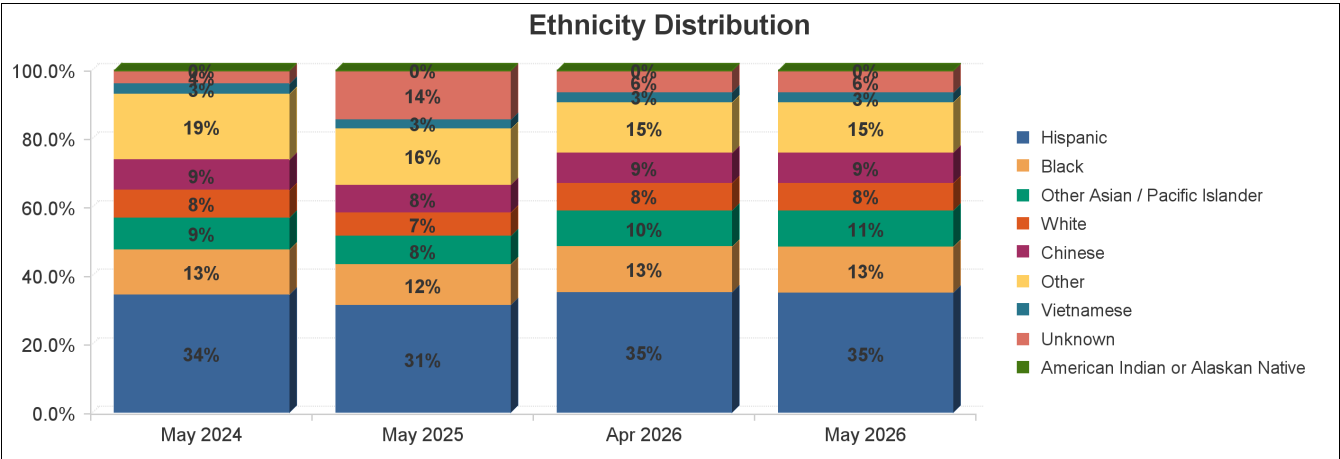


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Gender Trend											
Gender	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2024	May 2025	Apr 2026	May 2026	May 2024	May 2025	Apr 2026	May 2026	May 2024 to May 2025	May 2025 to May 2026	Apr 2026 to May 2026
F	212,650	213,172	200,666	198,088	52%	52%	53%	53%	0%	-8%	-1%
M	192,693	196,257	179,725	176,917	48%	48%	47%	47%	2%	-11%	-2%
Total	405,343	409,429	380,391	375,005	100%	100%	100%	100%	1%	-9%	-1%



Ethnicity Trend											
Ethnicity	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2024	May 2025	Apr 2026	May 2026	May 2024	May 2025	Apr 2026	May 2026	May 2024 to May 2025	May 2025 to May 2026	Apr 2026 to May 2026
Hispanic	139,254	128,260	133,496	131,004	34%	31%	35%	35%	-9%	2%	-2%
Black	53,353	48,641	50,764	50,300	13%	12%	13%	13%	-10%	3%	-1%
Other Asian / Pacific Islander	37,596	33,892	39,738	39,472	9%	8%	10%	11%	-11%	14%	-1%
White	32,881	28,217	30,622	30,366	8%	7%	8%	8%	-17%	7%	-1%
Chinese	35,951	32,710	33,486	33,098	9%	8%	9%	9%	-10%	1%	-1%
Other	77,966	67,243	56,149	54,939	19%	16%	15%	15%	-16%	-22%	-2%
Vietnamese	11,993	10,702	10,863	10,768	3%	3%	3%	3%	-12%	1%	-1%
Unknown	15,550	59,045	24,531	24,326	4%	14%	6%	6%	74%	-143%	-1%
American Indian or Alaskan Native	799	719	742	732	0%	0%	0%	0%	-11%	2%	-1%
Total	405,343	409,429	380,391	375,005	100%	100%	100%	100%	1%	-9%	-1%



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

Medi-Cal By City						
City	May 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	146,030	40%	21,943	37,123	15,817	71,147
HAYWARD	47,464	13%	11,252	12,508	5,294	18,410
FREMONT	35,353	10%	15,114	5,608	1,909	12,722
SAN LEANDRO	23,167	6%	6,214	3,669	2,907	10,377
UNION CITY	13,327	4%	5,426	2,227	753	4,921
ALAMEDA	12,832	3%	3,185	2,317	1,988	5,342
BERKELEY	15,133	4%	3,259	2,441	1,674	7,759
LIVERMORE	12,146	3%	1,977	334	1,972	7,863
NEWARK	8,409	2%	2,705	3,257	433	2,014
CASTRO VALLEY	10,400	3%	3,050	1,541	1,639	4,170
SAN LORENZO	5,565	2%	1,161	1,248	649	2,507
PLEASANTON	7,487	2%	2,256	269	797	4,165
DUBLIN	7,333	2%	2,473	275	863	3,722
EMERYVILLE	2,898	1%	546	626	511	1,215
ALBANY	2,386	1%	451	276	539	1,120
PIEDMONT	407	0%	82	150	61	114
SUNOL	87	0%	32	9	6	40
ANTIOCH	29	0%	9	6	5	9
Other	17,996	5%	3,517	3,552	2,421	8,506
Total	368,449	100%	84,652	77,436	40,238	166,123

Group Care By City						
City	May 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,878	30%	336	427	0	1,115
HAYWARD	724	11%	342	189	0	193
FREMONT	719	11%	447	85	0	187
SAN LEANDRO	688	11%	274	105	0	309
UNION CITY	294	5%	174	51	0	69
ALAMEDA	327	5%	96	40	0	191
BERKELEY	163	3%	41	16	0	106
LIVERMORE	102	2%	29	1	0	72
NEWARK	158	3%	91	38	0	29
CASTRO VALLEY	230	4%	97	33	0	100
SAN LORENZO	180	3%	57	42	0	81
PLEASANTON	80	1%	28	4	0	48
DUBLIN	136	2%	48	7	0	81
EMERYVILLE	43	1%	9	8	0	26
ALBANY	27	0%	10	3	0	14
PIEDMONT	4	0%	0	1	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	7	5	0	12
Other	533	8%	190	89	0	254
Total	6,311	100%	2,277	1,144	0	2,890

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

D-SNP By City						
City	May 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	94	38%	18	9	0	67
HAYWARD	30	12%	12	2	0	16
FREMONT	19	8%	10	1	0	8
SAN LEANDRO	17	7%	6	5	0	6
UNION CITY	3	1%	1	0	0	2
ALAMEDA	17	7%	4	4	0	9
BERKELEY	15	6%	1	0	0	14
LIVERMORE	12	5%	2	1	0	9
NEWARK	6	2%	6	0	0	0
CASTRO VALLEY	3	1%	2	1	0	0
SAN LORENZO	5	2%	3	0	0	2
PLEASANTON	5	2%	3	0	0	2
DUBLIN	6	2%	2	0	0	4
EMERYVILLE	2	1%	1	0	0	1
ALBANY	0	0%	0	0	0	0
PIEDMONT	0	0%	0	0	0	0
SUNOL	0	0%	0	0	0	0
ANTIOCH	0	0%	0	0	0	0
Other	11	4%	6	1	0	4
Sum:			2,277	1,144	0	2,890

Total By City						
City	May 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	147,908	39%	22,279	37,550	15,817	72,262
HAYWARD	48,188	13%	11,594	12,697	5,294	18,603
FREMONT	36,072	10%	15,561	5,693	1,909	12,909
SAN LEANDRO	23,855	6%	6,488	3,774	2,907	10,686
UNION CITY	13,621	4%	5,600	2,278	753	4,990
ALAMEDA	13,159	4%	3,281	2,357	1,988	5,533
BERKELEY	15,296	4%	3,300	2,457	1,674	7,865
LIVERMORE	12,248	3%	2,006	335	1,972	7,935
NEWARK	8,567	2%	2,796	3,295	433	2,043
CASTRO VALLEY	10,630	3%	3,147	1,574	1,639	4,270
SAN LORENZO	5,745	2%	1,218	1,290	649	2,588
PLEASANTON	7,567	2%	2,284	273	797	4,213
DUBLIN	7,469	2%	2,521	282	863	3,803
EMERYVILLE	2,941	1%	555	634	511	1,241
ALBANY	2,413	1%	461	279	539	1,134
PIEDMONT	411	0%	82	151	61	117
SUNOL	88	0%	33	9	6	40

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

ANTIOCH	53	0%	16	11	5	21
Other	18,529	5%	3,707	3,641	2,421	8,760
Total	374,760	100%	86,929	78,580	40,238	169,013

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

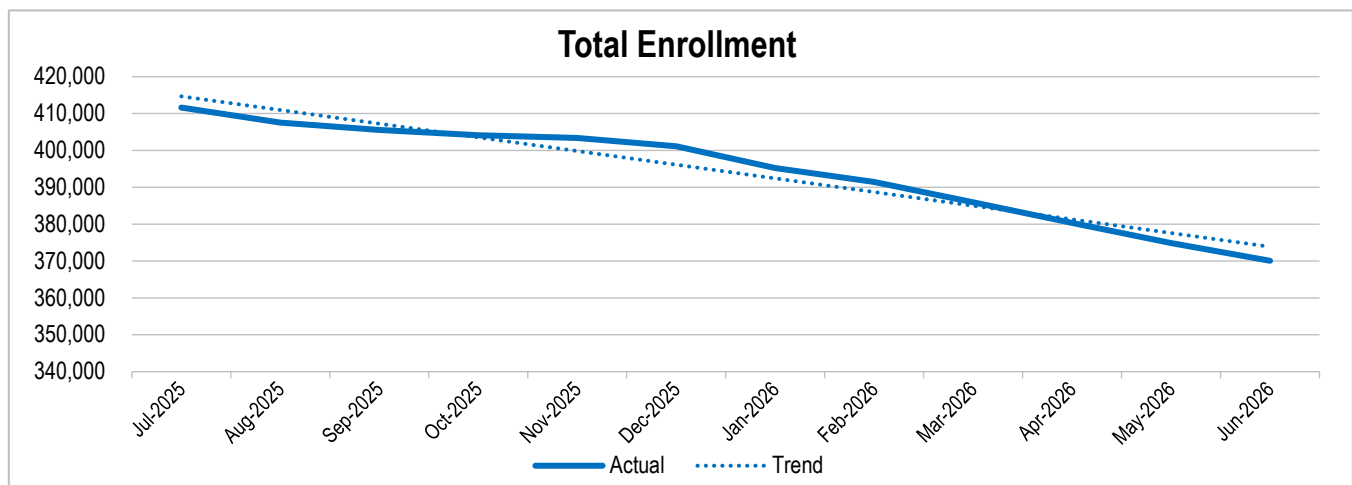
Date: August 14th, 2026

Subject: Finance Report – June 2026 Financials

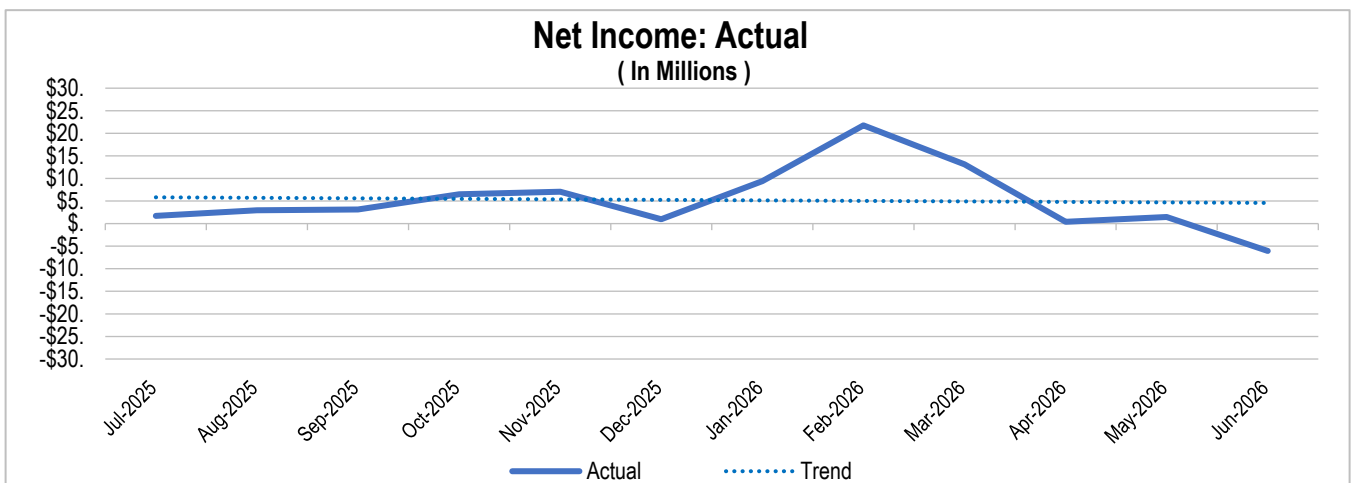
Executive Summary

For the month of June, the Alliance decreased in enrollment, down to 370,073 members. Net Loss of \$6.1 million was reported, and the Plan's Medical Expenses represented 97.2% of Premium Revenue. Alliance reserves increased to 291% of required and continue to remain above minimum requirements.

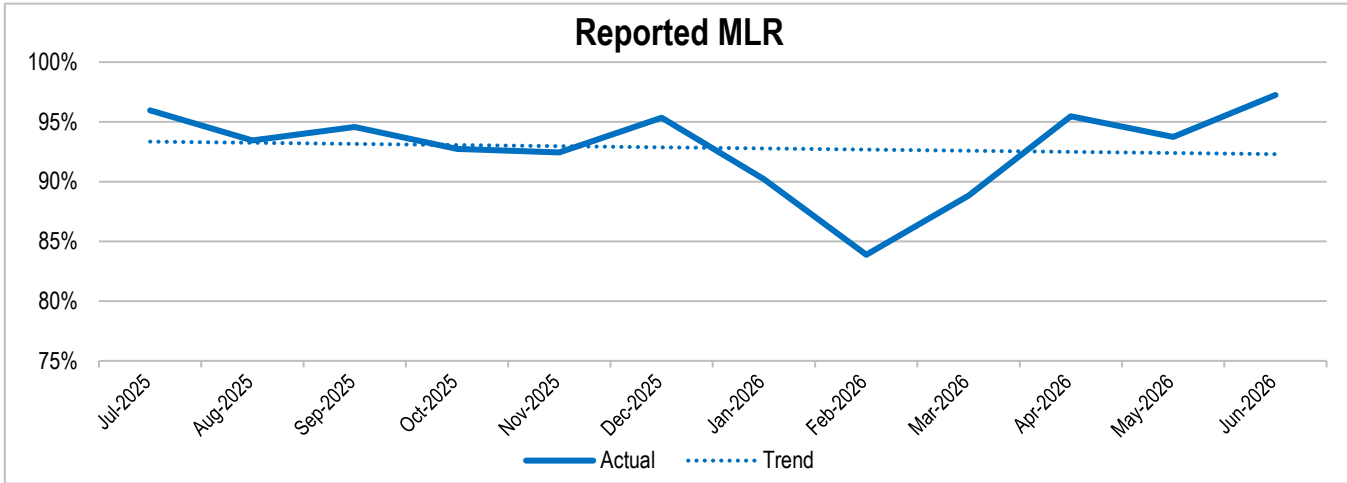
Enrollment – In June, Enrollment decreased by 4,813 members.



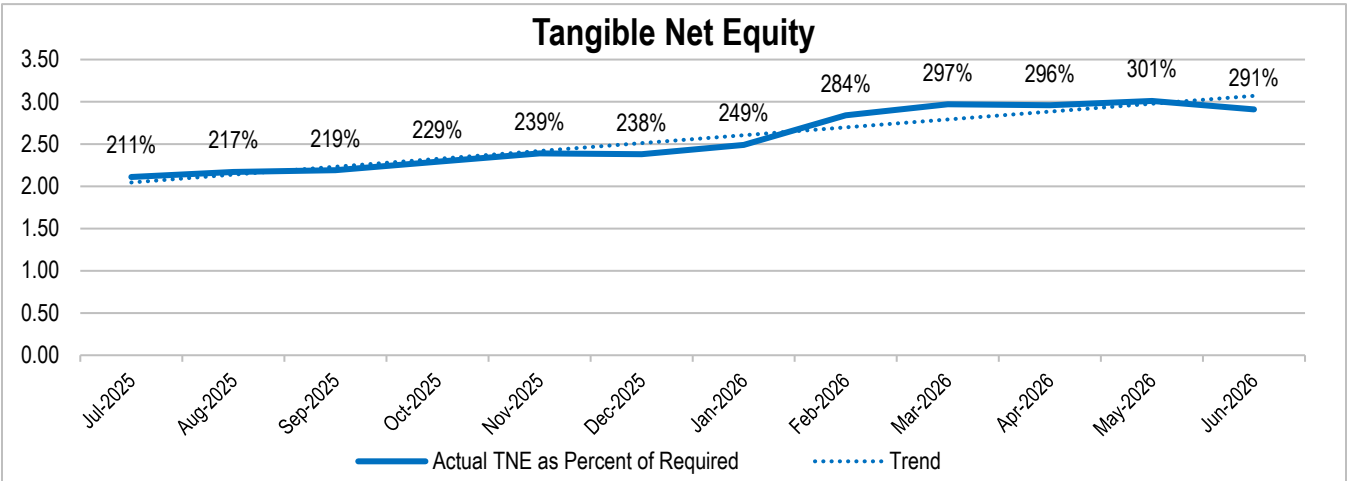
Net Income – For the month ended June, actual Net Loss was \$6.1 million vs. budgeted Net Income of \$913,000. For the fiscal YTD, actual Net Income was \$62.4 million vs. budgeted Net Income of \$21.0 million. For the month, Premium Revenue was favorable to budget, actual Revenue was \$190.6 million vs. budgeted Revenue of \$179.0 million. Premium Revenue favorable variance of \$11.6 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 97.2% for the month, and 92.8% for fiscal YTD.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required \$79.7 million in reserves, we reported \$231.7 million. Our overall TNE remains above DMHC requirements at 291%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, investments show a gain of \$29.5 million and capital assets acquired are \$51,000.

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: August 14th, 2026

Subject: Finance Report – June 2026

Executive Summary

- For the month ended June 30th, 2026, the Alliance had enrollment of 370,073 members, a Net Loss of \$6.1 million and 291% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)		
	Month	YTD
Revenue	\$252,673	\$3,046,062
Medical Expense	185,402	2,111,813
Admin. Expense	13,551	130,537
MCO Tax Expense	62,026	770,748
Other Inc. / (Exp.)	2,250	29,458
Net Income	(\$6,055)	\$62,421

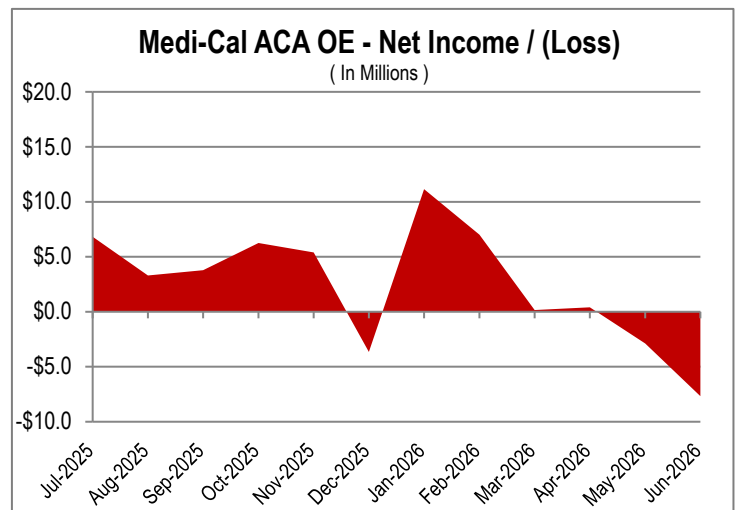
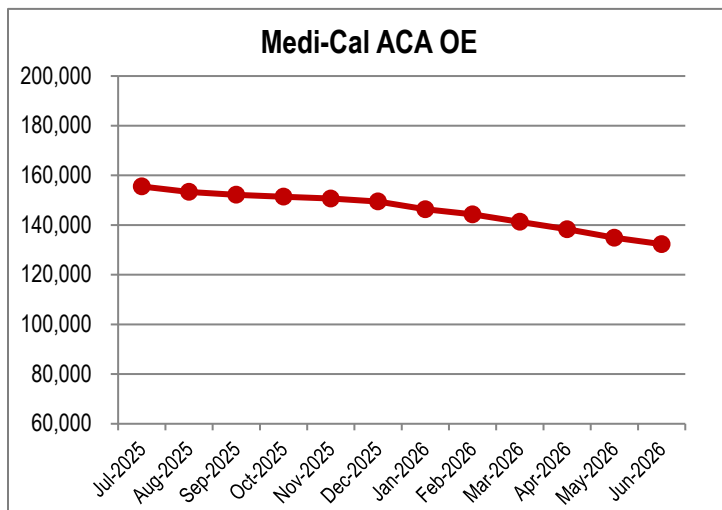
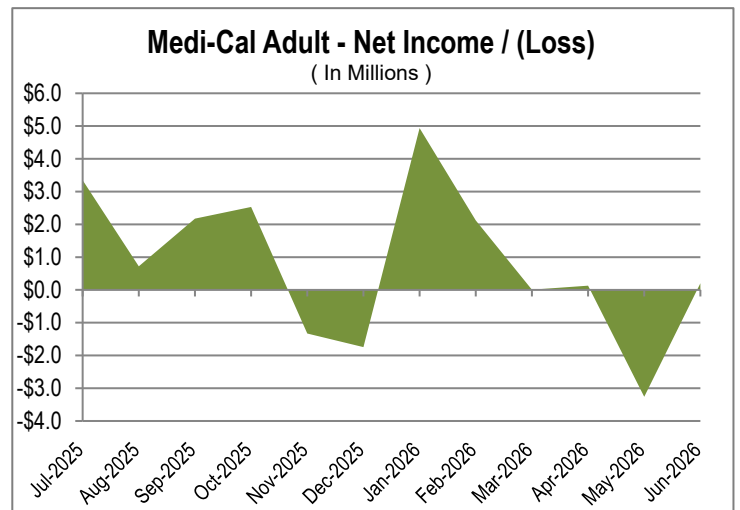
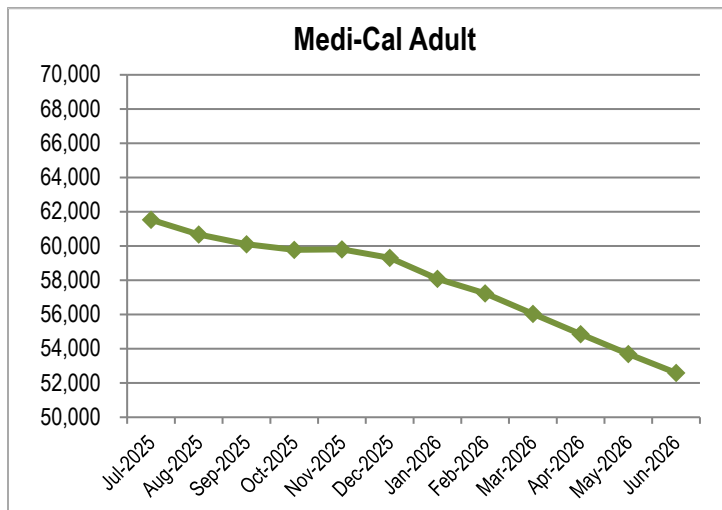
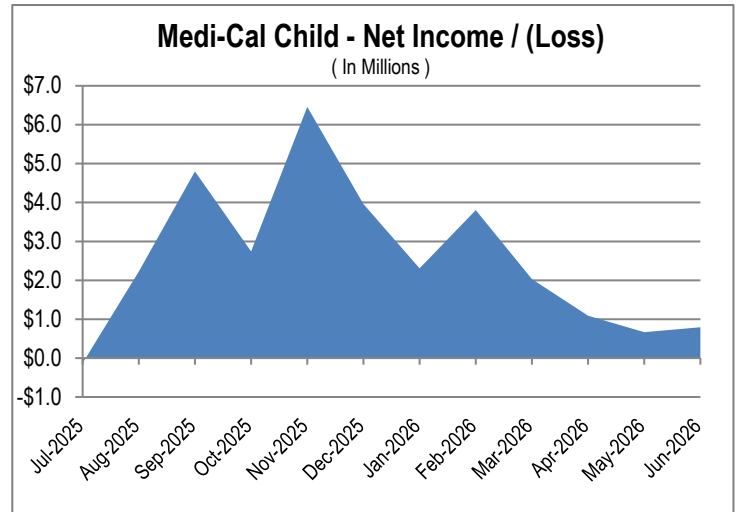
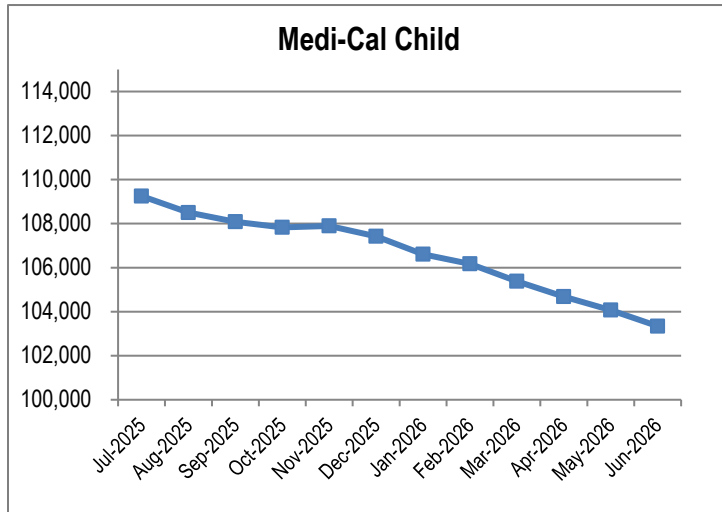
Net Income by Program: (in Thousands)		
	Month	YTD
Medi-Cal	(\$4,669)	\$78,130
Group Care	(527)	(4,654)
Medicare	(860)	(11,056)
	(\$6,055)	\$62,421

Enrollment

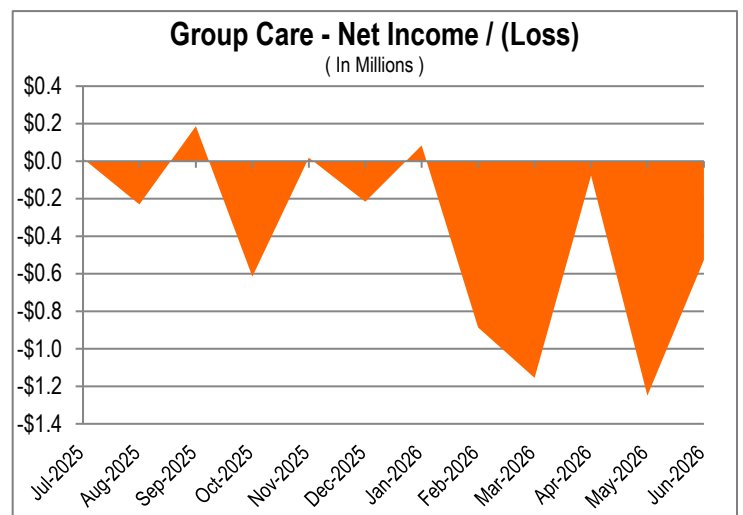
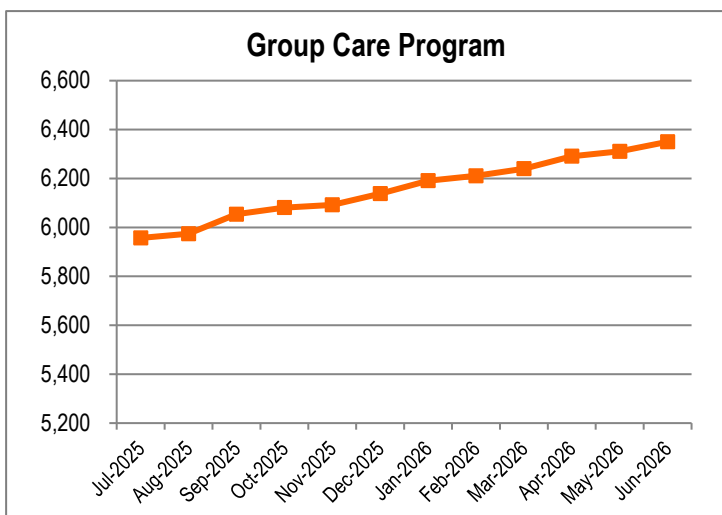
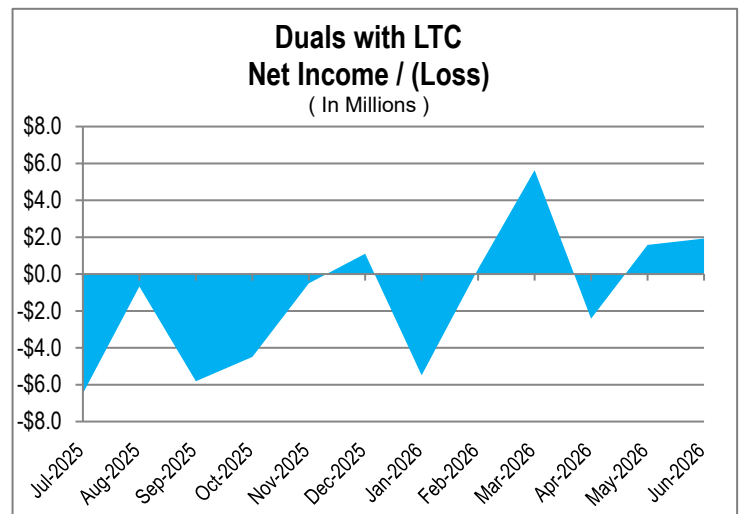
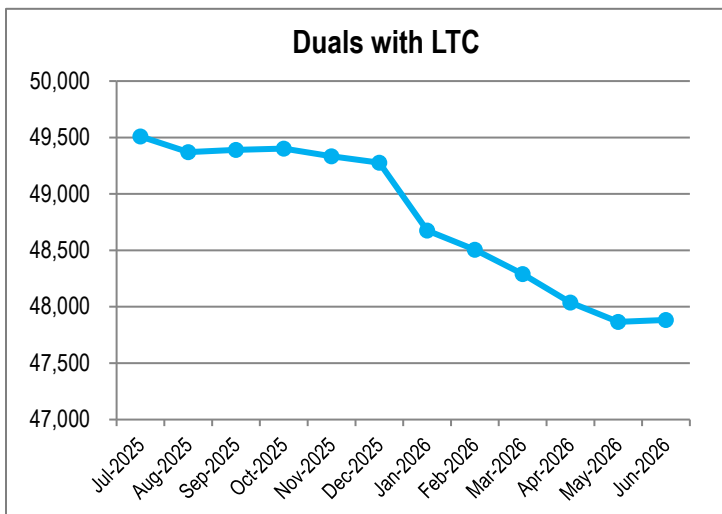
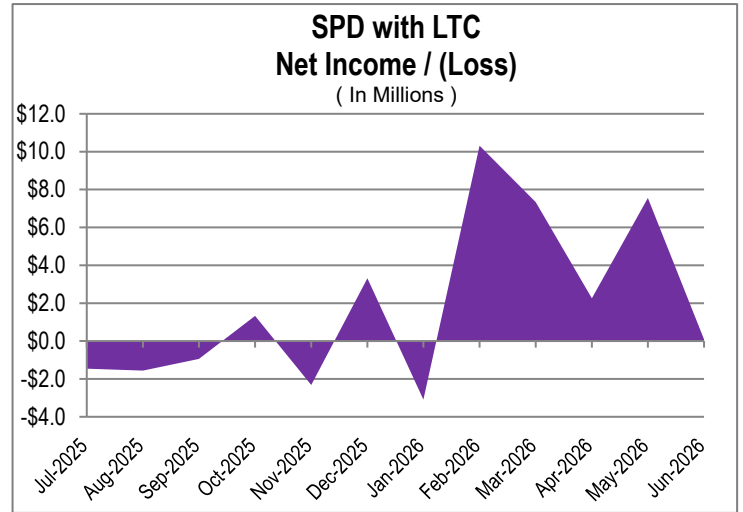
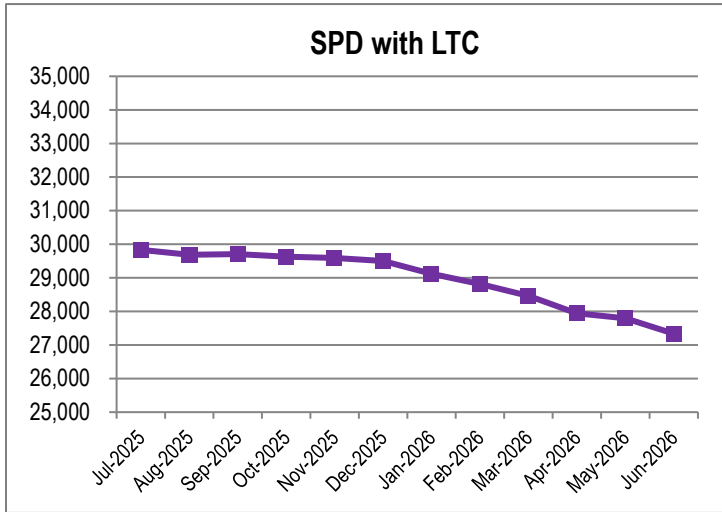
- Total enrollment decreased by 4,813 members since May 2026.
- Total enrollment decreased by 41,310 members since June 2025.

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 %
103,343	103,439	(96)	(0.1%)		Child	1,279,251	1,277,808	1,443
52,592	54,167	(1,575)	(2.9%)	Adult	693,728	696,514	(2,786)	(0.4%)
132,315	128,840	3,475	2.7%	ACA OE	1,750,128	1,735,352	14,776	0.9%
27,337	21,100	6,237	29.6%	SPD with LTC	347,416	306,613	40,803	13.3%
47,883	55,850	(7,967)	(14.3%)	Duals with LTC	585,540	632,890	(47,350)	(7.5%)
363,470	363,396	74	0.0%	Medi-Cal Total	4,656,063	4,649,177	6,886	0.1%
6,350	6,109	241	3.9%	Group Care	73,890	72,794	1,096	1.5%
253	825	(572)	(69.3%)	Medicare	1,302	3,275	(1,973)	(60.2%)
370,073	370,330	(257)	(0.1%)	Total	4,731,255	4,725,246	6,009	0.1%

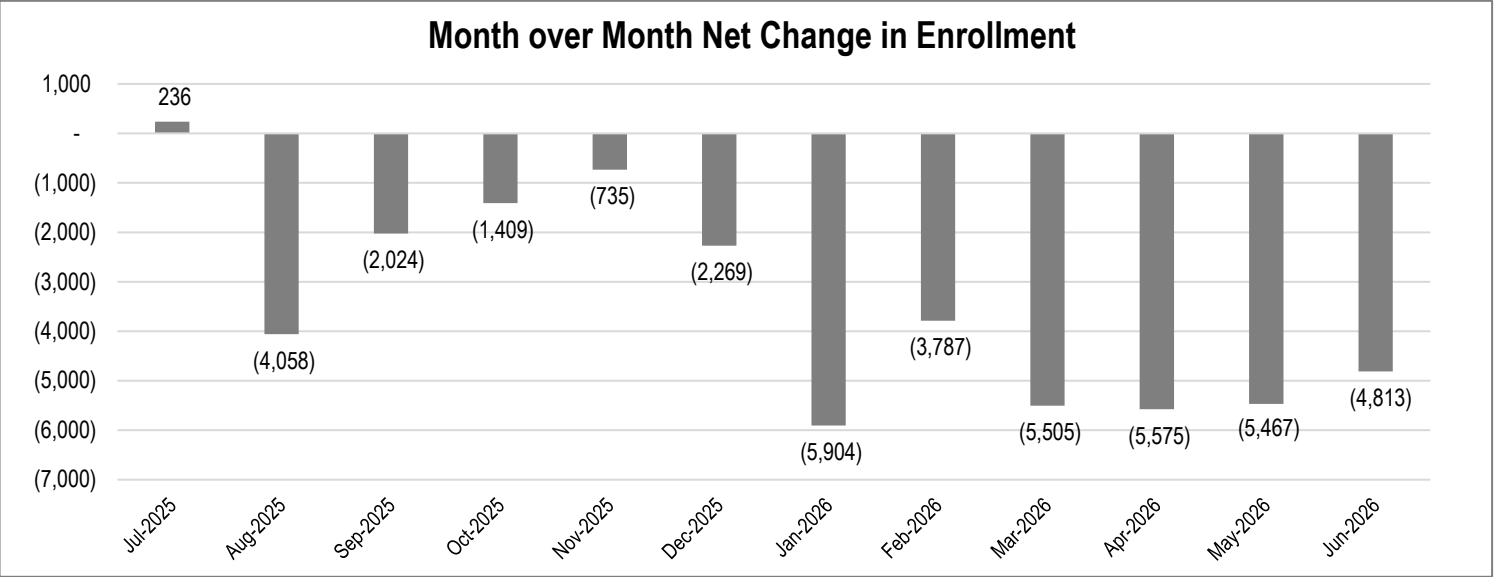
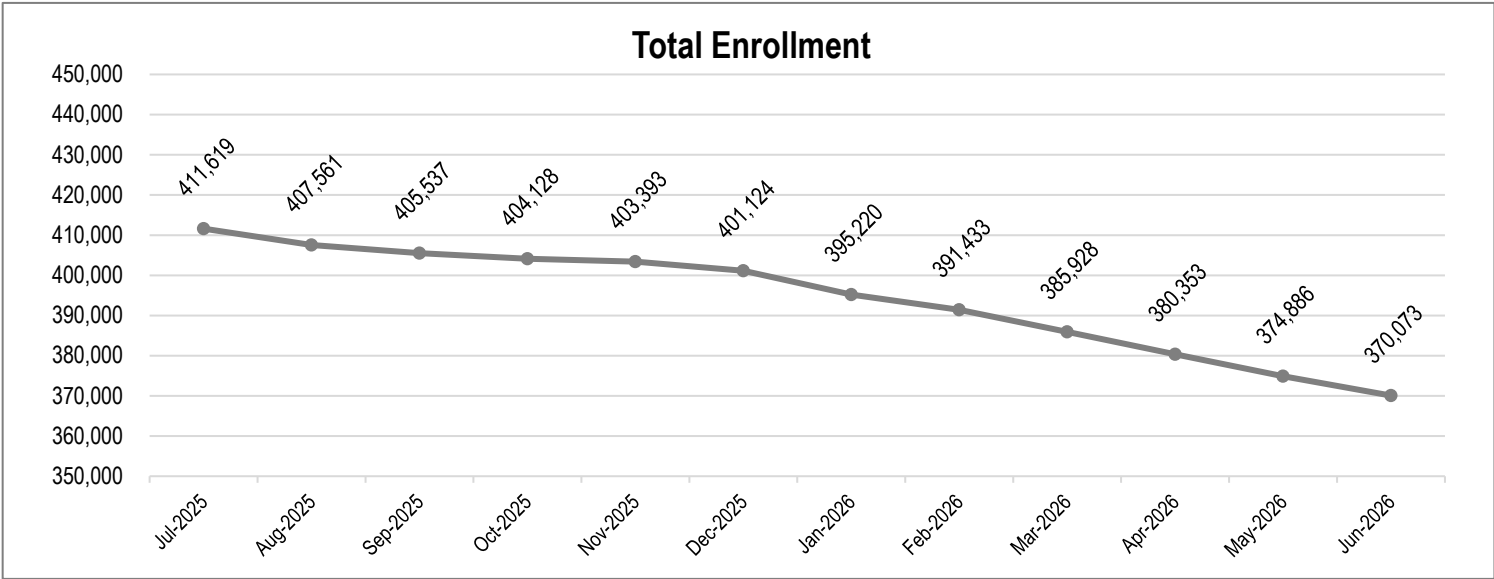
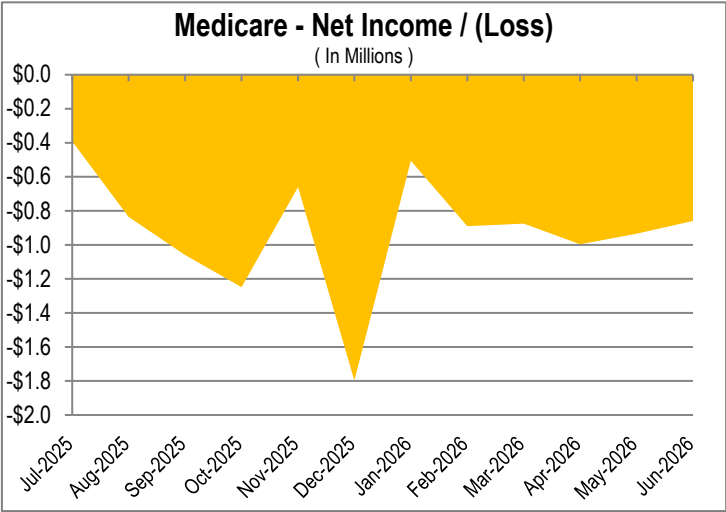
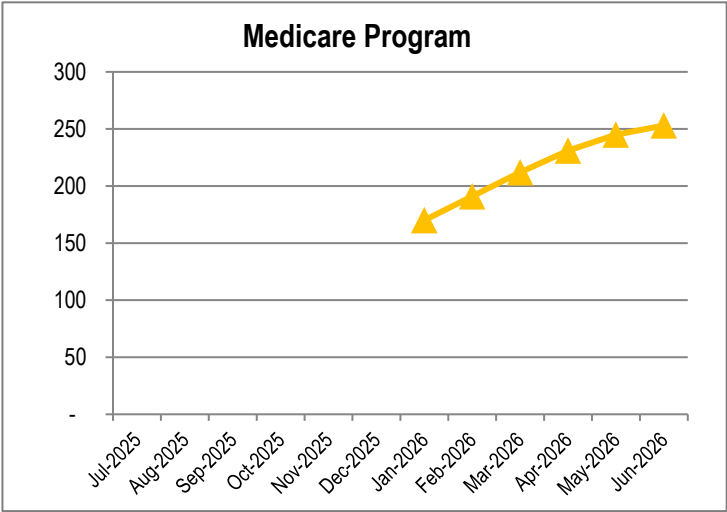
Enrollment and Profitability by Program and Category of Aid



Enrollment and Profitability by Program and Category of Aid

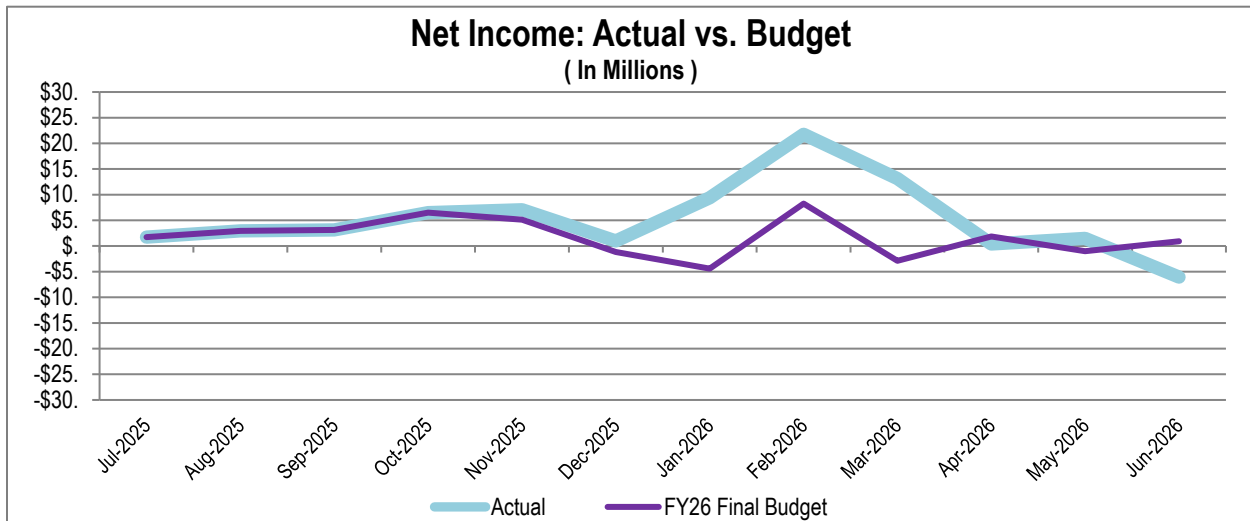


Enrollment and Profitability by Program and Category of Aid



Net Income

- For the month ended June 30th, 2026:
 - Actual Net Loss: \$6.1 million.
 - Budgeted Net Income: \$913,000.
- For the fiscal YTD ended June 30th, 2026:
 - Actual Net Income \$62.4 million.
 - Budgeted Net Income \$21.0 million.

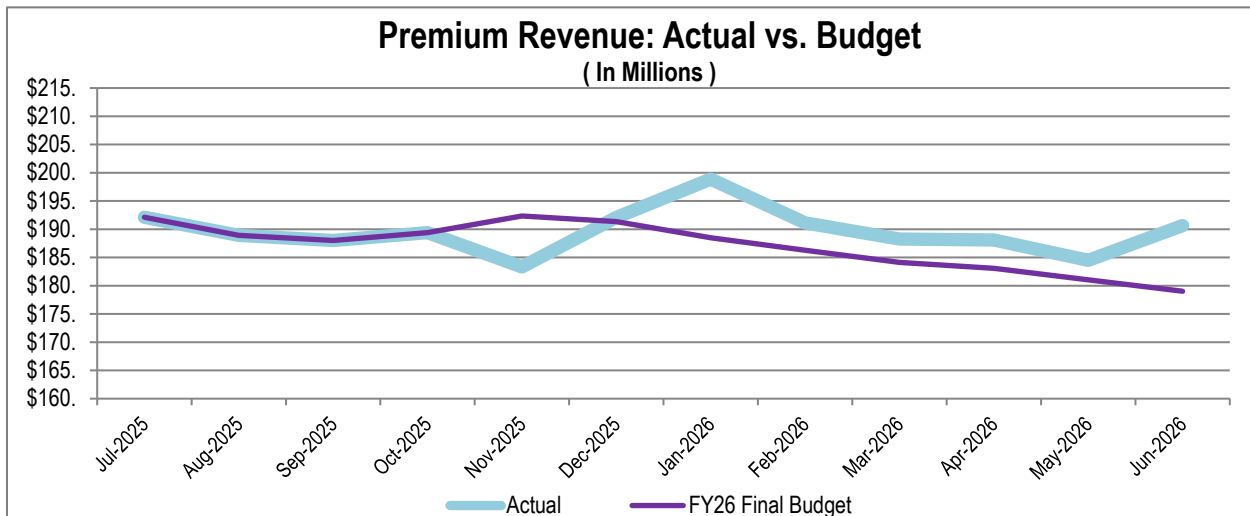


The unfavorable variance of \$7.0 million in the current month is primarily due to:

- Unfavorable \$15.6 million higher than anticipated Medical Expense.
- Unfavorable \$2.3 million higher than anticipated Administrative Expense.
- Favorable \$11.6 million higher than anticipated Premium Revenue.

Premium Revenue

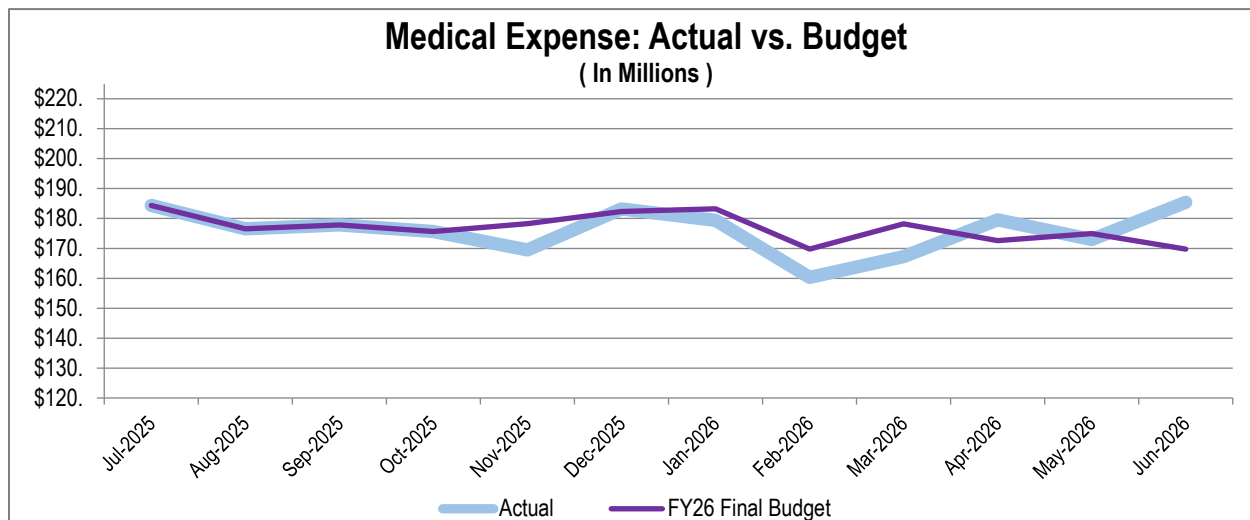
- For the month ended June 30th, 2026:
 - Actual Revenue: \$190.6 million.
 - Budgeted Revenue: \$179.0 million.
- For the fiscal YTD ended June 30th, 2026:
 - Actual Revenue: \$2.3 billion.
 - Budgeted Revenue: \$2.2 billion.



- For the month ended June 30th, 2026, the favorable Premium Revenue variance of \$11.6 million is primarily due to favorable \$4.9 million Medi-Cal and IHSS volume variance for June 2026 which includes favorable \$6.2 million budgeted Medicare Part A “buy-in” for June 2026 that did not occur, and favorable \$4.9 million retroactive membership for January 2024 through April 2026. This was partially offset by an unfavorable \$900,000 Medicare revenue for June 2026 and \$1.0 million for the May 2026 True-up.

Medical Expense

- For the month ended June 30th, 2026:
 - Actual Medical Expense: \$185.4 million.
 - Budgeted Medical Expense: \$169.8 million.
- For the fiscal YTD ended June 30th, 2026:
 - Actual Medical Expense: \$2.1 billion.
 - Budgeted Medical Expense: \$2.1 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 June, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by \$2.8 million. Year to date, the estimate for prior years decreased by \$14.0 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)						
Adjusted to Eliminate the Impact of Prior Period IBNP Estimates						
	Actual			Budget	Variance: Actual Adjusted vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical Expense	\$210,272,365	\$0	\$210,272,365	\$205,891,087	(\$4,381,278)	-2.1%
Primary Care FFS	41,585,756	11,371,395	52,957,151	57,563,194	15,977,438	27.8%
Specialty Care FFS	98,144,634	2,014,027	100,158,660	100,781,048	2,636,414	2.6%
Outpatient FFS	152,621,248	(121,073)	152,500,175	154,220,671	1,599,424	1.0%
Ancillary FFS	256,738,442	2,910,600	259,649,043	242,489,161	(14,249,281)	-5.9%
Pharmacy FFS	165,722,689	(6,741,225)	158,981,465	133,492,223	(32,230,466)	-24.1%
ER Services FFS	127,725,273	268,339	127,993,611	123,011,622	(4,713,651)	-3.8%
Inpatient Hospital FFS	591,999,588	(14,870,395)	577,129,193	580,612,309	(11,387,279)	-2.0%
Long Term Care & SNF FFS	422,032,672	(8,791,503)	413,241,169	459,758,083	37,725,411	8.2%
Other Benefits & Services	48,388,559	0	48,388,559	53,967,660	5,579,101	10.3%
Net Reinsurance	(357,219)	0	(357,219)	3,772,688	4,129,907	109.5%
Provider Incentive	10,899,099	0	10,899,099	7,859,099	(3,040,000)	-38.7%
	\$2,125,773,105	(\$13,959,836)	\$2,111,813,269	\$2,123,418,845	(\$2,354,260)	-0.1%

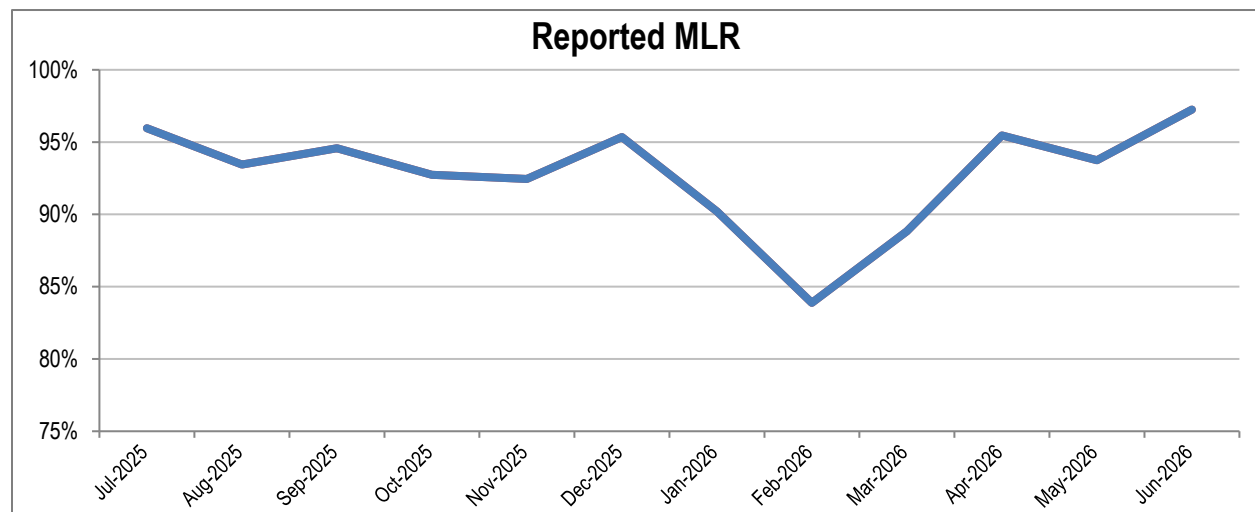
Medical Expense - Actual vs. Budget (Per Member Per Month)						
Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance: Actual Adjusted vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical Expense	\$44.44	0.00	\$44.44	\$43.57	(\$0.87)	-2.0%
Primary Care FFS	\$8.79	2.40	\$11.19	\$12.18	\$3.39	27.8%
Specialty Care FFS	\$20.74	0.43	\$21.17	\$21.33	\$0.58	2.7%
Outpatient FFS	\$32.26	(0.03)	\$32.23	\$32.64	\$0.38	1.2%
Ancillary FFS	\$54.26	0.62	\$54.88	\$51.32	(\$2.95)	-5.7%
Pharmacy FFS	\$35.03	(1.42)	\$33.60	\$28.25	(\$6.78)	-24.0%
ER Services FFS	\$27.00	0.06	\$27.05	\$26.03	(\$0.96)	-3.7%
Inpatient Hospital & SNF FFS	\$125.13	(3.14)	\$121.98	\$122.87	(\$2.25)	-1.8%
Long Term Care & SNF FFS	\$89.20	(1.86)	\$87.34	\$97.30	\$8.10	8.3%
Other Benefits & Services	\$10.23	0.00	\$10.23	\$11.42	\$1.19	10.5%
Net Reinsurance	(\$0.08)	0.00	(\$0.08)	\$0.80	\$0.87	109.5%
Provider Incentive	\$2.30	0.00	\$2.30	\$1.66	(\$0.64)	-38.5%
	\$449.30	(\$2.95)	\$446.35	\$449.38	\$0.07	0.0%

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is \$2.4 million unfavorable to budget. On a PMPM basis, medical expense is neutral to budget. For per-member-per-month expense:
 - Capitated Expense is over budget, primarily driven by unfavorable PCP Capitation FQHC expense.
 - Primary Care Expense is under budget due to TRI reclassifications across all populations except for Group Care and Medicare.

- Specialty Care Expense is under budget, driven by low unit cost and flat utilization.
- Outpatient Expense is under budget due to lower dialysis unit cost and utilization.
- Ancillary Expense is over budget due to higher utilization in the Child and ACA OE aid code categories.
- Pharmacy Expense is over budget, driven by prior period expense related to overpayments made to UCSF last fiscal year and higher unit cost in the current budget period. The offsetting accruals for the recoveries were already made in a prior accounting period.
- Emergency Expense is over budget, driven by higher utilization and unit cost in the SPD with LTC and the Duals with LTC Duals aid codes categories.
- Inpatient Expense is over budget, driven by higher utilization and unit cost in the Adult, Child, and SPD with LTC aid code categories.
- Long Term Care Expense is under budget, driven by lower utilization in the SPD with LTC and Duals with LTC Duals aid code categories.
- Other Benefits & Services is under budget, due to lower-than-expected Employee, Interpreter, Professional Services, Nurseline costs, Community Reinvestment and Relations, Licenses, Subscriptions, Dues and Permits expense.
- Net Reinsurance is under budget because more recoveries were received than expected.
- Provider Incentive is over budget, due to timing and accruals.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported Medical Expense divided by Premium Revenue) was 97.2% for the month and 92.8% for the fiscal year-to-date.



Administrative Expense

- For the month ended June 30th, 2026:
 - Actual Administrative Expense: \$13.6 million.
 - Budgeted Administrative Expense: \$11.2 million.
- For the fiscal YTD ended June 30th, 2026:
 - Actual Administrative Expense: \$130.5 million.
 - Budgeted Administrative Expense: \$132.9 million.

Summary of Administrative Expense (In Dollars)									
For the Month and Fiscal Year-to-Date									
Favorable/(Unfavorable)									
Current Month					Year-to-Date				
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %	
\$5,837,338	\$6,910,589	\$1,073,251	15.5%		Personnel Expense	\$80,989,913	\$81,316,375	\$326,462	0.4%
93,067	94,156	1,090	1.2%		Medical Benefits Admin Expense	925,284	1,135,912	210,627	18.5%
5,228,231	2,601,044	(2,627,187)	(101.0%)		Purchased & Professional Services	28,866,000	29,609,283	743,283	2.5%
2,392,848	1,596,683	(796,165)	(49.9%)	Other Admin Expense	19,756,169	20,811,675	1,055,506	5.1%	
\$13,551,484	\$11,202,472	(\$2,349,012)	(21.0%)	Total Administrative Expense	\$130,537,366	\$132,873,244	\$2,335,879	1.8%	

The year-to-date variances include:

- Licenses, Insurance & Fees primarily due to favorable licenses and regulatory penalties, bank fees, insurance and subscriptions.
- Favorable Supplies and Other expenses primarily due to new account: Community Reinvestment Expense, formerly captured under Printing, Postage & Promotions.
- Other Purchases & Fees are favorable primarily due to favorable costs in Supplies, Commissary, Member Incentives and Miscellaneous activities.
- Favorable in Purchased & Professional Services, primarily due to Consultant Fees and Purchased Services, Hardware Purchases, Legal Fees, and Other Expenses.
- Employee Expense is favorable for an accrual for the workforce adjustment.
- Favorable Benefit Administration Expense, primarily for the decreases in Behavioral Health Administration Fees, M3P fees, and Pharmacy Admin Fees.
- Partially offset by unfavorable Building Occupancy costs due to SBITA Amortization.
- Partially offset by unfavorable Provider Interest Fees across lines of business including IHSS and MCAL.
- Partially offset by unfavorable Printing/Postage/Promotions, result of the realignment of Reinvestment Expenses now covered under Other Expense (above) affecting Community Reinvestment now under Supplies and Other Expenses.
- Partially offset by unfavorable Translation Services, Provider Credentialing, IT Software Licenses/Subscriptions, and HMS Recovery Fees.

The Administrative Loss Ratio (ALR) is 7.1% of net revenue for the month and 5.7% 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 \$4.1 million.

Other Income / (Expense)

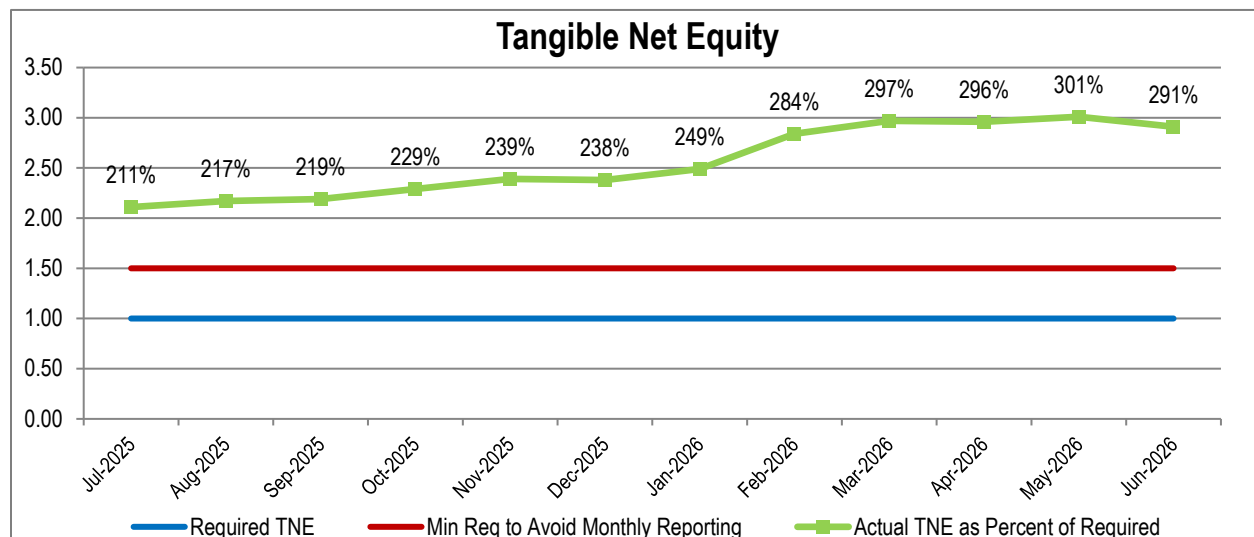
Other Income & Expense is comprised primarily of investment income. Fiscal year-to-date net investments show a gain of \$29.5 million.

Managed Care Organization (MCO) Provider Tax

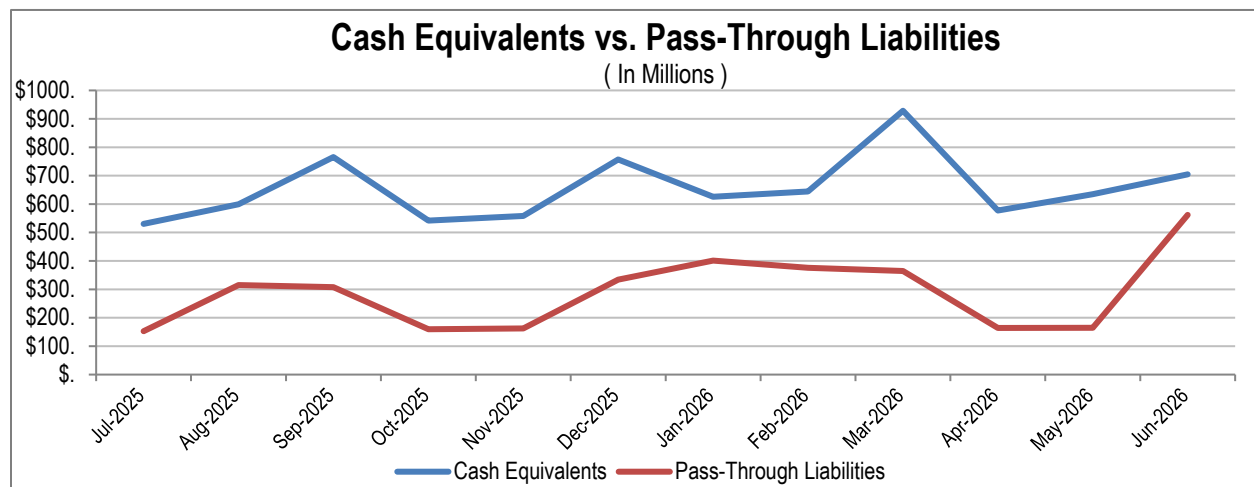
- Revenue:
 - For the month ended June 30th, 2026:
 - Actual: \$62.0 million.
 - Budgeted: \$58.7 million.
 - For the fiscal YTD ended June 30th, 2026:
 - Actual: \$770.7 million.
 - Budgeted: \$751.6 million.
- Expense:
 - For the month ended June 30th, 2026:
 - Actual: \$62.0 million.
 - Budgeted: \$58.7 million.
 - For the fiscal YTD ended June 30th, 2026:
 - Actual: \$770.7 million.
 - Budgeted: \$751.6 million.

Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus total liabilities divided by a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
 - Required TNE \$79.7 million
 - Actual TNE \$231.7 million
 - Excess TNE \$152.0 million
 - TNE % of Required TNE 291%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics:
 - Cash & Cash Equivalents \$704.6 million
 - Pass-Through Liabilities \$562.0 million



- Uncommitted Cash \$142.6 million
- Working Capital \$183.9 million
- Current Ratio 1.14 (regulatory minimum is 1.00)

Capital Investment

- Fiscal year-to-date capital assets acquired: \$51,000.
- Annual capital budget: \$1.4 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

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

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED 30 JUNE, 2026

CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance	% Variance	Account Description	Actual	Budget	\$ Variance	% Variance
		(Unfavorable)	(Unfavorable)				(Unfavorable)	(Unfavorable)
MEMBERSHIP								
363,470	363,396	74	0.0%	1. Medi-Cal	4,656,063	4,649,177	6,886	0.1%
6,350	6,109	241	3.9%	2. GroupCare	73,890	72,794	1,096	1.5%
253	825	(572)	(69.3%)	3. Medicare SNP	1,302	3,275	(1,973)	(60.2%)
370,073	370,330	(257)	(0.1%)	3. TOTAL MEMBER MONTHS	4,731,255	4,725,246	6,009	0.1%
REVENUE								
\$190,647,200	\$179,023,381	\$11,623,819	6.5%	4. Premium Revenue	\$2,275,313,414	\$2,244,154,862	\$31,158,552	1.4%
\$62,025,972	\$58,710,258	\$3,315,714	5.6%	5. MCO Tax Revenue AB119	\$770,748,265	\$751,648,843	\$19,099,422	2.5%
\$252,673,172	\$237,733,639	\$14,939,533	6.3%	6. TOTAL REVENUE	\$3,046,061,679	\$2,995,803,705	\$50,257,974	1.7%
MEDICAL EXPENSES								
Capitated Medical Expenses								
\$16,042,621	\$15,120,556	(\$922,065)	(6.1%)	7. Capitated Medical Expense	\$210,272,365	\$205,891,087	(\$4,381,278)	(2.1%)
Fee for Service Medical Expenses								
\$57,429,508	\$46,653,463	(\$10,776,045)	(23.1%)	8. Inpatient Hospital Expense	\$577,129,193	\$580,612,309	\$3,483,115	0.6%
\$3,222,835	\$4,203,261	\$980,426	23.3%	9. Primary Care Physician Expense	\$52,957,151	\$57,563,194	\$4,606,044	8.0%
\$7,670,748	\$7,587,439	(\$83,310)	(1.1%)	10. Specialty Care Physician Expense	\$100,158,660	\$100,781,048	\$622,387	0.6%
\$20,871,105	\$19,881,900	(\$989,206)	(5.0%)	11. Ancillary Medical Expense	\$259,649,043	\$242,489,161	(\$17,159,881)	(7.1%)
\$12,827,542	\$11,361,674	(\$1,465,868)	(12.9%)	12. Outpatient Medical Expense	\$152,500,175	\$154,220,671	\$1,720,497	1.1%
\$10,239,289	\$9,768,147	(\$471,142)	(4.8%)	13. Emergency Expense	\$127,993,611	\$123,011,622	(\$4,981,990)	(4.1%)
\$18,790,984	\$11,616,454	(\$7,174,531)	(61.8%)	14. Pharmacy Expense	\$158,981,465	\$133,492,223	(\$25,489,241)	(19.1%)
\$33,430,487	\$38,096,593	\$4,666,106	12.2%	15. Long Term Care Expense	\$413,241,169	\$459,758,083	\$46,516,914	10.1%
\$164,482,499	\$149,168,930	(\$15,313,569)	(10.3%)	16. Total Fee for Service Expense	\$1,842,610,466	\$1,851,928,312	\$9,317,846	0.5%
\$5,195,055	\$4,681,784	(\$513,270)	(11.0%)	17. Other Benefits & Services	\$48,388,559	\$53,967,660	\$5,579,101	10.3%
(\$608,529)	\$521,684	\$1,130,213	216.6%	18. Reinsurance Expense	(\$357,219)	\$3,772,688	\$4,129,907	109.5%
\$290,000	\$290,000	\$0	0.0%	19. Risk Pool Distribution	\$10,899,099	\$7,859,099	(\$3,040,000)	(38.7%)
\$185,401,646	\$169,782,955	(\$15,618,691)	(9.2%)	20. TOTAL MEDICAL EXPENSES	\$2,111,813,269	\$2,123,418,845	\$11,605,575	0.5%
\$67,271,526	\$67,950,684	(\$679,159)	(1.0%)	21. GROSS MARGIN	\$934,248,410	\$872,384,860	\$61,863,550	7.1%
ADMINISTRATIVE EXPENSES								
\$5,837,338	\$6,910,589	\$1,073,251	15.5%	22. Personnel Expense	\$80,989,913	\$81,316,375	\$326,462	0.4%
\$93,067	\$94,156	\$1,090	1.2%	23. Benefits Administration Expense	\$925,284	\$1,135,912	\$210,627	18.5%
\$5,228,231	\$2,601,044	(\$2,627,187)	(101.0%)	24. Purchased & Professional Services	\$28,866,000	\$29,609,283	\$743,283	2.5%
\$2,392,848	\$1,596,683	(\$796,165)	(49.9%)	25. Other Administrative Expense	\$19,756,169	\$20,811,675	\$1,055,506	5.1%
\$13,551,484	\$11,202,472	(\$2,349,012)	(21.0%)	26. TOTAL ADMINISTRATIVE EXPENSES	\$130,537,366	\$132,873,244	\$2,335,879	1.8%
\$62,025,972	\$58,710,258	(\$3,315,714)	(5.6%)	27. MCO TAX EXPENSES	\$770,748,265	\$751,648,843	(\$19,099,422)	(2.5%)
(\$8,305,930)	(\$1,962,045)	(\$6,343,884)	(323.3%)	28. NET OPERATING INCOME / (LOSS)	\$32,962,779	(\$12,137,227)	\$45,100,006	371.6%
OTHER INCOME / EXPENSES								
\$2,250,436	\$2,875,464	(\$625,028)	(21.7%)	29. TOTAL OTHER INCOME / (EXPENSES)	\$29,458,294	\$33,153,115	(\$3,694,821)	(11.1%)
(\$6,055,493)	\$913,419	(\$6,968,912)	(762.9%)	30. NET SURPLUS (DEFICIT)	\$62,421,073	\$21,015,888	\$41,405,185	197.0%
97.2%	94.8%	(2.4%)	(2.5%)	31. Medical Loss Ratio	92.8%	94.6%	1.8%	1.9%
7.1%	6.3%	(0.8%)	(12.7%)	32. Administrative Expense Ratio	5.7%	5.9%	0.2%	3.4%
(2.4%)	0.4%	(2.8%)	(700.0%)	33. Net Surplus (Deficit) Ratio	2.0%	0.7%	1.3%	185.7%

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

	6/30/2026	5/31/2026	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	\$27,127,394	\$25,186,278	\$1,941,116	7.7%
CNB Short-Term Investment	677,479,552	609,884,182	67,595,369	11.1%
Interest Receivable	3,605,608	3,304,671	300,937	9.1%
Premium Receivables	762,206,941	363,006,778	399,200,163	110.0%
Reinsurance Recovery Receivable	14,712,236	14,290,310	421,926	3.0%
Other Receivables	2,007,267	2,380,452	(373,185)	(15.7%)
Prepaid Expenses	594,892	716,683	(121,791)	(17.0%)
TOTAL CURRENT ASSETS	1,487,733,890	1,018,769,354	468,964,536	46.0%
OTHER ASSETS				
CNB Long-Term Investment	31,751,939	37,486,717	(5,734,779)	(15.3%)
CalPERS Net Pension Asset	(4,224,236)	(6,465,233)	2,240,997	(34.7%)
Deferred Outflow	15,559,551	15,271,214	288,337	1.9%
Restricted Asset-Bank Note	365,889	364,852	1,037	0.3%
GASB 87-Lease Assets (Net)	39,300	42,575	(3,275)	(7.7%)
GASB 96-SBITA Assets (Net)	7,002,940	7,306,844	(303,904)	(4.2%)
TOTAL OTHER ASSETS	50,495,382	54,006,969	(3,511,587)	(6.5%)
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,893,508	9,893,508	0	0.0%
Furniture And Equipment	13,400,309	13,400,309	0	0.0%
Leasehold Improvement	902,447	902,447	0	0.0%
Internally Developed Software	14,824,002	14,824,002	0	0.0%
Fixed Assets at Cost	39,020,265	39,020,265	0	0.0%
Less: Accumulated Depreciation	(34,133,653)	(34,077,836)	(55,817)	0.2%
PROPERTY AND EQUIPMENT (NET)	4,886,612	4,942,429	(55,817)	(1.1%)
TOTAL ASSETS	1,543,115,883	1,077,718,752	465,397,131	43.2%
CURRENT LIABILITIES				
Trade Accounts Payable	13,363,668	11,663,872	1,699,796	14.6%
Incurred But Not Reported Claims	315,239,857	310,505,030	4,734,827	1.5%
Other Medical Liabilities	155,925,936	151,725,198	4,200,738	2.8%
Pass-Through Liabilities	561,960,069	164,834,303	397,125,767	240.9%
MCO Tax Liabilities	243,041,912	181,015,941	62,025,972	34.3%
GASB 87 and 96 ST Liabilities	2,741,659	3,041,162	(299,503)	(9.8%)
Payroll Liabilities	11,558,808	11,533,934	24,874	0.2%
TOTAL CURRENT LIABILITIES	1,303,831,910	834,319,439	469,512,471	56.3%
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	2,399,806	2,403,081	(3,275)	(0.1%)
Deferred Inflow	5,183,734	3,240,306	1,943,428	60.0%
TOTAL LONG TERM LIABILITIES	7,583,539	5,643,386	1,940,153	34.4%
TOTAL LIABILITIES	1,311,415,449	839,962,825	471,452,624	56.1%
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	168,439,128	168,439,128	0	0.0%
Year-To-Date Net Surplus (Deficit)	62,421,073	68,476,567	(6,055,493)	(8.8%)
TOTAL NET WORTH	231,700,434	237,755,927	(6,055,493)	(2.5%)
TOTAL LIABILITIES AND NET WORTH	1,543,115,884	1,077,718,752	465,397,131	43.2%
Supplemental Information				
Cash Equivalents	704,606,946	635,070,460	69,536,486	10.9%
Pass-Through	561,960,069	164,834,303	397,125,767	240.9%
Uncommitted Cash	142,646,877	470,236,158	(327,589,281)	(69.7%)
Working Capital	183,901,980	184,449,916	(547,936)	(0.3%)
Current Ratio	114.1%	122.1%	(8.0%)	(6.6%)

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

June 30, 2026

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	\$3,467,171	\$10,356,685	\$20,507,658	\$40,356,148
GroupCare Receivable	1,640	552	7,539	2,121
Total	3,468,811	10,357,237	20,515,197	40,358,269
Medicare Premiums				
Medicare Premiums	500,554	1,273,740	2,523,494	2,523,494
Deferred Premium Revenue	0	0	0	0
Medicare Receivable	2,172	44,654	(16,686)	(16,686)
Total	502,726	1,318,394	2,506,808	2,506,808
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	248,705,447	739,337,758	1,500,921,352	3,003,182,036
Premium Receivable	(399,203,973)	(392,054,893)	(290,439,649)	(263,919,705)
Total	(150,498,526)	347,282,865	1,210,481,703	2,739,262,331
Investment & Other Income Cash Flows				
Other Revenues	292,058	(60,786)	493,776	957,686
Interest Income	1,973,777	7,960,377	14,542,093	28,631,907
Interest Receivable	(300,937)	(1,014,538)	481,608	(18,650)
Total	1,964,898	6,885,053	15,517,477	29,570,943
Medical & Hospital Cash Flows				
Total Medical Expenses	(185,401,643)	(537,902,084)	(1,044,835,527)	(2,111,813,268)
Other Health Care Receivables	(54,084)	(2,206,873)	(1,380,413)	(6,539,843)
Capitation Payable	-	-	-	-
IBNP Payable	4,734,827	(28,239,596)	(71,224,864)	(96,877,438)
Other Medical Payable	401,036,505	204,320,151	244,393,159	441,192,442
Risk Share Payable	290,000	870,000	5,240,000	6,290,856
New Health Program Payable	-	-	-	-
Total	220,605,605	(363,158,402)	(867,807,645)	(1,767,747,251)
Administrative Cash Flows				
Total Administrative Expenses	(13,566,884)	(37,406,560)	(71,575,421)	(130,668,670)
Prepaid Expenses	121,790	283,718	472,591	122,919
Other Receivables	5,343	7,922	11,581	1,466
CalPERS Pension	(2,529,334)	(2,529,334)	(2,529,334)	(2,529,334)
Trade Accounts Payable	1,699,797	1,608,279	2,969,877	1,846,745
Payroll Liabilities	1,968,303	3,205,430	4,954,015	4,138,321
GASB Assets and Liabilities	4,401	345,089	(474,390)	171,376
Depreciation Expense	55,817	181,215	368,872	741,060
Total	(12,240,767)	(34,304,241)	(65,802,209)	(126,176,117)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(62,025,972)	(187,753,413)	(382,490,007)	(770,748,265)
MCO Tax Liabilities	62,025,972	(621,587)	5,740,007	17,223,509
Total	0	(188,375,000)	(376,750,000)	(753,524,756)
Net Cash Flows from Operating Activities	63,802,747	(219,994,094)	(61,338,669)	164,250,227

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

June 30, 2026

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	5,734,775	(3,817,939)	9,090,202	7,403,430
Total	5,734,775	(3,817,939)	9,090,202	7,403,430
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(1,037)	(3,068)	(6,045)	(12,023)
Total	(1,037)	(3,068)	(6,045)	(12,023)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	-	(26,407)	(50,860)
Depreciation expense				
Change in A/D				
Purchases of Property and Equipment	-	-	(26,407)	(50,860)
Net Cash Flows from Investing Activities	5,733,738	(3,821,007)	9,057,750	7,340,547
Financing Cash Flows				
Subordinated Debt Proceeds	-	-	-	-
Net Change in Cash	69,536,485	(223,815,101)	(52,280,919)	171,590,774
Rounding	-	-	-	-
Cash @ Beginning of Period	635,070,460	928,422,046	756,887,864	533,016,171
Cash @ End of Period	\$704,606,945	\$704,606,945	\$704,606,945	\$704,606,945
Variance	-	-	-	-

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

June 30, 2026

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	(\$6,055,492)	(\$4,194,284)	\$40,087,418	\$62,421,068
Add back: Depreciation & Amortization	55,817	181,215	368,872	741,060
Receivables				
Premiums Receivable	(399,201,801)	(392,010,239)	(290,456,335)	(263,936,391)
Interest Receivable	(300,937)	(1,014,538)	481,608	(18,650)
Other Health Care Receivables	(54,084)	(2,206,873)	(1,380,413)	(6,539,843)
Other Receivables	5,343	7,922	11,581	1,466
GroupCare Receivable	1,640	552	7,539	2,121
Total	(399,549,839)	(395,223,176)	(291,336,020)	(270,491,297)
Prepaid Expenses	121,790	283,718	472,591	122,919
Trade Payables	1,699,797	1,608,279	2,969,877	1,846,745
Claims Payable and Shared Risk Pool				
IBNP Payable	4,734,827	(28,239,596)	(71,224,864)	(96,877,438)
Capitation Payable & Other Medical Payable	401,036,505	204,320,151	244,393,159	441,192,442
Risk Share Payable	290,000.00	870,000.00	5,240,000	6,290,856
Claims Payable				
Total	406,061,332	176,950,555	178,408,295	350,605,860
Unearned Revenue				
Deferred Premium Revenue				
Deferred Revenue - IHSS				
Deferred Revenue - Medicare (DSNP)	0	0	0	0
Total	-	-	-	-
Other Liabilities				
CalPERS Pension	(2,529,334.00)	(2,529,334.00)	(2,529,334.00)	(2,529,334.00)
Payroll Liabilities	1,968,303	3,205,431	4,954,015	4,138,321
GASB Assets and Liabilities	4,401	345,089	(474,390)	171,376
New Health Program	-	-	-	-
MCO Tax Liabilities	62,025,972	(621,587)	5,740,007	17,223,509
Total	61,469,342	399,599	7,690,298	19,003,872
Rounding	-	-	-	-
Cash Flows from Operating Activities	63,802,747	(219,994,094)	(61,338,669)	164,250,227
Variance	-	-	-	-

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

June 30, 2026

	MONTH	3 MONTHS	6 MONTHS	YTD
<u>CASH FLOW STATEMENT:</u>				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	(\$150,498,526)	\$347,282,865	\$1,210,481,703	\$2,739,262,331
Medicare Revenue	\$502,726	\$1,318,394	\$2,506,808	\$2,506,808
GroupCare Premium Revenue	3,468,811	10,357,237	20,515,197	40,358,269
Other Income	292,058	(60,786)	493,776	957,686
Interest Income	1,672,840	6,945,839	15,023,701	28,613,257
Less Cash Paid				
Medical Expenses	220,605,605	(363,158,402)	(867,807,645)	(1,767,747,251)
Vendor & Employee Expenses	(12,240,767)	(34,304,241)	(65,802,209)	(126,176,117)
MCO Tax Expense AB119	0	(188,375,000)	(376,750,000)	(753,524,756)
Net Cash Flows from Operating Activities	63,802,747	(219,994,094)	(61,338,669)	164,250,227
Cash Flows from Investing Activities:				
Long Term Investments	5,734,775	(3,817,939)	9,090,202	7,403,430
Restricted Assets-Treasury Account	(1,037)	(3,068)	(6,045)	(12,023)
Purchases of Property and Equipment	0	0	(26,407)	(50,860)
Net Cash Flows from Investing Activities	5,733,738	(3,821,007)	9,057,750	7,340,547
Net Change in Cash	69,536,485	(223,815,101)	(52,280,919)	171,590,774
Rounding	-	-	-	-
Cash @ Beginning of Period	635,070,460	928,422,046	756,887,864	533,016,171
Cash @ End of Period	\$704,606,945	\$704,606,945	\$704,606,945	\$704,606,945
Variance	\$0	-	-	-
<u>RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:</u>				
Net Income / (Loss)	(\$6,055,492)	(\$4,194,283)	\$40,087,417	\$62,421,068
Add Back: Depreciation	55,817	181,215	368,872	741,060
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(399,549,839)	(395,223,176)	(291,336,020)	(270,491,297)
Prepaid Expenses	121,790	283,717	472,592	122,919
Trade Payables	1,699,797	1,608,279	2,969,877	1,846,745
Claims Payable, IBNP and Risk Sharing	406,061,332	176,950,555	178,408,295	350,605,860
Deferred Revenue- Medicare (DSNP)	0	0	0	0
Other Liabilities	61,469,342	399,599	7,690,298	19,003,872
Total	63,802,747	(219,994,094)	(61,338,669)	164,250,227
Rounding	-	-	-	-
Cash Flows from Operating Activities	\$63,802,747	(\$219,994,094)	(\$61,338,669)	\$164,250,227
Variance	\$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF JUNE 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	103,343	52,592	132,315	27,337	47,883	363,470	6,350	253	370,073
Revenue	\$34,333,538	\$32,179,176	\$86,563,422	\$51,221,571	\$44,407,741	\$248,705,447	\$3,467,171	\$500,553	\$252,673,172
Medical Expense	\$15,395,121	\$21,932,493	\$67,829,667	\$43,447,223	\$32,438,032	\$181,042,535	\$3,754,764	\$604,346	\$185,401,646
Gross Margin	\$18,938,417	\$10,246,683	\$18,733,755	\$7,774,348	\$11,969,709	\$67,662,912	(\$287,593)	(\$103,793)	\$67,271,526
Administrative Expense	\$653,060	\$1,421,649	\$4,743,306	\$3,543,601	\$2,157,251	\$12,518,867	\$272,332	\$760,285	\$13,551,484
MCO Tax Expense	\$17,602,767	\$8,882,369	\$22,404,946	\$4,825,983	\$8,309,907	\$62,025,972	\$0	\$0	\$62,025,972
Operating Income / (Expense)	\$682,591	(\$57,334)	(\$8,414,497)	(\$595,236)	\$1,502,551	(\$6,881,926)	(\$559,925)	(\$864,078)	(\$8,305,930)
Other Income / (Expense)	\$109,034	\$259,312	\$738,950	\$684,259	\$420,994	\$2,212,549	\$33,425	\$4,462	\$2,250,436
Net Income / (Loss)	\$791,625	\$201,978	(\$7,675,547)	\$89,023	\$1,923,545	(\$4,669,377)	(\$526,500)	(\$859,616)	(\$6,055,493)
PMPM Metrics:									
Revenue PMPM	\$332.23	\$611.86	\$654.22	\$1,873.71	\$927.42	\$684.25	\$546.01	\$1,978.47	\$682.77
Medical Expense PMPM	\$148.97	\$417.03	\$512.64	\$1,589.32	\$677.44	\$498.09	\$591.30	\$2,388.72	\$500.99
Gross Margin PMPM	\$183.26	\$194.83	\$141.58	\$284.39	\$249.98	\$186.16	(\$45.29)	(\$410.25)	\$181.78
Administrative Expense PMPM	\$6.32	\$27.03	\$35.85	\$129.63	\$45.05	\$34.44	\$42.89	\$3,005.08	\$36.62
MCO Tax Expense PMPM	\$170.33	\$168.89	\$169.33	\$176.54	\$173.55	\$170.65	\$0.00	\$0.00	\$167.60
Operating Income / (Expense) PMPM	\$6.61	(\$1.09)	(\$63.59)	(\$21.77)	\$31.38	(\$18.93)	(\$88.18)	(\$3,415.33)	(\$22.44)
Other Income / (Expense) PMPM	\$1.06	\$4.93	\$5.58	\$25.03	\$8.79	\$6.09	\$5.26	\$17.64	\$6.08
Net Income / (Loss) PMPM	\$7.66	\$3.84	(\$58.01)	\$3.26	\$40.17	(\$12.85)	(\$82.91)	(\$3,397.69)	(\$16.36)
Ratio:									
Medical Loss Ratio	92.0%	94.1%	105.7%	93.6%	89.9%	97.0%	108.3%	120.7%	97.2%
Administrative Expense Ratio	3.9%	6.1%	7.4%	7.6%	6.0%	6.7%	7.9%	151.9%	7.1%
Net Income Ratio	2.3%	0.6%	-8.9%	0.2%	4.3%	-1.9%	-15.2%	-171.7%	-2.4%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE JUNE 2026

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal ACA OE	Medi-Cal SPD with LTC	Medi-Cal Duals with LTC	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	1,279,251	693,728	1,750,128	347,416	585,540	4,656,063	73,890	1,302	4,731,255
Revenue	\$419,583,815	\$380,807,658	\$1,085,936,901	\$596,857,269	\$519,996,394	\$3,003,182,037	\$40,356,148	\$2,523,494	\$3,046,061,679
Medical Expense	\$171,951,447	\$246,015,654	\$735,472,123	\$490,060,214	\$421,763,392	\$2,065,262,829	\$42,865,233	\$3,685,207	\$2,111,813,269
Gross Margin	\$247,632,368	\$134,792,004	\$350,464,778	\$106,797,055	\$98,233,002	\$937,919,208	(\$2,509,085)	(\$1,161,713)	\$934,248,410
Administrative Expense	\$6,296,985	\$13,905,603	\$41,800,828	\$34,641,001	\$21,405,958	\$118,050,374	\$2,582,852	\$9,904,140	\$130,537,366
MCO Tax Expense	\$212,016,400	\$114,450,825	\$288,278,331	\$58,303,797	\$97,698,912	\$770,748,265	\$0	\$0	\$770,748,265
Operating Income / (Expense)	\$29,318,984	\$6,435,576	\$20,385,619	\$13,852,257	(\$20,871,868)	\$49,120,569	(\$5,091,937)	(\$11,065,853)	\$32,962,779
Other Income / (Expense)	\$1,430,245	\$3,400,149	\$9,689,258	\$8,969,381	\$5,520,895	\$29,009,927	\$438,411	\$9,955	\$29,458,294
Net Income / (Loss)	\$30,749,229	\$9,835,726	\$30,074,877	\$22,821,638	(\$15,350,973)	\$78,130,497	(\$4,653,526)	(\$11,055,897)	\$62,421,073
PMPM Metrics:									
Revenue PMPM	\$327.99	\$548.93	\$620.49	\$1,717.99	\$888.06	\$645.00	\$546.17	\$1,938.17	\$643.82
Medical Expense PMPM	\$134.42	\$354.63	\$420.24	\$1,410.59	\$720.30	\$443.56	\$580.12	\$2,830.42	\$446.35
Gross Margin PMPM	\$193.58	\$194.30	\$200.25	\$307.40	\$167.76	\$201.44	(\$33.96)	(\$892.25)	\$197.46
Administrative Expense PMPM	\$4.92	\$20.04	\$23.88	\$99.71	\$36.56	\$25.35	\$34.96	\$7,606.87	\$27.59
MCO Tax Expense PMPM	\$165.73	\$164.98	\$164.72	\$167.82	\$166.85	\$165.54	\$0.00	\$0.00	\$162.91
Operating Income / (Expense) PMPM	\$22.92	\$9.28	\$11.65	\$39.87	(\$35.65)	\$10.55	(\$68.91)	(\$8,499.12)	\$6.97
Other Income / (Expense) PMPM	\$1.12	\$4.90	\$5.54	\$25.82	\$9.43	\$6.23	\$5.93	\$7.65	\$6.23
Net Income / (Loss) PMPM	\$24.04	\$14.18	\$17.18	\$65.69	(\$26.22)	\$16.78	(\$62.98)	(\$8,491.47)	\$13.19
Ratio:									
Medical Loss Ratio	82.8%	92.4%	92.2%	91.0%	99.9%	92.5%	106.2%	146.0%	92.8%
Administrative Expense Ratio	3.0%	5.2%	5.2%	6.4%	5.1%	5.3%	6.4%	392.5%	5.7%
Net Income Ratio	7.3%	2.6%	2.8%	3.8%	-3.0%	2.6%	-11.5%	-438.1%	2.0%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 June, 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)								
\$5,837,338	\$6,910,589	\$1,073,251	15.5%	Personnel Expenses	\$80,989,913	\$81,316,375	\$326,462	0.4%
\$93,067	\$94,156	\$1,090	1.2%	Benefits Administration Expense	\$925,284	\$1,135,912	\$210,627	18.5%
\$5,228,231	\$2,601,044	(\$2,627,187)	(101.0%)	Purchased & Professional Services	\$28,866,000	\$29,609,283	\$743,283	2.5%
\$452,849	\$498,744	\$45,895	9.2%	Occupancy	\$5,979,526	\$5,858,977	(\$120,549)	(2.1%)
(\$75,564)	\$154,102	\$229,666	149.0%	Printing Postage & Promotion	\$3,507,664	(\$40,941)	(\$3,548,605)	8,667.6%
\$106,556	\$382,025	\$275,469	72.1%	Licenses Insurance & Fees	\$2,908,232	\$5,629,031	\$2,720,799	48.3%
\$1,909,007	\$561,812	(\$1,347,195)	(239.8%)	Other Administrative Expense	\$7,360,747	\$9,364,609	\$2,003,862	21.4%
\$7,714,145	\$4,291,883	(\$3,422,262)	(79.7%)	Total Other Administrative Expenses (excludes Personnel Expenses)	\$49,547,453	\$51,556,869	\$2,009,416	3.9%
\$13,551,484	\$11,202,472	(\$2,349,012)	(21.0%)	Total Administrative Expenses	\$130,537,366	\$132,873,244	\$2,335,879	1.8%

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

CURRENT MONTH				Account Description	FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)		Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
3,025,537	4,411,196	1,385,659	31.4%	Salaries & Wages	52,611,703	51,123,606	(1,488,097)	(2.9%)
374,409	365,575	(8,834)	(2.4%)	Paid Time Off	4,944,245	4,971,411	27,166	0.5%
450	63,130	62,680	99.3%	Compensated Incentives	8,401	377,454	369,053	97.8%
0	0	0	0.0%	Severance	431,031	400,000	(31,031)	(7.8%)
71,657	59,979	(11,678)	(19.5%)	Payroll Taxes	984,063	1,104,633	120,570	10.9%
20,829	47,845	27,016	56.5%	Overtime	729,104	698,600	(30,503)	(4.4%)
5,368	0	(5,368)	0.0%	Commission Pay	29,113	0	(29,113)	0.0%
722,721	317,986	(404,735)	(127.3%)	CalPERS ER Match	4,711,690	4,206,804	(504,886)	(12.0%)
1,218,826	1,256,073	37,248	3.0%	Employee Benefits	13,967,222	14,541,599	574,377	3.9%
336	0	(336)	0.0%	Personal Floating Holiday	211,827	218,795	6,968	3.2%
19,416	48,500	29,084	60.0%	Language Pay	263,208	454,522	191,314	42.1%
5,270	0	(5,270)	0.0%	Med Ins Opted Out Stipend	40,770	12,100	(28,670)	(236.9%)
145,674	0	(145,674)	0.0%	Sick Leave	946,169	77,895	(868,274)	(1,114.7%)
1,817	34,407	32,590	94.7%	Compensated Employee Relations	1,771	267,238	265,467	99.3%
21,360	26,240	4,880	18.6%	Work from Home Stipend	264,150	288,000	23,850	8.3%
2,073	4,006	1,933	48.2%	Mileage, Parking & Local Travel	17,542	39,758	22,216	55.9%
8,168	22,120	13,952	63.1%	Travel & Lodging	48,642	239,149	190,507	79.7%
158,787	126,296	(32,491)	(25.7%)	Temporary Help Services	541,134	1,192,871	651,737	54.6%
28,420	48,168	19,748	41.0%	Staff Development/Training	178,750	484,067	305,317	63.1%
6,218	79,067	72,849	92.1%	Staff Recruitment/Advertisement	59,381	617,874	558,493	90.4%
5,837,338	6,910,589	1,073,251	15.5%	Personnel Expense	80,989,913	81,316,375	326,462	0.4%
41,221	35,626	(5,595)	(15.7%)	Pharmacy Administrative Fees	400,795	356,171	(44,625)	(12.5%)
0	0	0	0.0%	Behavioral Hlth Administration	(236,422)	0	236,422	0.0%
0	10,000	10,000	100.0%	M3P Admin Fees	115,000	165,000	50,000	30.3%
3,945	495	(3,450)	(697.0%)	OTC Administrative	33,740	1,965	(31,775)	(1,617.0%)
292	0	(292)	0.0%	Capitation Admin Fees	747	0	(747)	0.0%
47,609	48,036	427	0.9%	Telemedicine Admin. Fees	611,424	612,776	1,352	0.2%
93,067	94,156	1,090	1.2%	Benefits Administration Expense	925,284	1,135,912	210,627	18.5%
1,487,307	617,834	(869,473)	(140.7%)	Consultant Fees - Non Medical	7,518,034	8,539,317	1,021,283	12.0%
353,154	519,509	166,355	32.0%	Computer Support Services	4,750,454	5,457,063	706,609	12.9%
0	11,750	11,750	100.0%	Audit Fees	98,046	160,455	62,409	38.9%
0	0	0	0.0%	Consultant Fees - Medical	17,593	117,593	100,000	85.0%
909,782	372,682	(537,100)	(144.1%)	Other Purchased Services	3,892,121	3,675,414	(216,707)	(5.9%)
1,555	1,879	324	17.3%	Maint.&Repair-Office Equipment	1,555	15,032	13,477	89.7%
49,126	62,267	13,141	21.1%	Legal Fees	519,847	697,107	177,260	25.4%
(34)	0	34	0.0%	Member Health Education	(59)	(17)	42	(250.0%)
66,400	26,000	(40,400)	(155.4%)	Translation Services	643,279	455,523	(187,756)	(41.2%)
607,374	151,900	(455,474)	(299.9%)	Medical Refund Recovery Fees	2,585,054	2,041,350	(543,704)	(26.6%)
1,540,731	721,752	(818,979)	(113.5%)	Software - IT Licenses & Subsc	7,725,350	7,214,498	(510,852)	(7.1%)
76,109	55,071	(21,038)	(38.2%)	Hardware (Non-Capital)	377,467	735,815	358,348	48.7%
136,728	60,400	(76,328)	(126.4%)	Provider Credentialing	737,260	500,133	(237,127)	(47.4%)
5,228,231	2,601,044	(2,627,187)	(101.0%)	Purchased & Professional Services	28,866,000	29,609,283	743,283	2.5%
55,817	77,578	21,761	28.1%	Depreciation	741,060	839,009	97,949	11.7%
352	9,235	8,883	96.2%	Lease Rented Office Equipment	54,605	112,530	57,925	51.5%
(3,961)	19,015	22,976	120.8%	Utilities	190,283	224,813	34,530	15.4%
39,879	108,156	68,277	63.1%	Telephone	1,023,135	1,241,264	218,130	17.6%
56,857	34,760	(22,097)	(63.6%)	Building Maintenance	271,173	315,207	44,034	14.0%

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

CURRENT MONTH					FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	
303,904	250,000	(53,904)	(21.6%)	GASB96 SBITA Amort. Expense	3,699,271	3,126,154	(573,117)	(18.3%)	
452,849	498,744	45,895	9.2%	Occupancy	5,979,526	5,858,977	(120,549)	(2.1%)	
(42,800)	39,560	82,360	208.2%	Postage	974,007	1,063,162	89,155	8.4%	
7,948	5,700	(2,248)	(39.4%)	Design & Layout	99,219	90,142	(9,077)	(10.1%)	
(105,938)	49,843	155,781	312.5%	Printing Services	1,748,173	1,569,466	(178,707)	(11.4%)	
23,405	15,600	(7,805)	(50.0%)	Mailing Services	326,033	138,265	(187,768)	(135.8%)	
24,144	19,204	(4,940)	(25.7%)	Courier/Delivery Service	100,898	148,789	47,891	32.2%	
0	2,345	2,345	100.0%	Pre-Printed Materials & Public	1,470	12,760	11,290	88.5%	
0	0	0	0.0%	Promotional Products	34,683	35,000	317	0.9%	
0	150	150	100.0%	Promotional Services	358	6,558	6,200	94.5%	
17,678	21,700	4,022	18.5%	Community Relations	222,824	(3,105,082)	(3,327,906)	107.2%	
(75,564)	154,102	229,666	149.0%	Printing Postage & Promotion	3,507,664	(40,941)	(3,548,605)	8,667.6%	
0	75,000	75,000	100.0%	Regulatory Penalties	0	300,000	300,000	100.0%	
36,558	45,500	8,942	19.7%	Bank Fees	466,597	532,638	66,041	12.4%	
0	200	200	100.0%	Insurance Premium	1,143,841	1,140,179	(3,662)	(0.3%)	
24,299	251,002	226,703	90.3%	License,Permits, & Fee - NonIT	637,966	2,761,128	2,123,162	76.9%	
45,700	10,324	(35,376)	(342.7%)	Subscriptions and Dues - NonIT	659,828	895,085	235,258	26.3%	
106,556	382,025	275,469	72.1%	License Insurance & Fees	2,908,232	5,629,031	2,720,799	48.3%	
3,233	5,885	2,652	45.1%	Office and Other Supplies	45,598	60,031	14,433	24.0%	
0	1,000	1,000	100.0%	Furniture & Equipment	0	7,000	7,000	100.0%	
5,703	41,157	35,454	86.1%	Ergonomic Supplies	99,480	295,355	195,875	66.3%	
11,862	12,880	1,018	7.9%	Meals and Entertainment	165,291	201,832	36,541	18.1%	
0	0	0	0.0%	Miscellaneous	(865,606)	(245,248)	620,358	(253.0%)	
4,400	3,125	(1,275)	(40.8%)	Member Incentive	8,150	25,000	16,850	67.4%	
1,687,146	164,432	(1,522,714)	(926.0%)	Provider Interest (All Depts)	4,109,834	2,250,713	(1,859,120)	(82.6%)	
196,663	333,333	136,670	41.0%	Community Reinvestment Expense	3,798,000	6,769,926	2,971,926	43.9%	
1,909,007	561,812	(1,347,195)	(239.8%)	Other Administrative Expense	7,360,747	9,364,609	2,003,862	21.4%	
7,714,145	4,291,883	(3,422,262)	(79.7%)	Total Other Administrative ExpenseS (excludes Personnel Expenses)	49,547,453	51,556,869	2,009,416	3.9%	
13,551,484	11,202,472	(2,349,012)	(21.0%)	TOTAL ADMINISTRATIVE EXPENSES	130,537,366	132,873,244	2,335,879	1.8%	

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

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	\$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Routers	IT-FY26-01	\$ -	\$ -	\$ -	\$ 45,000	\$ 45,000
	Firewall AAH Location	IT-FY26-02	\$ -	\$ -	\$ -	\$ 110,000	\$ 110,000
	Firewall Roseville Location	IT-FY26-03	\$ -	\$ -	\$ -	\$ 110,000	\$ 110,000
	VPN Device	IT-FY26-04	\$ -	\$ -	\$ -	\$ 115,000	\$ 115,000
	CISCO UCS Blades	IT-FY26-05	\$ -	\$ -	\$ -	\$ 300,000	\$ 300,000
	CISCO UCS Blades	IT-FY26-05	\$ -	\$ -	\$ -	\$ 275,000	\$ 275,000
	Pure Storage	IT-FY26-06	\$ -	\$ -	\$ -	\$ 150,000	\$ 150,000
	Teams Meeting Hardware	IT-FY26-07	\$ -	\$ -	\$ -	\$ 100,000	\$ 100,000
	Network Cabeling and WIFI Access	IT-FY26-08	\$ -	\$ -	\$ -	\$ 40,000	\$ 40,000
Hardware Subtotal			\$ -	\$ -	\$ -	\$ 1,245,000	\$ 1,245,000
3. Building Improvement:							
	1240 Exterior lighting update	FA-FY26-01	\$ -	\$ -	\$ -	\$ 30,000	\$ 30,000
	1240 Secured Fencing for Warehouse	FA-FY26-02	\$ 19,727	\$ -	\$ 19,727	\$ 30,000	\$ 10,273
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	\$ -	\$ -	\$ -	\$ 10,000	\$ 10,000
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	\$ -	\$ -	\$ -	\$ 5,000	\$ 5,000
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	\$ -	\$ -	\$ -	\$ 10,000	\$ 10,000
	1240 Exterior Landscaping	FA-FY26-04	\$ 1,133	\$ -	\$ 1,133	\$ 6,500	\$ 5,367
	1240 Exterior Landscaping	FA-FY26-04	\$ 15,000	\$ -	\$ 15,000	\$ 15,000	\$ -
	1240 Exterior Landscaping	FA-FY26-04	\$ 15,000	\$ -	\$ 15,000	\$ 15,000	\$ -
Building Improvement Subtotal			\$ 50,860	\$ -	\$ 50,860	\$ 121,500	\$ 70,640
GRAND TOTAL			\$ 50,860	\$ -	\$ 50,860	\$ 1,366,500	\$ 1,315,640
6. Reconciliation to Balance Sheet:							
	Fixed Assets @ Cost - 6/30/26				\$ 39,020,265		
	Fixed Assets @ Cost - 6/30/25				\$ 38,969,405		
	Fixed Assets Acquired YTD				<u>\$ 50,860</u>		

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

TANGIBLE NET EQUITY (TNE)	QRT. END Jun-25	Jul-25	Aug-25	QRT. END Sep-25	Oct-25	Nov-25	QRT. END Dec-25	Jan-26	Feb-26	QRT. END Mar-26	Apr-26	May-26	QRT. END Jun-26
Current Month Net Income / (Loss)	\$ 4,912,222	\$ 1,727,933	\$ 2,950,359	\$ 3,127,768	\$ 6,501,450	\$ 7,058,478	\$ 967,656	\$ 9,388,630	\$ 21,757,529	\$ 13,135,534	\$ 387,650	\$ 1,473,555	\$ (6,055,490)
YTD Net Income / (Loss)	\$ (86,095,783)	\$ 1,727,938	\$ 4,678,300	\$ 7,806,066	\$ 14,307,514	\$ 21,365,998	\$ 22,333,655	\$ 31,722,281	\$ 53,479,813	\$ 66,615,357	\$ 67,003,009	\$ 68,476,567	\$ 62,421,073
Net Assets	\$ 169,279,360	\$ 171,007,298	\$ 173,957,660	\$ 177,085,426	\$ 183,586,874	\$ 190,645,358	\$ 191,613,015	\$ 201,001,641	\$ 222,759,173	\$ 235,894,717	\$ 236,282,369	\$ 237,755,927	\$ 231,700,433
Subordinated Debt & Interest	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Actual TNE	\$ 169,279,360	\$ 171,007,298	\$ 173,957,660	\$ 177,085,426	\$ 183,586,874	\$ 190,645,358	\$ 191,613,015	\$ 201,001,641	\$ 222,759,173	\$ 235,894,717	\$ 236,282,369	\$ 237,755,927	\$ 231,700,433
Increase/(Decrease) in Actual TNE	\$ 4,912,222	\$ 1,727,933	\$ 2,950,359	\$ 3,127,768	\$ 6,501,450	\$ 7,058,478	\$ 967,656	\$ 9,388,630	\$ 21,757,529	\$ 13,135,534	\$ 387,650	\$ 1,473,555	\$ (6,055,490)
Required TNE ⁽¹⁾	\$ 80,653,661	\$ 81,235,858	\$ 80,224,390	\$ 80,693,435	\$ 80,147,121	\$ 79,750,550	\$ 80,436,968	\$ 80,592,303	\$ 78,360,003	\$ 79,446,994	\$ 79,829,374	\$ 78,913,801	\$ 79,704,419
Min. Req'd to Avoid Monthly Reporting at 150% of Required TNE	\$ 120,980,491	\$ 121,853,786	\$ 120,336,585	\$ 121,040,152	\$ 120,220,681	\$ 119,625,824	\$ 120,655,452	\$ 120,888,454	\$ 117,540,005	\$ 119,170,490	\$ 119,744,061	\$ 118,370,702	\$ 119,556,628
TNE Excess / (Deficiency)	\$ 88,625,699	\$ 89,771,440	\$ 93,733,270	\$ 96,391,991	\$ 103,439,753	\$ 110,894,808	\$ 111,176,047	\$ 120,409,338	\$ 144,399,170	\$ 156,447,723	\$ 156,452,995	\$ 158,842,126	\$ 151,996,014
Actual TNE as a Multiple of Required	2.10	2.11	2.17	2.19	2.29	2.39	2.38	2.49	2.84	2.97	2.96	3.01	2.91
LIQUID TANGIBLE NET EQUITY													
Net Assets	\$ 169,279,360	\$ 171,007,298	\$ 173,957,660	\$ 177,085,426	\$ 183,586,874	\$ 190,645,358	\$ 191,613,015	\$ 201,001,641	\$ 222,759,173	\$ 235,894,717	\$ 236,282,369	\$ 237,755,927	\$ 231,700,433
Less: Fixed Assets at Net Book Value	(5,576,811)	(5,514,960)	(5,453,108)	(5,391,257)	(5,329,406)	(5,291,335)	(5,229,076)	(5,166,817)	(5,115,549)	(5,067,826)	(5,005,127)	(4,942,428)	(4,886,612)
Net Lease Assets	(2,072,151)	(1,979,137)	(1,678,452)	(1,751,482)	(1,932,587)	(1,672,654)	(1,426,385)	(3,031,854)	(2,673,163)	(2,245,863)	(2,250,278)	(1,905,177)	(1,900,774)
CD Pledged to DMHC	(353,866)	(354,839)	(355,847)	(356,859)	(357,840)	(358,857)	(359,844)	(360,866)	(361,892)	(362,821)	(363,852)	(364,852)	(365,889)
Liquid TNE (Liquid Reserves)	\$ 161,276,532	\$ 163,158,362	\$ 166,470,253	\$ 169,585,828	\$ 175,967,041	\$ 183,322,512	\$ 184,597,710	\$ 192,442,104	\$ 214,608,569	\$ 228,218,207	\$ 228,663,112	\$ 230,543,470	\$ 224,547,158
Liquid TNE as Multiple of Required	2.00	2.01	2.08	2.10	2.20	2.30	2.29	2.39	2.74	2.87	2.86	2.92	2.82

**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	105,381	104,683	104,072	103,343	1,279,251
Adult	61,536	60,679	60,106	59,780	59,806	59,312	58,090	57,240	56,039	54,857	53,691	52,592	693,728
ACA OE	155,533	153,348	152,196	151,404	150,677	149,473	146,364	144,297	141,305	138,309	134,907	132,315	1,750,128
SPD with LTC	29,833	29,686	29,708	29,631	29,590	29,500	29,119	28,813	28,461	27,944	27,794	27,337	347,416
Duals with LTC	49,509	49,371	49,390	49,401	49,334	49,277	48,675	48,506	48,290	48,038	47,866	47,883	585,540
Medi-Cal Program	405,662	401,587	399,483	398,047	397,301	394,986	388,859	385,031	379,476	373,831	368,330	363,470	4,656,063
Group Care Program	5,957	5,974	6,054	6,081	6,092	6,138	6,191	6,211	6,240	6,291	6,311	6,350	73,890
Medicare Program	0	0	0	0	0	0	170	191	212	231	245	253	1,302
Total	411,619	407,561	405,537	404,128	403,393	401,124	395,220	391,433	385,928	380,353	374,886	370,073	4,731,255

Month Over Month Enrollment Change:

Medi-Cal Monthly Change:													
Child	(323)	(748)	(420)	(252)	63	(470)	(813)	(436)	(794)	(698)	(611)	(729)	(6,231)
Adult	(133)	(857)	(573)	(326)	26	(494)	(1,222)	(850)	(1,201)	(1,182)	(1,166)	(1,099)	(9,077)
ACA OE	357	(2,185)	(1,152)	(792)	(727)	(1,204)	(3,109)	(2,067)	(2,992)	(2,996)	(3,402)	(2,592)	(22,861)
SPD with LTC	83	(147)	22	(77)	(41)	(90)	(381)	(306)	(352)	(517)	(150)	(457)	(2,413)
Duals with LTC	205	(138)	19	11	(67)	(57)	(602)	(169)	(216)	(252)	(172)	17	(1,421)
Medi-Cal Program	189	(4,075)	(2,104)	(1,436)	(746)	(2,315)	(6,127)	(3,828)	(5,555)	(5,645)	(5,501)	(4,860)	(42,003)
Group Care Program	47	17	80	27	11	46	53	20	29	51	20	39	440
Medicare Program	0	0	0	0	0	0	170	21	21	19	14	8	253
Total	236	(4,058)	(2,024)	(1,409)	(735)	(2,269)	(5,904)	(3,787)	(5,505)	(5,575)	(5,467)	(4,813)	(41,310)

Enrollment Percentages:

Medi-Cal Program % of Total:													
Child % of Medi-Cal	26.9%	27.0%	27.1%	27.1%	27.2%	27.2%	27.4%	27.6%	27.8%	28.0%	28.3%	28.4%	27.5%
Adult % of Medi-Cal	15.2%	15.1%	15.0%	15.0%	15.1%	15.0%	14.9%	14.9%	14.8%	14.7%	14.6%	14.5%	14.9%
ACA OE % of Medi-Cal	38.3%	38.2%	38.1%	38.0%	37.9%	37.8%	37.6%	37.5%	37.2%	37.0%	36.6%	36.4%	37.6%
SPD with LTC % of Medi-Cal	7.4%	7.4%	7.4%	7.4%	7.4%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%
Duals with LTC % of Medi-Cal	12.2%	12.3%	12.4%	12.4%	12.4%	12.5%	12.5%	12.6%	12.7%	12.9%	13.0%	13.2%	12.6%
Medi-Cal Program % of Total	98.6%	98.5%	98.5%	98.5%	98.5%	98.5%	98.4%	98.4%	98.3%	98.3%	98.3%	98.2%	98.4%
Group Care Program % of Total	1.4%	1.5%	1.5%	1.5%	1.5%	1.5%	1.6%	1.6%	1.6%	1.7%	1.7%	1.7%	1.6%
Medicare Program % of Total	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**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	87,617	87,480	86,918	85,612	1,086,240
Alameda Health System	92,861	91,758	91,032	91,084	90,621	90,714	88,985	87,443	86,119	81,995	78,601	77,476	1,048,689
Directly-Contracted Subtotal	186,794	185,026	184,631	183,754	184,036	182,180	179,024	177,666	173,736	169,475	165,519	163,088	2,134,929
Delegated:													
CFMG	43,381	42,852	42,253	42,053	41,790	41,683	41,247	40,893	40,565	40,449	40,233	39,847	497,246
CHCN	181,444	179,683	178,653	178,321	177,567	177,261	174,949	172,874	171,627	170,429	169,134	167,138	2,099,080
Delegated Subtotal	224,825	222,535	220,906	220,374	219,357	218,944	216,196	213,767	212,192	210,878	209,367	206,985	2,596,326
Total	411,619	407,561	405,537	404,128	403,393	401,124	395,220	391,433	385,928	380,353	374,886	370,073	4,731,255
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(518)	(1,768)	(395)	(877)	282	(1,856)	(3,156)	(1,358)	(3,930)	(4,261)	(3,956)	(2,431)	(24,224)
Delegated:													
CFMG	(128)	(529)	(599)	(200)	(263)	(107)	(436)	(354)	(328)	(116)	(216)	(386)	(3,662)
CHCN	882	(1,761)	(1,030)	(332)	(754)	(306)	(2,312)	(2,075)	(1,247)	(1,198)	(1,295)	(1,996)	(13,424)
Delegated Subtotal	754	(2,290)	(1,629)	(532)	(1,017)	(413)	(2,748)	(2,429)	(1,575)	(1,314)	(1,511)	(2,382)	(17,086)
Total	236	(4,058)	(2,024)	(1,409)	(735)	(2,269)	(5,904)	(3,787)	(5,505)	(5,575)	(5,467)	(4,813)	(41,310)
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	45.4%	45.4%	45.5%	45.5%	45.6%	45.4%	45.3%	45.4%	45.0%	44.6%	44.2%	44.1%	45.1%
Delegated:													
CFMG	10.5%	10.5%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	10.5%	10.6%	10.7%	10.8%	10.5%
CHCN	44.1%	44.1%	44.1%	44.1%	44.0%	44.2%	44.3%	44.2%	44.5%	44.8%	45.1%	45.2%	44.4%
Delegated Subtotal	54.6%	54.6%	54.5%	54.5%	54.4%	54.6%	54.7%	54.6%	55.0%	55.4%	55.8%	55.9%	54.9%
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
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)

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
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	171	68	47	(96)	1,443
Adult	0	0	0	0	505	534	108	43	(383)	(802)	(1,216)	(1,575)	(2,786)
ACA OE	0	0	0	0	216	(9)	572	2,092	2,586	2,977	2,867	3,475	14,776
Total	0	0	0	0	16	44	7,308	7,147	6,936	6,562	6,553	6,237	40,803
Duals with LTC*	0	0	0	0	139	205	(7,794)	(7,838)	(7,930)	(8,058)	(8,107)	(7,967)	(47,350)
Medi-Cal Program	0	0	0	0	1,147	1,184	397	1,813	1,380	747	144	74	6,886
Group Care Program	0	0	0	0	13	53	112	126	149	194	208	241	1,096
Medicare Program	0	0	0	0	0	0	(96)	(179)	(261)	(388)	(477)	(572)	(1,973)
Total	0	0	0	0	1,160	1,237	413	1,760	1,268	553	(125)	(257)	6,009
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	5	(1,480)	(4,741)	(3,585)	(5,243)	(4,482)	(4,140)	(4,565)	(28,231)
Alameda Health System	0	0	0	0	296	961	1,564	1,544	1,705	(974)	(2,957)	(2,705)	(566)
Directly-Contracted Subtotal	0	0	0	0	301	(519)	(3,177)	(2,041)	(3,538)	(5,456)	(7,097)	(7,270)	(28,797)
Delegated:													
CFMG	0	0	0	0	117	236	534	437	362	498	532	393	3,109
CHCN	0	0	0	0	742	1,520	3,056	3,364	4,444	5,511	6,440	6,620	31,697
Delegated Subtotal	0	0	0	0	859	1,756	3,590	3,801	4,806	6,009	6,972	7,013	34,806
Total	0	0	0	0	1,160	1,237	413	1,760	1,268	553	(125)	(257)	6,009

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

MEDICARE SUPPLEMENT

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Current Direct/Provider Network Enrollment:													
Directly-Contracted:													
Directly Contracted (DCP)	0	0	0	0	0	0	74	67	59	68	77	80	425
Alameda Health System	0	0	0	0	0	0	15	16	25	27	24	26	133
Directly-Contracted Subtotal	0	0	0	0	0	0	89	83	84	95	101	106	558
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	0	0	0	0	0	0	81	108	128	136	144	147	744
Provider Network Subtotal	0	0	0	0	0	0	81	108	128	136	144	147	744
Total	0	0	0	0	0	0	170	191	212	231	245	253	1,302

Direct/Provider Network Month Over Month Enrollment Change:

Directly-Contracted	0	0	0	0	0	0	89	(6)	1	11	6	5	106
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	0	0	0	0	0	0	81	27	20	8	8	3	147
Provider Network Subtotal	0	0	0	0	0	0	81	27	20	8	8	3	147
Total	0	0	0	0	0	0	170	21	21	19	14	8	253

Direct/Provider Network Enrollment Percentages:

Directly-Contracted	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	52.4%	43.5%	39.6%	41.1%	41.2%	41.9%	42.9%
Provider Network:													
CFMG	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CHCN	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	47.6%	56.5%	60.4%	58.9%	58.8%	58.1%	57.1%
Provider Network Subtotal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	47.6%	56.5%	60.4%	58.9%	58.8%	58.1%	57.1%
Total	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Final Budget Jul-25	Final Budget Aug-25	Final Budget Sep-25	Final Budget Oct-25	Final Budget Nov-25	Final Budget Dec-25	Final Budget Jan-26	Final Budget Feb-26	Final Budget Mar-26	Final Budget Apr-26	Final Budget May-26	Final Budget Jun-26	YTD Member Months
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Current Direct/Provider Network Enrollment:

Directly-Contracted:													
Directly Contracted (DCP)	0	0	0	0	0	0	172	240	307	402	469	536	2,126
Alameda Health System	0	0	0	0	0	0	19	26	33	43	50	57	228
Directly-Contracted Subtotal	0	0	0	0	0	0	191	266	340	445	519	593	2,354
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	0	0	0	0	0	0	75	104	133	174	203	232	921
Provider Network Subtotal	0	0	0	0	0	0	75	104	133	174	203	232	921
Total	0	0	0	0	0	0	266	370	473	619	722	825	3,275

Direct/Provider Network Month Over Month Enrollment Change:

Directly-Contracted	0	0	0	0	0	0	191	75	74	105	74	74	593
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	0	0	0	0	0	0	75	29	29	41	29	29	232
Provider Network Subtotal	0	0	0	0	0	0	75	29	29	41	29	29	232
Total	0	0	0	0	0	0	266	104	103	146	103	103	825

Direct/Provider Network Enrollment Percentages:

Directly-Contracted	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	71.8%	71.9%	71.9%	71.9%	71.9%	71.9%	71.9%
Provider Network:													
CFMG	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CHCN	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	28.2%	28.1%	28.1%	28.1%	28.1%	28.1%	28.1%
Provider Network Subtotal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	28.2%	28.1%	28.1%	28.1%	28.1%	28.1%	28.1%
Total	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Variance Jul-25	Variance Aug-25	Variance Sep-25	Variance Oct-25	Variance Nov-25	Variance Dec-25	Variance Jan-26	Variance Feb-26	Variance Mar-26	Variance Apr-26	Variance May-26	Variance Jun-26	YTD Member Variance
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Current Direct/Provider Network Enrollment Variance - Favorable/(Unfavorable)

Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	0	0	(98)	(173)	(248)	(334)	(392)	(456)	(1,701)
Alameda Health System	0	0	0	0	0	0	(4)	(10)	(8)	(16)	(26)	(31)	(95)
Directly-Contracted Subtotal	0	0	0	0	0	0	(102)	(183)	(256)	(350)	(418)	(487)	(1,796)
Provider Network:													
CFMG	0	0	0	0	0	0	0	0	0	0	0	0	0
CHCN	0	0	0	0	0	0	6	4	(5)	(38)	(59)	(85)	(177)
Provider Network Subtotal	0	0	0	0	0	0	6	4	(5)	(38)	(59)	(85)	(177)
Total	0	0	0	0	0	0	(96)	(179)	(261)	(388)	(477)	(572)	(1,973)

**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 JUNE, 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>								
\$1,464,799	\$1,467,534	\$2,734	0.2%	PCP Capitation	\$23,202,261	\$22,976,961	(\$225,300)	(1.0%)
5,824,339	5,627,901	(196,438)	(3.5%)	PCP Capitation FQHC	82,023,523	79,837,122	(2,186,401)	(2.7%)
430,491	432,779	2,288	0.5%	Specialty Capitation	5,499,723	5,437,181	(62,542)	(1.2%)
5,435,490	4,824,165	(611,325)	(12.7%)	Specialty Capitation FQHC	62,437,624	61,481,634	(955,990)	(1.6%)
740,888	693,341	(47,547)	(6.9%)	Laboratory Capitation	9,334,562	8,975,771	(358,791)	(4.0%)
318,581	312,186	(6,394)	(2.0%)	Vision Capitation	4,018,171	3,954,011	(64,160)	(1.6%)
97,913	98,435	522	0.5%	CFMG Capitation	1,250,905	1,236,687	(14,218)	(1.1%)
767,907	746,320	(21,587)	(2.9%)	ANC IPA Admin Capitation FQHC	10,382,493	10,219,576	(162,917)	(1.6%)
0	0	0	0.0%	Kaiser Capitation	(21,749)	(12,511)	9,238	(73.8%)
961,484	915,486	(45,998)	(5.0%)	DME Capitation	12,141,126	11,775,092	(366,034)	(3.1%)
730	2,409	1,679	69.7%	Dental Capitation	3,726	5,563	5,837	61.0%
16,042,621	15,120,556	(922,065)	(6.1%)	7. TOTAL CAPITATED EXPENSES	210,272,365	205,891,087	(4,381,278)	(2.1%)
<u>FEE FOR SERVICE MEDICAL EXPENSES</u>								
1,371,397	0	(1,371,397)	0.0%	IBNR Inpatient Services	(43,491,500)	(20,241,559)	23,249,941	(114.9%)
41,143	0	(41,143)	0.0%	IBNR Settlement (IP)	(1,304,745)	(607,245)	697,500	(114.9%)
109,710	0	(109,710)	0.0%	IBNR Claims Fluctuation (IP)	(3,479,322)	(1,619,325)	1,859,997	(114.9%)
51,994,930	42,048,348	(9,946,582)	(23.7%)	Inpatient Hospitalization FFS	566,198,881	543,914,937	(22,283,943)	(4.1%)
2,433,272	3,188,146	754,874	23.7%	IP OB - Mom & NB	39,838,328	40,684,459	846,132	2.1%
643,458	134,313	(509,145)	(379.1%)	IP Behavioral Health	3,453,559	2,045,113	(1,408,446)	(68.9%)
835,597	1,282,656	447,059	34.9%	Inpatient Facility Rehab FFS	15,913,992	16,435,928	521,935	3.2%
57,429,508	46,653,463	(10,776,045)	(23.1%)	8. Inpatient Hospital Expense	577,129,193	580,612,309	3,483,115	0.6%
(139,014)	0	139,014	0.0%	IBNR PCP	2,704,671	3,433,331	728,660	21.2%
(4,170)	0	4,170	0.0%	IBNR Settlement (PCP)	81,140	103,000	21,860	21.2%
(11,121)	0	11,121	0.0%	IBNR Claims Fluctuation (PCP)	216,373	274,669	58,296	21.2%
2,120,243	2,983,034	862,791	28.9%	PCP FFS	33,697,216	38,534,406	4,837,190	12.6%
0	0	0	0.0%	Special Needs Medical Expense	278	278	0	0.0%
422,497	378,904	(43,593)	(11.5%)	PCP FQHC FFS	6,059,424	5,012,462	(1,046,961)	(20.9%)
0	0	0	0.0%	Prop 56 Physician Pmt	(3,778)	(3,778)	0	0.0%
20,371	0	(20,371)	0.0%	Prop 56 Hyde	222,686	64,417	(158,269)	(245.7%)
101,379	0	(101,379)	0.0%	Prop 56 Trauma Screening	1,076,666	303,469	(773,197)	(254.8%)
107,690	0	(107,690)	0.0%	Prop 56 Developmentl Screening	1,199,931	361,844	(838,087)	(231.6%)
604,961	841,324	236,363	28.1%	Prop 56 Family Planning	7,702,803	9,479,355	1,776,552	18.7%
0	0	0	0.0%	Prop 56 VBP	(259)	(259)	0	0.0%
3,222,835	4,203,261	980,426	23.3%	9. Primary Care Physician Expense	52,957,151	57,563,194	4,606,044	8.0%
22,561	0	(22,561)	0.0%	IBNR Specialist	(1,935,791)	(334,249)	1,601,542	(479.1%)
677	0	(677)	0.0%	IBNR Settlement (SCP)	(58,073)	(10,026)	48,047	(479.2%)
1,805	0	(1,805)	0.0%	IBNR Claims Fluctuation (SCP)	(154,867)	(26,743)	128,124	(479.1%)
759,114	10,120	(748,995)	(7,401.4%)	Psychiatrist FFS	8,312,969	2,779,805	(5,533,165)	(199.0%)
3,205,312	7,454,927	4,249,616	57.0%	Specialty Care FFS	41,912,155	78,737,343	36,825,188	46.8%
271,955	0	(271,955)	0.0%	Specialty Anesthesiology	3,516,239	1,349,666	(2,166,573)	(160.5%)
1,423,913	0	(1,423,913)	0.0%	Specialty Imaging FFS	21,053,417	6,999,284	(14,054,133)	(200.8%)
52,871	0	(52,871)	0.0%	Obstetrics FFS	562,787	236,824	(325,963)	(137.6%)
335,489	0	(335,489)	0.0%	Specialty IP Surgery FFS	5,133,840	1,954,243	(3,179,596)	(162.7%)
928,025	0	(928,025)	0.0%	Specialty OP Surgery FFS	12,213,441	4,456,894	(7,756,548)	(174.0%)
467,030	0	(467,030)	0.0%	Specialty IP Physician	7,521,229	2,930,480	(4,590,749)	(156.7%)
201,996	122,392	(79,604)	(65.0%)	Specialist FQHC FFS	2,081,313	1,707,527	(373,786)	(21.9%)
7,670,748	7,587,439	(83,310)	(1.1%)	10. Specialty Care Physician Expense	100,158,660	100,781,048	622,387	0.6%
1,803,528	0	(1,803,528)	0.0%	IBNR Ancillary (ANC)	(1,352,114)	(3,205,959)	(1,853,845)	57.8%
54,107	0	(54,107)	0.0%	IBNR Settlement (ANC)	(40,567)	(96,181)	(55,614)	57.8%

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

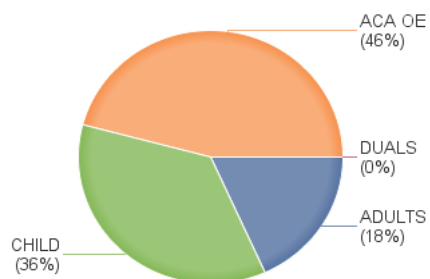
CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
144,282	0	(144,282)	0.0%	IBNR Claims Fluctuation (ANC)	(108,171)	(256,479)	(148,308)	57.8%
(391,000)	0	391,000	0.0%	IBNR Transportation FFS	33,268	(320,108)	(353,376)	110.4%
3,255,699	2,429,412	(826,287)	(34.0%)	Behavioral Health Therapy FFS	38,141,851	32,872,245	(5,269,606)	(16.0%)
2,928,472	0	(2,928,472)	0.0%	Psychologist & Other MH Prof	34,472,714	10,562,380	(23,910,334)	(226.4%)
745,035	0	(745,035)	0.0%	Other Medical Professional	8,894,822	2,326,374	(6,568,448)	(282.3%)
113,198	2,558	(110,640)	(4,326.1%)	Hearing Devices	1,967,677	693,429	(1,274,248)	(183.8%)
33,687	0	(33,687)	0.0%	ANC Imaging	341,039	138,286	(202,752)	(146.6%)
9,329	0	(9,329)	0.0%	Vision FFS	535,569	330,028	(205,541)	(62.3%)
0	0	0	0.0%	Family Planning	5	5	0	0.0%
871,007	771,516	(99,490)	(12.9%)	Laboratory FFS	9,784,439	9,436,806	(347,633)	(3.7%)
208,726	0	(208,726)	0.0%	ANC Therapist	2,191,682	667,783	(1,523,899)	(228.2%)
12,427	24,750	12,323	49.8%	OTC Card	23,183	98,250	75,067	76.4%
1,544,701	1,589,999	45,299	2.8%	Transp/Ambulance FFS	21,465,463	20,636,362	(829,101)	(4.0%)
0	103	103	100.0%	Worldwide Emergency Benefit	0	409	409	100.0%
1,647,549	2,637,784	990,235	37.5%	Non-ER Transportation FFS	33,068,457	31,098,898	(1,969,559)	(6.3%)
647,496	2,104,122	1,456,626	69.2%	Hospice FFS	19,915,433	24,274,528	4,359,095	18.0%
2,539,111	3,162,618	623,507	19.7%	Home Health Services	31,360,742	36,072,546	4,711,804	13.1%
0	102,502	102,502	100.0%	Other Medical FFS	9,800	409,350	399,550	97.6%
335,210	0	(335,210)	0.0%	Medical Refunds through HMS	(1,612,581)	(883,969)	728,612	(82.4%)
22,739	1,799,717	1,776,979	98.7%	DME & Medical Supplies FFS	311,508	15,137,391	14,825,883	97.9%
3,380,295	3,189,905	(190,390)	(6.0%)	ECM Base/Outreach FFS ANC	36,209,054	34,895,166	(1,313,888)	(3.8%)
177,660	177,932	272	0.2%	CS Housing Deposits FFS ANC	1,911,873	2,103,637	191,763	9.1%
(125,550)	698,572	824,122	118.0%	CS Housing Tenancy FFS ANC	5,824,272	9,284,423	3,460,152	37.3%
(55,278)	419,297	474,575	113.2%	CS Housing Navi Servic FFS ANC	3,781,771	5,721,603	1,939,832	33.9%
120,736	367,709	246,972	67.2%	CS Medical Respite FFS ANC	3,374,588	4,317,216	942,629	21.8%
264,000	269,939	5,939	2.2%	CS Med. Tailored Meals FFS ANC	2,724,074	3,052,483	328,410	10.8%
762	11,320	10,558	93.3%	CS Asthma Remediation FFS ANC	196,928	240,811	43,883	18.2%
0	0	0	0.0%	MOT Wrap Around (Non Med MOT)	6,868	6,868	0	0.0%
0	2,582	2,582	100.0%	CS Home Modifications FFS ANC	6,743	20,741	13,997	67.5%
98,948	96,274	(2,673)	(2.8%)	CS P.Care & Hmker Svcs FFS ANC	661,527	1,057,082	395,555	37.4%
0	6,466	6,466	100.0%	CS Cgiver Respite Svcs FFS ANC	25,156	59,695	34,539	57.9%
0	(11)	(11)	100.0%	CS ST PostHospital Housing FFS	0	(17)	(17)	100.0%
420	998	578	57.9%	CS Housing Outreach	8,740	9,164	424	4.6%
74,642	0	(74,642)	0.0%	CS Transitional Rent FFS ANC	74,642	0	(74,642)	0.0%
29,088	0	(29,088)	0.0%	CS Transitional Rent Admin ANC Expense	29,088	0	(29,088)	0.0%
380,843	0	(380,843)	0.0%	CommunityBased Adult Svc(CBAS)	5,254,917	1,519,540	(3,735,377)	(245.8%)
(765)	10,831	11,596	107.1%	CS LTC to ALF Transition FFS ANC	135,717	150,496	14,779	9.8%
0	5,003	5,003	100.0%	CS LTC to Home Transition FFS ANC	18,866	57,877	39,011	67.4%
20,871,105	19,881,900	(989,206)	(5.0%)	11. Ancillary Medical Expense	259,649,043	242,489,161	(17,159,881)	(7.1%)
862,383	0	(862,383)	0.0%	IBNR Outpatient	(4,193,344)	1,452,995	5,646,339	388.6%
25,871	0	(25,871)	0.0%	IBNR Settlement (OP)	(125,804)	43,588	169,392	388.6%
68,992	0	(68,992)	0.0%	IBNR Claims Fluctuation (OP)	(335,464)	116,241	451,705	388.6%
2,689,776	5,317,018	2,627,242	49.4%	Outpatient FFS	37,417,644	57,270,045	19,852,401	34.7%
3,303,418	171,576	(3,131,841)	(1,825.3%)	OP Ambul Surgery FFS	37,680,978	14,272,938	(23,408,040)	(164.0%)
1,931,820	3,179,966	1,248,146	39.3%	Imaging Services FFS	31,507,168	39,403,980	7,896,812	20.0%
86,227	0	(86,227)	0.0%	Behavioral Health FFS	1,419,844	493,539	(926,305)	(187.7%)
808,572	0	(808,572)	0.0%	Outpatient Facility Lab FFS	10,497,748	3,448,349	(7,049,399)	(204.4%)
230,492	0	(230,492)	0.0%	Outpatient Facility Cardio FFS	3,007,261	1,028,586	(1,978,675)	(192.4%)
117,848	0	(117,848)	0.0%	OP Facility PT/OT/ST FFS	1,500,545	461,172	(1,039,372)	(225.4%)
2,702,144	2,693,114	(9,030)	(0.3%)	OP Facility Dialysis Ctr FFS	34,123,599	36,229,239	2,105,640	5.8%
12,827,542	11,361,674	(1,465,868)	(12.9%)	12. Outpatient Medical Expense	152,500,175	154,220,671	1,720,497	1.1%
521,955	0	(521,955)	0.0%	IBNR Emergency	(2,449,022)	(2,513,669)	(64,647)	2.6%
15,659	0	(15,659)	0.0%	IBNR Settlement (ER)	(73,465)	(75,408)	(1,943)	2.6%
41,757	0	(41,757)	0.0%	IBNR Claims Fluctuation (ER)	(195,919)	(201,094)	(5,175)	2.6%
8,604,263	9,768,147	1,163,884	11.9%	ER Facility	115,964,197	120,850,014	4,885,817	4.0%

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

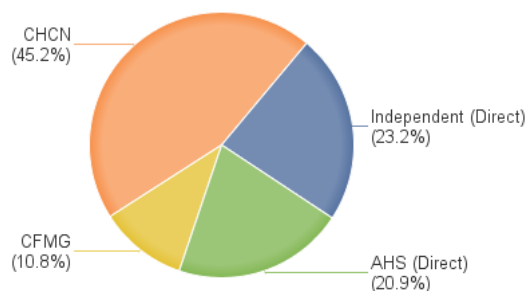
CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
1,055,655	0	(1,055,655)	0.0%	Specialty ER Physician FFS	14,747,820	4,951,779	(9,796,041)	(197.8%)
10,239,289	9,768,147	(471,142)	(4.8%)	13. Emergency Expense	127,993,611	123,011,622	(4,981,990)	(4.1%)
1,658,026	0	(1,658,026)	0.0%	IBNR Pharmacy (OP)	(228,719)	(2,257,911)	(2,029,192)	89.9%
49,740	0	(49,740)	0.0%	IBNR Settlement Rx (OP)	(6,859)	(67,734)	(60,875)	89.9%
132,642	0	(132,642)	0.0%	IBNR Claims Fluctuation Rx(OP)	(18,298)	(180,633)	(162,335)	89.9%
886,084	1,074,407	188,322	17.5%	Pharmacy FFS (OP)	9,332,475	10,491,120	1,158,645	11.0%
126,173	0	(126,173)	0.0%	Pharmacy Non PBM FFS Other-ANC	1,793,394	479,027	(1,314,368)	(274.4%)
11,662,486	10,628,644	(1,033,842)	(9.7%)	Pharmacy Non PBM FFS OP-FAC	101,477,673	112,886,248	11,408,574	10.1%
534,107	0	(534,107)	0.0%	Pharmacy Non PBM FFS PCP	4,930,548	1,140,883	(3,789,666)	(332.2%)
3,694,851	0	(3,694,851)	0.0%	Pharmacy Non PBM FFS SCP	41,511,796	11,779,726	(29,732,070)	(252.4%)
72,381	0	(72,381)	0.0%	Pharmacy Non PBM FFS FQHC	894,269	165,336	(728,932)	(440.9%)
14,492	0	(14,492)	0.0%	Pharmacy Non PBM FFS HH	175,766	78,426	(97,340)	(124.1%)
(40,000)	(86,597)	(46,597)	53.8%	Medical Expenses Pharm Rebate	(880,581)	(1,022,264)	(141,684)	13.9%
18,790,984	11,616,454	(7,174,531)	(61.8%)	14. Pharmacy Expense	158,981,465	133,492,223	(25,489,241)	(19.1%)
(596,073)	0	596,073	0.0%	IBNR LTC	(21,977,260)	(5,530,063)	16,447,197	(297.4%)
(17,882)	0	17,882	0.0%	IBNR Settlement (LTC)	(659,319)	(165,902)	493,417	(297.4%)
(47,685)	0	47,685	0.0%	IBNR Claims Fluctuation (LTC)	(1,758,184)	(442,407)	1,315,777	(297.4%)
1,537,308	1,923,154	385,846	20.1%	LTC - ICF/DD	21,750,005	23,383,351	1,633,346	7.0%
24,141,782	28,532,126	4,390,343	15.4%	LTC Custodial Care	311,771,552	343,039,504	31,267,952	9.1%
8,413,037	7,641,314	(771,723)	(10.1%)	LTC SNF	104,114,375	99,473,600	(4,640,775)	(4.7%)
33,430,487	38,096,593	4,666,106	12.2%	15. Long Term Care Expense	413,241,169	459,758,083	46,516,914	10.1%
164,482,499	149,168,930	(15,313,569)	(10.3%)	16. TOTAL FFS MEDICAL EXPENSES	1,842,610,466	1,851,928,312	9,317,846	0.5%
0	(279,807)	(279,807)	100.0%	Clinical Vacancy #102	0	(3,039,512)	(3,039,512)	100.0%
253,067	135,582	(117,485)	(86.7%)	Quality Analytics #123	2,364,231	3,130,527	766,296	24.5%
393,064	385,506	(7,558)	(2.0%)	LongTerm Services and Support #139	4,658,213	4,906,726	248,513	5.1%
966,678	1,215,503	248,825	20.5%	Utilization Management #140	11,192,549	12,677,105	1,484,556	11.7%
750,456	832,171	81,715	9.8%	Case & Disease Management #185	8,267,634	10,291,599	2,023,965	19.7%
310,686	297,508	(13,178)	(4.4%)	Medical Management #230	655,815	980,017	324,202	33.1%
1,937,845	1,399,229	(538,616)	(38.5%)	Quality Improvement #235	14,815,512	16,946,124	2,130,612	12.6%
410,723	435,613	24,890	5.7%	HCS Behavioral Health #238	4,804,281	5,341,796	537,515	10.1%
172,535	260,478	87,943	33.8%	Pharmacy Services #245	1,634,350	2,738,566	1,104,216	40.3%
0	0	0	0.0%	Regulatory Readiness #268	(4,027)	(5,289)	(1,262)	23.9%
5,195,055	4,681,784	(513,270)	(11.0%)	17. Other Benefits & Services	48,388,559	53,967,660	5,579,101	10.3%
(2,824,557)	(1,565,052)	1,259,505	(80.5%)	Reinsurance Recoveries	(28,933,664)	(23,985,245)	4,948,419	(20.6%)
2,216,028	2,086,736	(129,291)	(6.2%)	Reinsurance Premium	28,576,445	27,757,933	(818,512)	(2.9%)
(608,529)	521,684	1,130,213	216.6%	18. Reinsurance (Net)	(357,219)	3,772,688	4,129,907	109.5%
290,000	290,000	0	0.0%	P4P Risk Pool Provider Incenti	10,899,099	7,859,099	(3,040,000)	(38.7%)
290,000	290,000	0	0.0%	19. Risk Pool Distribution	10,899,099	7,859,099	(3,040,000)	(38.7%)
185,401,646	169,782,955	(15,618,691)	(9.2%)	20. TOTAL MEDICAL EXPENSES	2,111,813,269	2,123,418,845	11,605,575	0.5%

Category of Aid Trend						
Category of Aid	Jun 2026	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	52663	14%	10704	12532	1	29426
CHILD	103377	28%	9362	13585	36920	43510
SPD	0	0%	0	0	0	0
ACA OE	132326	36%	24606	41844	1402	64474
DUALS	9	0%	9	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	27360	8%	7841	4934	1532	13053
SPD-LTC/Full Dual	47882	13%	30847	3397	1	13637
Other	0		0	0	0	0
Medi-Cal	363617		83369	76292	39856	164100
Group Care	6350		2262	1169	0	2919
D-SNP	253		80	26	0	147
Total	370220	100%	85711	77487	39856	167166
Other %	0.0%		0.0%	0.0%	0.0%	0.0%
Medi-Cal %	98.2%		97.3%	98.5%	100.0%	98.2%
Group Care %	1.7%		2.6%	1.5%	0.0%	1.7%
D-SNP %	0.1%		0.1%	0.0%	0.0%	0.1%
Network Distribution			23.2%	20.9%	10.8%	45.2%
			% Direct:	44%	% Delegated:	56%

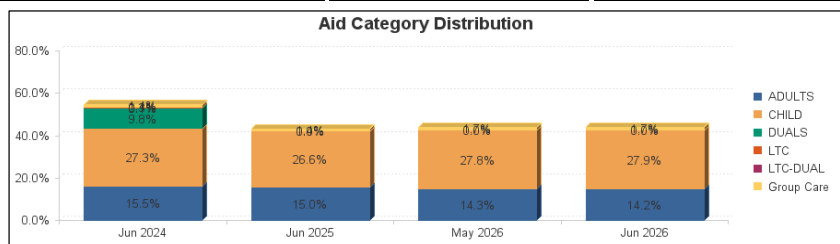
Medi-Cal By Aid Category



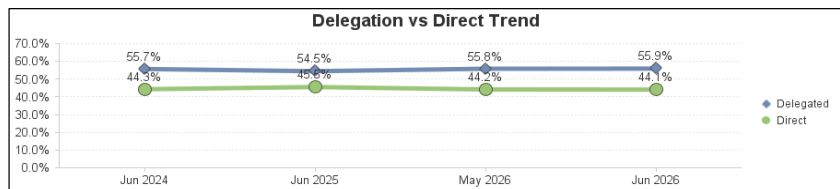
By Network



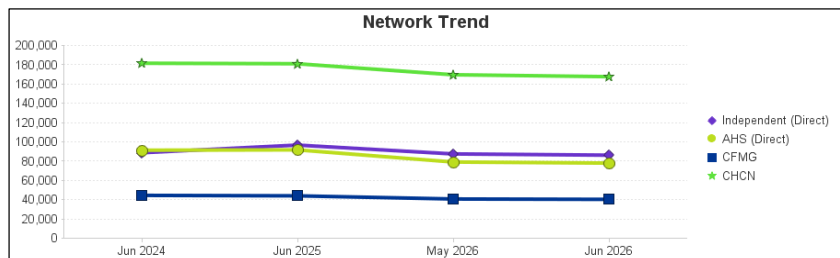
Category of Aid Trend											
Category of Aid	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026
ADULTS	62786	61699	53740	52663	15.5%	15.0%	14.3%	14.2%	-1.8%	-17.2%	-2.0%
CHILD	110164	109640	104137	103377	27.3%	26.6%	27.8%	27.9%	-0.5%	-6.1%	-0.7%
SPD	34935	0	0	0	8.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ACA OE	149359	155176	134907	132326	37.0%	37.7%	36.0%	35.7%	3.7%	-17.3%	-2.0%
DUALS	39789	1	5	9	9.8%	0.0%	0.0%	0.0%	-3,978,800.0%	88.9%	44.4%
LTC	224	0	0	0	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LTC-DUAL	1250	0	0	0	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SPD-LTC	0	29750	27794	27360	0.0%	7.2%	7.4%	7.4%	100.0%	-8.7%	-1.6%
SPD-LTC/Full Dual	0	49304	47866	47882	0.0%	12.0%	12.8%	12.9%	100.0%	-3.0%	0.0%
Other	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medi-Cal	398507	405570	368449	363617	98.6%	98.6%	98.3%	98.2%	1.7%	-11.5%	-1.3%
Group Care	5658	5910	6311	6350	1.4%	1.4%	1.7%	1.7%	4.3%	6.9%	0.6%
D-SNP	0	0	245	253	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
Total	404165	411480	375005	370220	100.0%	100.0%	100.0%	100.0%	1.8%	-11.2%	-1.3%



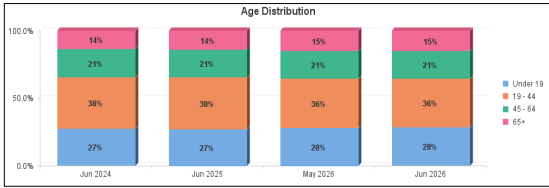
Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026
Delegated	225091	224102	209395	207022	55.7%	54.5%	55.8%	55.9%	-0.4%	-8.3%	-1.1%
Direct	179074	187378	165610	163198	44.3%	45.5%	44.2%	44.1%	4.4%	-14.9%	-1.5%
Total	404165	411480	375005	370220	100.0%	100.0%	100.0%	100.0%	1.8%	-11.2%	-1.3%



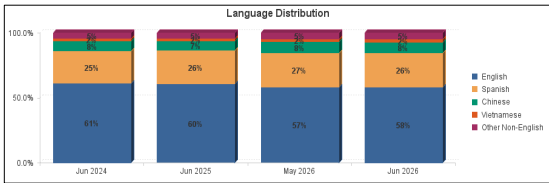
Network Trend											
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026
Independent (Direct)	88206	96173	87006	85711	21.8%	23.4%	23.2%	23.2%	8.3%	-12.3%	-1.5%
AHS (Direct)	90868	91205	78604	77487	22.5%	22.2%	21.0%	20.9%	0.4%	-17.7%	-1.4%
CFMG	43991	43522	40238	39856	10.9%	10.6%	10.7%	10.8%	-1.1%	-9.2%	-1.0%
CHCN	181100	180580	169157	167166	44.8%	43.9%	45.1%	45.2%	-0.3%	-8.1%	-1.2%
KAISER	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	404165	411480	375005	370220	100.0%	100.0%	100.0%	100.0%	1.8%	-11.2%	-1.3%



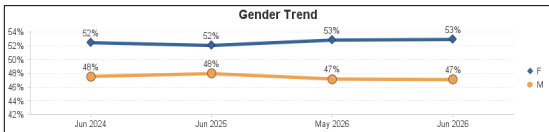
Age Category Trend												
Age Category	Members				% of Total (ie.Distribution)				% Growth (Loss)			
	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026	
Under 19	108701	109396	103989	103159	27%	27%	28%	28%	1%	-6%	-1%	
19 - 44	155198	157686	136512	133894	38%	38%	36%	36%	2%	-18%	-2%	
45 - 64	83870	84758	77090	76166	21%	21%	21%	21%	1%	-11%	-1%	
65+	56396	59640	57169	56748	14%	14%	15%	15%	5%	-5%	-1%	
Total	404165	411480	374760	369967	100%	100%	100%	100%	2%	-11%	-1%	



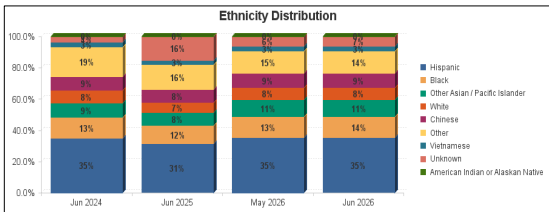
Language Trend												
Language	Members				% of Total (ie.Distribution)				% Growth (Loss)			
	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026	
English	245593	247110	215572	213402	61%	60%	57%	58%	1%	-16%	-1%	
Spanish	100576	105889	100122	98042	25%	26%	27%	26%	5%	-8%	-2%	
Chinese	30660	30503	30532	30269	8%	7%	8%	8%	-1%	-1%	-1%	
Vietnamese	8386	8135	8689	8647	2%	2%	2%	2%	-3%	6%	0%	
Other Non-English	18950	19843	19845	19607	5%	5%	5%	5%	5%	-1%	-1%	
Total	404165	411480	374760	369967	100%	100%	100%	100%	2%	-11%	-1%	



Gender Trend												
Gender	Members				% of Total (ie.Distribution)				% Growth (Loss)			
	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026	
F	211959	214154	198088	195898	52%	52%	53%	53%	1%	-9%	-1%	
M	192206	197326	176917	174322	48%	48%	47%	47%	3%	-13%	-1%	
Total	404165	411480	375005	370220	100%	100%	100%	100%	2%	-11%	-1%	



Ethnicity Trend												
Ethnicity	Members				% of Total (ie.Distribution)				% Growth (Loss)			
	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026	
Hispanic	139887	127002	131004	128769	35%	31%	35%	35%	-10%	1%	-2%	
Black	53044	48489	50300	50123	13%	12%	13%	14%	-9%	3%	0%	
Other Asian / Pacific Islander	37615	33457	39472	39082	9%	8%	11%	11%	-12%	14%	-1%	
White	32738	27820	30366	30171	8%	7%	8%	8%	-18%	8%	-1%	
Chinese	35855	32481	33098	32764	9%	8%	9%	9%	-10%	1%	-1%	
Other	76430	66579	54939	53712	19%	16%	15%	15%	-15%	-24%	-2%	
Vietnamese	11893	10610	10768	10679	3%	3%	3%	3%	-12%	1%	-1%	
Unknown	15906	64320	24326	24199	4%	16%	6%	7%	75%	-166%	-1%	
American Indian or Alaskan Native	797	722	732	721	0%	0%	0%	0%	-10%	-1%	-2%	
Total	404165	411480	375005	370220	100%	100%	100%	100%	2%	-11%	-1%	



City	Jun 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	144272	40%	21538	36570	15719	70445
HAYWARD	46596	13%	10985	12312	5236	18063
FREMONT	34865	10%	14902	5498	1876	12589
SAN LEANDRO	22955	6%	6170	3617	2878	10290
UNION CITY	13175	4%	5375	2199	741	4860
ALAMEDA	12695	3%	3144	2312	1982	5257
BERKELEY	14750	4%	3153	2390	1644	7563
LIVERMORE	11997	3%	1940	320	1959	7778
NEWARK	8315	2%	2677	3210	418	2010
CASTRO VALLEY	10264	3%	2978	1531	1636	4119
SAN LORENZO	5529	2%	1145	1227	643	2514
PLEASANTON	7437	2%	2265	256	784	4132
DUBLIN	7248	2%	2486	268	843	3651
EMERYVILLE	2875	1%	533	638	502	1202
ALBANY	2299	1%	402	272	528	1097
PIEDMONT	398	0%	86	147	58	107
SUNOL	80	0%	31	8	6	35
ANTIOCH	34	0%	12	10	4	8
Other	17833	5%	3547	3507	2399	8380
Total	363617	100%	83369	76292	39856	164100

Group Care By City						
City	Jun 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1883	30%	332	426	0	1125
HAYWARD	729	11%	336	195	0	198
FREMONT	730	11%	455	89	0	186
SAN LEANDRO	698	11%	275	105	0	318
UNION CITY	295	5%	173	52	0	70
ALAMEDA	322	5%	95	39	0	188
BERKELEY	161	3%	40	19	0	102
LIVERMORE	101	2%	28	1	0	72
NEWARK	160	3%	90	41	0	29
CASTRO VALLEY	226	4%	95	37	0	94
SAN LORENZO	187	3%	59	45	0	83
PLEASANTON	78	1%	27	3	0	48
DUBLIN	137	2%	50	5	0	82
EMERYVILLE	46	1%	10	10	0	26
ALBANY	26	0%	9	4	0	13
PIEDMONT	4	0%	0	1	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	7	5	0	12
Other	542	9%	180	92	0	270
Total	6350	100%	2262	1169	0	2919

D-SNP By City						
City	Jun 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	93	37%	20	9	0	64
HAYWARD	30	12%	11	3	0	16
FREMONT	19	8%	12	0	0	7
SAN LEANDRO	17	7%	5	5	0	7
UNION CITY	5	2%	3	0	0	2
ALAMEDA	18	7%	4	5	0	9
BERKELEY	16	6%	1	0	0	15
LIVERMORE	12	5%	2	1	0	9
NEWARK	7	3%	6	1	0	0
CASTRO VALLEY	3	1%	2	1	0	0
SAN LORENZO	5	2%	3	0	0	2
PLEASANTON	5	2%	3	0	0	2
DUBLIN	7	3%	0	0	0	7
EMERYVILLE	3	1%	1	0	0	2
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	13	5%	7	1	0	5
Sum:			2262	1169	0	2919

Total By City						
City	Jun 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	146155	39%	21870	36996	15719	71570
HAYWARD	47325	13%	11321	12507	5236	18261
FREMONT	35595	10%	15357	5587	1876	12775
SAN LEANDRO	23653	6%	6445	3722	2878	10608
UNION CITY	13470	4%	5548	2251	741	4930
ALAMEDA	13017	4%	3239	2351	1982	5445
BERKELEY	14911	4%	3193	2409	1644	7665
LIVERMORE	12098	3%	1968	321	1959	7850
NEWARK	8475	2%	2767	3251	418	2039
CASTRO VALLEY	10490	3%	3073	1568	1636	4213
SAN LORENZO	5716	2%	1204	1272	643	2597
PLEASANTON	7515	2%	2292	259	784	4180
DUBLIN	7385	2%	2536	273	843	3733
EMERYVILLE	2921	1%	543	648	502	1228
ALBANY	2325	1%	411	276	528	1110
PIEDMONT	402	0%	86	148	58	110
SUNOL	81	0%	32	8	6	35
ANTIOCH	58	0%	19	15	4	20
Other	18375	5%	3727	3599	2399	8650
Total	369067	100%	85631	77461	39856	167019



Operations

Beau Hennemann

To: Alameda Alliance for Health Board of Governors

From: Operations Department

Date: August 14th, 2026

Subject: Operations Report

Member Services

- 12-Month Trend Blended Summary:
 - The Member Services Department received 17,650 calls in July 2026 compared to 18,993 in July 2025 which represents a 7% decrease in calls.
 - The abandonment rate for July 2026 was 2% compared to 4% in July 2025.
 - The Department's service level was 97% in July 2026, compared to 94% in July 2025. The average speed to answer (ASA) was seven seconds (00:07) in July 2026, compared to thirteen seconds (00:13) in July 2025. The Department continues to recruit to fill open positions, when approved. Customer Service support service vendor continues to provide overflow call center support.
 - The average talk time (ATT) was seven minutes and thirty-one seconds (7:31) for July 2026 compared to seven minutes and thirty-nine seconds (7:39) for July 2025.
 - 100% of calls were answered within 10 minutes for July 2026 and 100% of calls were answered within 10 minutes for July 2025.
 - Outbound calls totaled 10,506 in July 2026 compared to 9,544 in July 2025.
 - The top five (5) call reasons for July 2026 were 1) Grievances/Appeals, 2) Change of PCP, 3) Eligibility/Enrollment, 4) Benefits, and 5) Provider Network Information. The top five (5) call reasons for July 2025 were: 1) Eligibility/Enrollment, 2) Change of PCP, 3) Grievances/Appeals, 4) Benefits, and 5) Provider Network Information.
 - July 2026 utilization of the member automated eligibility IVR system totaled 1,441 compared to 1,302 in July 2025.
 - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests, and in-person). The Department responded to 921 web-based requests in July 2026 compared to 1,332 in July 2025. The top three (3) web request reasons for July 2026 were: 1) Change of PCP, 2) ID Card Requests, and 3) Update Contact Information. 46 members were assisted in-person in July 2026 compared to 53 in July 2025.

- MS Behavioral Health:
 - The Member Services Behavioral Health (MS BH) Unit received a total of 985 calls in July 2026 compared to 1,191 in July 2025.
 - The abandonment rate was 3% in July 2026 compared to 9% in July 2025.
 - The service level was 94% in July 2026 and 75% in July 2025.
 - The average speed to answer (ASA) was fourteen seconds (00:14) compared to one minute and four seconds (01:04) in July 2025.
 - In both July 2026 and July 2025, 100% of calls were answered within 10 minutes.
 - The Average Talk Time (ATT) was nine minutes and fourteen seconds (9:14) compared to ten minutes and forty-two seconds (10:42) in July 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.
 - 2,005 outbound calls were completed in July 2026 compared to 1,214 in July 2025.
 - 125 screenings were completed in July 2026 compared to 142 in July 2025.
 - 23 referrals were made to the County (ACCESS) in July 2026 compared to 41 July 2025.
 - 27 members were referred to Center Point for SUD services in July 2026 compared to 15 in July 2025.

- D-SNP Member Services blended:
 - The Member Services D-SNP Unit received a total of 557 calls in July 2026.
 - The abandonment rate was 2%.
 - The Average Speed to Answer (ASA) was six seconds (00:06).
 - The service level was 100%.
 - The Average Talk Time (ATT) was seven minutes and fourteen seconds (7:14).
 - The top five (5) call reasons were: 1) Appeals/Grievances, 2) Benefits/Organizational Determinations, 3) Eligibility/Enrollment, 4) Provider Network Information, and 5) Change of PCP.

Claims

- 12-Month Trend Summary:
 - The Claims Department received 408,603 claims for all lines of business in July 2026 compared to 355,255 in July 2025.
 - The Auto Adjudication rate was 84% in July 2026 compared to 84% in July 2025.
 - Claims compliance for the 30-day turn-around time was 94.4% in July 2026 compared to 81.8% in July 2025.
 - Routine training is being conducted remotely and onsite by the Claims Trainer.
- Medi-Cal/Group Care Monthly Analysis:
 - In July, we received a total of 407,464 claims in the HEALTHsuite system, which represents an increase of 9.6% from June 2026. It is also 14.7% higher than the number of claims received in July 2025 (355,255).
 - 89% of claims were received via EDI and 11% of claims via paper during July.
 - The Auto Adjudication rate was 84% for July.
- D-SNP Monthly Analysis:
 - In July, we received a total of 1,139 claims in the HEALTHsuite system, which represents a 30.3% increase from June 2026, when 874 claims were received.
 - 880 claims (77%) were received via EDI, and 259 claims (23%) were received via paper in July.
 - Out of 1,139 claims, 534 claims have been finalized.
 - The Auto Adjudication rate was 51.4% for July.
- D-SNP YTD Analysis
 - A total of 5,426 D-SNP claims have been received since January 1st, 2026, go-live, and 4,807 claims have been finalized.

Provider Dispute Resolution

- 12-Month Trend Summary:
 - In July 2026, the Provider Dispute Resolution (PDR) team received 3,239 PDRs versus 4,426 in July 2025.
 - The PDR team resolved 2,212 cases in July 2026 compared to 2,819 cases in July 2025.
 - In July 2026, the PDR team upheld 71 % of cases versus 72% in July 2025.
 - The PDR team resolved 98% of cases within the compliance standard of 95% within 45 working days in July 2026, compared to 99.8% in July 2025.
- Monthly Analysis:
 - In July 2026, the Provider Dispute Resolution (PDR) team received 3,239 PDRs versus 2,800 in June 2026. This represents a 15.7% increase from June 2026.
 - In July 2026, 2,212 PDRs were resolved, with 1,573 upheld and 639 overturned.
 - 2,168 of 2,212 cases were resolved within 45 working days, resulting in a 98% compliance rate.
 - The average turnaround time for resolving PDRs in July was 41 days.
 - There were 4,465 PDRs pending resolution as of 07/31/2026, with no cases older than 45 working days.
 - The overturn rate for PDRs was 29%, which did not meet our goal of 25% or less.
 - Primary reasons for the missed goal include:
 - Member OHC corrections – 104 cases with incorrect claim denials.
 - Authorization issues – 157 cases with incorrect claim denials (claim denied in error; authorization was on file).
 - Incorrect Rate Configuration – 174 cases were underpaid due to the contract not being loaded in the system correctly.

- The full breakdown of all **639** overturned PDRs is:

Category	# of Cases	% of Cases	Comments
System Related Issues	86	13%	
General configuration issues	15	2%	Non-covered code, modifier, NDC etc.
Financial responsibility	59	9%	Member Not Found, Eligibility
Claims Editing System (CES)	12	2%	
Authorization Issues	157	24%	
Processor error	78	12%	Authorization was on file
UM/retro auth review	32	5%	Retro medical necessity review
Auth System error	47	7%	
OHC Issues	104	15%	Inaccurate OHC Member TPL data
Incorrect Rates	174	27%	
Incorrect rate - System	57	8%	Contract not updated in the system at the time of claim processing
Letter of Agreement (LOA)	11	2%	Underpaid; LOA on file
COB calculation	58	9%	Incorrectly calculated
Incorrect rate – Processor	48	8%	The processor did not calculate the rate correctly according to the contract or rate sheet
Claim Processing Error	95	18%	
Duplicate claim	58	9%	The claim was not a duplicate; the processor denied it in error
Incorrect Manual Denial	16	3%	The claim was manually denied incorrectly
Overpayment	21	3%	Provider requests recoupment due to overpayment
Additional Documentation	23	3%	
Provider duplicate documentation provided	9	1%	The documentation received confirmed that the claim was not a duplicate
Timely filing	14	2%	The documentation received confirmed that the claim was submitted on time
PDR Overturn Totals	639	100%	

Grievances & Appeals (MCAL & IHSS)

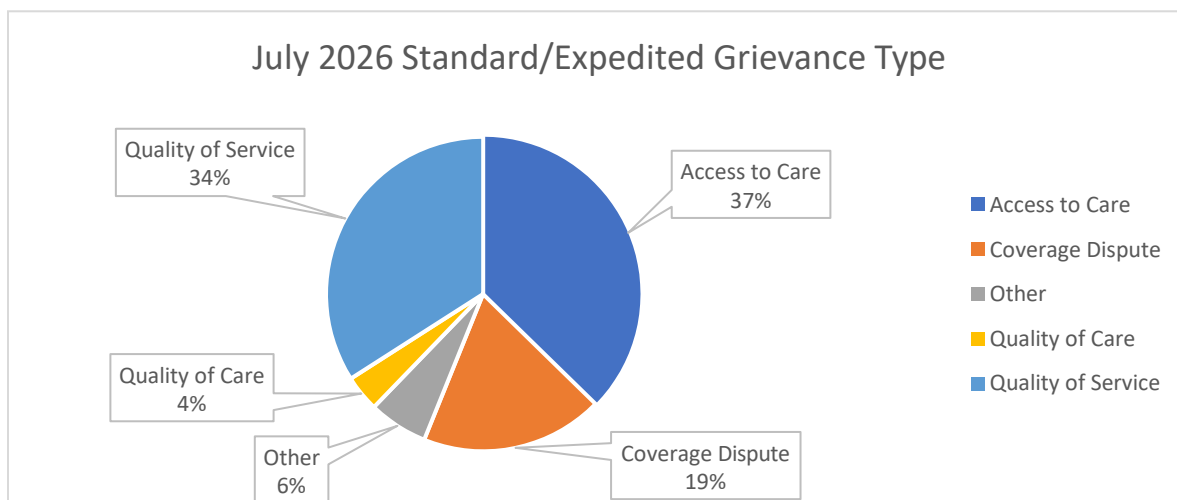
- Standard Grievance cases were not resolved within the goal of 95% of regulatory timeframes.
- Exempt Grievance and Expedited Grievance cases were resolved within the goal of 95% of regulatory timeframes.
- Standard Appeal and Expedited Appeal cases were resolved within the goal of 95% of regulatory timeframes.
- Total Unique grievances resolved in July were 11.4 complaints per 1,000 members.

July 2026 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,389	30 Calendar Days	95% compliance within standard	2,249	94.2%	5.50
Expedited Grievance	2	72 Hours	95% compliance within standard	2	100.0%	0.00
Exempt Grievance	2,156	Next Business Day	95% compliance within standard	2,154	99.9%	4.91
Standard Appeal	91	30 Calendar Days	95% compliance within standard	91	100.0%	0.24
Expedited Appeal	2	72 Hours	95% compliance within standard	2	100.0%	0.00
Total Cases:	4,640		95% compliance within standard	4,498	96.9%	10.4

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

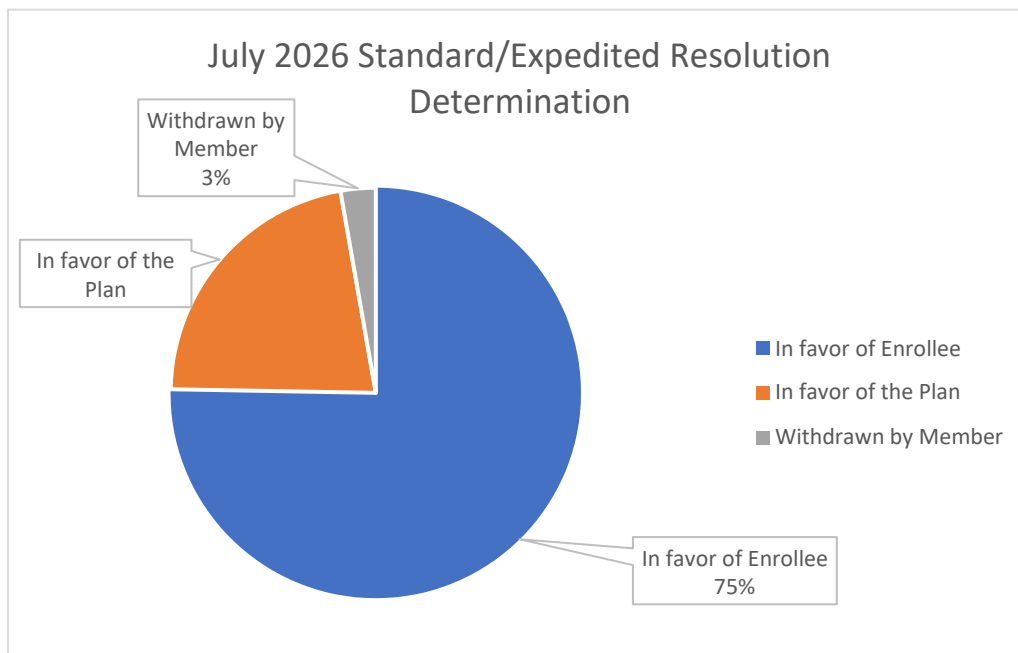
Standard/Expedited Grievances:

There were 2,018 unique grievance cases resolved during the reporting period, with a total of 2,391 grievances including 373 shadow cases.



- **892** of 2,391 (37%) cases were related to Access to Care; the following are the top four (4) categories:
 - Technology/telephone – 263
 - Timely Access – 259
 - Authorization – 140
 - Provider Availability – 96
- **814** of 2,391 (34%) cases were related to Quality of Service; the following are the top four (4) categories:
 - Authorization – 168
 - Provider / Staff Attitude – 167
 - Plan Customer Service – 145
 - Referral – 136
- **450** of 2,391 (19%) cases were related to Coverage Dispute; the following are the top two (2) categories:
 - Provider Direct Member Billing – 189
 - Provider Balance Billing – 179
- **146** of 2,391 (6%) cases were related to Other; the following are the top two (2) categories:
 - Enrollment – 72
 - Eligibility – 57
- **89** of 2,391 (4%) cases were related to Quality of Care; the top category was:
 - Quality of Care – 66

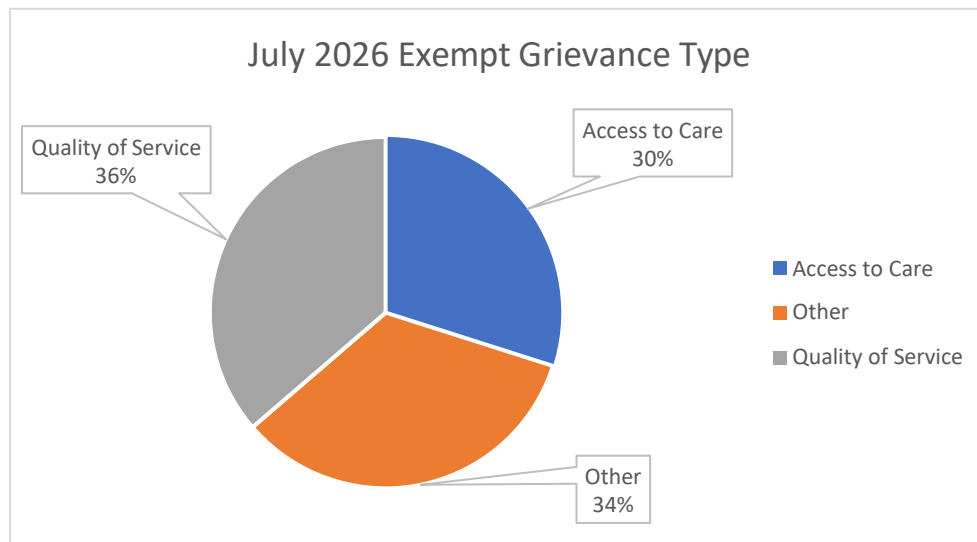
Resolution Determination:



- **1,800** of 2,391 (75%) cases were resolved In Favor of Enrollee
- **525** of 2,391 (22%) cases were resolved In Favor of the Plan
- **66** of 2,391 (3%) cases were Withdrawn by Member

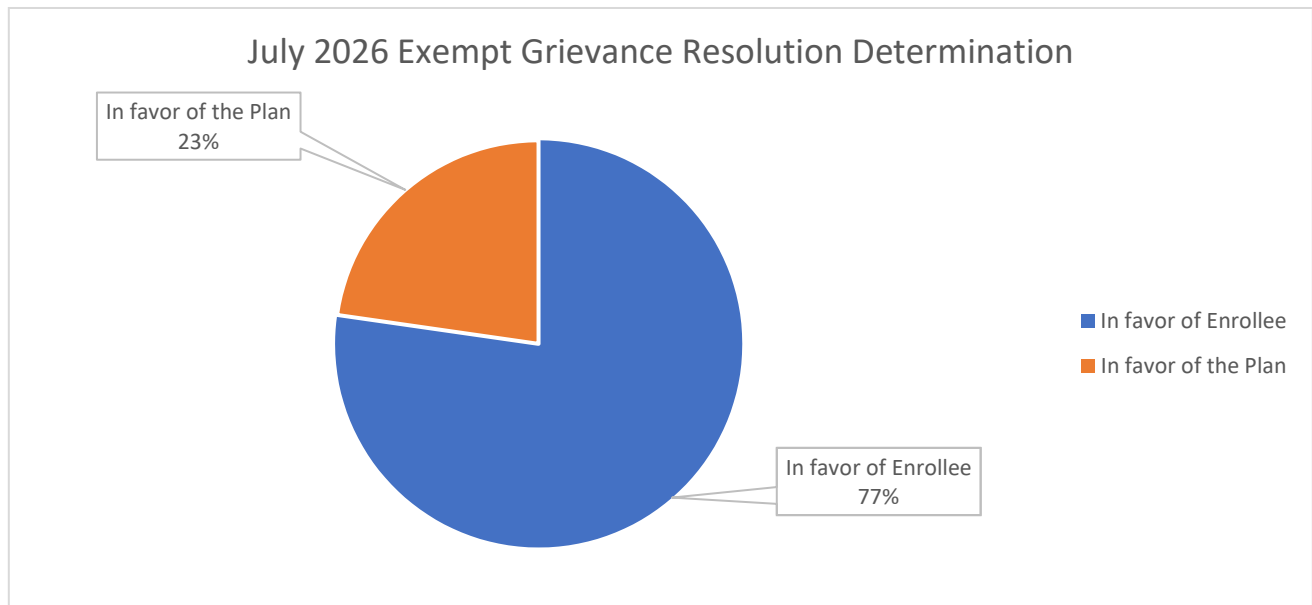
Exempt Grievances:

There were 1,800 unique exempt grievance cases resolved during the reporting period, with a total of 2,156 exempt grievances including 356 shadow cases.



- **783** of 2,156 (36%) cases were related to Quality of Service; the following are the top two (2) categories:
 - Plan Customer Service – 459
 - Provider / Staff Attitude – 274
- **728** of 2,156 (34%) cases were related to Other; the following are the top two (2) categories:
 - Enrollment – 660
 - Eligibility – 68
- **645** of 2,156 (30%) cases were related to Access to Care; the following are the top two (2) categories:
 - Provider Availability – 319
 - Technology / Telephone – 179

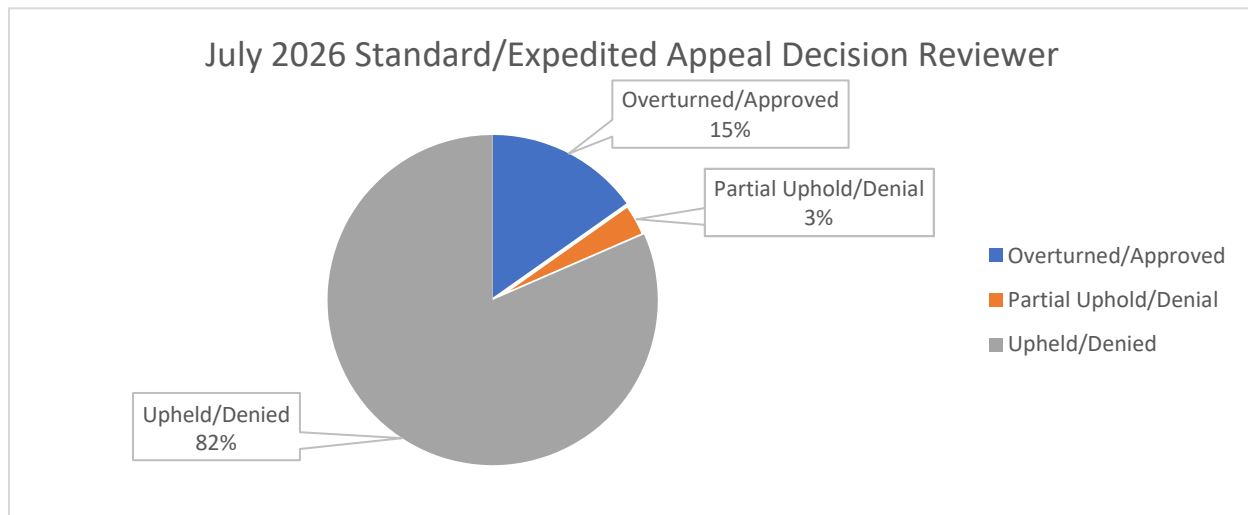
Resolution Determination:



- **1,666** of 2,156 (77%) cases were resolved In Favor of Enrollee
- **490** of 2,156 (23%) 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 July 2026, we met our goal with a 15% overturn/approved rate.



- **75** out of 92 (82%) cases had an upheld/denied decision for the month of July 2026:
 - Disputes Involving Medical Necessity – 55
 - Out of Network – 20

- **14** out of 92 (15%) cases had an overturn/approved decision for the month of July 2026:
 - Disputes Involving Medical Necessity – 14
- **3** out of 92 (3%) cases had a partial uphold/denial decision for the month of June 2026:
 - Disputes Involving Medical Necessity – 3

D-S NP Grievances & Appeals (Resolved)

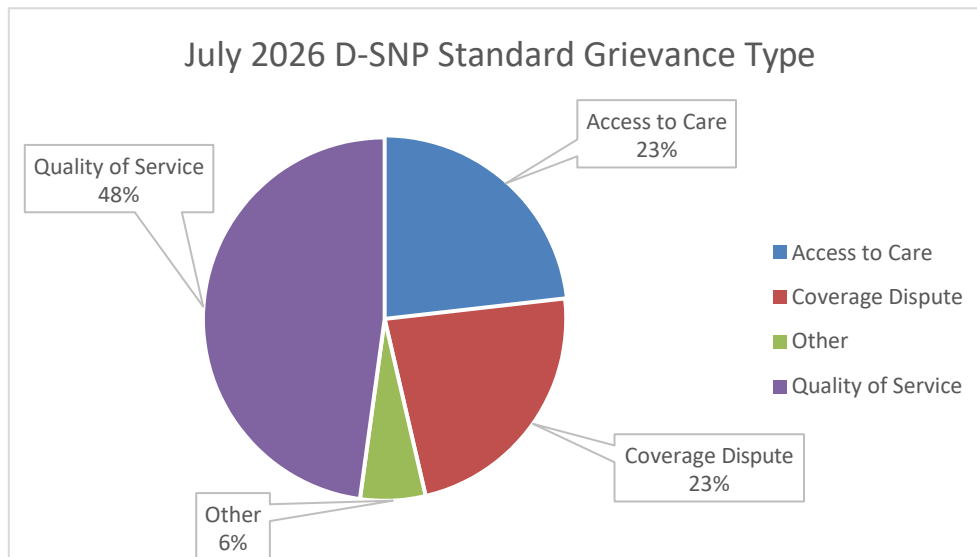
- Standard Grievance and First Call Resolution cases were resolved within the goal of 95% of regulatory timeframes
- Standard Appeal cases were resolved within the goal of 95% of regulatory timeframes.
- There were no Expedited Grievance cases filed in July 2026.

July 2026 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate
Standard Grievance	69	30 Calendar Days	95% compliance within standard	69	100.0%
Expedited Grievance	0	72 Hours	95% compliance within standard	0	N/A
First Call Resolution	40	Next Business Day	95% compliance within standard	39	97.5%
Standard Appeal	3	30 Calendar Days	95% compliance within standard	3	100.0%
Expedited Appeal	0	72 Hours	95% compliance within standard	0	N/A
Total Cases:	112		95% compliance within standard	111	99.1%

*Per 1,000 not calculated for DSNP because enrollment is below 10,00.

Standard Grievances:

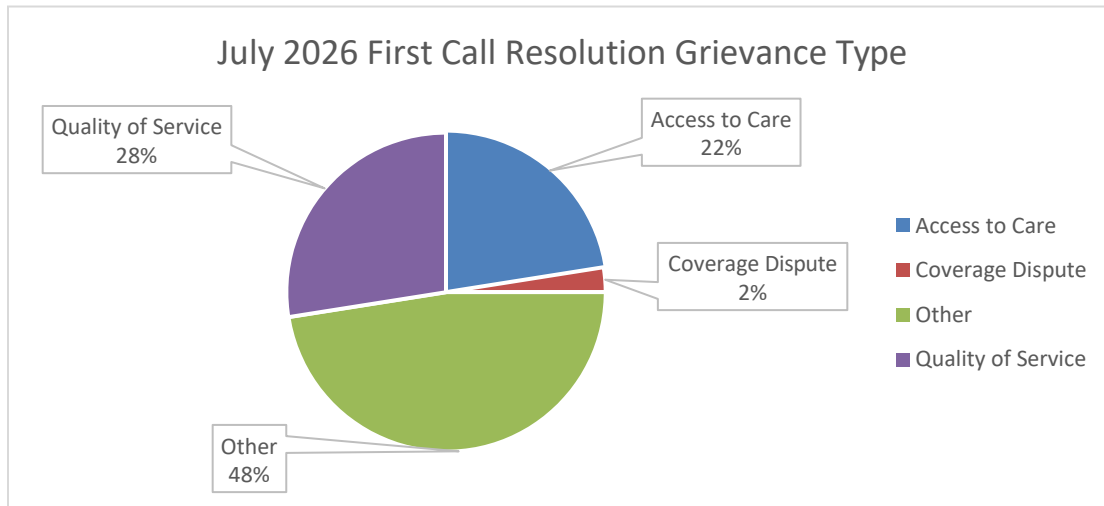
There were 52 unique grievance cases resolved during the reporting period, with a total of 69 grievances including 17 shadow cases.



- **33** of 69 (48%) cases were related to Quality of Service; the categories are:
 - Plan Customer Service – 10
 - Member Services – 6
 - CHME – 1
 - CM Department – 1
 - Communications & Outreach – 1
 - Grievance & Appeals – 1
 - Referral – 9
 - Member Informing Materials – 5
 - Case Management / Care Coordination – 3
 - Provider / Staff Attitude – 2
 - Authorization – 2
 - Transportation – 2
- **16** of 69 (23%) cases were related to Access to Care; the categories are:
 - Technology / Telephone – 6
 - Authorization – 4
 - Timely Access – 3
 - Geographic Access – 1
 - Out-of-Network – 1
 - Physical Access – 1
- **16** of 69 (23%) cases were related to Coverage Dispute; the categories are:
 - Provider Balance Billing – 6
 - Provider Direct Member Billing – 6
 - Benefit – 4
- **4** of 69 (6%) cases were related to Other; the categories are:
 - Enrollment – 3
 - Eligibility – 1

First Call Resolution (FCR) Grievances:

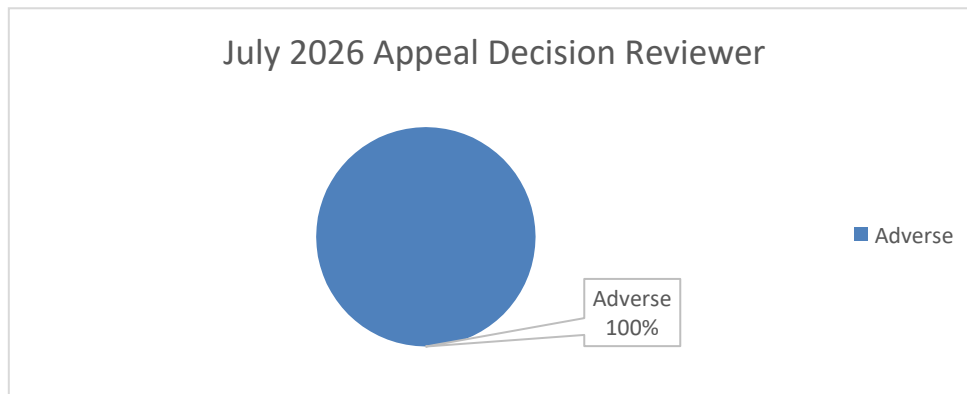
There were 31 unique exempt grievance cases resolved during the reporting period, with a total of 40 cases, including 9 shadow cases.



- **19** of 40 (48%) cases were related to Other; the categories are:
 - Enrollment – 16
 - Eligibility – 3
- **11** of 40 (28%) cases were related to Quality of Service; the categories were:
 - Plan Customer Service – 6
 - Member Services – 3
 - Communications & Outreach – 1
 - Liberty – 1
 - Xaqt – 1
 - Member Informing Materials – 4
 - Transportation – 1
- **9** of 40 (22%) cases were related to Access to Care; the categories were:
 - Technology / Telephone – 6
 - Geographic Access – 2
 - Out-of-Network – 1
- **1** of 40 (2%) cases was related to Coverage Dispute; the category was:
 - Benefit – 1

Appeals:

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



- 3 cases had an adverse decision (upheld/denied) for the month of July 2026:
 - Disputes Involving Medical Necessity – 1
 - Coverage Dispute – 1
 - Out-of-Network – 1

CTM Information for July 2026:

- There were no CTMs closed in the month of July 2026.

Provider Services

- 12-Month Trend Summary:
 - The Provider Services department's call volume in July 2026 was 8,794 calls (7,383 Medi-Cal/Group Care and 1,411 D-SNP) compared to 9,330 calls in July 2025.
- Monthly Analysis:
 - The Provider Services department completed 404 calls/visits during July 2026.
 - The Provider Services department answered 5,831 calls (4,848 Medi-Cal/Group Care and 983 D-SNP) for July 2026 and made 288 outbound calls (259 Medi-Cal/IHSS and 29 D-SNP).

Credentialing

- Monthly Analysis:
 - At the Peer Review and Credentialing (PRCC) meetings held on July 21st, 2026, there were one hundred and sixty-one (161) initial network providers approved.
 - One (1) primary care provider
 - Ten (10) specialists
 - Twenty-three (23) ancillary providers
 - Ten (10) mid-level providers
 - One hundred and seventeen (117) behavioral health providers
 - 60 providers were re-credentialed at this meeting
 - Five (5) primary care providers
 - Fourteen (14) specialists
 - One (1) ancillary providers
 - Nine (9) mid-level providers
 - Thirty-one (31) behavioral health providers
 - 433 facilities are currently credentialed.

Community Relations and Outreach

- 12-Month Trend Summary:
 - In July 2026, the Alliance completed 498 member orientation outreach calls and 77 member orientations by phone.
 - The C&O Department reached 729 people (43% identified as Alliance members) during outreach activities, compared to 1,718 individuals (65 % self-identified as Alliance members) in July 2025.
 - The C&O Department spent a total of \$2,500 in donations, fees, and/or sponsorships, compared to \$0 in July 2025.
 - The C&O Department reached members in 15 cities/unincorporated areas throughout Alameda County and the Bay Area, compared to 14 cities in July 2025.
- Monthly Analysis:
 - In June 2026, the C&O Department completed 594 member orientation outreach calls, 54 new member orientations by phone, 10 non-utilizer member orientations by phone, and 25 Alliance website inquiries.
 - Among the 30,979 people reached during outreach activities, 2% identified as Alliance members.
 - In June 2026, the C&O Department reached members in 10 locations throughout Alameda County, the Bay Area, and the U.S.
 - Please see attached **Addendum A**.

Medicare Operations

Medicare Operations Division

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

- Rebate Allocation with CMS and Health Plan – July 28th - August 6th, 2026.
- Drug Pricing and Plan Benefit Data previews – August and September 2026.
- Annual Enrollment Period (AEP) – October 15th through December 7th, 2026.
- Open Enrollment Period (OEP) Begins – January 1st, 2027.

- **D-SNP Activities – July 2026**

- Medicare Product Updates:

- **Dental – Liberty Dental**

- Reviewed and updated 2027 Liberty Dental member Frequently Asked Questions (FAQs) to ensure accuracy, completeness, and alignment with current benefits, processes, and member communications. Incorporated feedback as needed and distributed finalized materials to relevant stakeholders for implementation and annual readiness activities.
- Partnering with Liberty and internal stakeholders to evaluate upcoming Medicare Plan Finder data integration requirements, including reviewing data submission specifications, implementation timelines, and operational impacts.

- **Vision – Vision Service Plan (VSP)**

- Created a 2027 VSP member FAQs document for member education purposes. Incorporated feedback as needed and distributed finalized materials to relevant stakeholders for implementation and annual readiness activities.
- Partnering with VSP and internal stakeholders to evaluate upcoming Medicare Plan Finder data integration requirements, including reviewing data submission specifications, implementation timelines, and operational impacts.
- A project closeout package for the VSP Vision project was completed, indicating that implementation activities have reached formal closure.

- **Over the Counter (OTC) and Hearing – Nations Benefits**

- Reviewed and updated 2027 Nations OTC member FAQs to ensure accuracy, completeness, and alignment with current benefits, processes, and member communications. Incorporated feedback as needed and distributed finalized materials to relevant stakeholders for implementation and annual readiness activities.
- Created a 2027 Nations Hearing member FAQs document for member education purposes. Incorporated feedback as needed and distributed finalized materials to relevant stakeholders for implementation and annual readiness activities.

- Partnering with Nations and internal stakeholders to evaluate upcoming Medicare Plan Finder data integration requirements, including reviewing data submission specifications, implementation timelines, and operational impacts.
- Medicare Online Enrollment Center (OEC):
 - Continued discussions to evaluate the feasibility and timeline of implementing the Medicare OEC functionality so that prospective members can enroll in Alameda Alliance Wellness (D-SNP) via medicare.gov. Progress has been made and testing is expected to commence in the next 30 days.
- 2027 Medicare Bid Submission:
 - State Medicaid Agency Contract (SMAC) has been fully executed by Alliance CEO and the State of California. Collaborated with Legal and Compliance on filling out the Matrixes and attestation associated with the SMAC. Documentation was submitted by the deadline of Monday, July 6th.
- Medicare Projects:
 - Work to implement new Pharmacy Benefit Manager (PBM), MedImpact, is in progress.
 - CHCN delegation project charter has been approved by AAH leadership and is currently under CHCN review. Currently working on delegation agreement and Delegation of Financial Responsibility DOFR).
- Medicare Sales & Retention Updates:
 - Staffing Updates:
 - Offer accepted for 2nd Medicare Field Sales and Community Agent with proposed start date targeted for August 24th.
 - Interview process ongoing for 3rd Medicare Field Sales and Community Agent.
 - Three (3) additional Medicare Field Sales and Community Agent positions approved and posted.
 - Sales/IT Enhancements and Projects:
 - Integration of pre-enrollment sales script initiated with Nations.
 - Outbound dialer function requested with Nations.
 - Phone tree enhancement in process and targeting early August for implementation.
 - Sales IVR verbiage finalized and targeting early August for implementation.
 - Four (4) new CHCN lead list files successfully uploaded into Cirrus.
 - Continued development of Cirrus CRM Sales Tool reporting dashboards for enrollment and retention data.
 - Individual D-SNP Sales queues created within Finesse for improved prospective member experience.
- Medicare Marketing, Communications, & Branding Updates:
 - Marketing Vendor Contracting:
 - Contracting (SOW/MSA) for the 65+ marketing campaign is complete, and work has officially begun with Anderson.

- The second SOW/MSA for the Age-In campaign is currently in progress.
- Enrollment and Onboarding Experience Improvement:
 - Enhancing enrollment kits and welcome materials to improve member experience and align with CY2027 plan year requirements.
 - Materials on track for AEP launch (10/1/2026), supporting compliance, clarity, and improved onboarding.
- D-SNP Centralized Website:
 - Upcoming milestones include building and deploying to the test environment, followed by Marketing QC in preparation for phased launches:
 - 8/17/2026: Shopping/Enrollment page
 - 10/1/2026: Member Resource pages and AEP cycle content
 - 1/1/2027: Removal of CY2026 plan year content
- FQHC Clinic Branding:
 - Co-branding work underway with Alameda Health Consortium (AHC) and clinic leadership to establish visual co-branding identity, messaging, and patient-facing experience.
 - Co-branded marketing campaign targeted for Q1 2027 launch.
 - D-SNP branded materials and promotional assets are complete and ready for use at upcoming clinic sales events.
- D-SNP Organizational Training:
 - Assessing enterprise-wide training needs to inform the 2026 learning strategy.
 - HR has approved the new Learning & Development Program Manager role. The position has been posted internally and is now open for internal applicants.
- Unplanned Regulator Required Notices:
 - Ongoing monitoring and communication of regulatory updates impacting members and benefits.
 - Medi-Cal Dental Changes (Effective 7/1/2026):
 - Member notice completed, approved, and mailed by regulatory deadline 7/1/2026; updated materials were posted to the public Medicare website following regulatory submission.
 - 7/7/2026 Update: Recent California legislation (SB 164) delays UIS dental benefit changes to 7/1/2027, requiring reversion to previously approved CY2026 materials and issuance of a new mid-year member notification.
 - California AIP D-SNPs must communicate these revisions to all applicable UIS enrollees per Mid-Year Change Notification to Enrollees guidelines no later than 8/5/2026, and this work is currently in progress.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	July 2026
Incoming Calls (R/V)	17,650
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	17,258
Average Speed to Answer (ASA)	00:07
Calls Answered in 30 Seconds (R/V)	97%
Average Talk Time (ATT)	07:31
Calls Answered in 10 minutes	100%
Outbound Calls	10,506

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

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

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

Change of PCP
ID Card Requests
Update Contact Information

Member Services Behavioral Health	July 2026
Incoming Calls (R/V)	985
Abandoned Rate (R/V)	3%
Answered Calls (R/V)	959
Average Speed to Answer (ASA)	00:14
Calls Answered in 30 Seconds (R/V)	93%
Average Talk Time (ATT)	09:14
Calls Answered in 10 minutes	100%
Outbound Calls	2,005
Screenings Completed	125
ACBH Referrals	23
SUD Referrals to Center Point	27

Blended Call Results

D-SNP Blended Results	July 2026
Incoming Calls (R/V)	557
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	547
Average Speed to Answer (ASA)	00:06
Calls Answered in 30 Seconds (R/V)	99%
Average Talk Time (ATT)	07:14
Calls Answered in 2 minutes	99%

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

Claims Department
June 2026 Final and July 2026 Final

METRICS

Claims Compliance

Jun-26

Jul-26

90% of clean claims processed within 30 calendar days

95.3%

94.4%

Claims Volume (Received)

Jun-26

Jul-26

Paper claims

37,946

43,714

EDI claims

334,821

364,889

Claim Volume Total

372,767

408,603

(includes D-SNP)

(includes D-SNP)

Percentage of Claims Volume by Submission Method

Jun-26

Jul-26

% Paper

10.2%

10.7%

% EDI

89.8%

89.3%

Claims Processed

Jun-26

Jul-26

HEALTHsuite Paid (original claims)

245,200

315,792

HEALTHsuite Denied (original claims)

98,102

126,756

HEALTHsuite Original Claims Sub-Total

343,302

442,548

HEALTHsuite Adjustments

3,424

6,648

HEALTHsuite Total

346,726

449,196

Claims Expense

Jun-26

Jul-26

Medical Claims Paid

\$144,907,848

\$178,476,848

Interest Paid

\$266,104

\$302,745

Auto Adjudication

Jun-26

Jul-26

Claims Auto Adjudicated

300,288

370,485

% Auto Adjudicated

87.5%

83.7%

Average Days from Receipt to Payment

Jun-26

Jul-26

HEALTHsuite

13

14

Pended Claim Age

Jun-26

Jul-26

0-30 calendar days

42,647

22,881

HEALTHsuite

31-62 calendar days

1,718

29

HEALTHsuite

Over 63 calendar days

4

6

HEALTHsuite

Overall Denial Rate

Jun-26

Jun-26

Claims denied in HEALTHsuite

98,102

126,756

% Denied

28.3%

28.2%

Claims Department

June 2026 Final and July 2026 Final

Jul-26

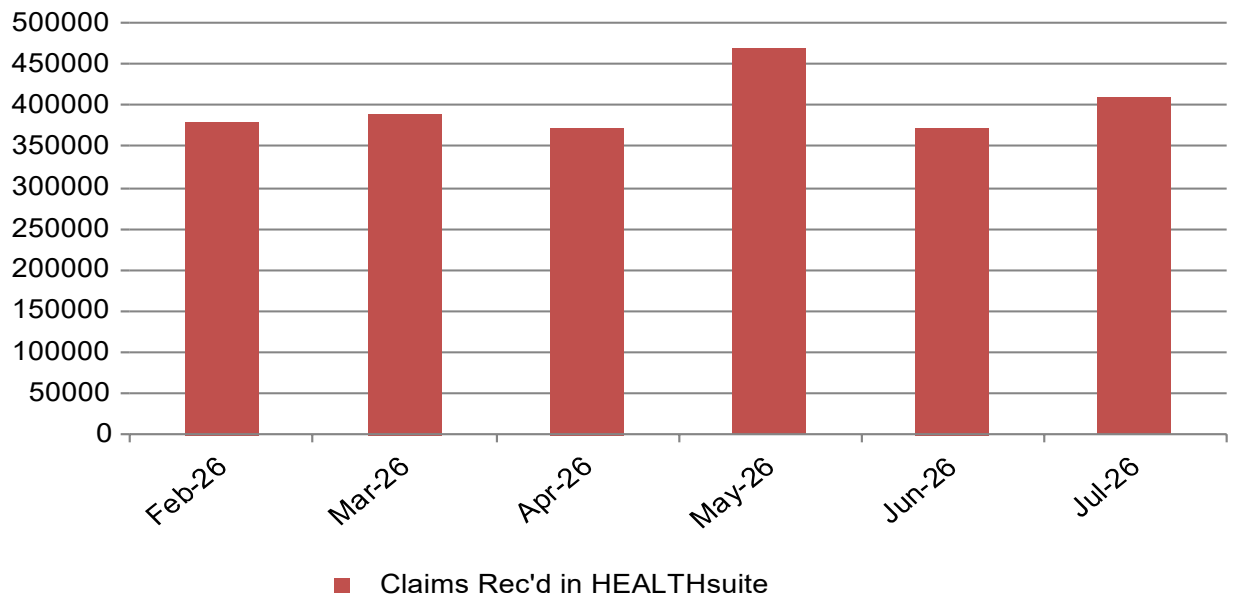
Top 5 HEALTHsuite Denial Reasons

% of all denials

Responsibility of Provider	17%
No Benefits Found For Dates Of Service	13%
Non-Covered Benefit For This Plan	12%
Must Submit Paper Claim With Copy of Primary Payor EOB	10%
Duplicate Claim	9%
% Total of all denials	61%

Claims Received By Month

	3/1/2026	4/1/2026	5/1/2026	6/1/2026	7/1/2026	8/1/2026
Claims Received Through	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Claims Rec'd in HEALTHsuite	378,925	389,550	373,472	468,360	372,767	408,603



Claims Year Over Year Summary		
Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing July 2026 to July 2025 as follows: 30 Days - 94.4% (2026) vs 81.8% (2025)	* 95% of clean claims in 30 calendar days (effective 1/1/2026) * 99% of all claims in 90 calendar days (interest is required on any claim paid after 30 calendar days)	* 95% of clean claims in 30 calendar days (effective 1/1/2026) * 99% of all claims in 90 calendar days (interest is required on any claim paid after 30 calendar days)
Claims Received - AAH received 408,603 claims for all lines of business in July 2026 vs 355,255 in July 2025	N/A	N/A
EDI - the volume of EDI submissions was 89% which is slightly above the normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 442,548 in July 2026 (23 working days) vs 420,444 in July 2025 (23 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in July 2026 was \$178,476,848 (5 check runs) vs \$169,869,293 in July 2025 (5 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in July 2026 was \$302,745 vs \$349,476 in July 2025	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in July 2026 was 83.7% vs 83.8% in July 2025	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in July 2026 was 14 days vs 21 days in July 2025	N/A	<= 25 days
Pended Claim Age - comparing July 2026 to July 2025 as follows: 0-30 calendar days - 22,881 (2026) vs 38,206 (2025) 31-62 calendar days - 29 (2026) vs 33,385 (2025) Over 63 calendar days - 6 (2026) vs 47,767 (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 July 2026 to July 2025	N/A	N/A

Provider Dispute Resolution

June 2026 and July 2026

METRICS

PDR Compliance	Jun-26	Jul-26
# of PDRs Resolved	2,147	2,212
# Resolved Within 45 Working Days	2,111	2,168
% of PDRs Resolved Within 45 Working Days	98.3%	98.0%
PDRs Received	Jun-26	Jul-26
# of PDRs Received	2,800	3,239
PDR Volume Total	2,800	3,239
PDRs Resolved	Jun-26	Jul-26
# of PDRs Upheld	1,625	1,573
% of PDRs Upheld	76%	71%
# of PDRs Overturned	522	639
% of PDRs Overturned	24%	29%
Total # of PDRs Resolved	2,147	2,212
Average Turnaround Time	Jun-26	Jul-26
Average # of Days to Resolve PDRs	37	41
Oldest Resolved PDR in Days	307	678
Unresolved PDR Age	Jun-26	Jul-26
0-45 Working Days	4,197	4,465
Over 45 Working Days	0	0
Total # of Unresolved PDRs	4,197	4,465

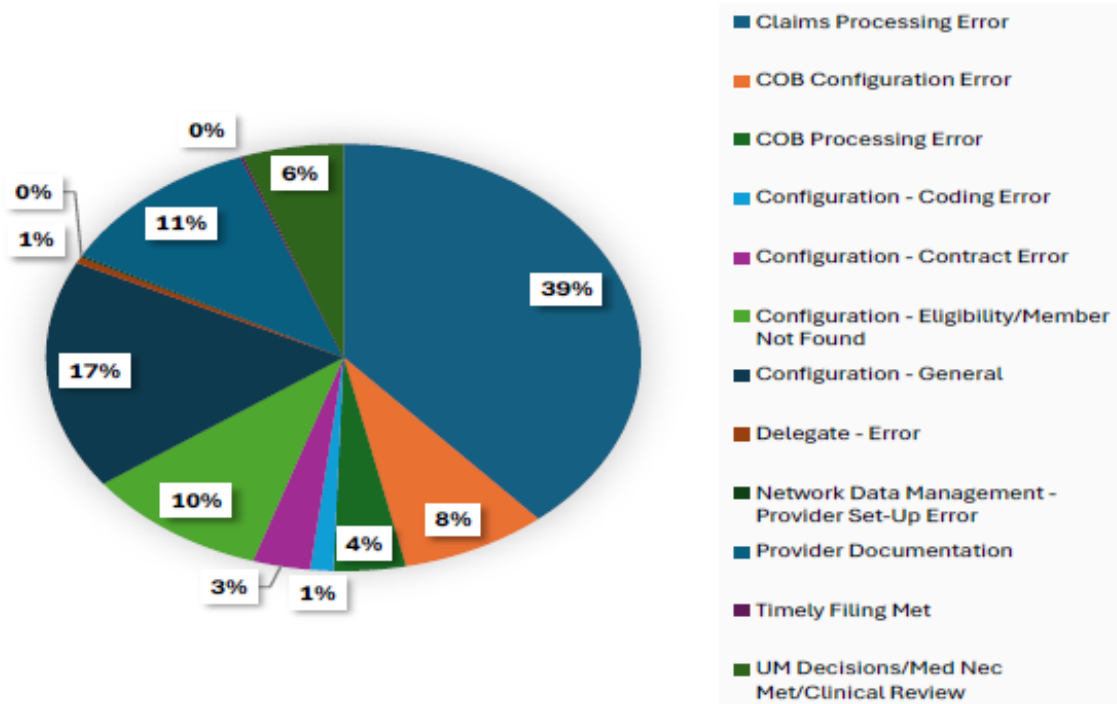
Provider Dispute Resolution

June 2026 and July 2026

Jul-26

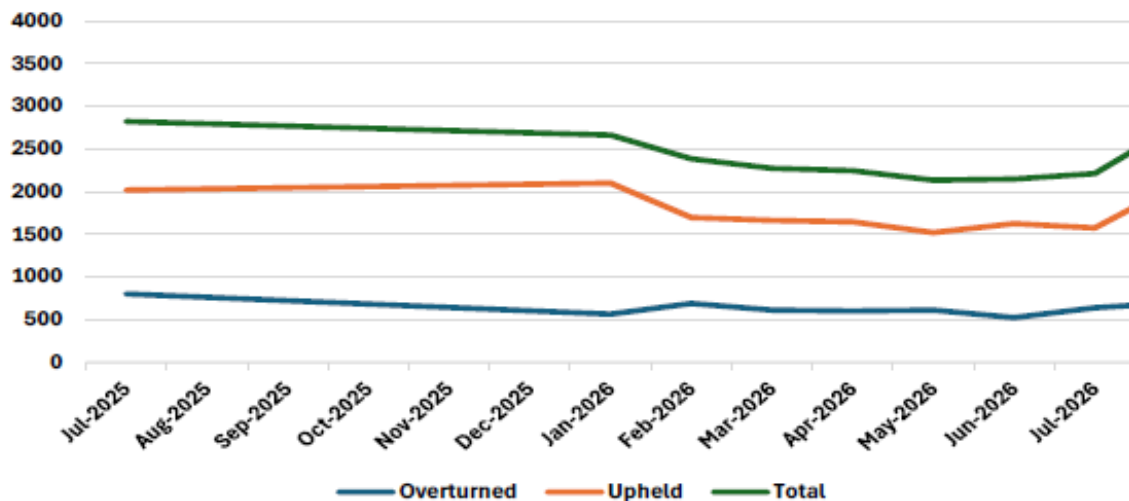
PDR Resolved Case Overturn Reasons

July 2026



Rolling 12-Month PDR Trend Line

July 2026



Provider Dispute Resolution Year Over Year Summary		
Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Resolved - 2,212 in July 2026 vs 2,819 in July 2025	N/A	N/A
# of PDRs Received - 3,239 in July 2026 vs 4,426 in July 2025	N/A	N/A
# of PDRs Resolved within 45 working days - 2,168 in July 2026 vs 2,816 in July 2025	N/A	N/A
% of PDRs Resolved within 45 working days - 98% in July 2026 vs 99.8% in July 2025	95%	95%
Average # of Days to Resolve PDRs - 41 days in July 2026 vs 37 days in July 2025	N/A	30
Oldest Resolved PDR in Days - 678 days in July 2026 vs 92 days in July 2025	N/A	N/A
# of PDRs Upheld - 1,573 in July 2026 vs 2,017 in July 2025	N/A	N/A
% of PDRs Upheld - 71% in July 2026 vs 72% in July 2025	N/A	> 75%
# of PDRs Overturned - 639 in July 2026 vs 802 in July 2025	N/A	N/A
% of PDRs Overturned - 29% in July 2026 vs 28% in July 2025	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 39% (2026) vs 34% (2025) Configuration errors - 32% (2026) vs 48% (2025) COB - 12% (2026) vs 6% (2025) Clinical Review/UM Decisions/Medical Necessity Met - 17% (2026) vs 12% (2025)	N/A	N/A

Provider Relations Call Center Dashboard

Medi-Cal and Group Care									
Alliance Provider Relations Staff	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls	7,416	5,195	5,918	7,383					
Answered Calls	5,410	4,375	4,843	4,848					
Abandoned Calls	2,006	820	1,075	2,535					
Outbound Calls	507	395	285	259					
Voicemails Received	21	3	22	17					
Agent Answered Rate $\geq 85\%$ or above	96%	96%	97%	98%					
Average Speed of Answer ≤ 30 seconds	207 seconds	133 seconds	162 seconds	264 seconds					
Call Abandonment Rate $\leq 15\%$ or less	27%	13%	18%	34%					
Totals	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Incoming, R/V, Outbound Calls	7,944	6,313	6,225	7,659					
Total Abandoned Calls	2,006	820	1,075	2,535					
Total Answered Incoming, R/V, Outbound Calls	5,938	4,773	5,150	5,124					

Alliance Wellness D-SNP									
Alliance Provider Relations Staff	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls	1,295	1,152	1,238	1,411					
Answered Calls	950	962	1,024	983					
Abandoned Calls	345	190	214	428					
Outbound Calls	56	43	49	29					
Voicemails Received	0	0	0	2					
Agent Answered Rate $\geq 85\%$ or above	96%	96%	97%	98%					
Average Speed of Answer ≤ 30 seconds	215 seconds	119 seconds	144 seconds	136 seconds					
Call Abandonment Rate $\leq 15\%$ or less	26%	16%	17%	30%					
Totals	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Incoming, R/V, Outbound Calls	1,351	1,195	1,287	1,442					
Total Abandoned Calls	345	190	214	428					
Total Answered Incoming, R/V, Outbound Calls	1,006	1,005	1,073	1,014					

Total All Lines of Business	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Incoming Calls	8,711	6,347	7,156	8,794					
Total Answered Calls	6,360	5,337	5,867	5,831					
Total Abandoned Calls	2,351	1,010	1,289	2,963					
Total Outbound Calls	563	438	334	288					
Total Voicemails Received	21	3	22	19					
Total Incoming, R/V, Outbound Calls	9,295	6788	7,512	9,101					
Total Answered Incoming, R/V, Outbound Calls	6,944	5778	6,223	6,138					

Provider Relations Call Reasons & Field Visits Dashboard

Medi-Cal and Group Care Call Reasons

Category	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	6%	6.1%	5.2%	5.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Benefits	5%	4.1%	3.7%	3.5%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Claims Inquiry	39%	41.9%	42.3%	40.5%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Change of PCP	3%	2.2%	2.4%	1.6%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Check Tracer	1%	0.9%	0.7%	0.7%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Complaint/Grievance (includes PDRs)	10%	12.2%	12.0%	12.9%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Contracts/Credentialing	0.7%	0.6%	1.1%	0.6%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Demographic Change	0.1%	0.0%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Disconnected Calls	4.7%	4.9%	4.6%	5.8%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Eligibility	19.6%	17.7%	18.3%	20.3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Exempt Grievance/ G&A	2.3%	0.0%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Intepreter Services Request	0.5%	0.4%	0.4%	0.6%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Provider Portal Assistance	1.0%	3.1%	2.4%	1.8%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Pharmacy	0.3%	0.1%	0.1%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Prop 56	0.0%	0.1%	0.1%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Provider Information Updates/ W9	1.0%	0.5%	0.5%	0.2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Transportation Services	0.1%	0.1%	0.3%	0.2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
All Other Calls	5.1%	5.0%	6.1%	6.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL	100%	100%	100%	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

D-SNP Call Reasons

Category	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
D-SNP Authorizations	3%	1%	2%	6%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Benefits	4%	3%	5%	8%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Claims	59%	53%	55%	38%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Eligibility	18%	27%	20%	46%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Enrollment	1%	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP PCP Assignment	4%	8%	9%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP PDR/Reconsideration	8%	3%	2%	2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Check Tracer	1%	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Provider Portal	1%	2%	2%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Contracts / Credentialing	1%	1%	4%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Interpreter Request	0%	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Member Call	1%	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Transportation Services	1%	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Provider Information Updates / W9	0%	0%	2%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Pharmacy	0%	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL	100%	100%	100%	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

Alliance Provider Relations Staff	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	47	33	43	33					
Contracting/Credentialing	87	70	99	76					
Drop-ins	72	142	43	73					
JOMs	1	2	1	3					
New Provider Orientation	172	246	168	177					
Quarterly Visits	0	40	40	40					
UM Issues	0	1	3	2					
Total Field Visits	379	534	397	404	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALLED PRACTITIONERS - July 2026

Practitioners			PCP 410	SPEC 799	AHP 918	BH/ABA 3,927	PCP/SPEC 12						
Direct Network vs Delegated Network Breakdown				AAH 4,730	AHS 295	CHCN 675	COMBINATION OF GROUPS 366						
Facilities	433												
VENDOR SUMMARY													
Credentialing Verification Organization, Symplr CVO													
	Number		Average Calendar Days in Process	Goal - 25 Business Days*	Goal - 98% Accuracy	Compliant							
Initial Files in Process	75		5	Y	Y	Y							
Recred Files in Process	254		11	Y	Y	Y							
Expirables updated Insurance, License, DEA, Board Certifications						Y							
Files currently in process	329												
* 25 business days = 35 calendar days													
July 2026 Peer Review and Credentialing Committee Approvals													
Initial Credentialing	Number												
PCP	1												
SPEC	10												
ANCILLARY	23												
MIDLEVEL/AHP	10												
BH/ABA	117												
Sub-total	161												
Recredentialing													
PCP	5												
SPEC	14												
ANCILLARY	1												
MIDLEVEL/AHP	9												
BH/ABA	31												
Sub-total	60												
TOTAL	221												
July 2026 Facility Approvals													
Initial Credentialing	4												
Recredentialing	12												
Sub-total	16												
Facility Files in Process	43												
July 2026 Employee Metrics (6 FTEs)													
	Goal	Met (Y/N)											
File Processing	Timely processing within 3 days of receipt		Y										
Credentialing Accuracy	<3% error rate		Y										
DHCS, DMHC, CMS, NCQA Compliant	98%		Y										
MBC Monitoring	Timely processing within 3 days of receipt		Y										

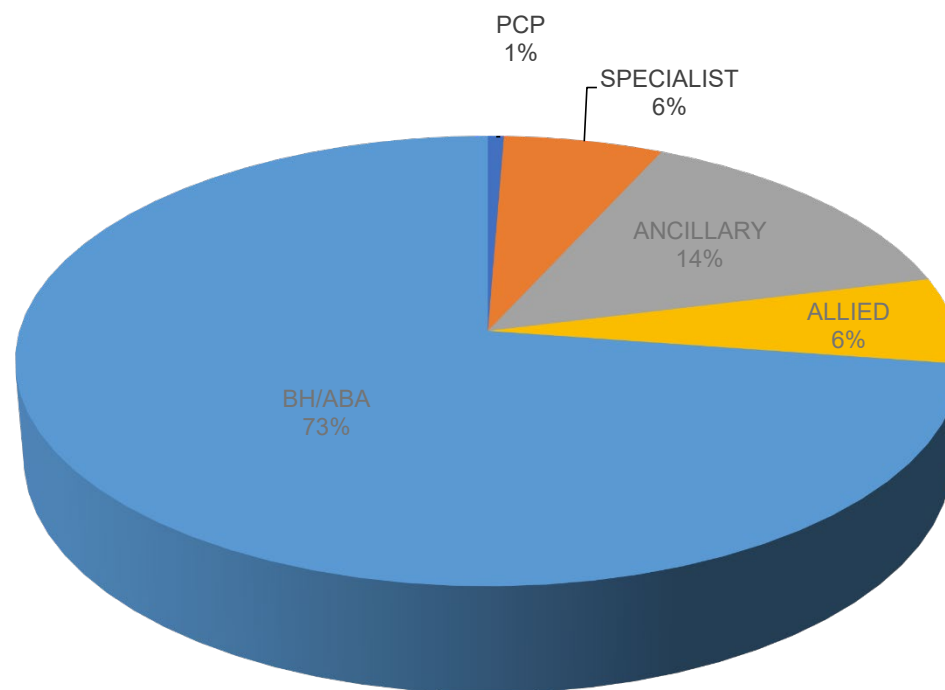
LAST_NAME	FIRST_NAME	CATEGORY	INITIAL_RECRED	CRED_DATE
Adeagbo	Taiye	Doula	INITIAL	7/21/2026
Aguinaldo	Laureen Kris	BH/ABA-Telehealth	INITIAL	7/21/2026
Ahmad	Faizan	Specialist	INITIAL	7/21/2026
Alcalde	Erika	BH/ABA-Telehealth	INITIAL	7/21/2026
Allen	Jeniece	BH/ABA-Telehealth	INITIAL	7/21/2026
Allen	Katie	BH/ABA	INITIAL	7/21/2026
Andros	Jesse	BH/ABA-Telehealth	INITIAL	7/21/2026
Armanious	Marina	BH/ABA-Telehealth	INITIAL	7/21/2026
Baldwin	Sanam	BH/ABA-Telehealth	INITIAL	7/21/2026
Banaag	Jhellies	BH/ABA-Telehealth	INITIAL	7/21/2026
Bassam	Veida	Doula	INITIAL	7/21/2026
Borchardt	Eric	BH/ABA-Telehealth	INITIAL	7/21/2026
Brown	Dawn	Doula	INITIAL	7/21/2026
Button	Hannah	BH/ABA	INITIAL	7/21/2026
Campbell	Teagan	BH/ABA-Telehealth	INITIAL	7/21/2026
Carlos	Angela	BH/ABA-Telehealth	INITIAL	7/21/2026
Carrera Vasquez	Valeria	BH/ABA-Telehealth	INITIAL	7/21/2026
Carson	Ameerah	Allied Health	INITIAL	7/21/2026
Carter	Deborah	BH/ABA-Telehealth	INITIAL	7/21/2026
Casarez	Genesha	BH/ABA-Telehealth	INITIAL	7/21/2026
Chaney-Workman	Tessa	Doula	INITIAL	7/21/2026
Chin Loy	Anthony	Specialist	INITIAL	7/21/2026
Chirichigno	Jason	PCP_ECM	INITIAL	7/21/2026
Coppetti	Celina	Doula	INITIAL	7/21/2026
Cozby	Brooke	Doula	INITIAL	7/21/2026
Dagesian	Lilit	BH/ABA-Telehealth	INITIAL	7/21/2026
Davis	Megan	BH/ABA-Telehealth	INITIAL	7/21/2026
Dayoan	Jennifer	BH/ABA-Telehealth	INITIAL	7/21/2026
Delaplain	Emily	BH/ABA	INITIAL	7/21/2026
Delorme	Emmanuella	BH/ABA-Telehealth	INITIAL	7/21/2026
Diep	Deanna	Allied Health	INITIAL	7/21/2026
Divino	Hannah Rhea	BH/ABA	INITIAL	7/21/2026
Dover	Carleta	BH/ABA-Telehealth	INITIAL	7/21/2026
Dowley	Ann	BH/ABA	INITIAL	7/21/2026
Drago-Spencer	Gabriela	Specialist	INITIAL	7/21/2026
D'Souza	Angela	Ancillary	INITIAL	7/21/2026
Elison	Jasmine	Specialist	INITIAL	7/21/2026
Estrada-Musgrave	Luis Manuel	BH/ABA-Telehealth	INITIAL	7/21/2026
Fagan	Molly	BH/ABA	INITIAL	7/21/2026
Far	Anahita	BH/ABA-Telehealth	INITIAL	7/21/2026
Farris	Tatyana	BH/ABA-Telehealth	INITIAL	7/21/2026
Felipe Castro	Synthia	BH/ABA-Telehealth	INITIAL	7/21/2026
Ferreira	Joseane	Doula	INITIAL	7/21/2026
Florida	Mariliana	BH/ABA	INITIAL	7/21/2026
Foti	Antonia	BH/ABA-Telehealth	INITIAL	7/21/2026
Fuentez	Crystal	Ancillary	INITIAL	7/21/2026
Gadson	Breanna	BH/ABA-Telehealth	INITIAL	7/21/2026
Garcia	Monica	BH/ABA-Telehealth	INITIAL	7/21/2026
Garg	Rachna	BH/ABA	INITIAL	7/21/2026
Gianelli	Jeffrey	BH/ABA-Telehealth	INITIAL	7/21/2026
Gibson	Hannah	BH/ABA-Telehealth	INITIAL	7/21/2026
Gonzalez	Ruben	BH/ABA-Telehealth	INITIAL	7/21/2026
Gonzalez	Veronica	BH/ABA-Telehealth	INITIAL	7/21/2026
Gonzalez Peralta	Marjolye	BH/ABA-Telehealth	INITIAL	7/21/2026
Goodrum	Andrew	Allied Health	INITIAL	7/21/2026

LAST_NAME	FIRST_NAME	CATEGORY	INITIAL_RECRED	CRED_DATE
Gray	Daphne	BH/ABA-Telehealth	INITIAL	7/21/2026
Grays	Ashton	BH/ABA-Telehealth	INITIAL	7/21/2026
Hajjar	Sarine	BH/ABA-Telehealth	INITIAL	7/21/2026
Hajyan	Karine	Specialist	INITIAL	7/21/2026
Hartley	Allye	BH/ABA-Telehealth	INITIAL	7/21/2026
Haydel	Angela	BH/ABA-Telehealth	INITIAL	7/21/2026
Hayes	Janine	BH/ABA-Telehealth	INITIAL	7/21/2026
Hernandez-Zamudio	Judith	BH/ABA-Telehealth	INITIAL	7/21/2026
Ho	Bao	BH/ABA	INITIAL	7/21/2026
Hoft	Juliana	BH/ABA-Telehealth	INITIAL	7/21/2026
Houston	Nathaniel	Allied Health	INITIAL	7/21/2026
Howard	Jaeden	Doula	INITIAL	7/21/2026
Javed Mohammad	Najwa	Specialist	INITIAL	7/21/2026
Johns	Darice	BH/ABA-Telehealth	INITIAL	7/21/2026
Johnson	Alysa	BH/ABA-Telehealth	INITIAL	7/21/2026
Johnson	Bridget	BH/ABA-Telehealth	INITIAL	7/21/2026
Kafley	Purnima	BH/ABA-Telehealth	INITIAL	7/21/2026
Kaneshiro	Shane	Ancillary	INITIAL	7/21/2026
Kaplan	Charles	Specialist	INITIAL	7/21/2026
Kaplan	Libra	BH/ABA	INITIAL	7/21/2026
Karimjee	Jabeen	Allied Health	INITIAL	7/21/2026
Khun Khun	Sharanjit	BH/ABA-Telehealth	INITIAL	7/21/2026
Krause	Thomas	BH/ABA-Telehealth	INITIAL	7/21/2026
Le	Hanh Nhi	Doula	INITIAL	7/21/2026
Lee	Mihyun	BH/ABA-Telehealth	INITIAL	7/21/2026
Liguori	Lisa	BH/ABA-Telehealth	INITIAL	7/21/2026
Linares	Lauren	BH/ABA	INITIAL	7/21/2026
Lodhi	Shafi	BH/ABA-Telehealth	INITIAL	7/21/2026
Lookabaugh	Aidee	BH/ABA-Telehealth	INITIAL	7/21/2026
Mack	Kimi	BH/ABA-Telehealth	INITIAL	7/21/2026
Magana-Hernandez	Karla	BH/ABA-Telehealth	INITIAL	7/21/2026
Malshe	Ketaki	Ancillary	INITIAL	7/21/2026
Manzo Padilla	Sandra	Ancillary	INITIAL	7/21/2026
Marigold	Lucy	BH/ABA-Telehealth	INITIAL	7/21/2026
McCallum	Yolanda	BH/ABA-Telehealth	INITIAL	7/21/2026
McClellan	Shawn	BH/ABA-Telehealth	INITIAL	7/21/2026
McDavit-Aron	Janice	BH/ABA-Telehealth	INITIAL	7/21/2026
Menke	Melinda	Allied Health	INITIAL	7/21/2026
Meza	Leslie	Doula	INITIAL	7/21/2026
Miklusicak	Eric	BH/ABA-Telehealth	INITIAL	7/21/2026
Miller	Nicole	BH/ABA-Telehealth	INITIAL	7/21/2026
Mills	Juliana	BH/ABA-Telehealth	INITIAL	7/21/2026
Mitchell Quan	Selena	BH/ABA	INITIAL	7/21/2026
Mohsenpour	Narges	BH/ABA-Telehealth	INITIAL	7/21/2026
Monahan	Catherine	Allied Health	INITIAL	7/21/2026
Morelli	Sophia	BH/ABA-Telehealth	INITIAL	7/21/2026
Moua	Cindy	BH/ABA-Telehealth	INITIAL	7/21/2026
Mueller Martinez	Ana	Doula	INITIAL	7/21/2026
Nash	Corey	BH/ABA-Telehealth	INITIAL	7/21/2026
Nguyen	Thai	Specialist	INITIAL	7/21/2026
Novotny	Ava	Allied Health	INITIAL	7/21/2026
Nunez	Sandra	BH/ABA-Telehealth	INITIAL	7/21/2026
Ogas	Rosa Linda	BH/ABA-Telehealth	INITIAL	7/21/2026
Ojeda	Jennifer	BH/ABA-Telehealth	INITIAL	7/21/2026
Okehi	Chisara	BH/ABA	INITIAL	7/21/2026
Olivier	Amanda	BH/ABA-Telehealth	INITIAL	7/21/2026

LAST_NAME	FIRST_NAME	CATEGORY	INITIAL_RECRED	CRED_DATE
Osi	Olawale	BH/ABA-Telehealth	INITIAL	7/21/2026
Oskuie	Camellia	BH/ABA-Telehealth	INITIAL	7/21/2026
O'Sullivan	Aoife	BH/ABA-Telehealth	INITIAL	7/21/2026
Otoo	Zekiya	BH/ABA-Telehealth	INITIAL	7/21/2026
Otto	Jennice	BH/ABA-Telehealth	INITIAL	7/21/2026
Padilla	Kirissa	BH/ABA-Telehealth	INITIAL	7/21/2026
Parodi-Cabral	Lacey	BH/ABA-Telehealth	INITIAL	7/21/2026
Patel	Rohan	BH/ABA-Telehealth	INITIAL	7/21/2026
Perez	Daniel	BH/ABA-Telehealth	INITIAL	7/21/2026
Phadke	Apoorva	Ancillary	INITIAL	7/21/2026
Pineda Tovar	Johanna	Doula	INITIAL	7/21/2026
Reeves	Monique	BH/ABA-Telehealth	INITIAL	7/21/2026
Reyes	Krystina	BH/ABA-Telehealth	INITIAL	7/21/2026
Rivera	Sharon	BH/ABA	INITIAL	7/21/2026
Roberts	Ariana	BH/ABA-Telehealth	INITIAL	7/21/2026
Rose	Laura	BH/ABA-Telehealth	INITIAL	7/21/2026
Rowe	Carly	BH/ABA-Telehealth	INITIAL	7/21/2026
Royal	Tanae	BH/ABA-Telehealth	INITIAL	7/21/2026
Ruvalcaba	Valeria	Ancillary	INITIAL	7/21/2026
Rynerson	Toni	BH/ABA-Telehealth	INITIAL	7/21/2026
Sanchez	Diego	BH/ABA-Telehealth	INITIAL	7/21/2026
Schmitt	Pearl	BH/ABA	INITIAL	7/21/2026
Schraufnagel	Ann	Specialist	INITIAL	7/21/2026
Shadron	Carly	BH/ABA-Telehealth	INITIAL	7/21/2026
Shilpa	Fnu	Ancillary	INITIAL	7/21/2026
Shiver	Alicia	BH/ABA	INITIAL	7/21/2026
Sleisenger	Jason	BH/ABA-Telehealth	INITIAL	7/21/2026
Soto	Jennifer	BH/ABA-Telehealth	INITIAL	7/21/2026
Staley	Sarah	BH/ABA-Telehealth	INITIAL	7/21/2026
Stecher	Ivy	BH/ABA-Telehealth	INITIAL	7/21/2026
Stollman	Neil	Specialist	INITIAL	7/21/2026
Thomas	Chris	BH/ABA	INITIAL	7/21/2026
Tomita	Chisato	BH/ABA-Telehealth	INITIAL	7/21/2026
Valentine	Ramiyah	BH/ABA	INITIAL	7/21/2026
Vance	Maija	BH/ABA-Telehealth	INITIAL	7/21/2026
Verduzco	Nicole	BH/ABA-Telehealth	INITIAL	7/21/2026
Vergis	Anita	Ancillary	INITIAL	7/21/2026
Vogt	Bibiana	Allied Health	INITIAL	7/21/2026
Wang	Dennis	BH/ABA-Telehealth	INITIAL	7/21/2026
Watson	Suzette	Allied Health	INITIAL	7/21/2026
Webb	Kimberly	BH/ABA-Telehealth	INITIAL	7/21/2026
Wen	Marcus	BH/ABA	INITIAL	7/21/2026
Wheeler	Brett	BH/ABA-Telehealth	INITIAL	7/21/2026
White	Michael	BH/ABA-Telehealth	INITIAL	7/21/2026
Whittle-Utter	Jesse	BH/ABA-Telehealth	INITIAL	7/21/2026
Williams	Reginae	Doula	INITIAL	7/21/2026
Wong	Zachary	BH/ABA	INITIAL	7/21/2026
Woolfolk	Cynthia	BH/ABA-Telehealth	INITIAL	7/21/2026
Yeh	Forrest	Primary Care Physician	INITIAL	7/21/2026
Ysla	Elizabeth	BH/ABA	INITIAL	7/21/2026
Aglubat	Emmanuel	Allied Health	RECRED	7/21/2026
Akande	Aderonke	BH/ABA-Telehealth	RECRED	7/21/2026
Ali	Zulfiqar	Primary Care Physician and Specialis	RECRED	7/21/2026
Angeley	Rachel	BH/ABA-Telehealth	RECRED	7/21/2026
Baldwin	Emily	BH/ABA	RECRED	7/21/2026
Barrett	Carol	BH/ABA	RECRED	7/21/2026

LAST_NAME	FIRST_NAME	CATEGORY	INITIAL_RECRED	CRED_DATE
Berry	Deborah	Allied Health	RECRED	7/21/2026
Berry-Golston	DeniQuia	BH/ABA	RECRED	7/21/2026
Blaschko	Sarah	Specialist	RECRED	7/21/2026
Booty	Andrew	BH/ABA	RECRED	7/21/2026
Broster	Lucas	BH/ABA	RECRED	7/21/2026
Carow	Bradley	BH/ABA-Telehealth	RECRED	7/21/2026
Chen	Cheng-I	Allied Health	RECRED	7/21/2026
Chin	Tammy	BH/ABA	RECRED	7/21/2026
Chitnis	Amit	Specialist	RECRED	7/21/2026
Cobian	Itzel	BH/ABA-Telehealth	RECRED	7/21/2026
Cohen	Lawrence	BH/ABA	RECRED	7/21/2026
Cohn	Susie	Specialist	RECRED	7/21/2026
Compton	Kaila	BH/ABA	RECRED	7/21/2026
Cruz	John	BH/ABA	RECRED	7/21/2026
DaCosta	Rachel	BH/ABA	RECRED	7/21/2026
Davidson	Alyson	Primary Care Physician	RECRED	7/21/2026
Diep	Claire	Primary Care Physician	RECRED	7/21/2026
Dinh	Thanh	Allied Health	RECRED	7/21/2026
Earle	Suzanne	BH/ABA	RECRED	7/21/2026
Elliott-DeMars	Joy	Allied Health	RECRED	7/21/2026
Estrada	Roberto	BH/ABA	RECRED	7/21/2026
Gamble	Cierra	Allied Health	RECRED	7/21/2026
Guerrero	Susan	BH/ABA	RECRED	7/21/2026
Hong	Jane	BH/ABA	RECRED	7/21/2026
Howell	Joanne	BH/ABA-Telehealth	RECRED	7/21/2026
Jain	Rashi	BH/ABA	RECRED	7/21/2026
Jamena	Gemma	Primary Care Physician	RECRED	7/21/2026
Kim	Jamie	Specialist	RECRED	7/21/2026
Kirsten	Kelli	BH/ABA-Telehealth	RECRED	7/21/2026
Lai	Jennifer	Specialist	RECRED	7/21/2026
Lau	Cynthia	Allied Health	RECRED	7/21/2026
Lee	Aaron	Specialist	RECRED	7/21/2026
Lee	Jennifer	BH/ABA	RECRED	7/21/2026
Marchiano	Michael	Primary Care Physician	RECRED	7/21/2026
Nanavati	Dhiren	Specialist	RECRED	7/21/2026
Pennybaker	Steven	BH/ABA	RECRED	7/21/2026
Salazar	Jeselle	BH/ABA-Telehealth	RECRED	7/21/2026
Shafi	Nabil	Specialist	RECRED	7/21/2026
Short-Fried	Rebecca	BH/ABA	RECRED	7/21/2026
Singh	Rajinder	Ancillary	RECRED	7/21/2026
Spencer	Ronald	BH/ABA	RECRED	7/21/2026
Story	Elana	BH/ABA	RECRED	7/21/2026
Sullivan	Tiffany	BH/ABA-Telehealth	RECRED	7/21/2026
Takahashi	Kenichi	BH/ABA	RECRED	7/21/2026
Tang	Sai Ying	Allied Health	RECRED	7/21/2026
Valika	Aziz	Specialist	RECRED	7/21/2026
Van Gompel	Gabriel	Specialist	RECRED	7/21/2026
Van Sickle	Alexis	Allied Health	RECRED	7/21/2026
Vargas	Alexandria	BH/ABA-Telehealth	RECRED	7/21/2026
Verdun	Matthew	BH/ABA	RECRED	7/21/2026
Virk	Bhupinder	Specialist	RECRED	7/21/2026
Vora	Samir	Specialist	RECRED	7/21/2026
Wright	Courtney	Specialist	RECRED	7/21/2026
Yan	Min	Specialist	RECRED	7/21/2026

JULY PEER REVIEW AND CREDENTIALING INITIAL APPROVALS BY SPECIALTY



PCP	1
SPECIALIST	10
ANCILLARY	23
ALLIED HEALTH	10
<u>BH/ABA</u>	<u>117</u>
TOTAL	161

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2026-2027 | **JULY 2026 OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

FY 2026-2027 | JULY 2026 OUTREACH REPORT

Alliance in the Community Events and Activities:

In July 2026, the Alliance completed **498** member orientation outreach calls among net new and non-utilizer members and conducted **66** net new member orientations and **11** non-utilizer member orientations (**15.5%** member participation rate). In addition, the Outreach team completed **7** service requests, **11** website inquiries, **2** community events, and **2** member education events. The Alliance reached a total of **652** people and spent a total of **\$2,500** on donations, fees, and/or sponsorships at the following events and activities: Lifesteps Spring Health Fair 2026, 2026 Alameda County Fair, and Oakland Unified School District (OUSD) Resource Fair. The final outreach totals for the 2026 Alameda County Fair will be updated once the final sponsorship report is received.

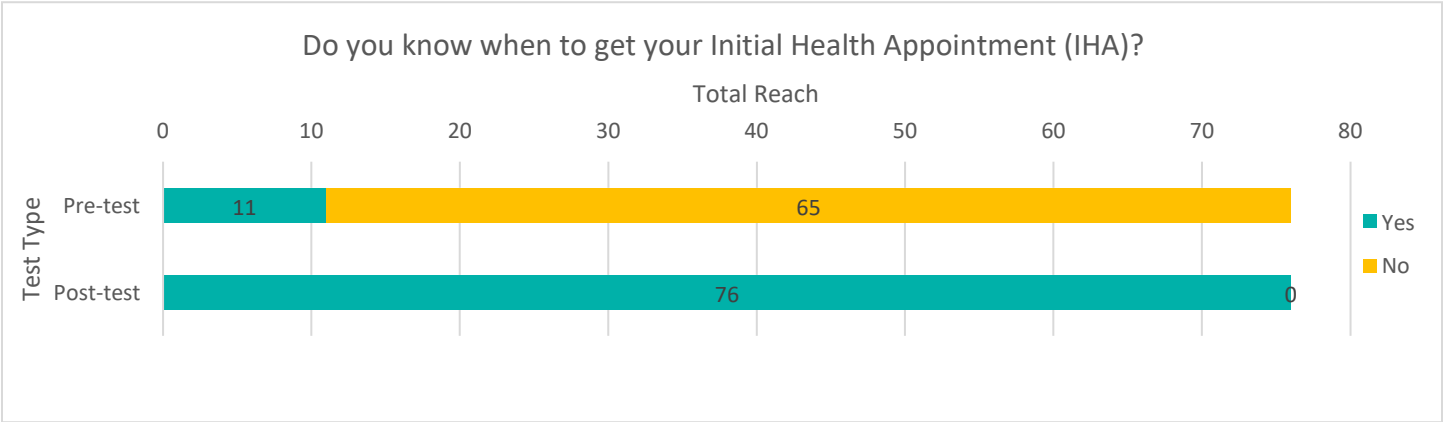
Since July 2018, **47,539** self-identified Alliance members have been reached during outreach activities.

Alliance Member Orientation Program:

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

On Wednesday, March 18, 2020, the Alliance began conducting member orientations by phone. As of July 31, 2026, the Outreach Team has completed **58,692** member orientation outreach calls and conducted **10,646** member orientations (**18.1%** member participation rate).

Between July 1, through July 31, 2026 (22 working days), **77** members completed an MO by phone. After completing the MO, **100%** of members who completed the post-test survey in July 2026 reported knowing when to get their IHA, compared to only **14.5%** 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 26-27\Q1\July 2026**

ALLIANCE IN THE COMMUNITY

FY 2026-2027 | JULY 2026 OUTREACH REPORT

FY 2026-2027 JULY 2026 TOTALS

			
2 COMMUNITY EVENTS	Alameda	356 TOTAL REACHED AT COMMUNITY EVENTS	
2 MEMBER EDUCATION EVENTS	Ashland	TOTAL REACHED AT MEMBER EDUCATION EVENTS	
77 MEMBER ORIENTATIONS	Berkeley	77 TOTAL REACHED AT MEMBER ORIENTATIONS	\$2500.00
0 MEETINGS/PRESENTATIONS	Castro Valley	TOTAL REACHED AT MEETINGS/PRESENTATIONS	TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*
0 COMMUNITY TRAINING	Dublin	0 COMMUNITY TRAINING	
9 TOTAL INITIATED/INVITED EVENTS	Emeryville	311 MEMBERS REACHED AT ALL EVENTS	
81 TOTAL COMPLETED EVENTS	Fremont	729 TOTAL REACHED AT ALL EVENTS	
	Hayward		
	Newark		
	Oakland		
	<i>San Francisco</i>		
	<i>San Jose</i>		
	San Leandro		
	San Lorenzo		
	Union City		

FY 2025-2026 JULY 2025 TOTALS

			
2 COMMUNITY EVENTS	Alameda	649 TOTAL REACHED AT COMMUNITY EVENTS	
3 MEMBER EDUCATION EVENTS	Ashland	TOTAL REACHED AT MEMBER EDUCATION EVENTS	
74 MEMBER ORIENTATIONS	Berkeley	74 TOTAL REACHED AT MEMBER ORIENTATIONS	\$0.00
1 MEETINGS/PRESENTATIONS/COMMUNITY TRAINING	Castro Valley	100 TOTAL REACHED AT MEETINGS/PRESENTATIONS	TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*
6 TOTAL INITIATED/INVITED EVENTS	Fremont	0 TOTAL REACHED AT COMMUNITY TRAINING	
80 TOTAL COMPLETED EVENTS	Hayward	1113 MEMBERS REACHED AT ALL EVENTS	
	Livermore	1718 TOTAL REACHED AT ALL EVENTS	
	Newark		
	Oakland		
	<i>San Jose</i>		
	San Leandro		
	San Lorenzo		
	Union City		
	<i>Winchester</i>		

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

COMMUNICATIONS & OUTREACH DEPARTMENT

SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2026-2027 | July 2026

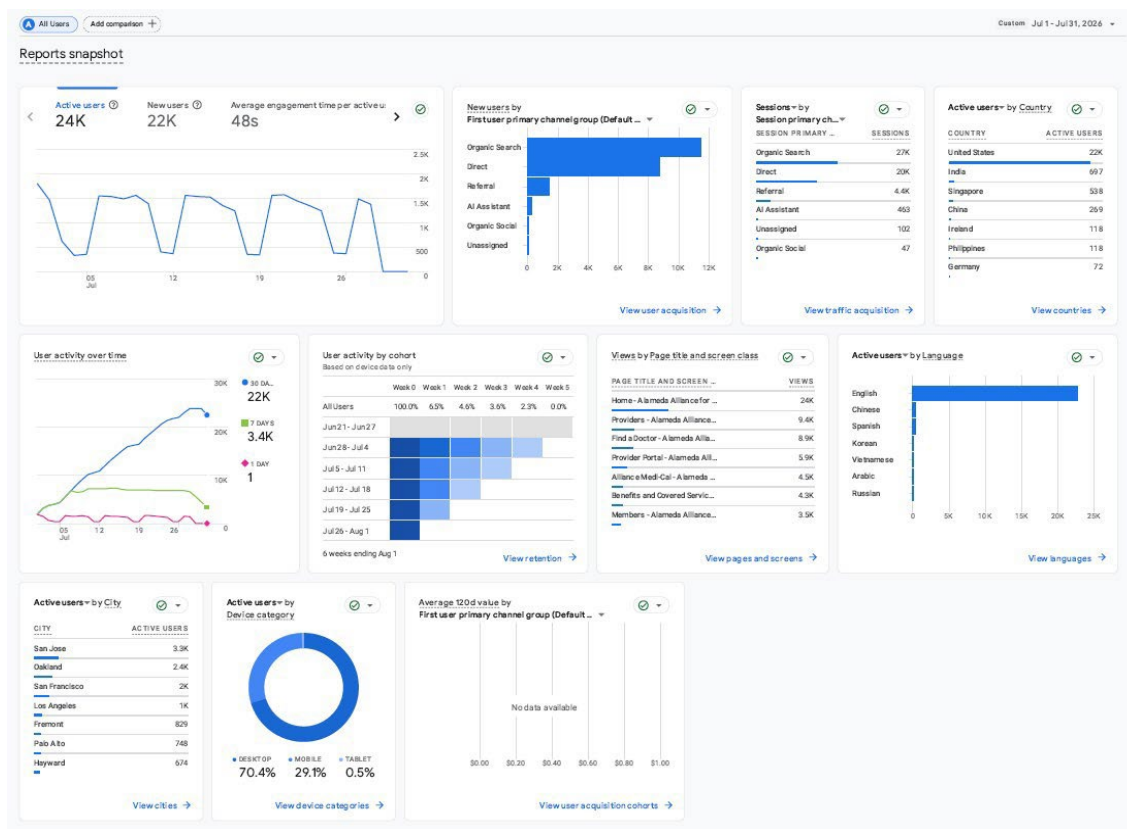
The Alliance Communications and Outreach (C&O) Department created the social media and website activity (SM&WA) Report to provide a high-level overview of stakeholder engagement through various digital media platforms. Between **July 1, 2026**, and **July 31, 2026**:

1. Alliance Website:
 - Received **187,900** unique visits
 - Served more than **2.5** million page visits
 - The top **10** website page visits were:
 - i. Homepage
 - ii. Providers
 - iii. Find a Doctor
 - iv. Provider Portal
 - v. Medi-Cal
 - vi. Benefits and Covered Services
 - vii. Members
 - viii. Get a New ID Card
 - ix. Contact Us
 - x. Find an Eye Doctor
2. Facebook Page:
 - Increased followers from **705** to **706**
 - Did not receive any reviews in **July 2026**
3. Glassdoor Page:
 - Maintained **3.1** out of a **5-star** overall rating
 - Did not receive any reviews in **July 2026**
4. Google Page:
 - **1,616** website clicks were made from the business profile
 - **1,668** calls were made from the business profile
 - Did not receive any reviews in **July 2026**
5. Instagram Page:
 - Increased in followers from **750** to **766**
6. LinkedIn Page:
 - Increased followers from **7.7k** to **7.8k**
 - Received **67** page clicks
7. X (previously Twitter) Page:
 - Slight decrease in followers from **351** to **349**
8. Yelp Page:
 - Page visits **57**
 - Appeared in Yelp searches **84** times
 - Did not receive any reviews in **July 2026**

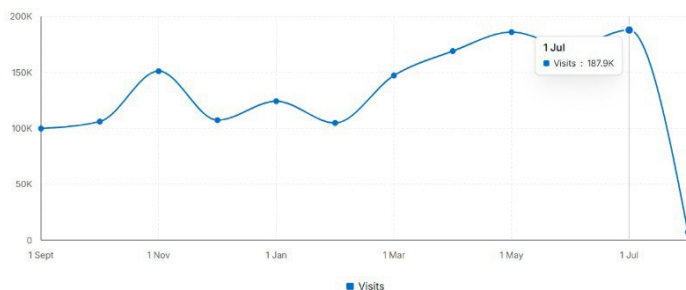
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2026-2027 | July 2026

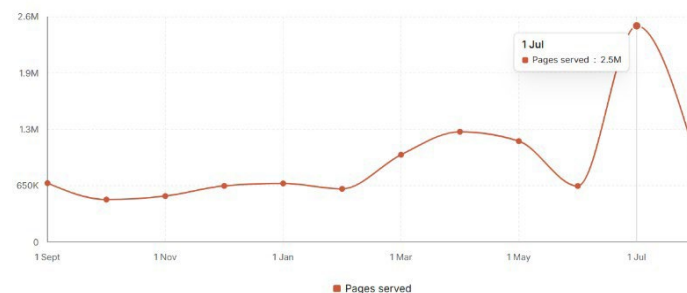
ALLIANCE WEBSITE OVERVIEW:



Visits for the last 12 months



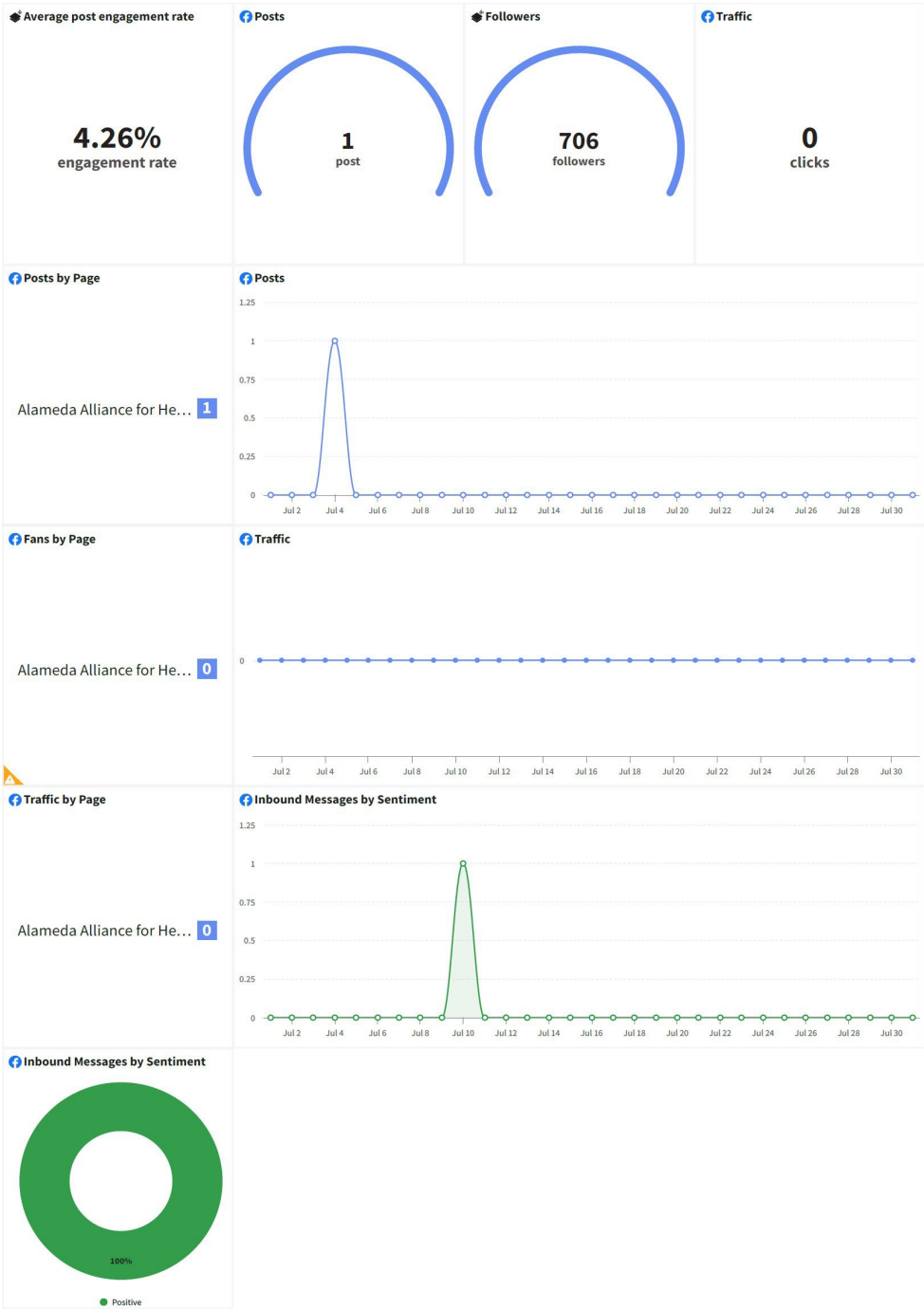
Pages served for the last 12 months



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2026-2027\Q1\1. July 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT
FY 2026-2027 | July 2026

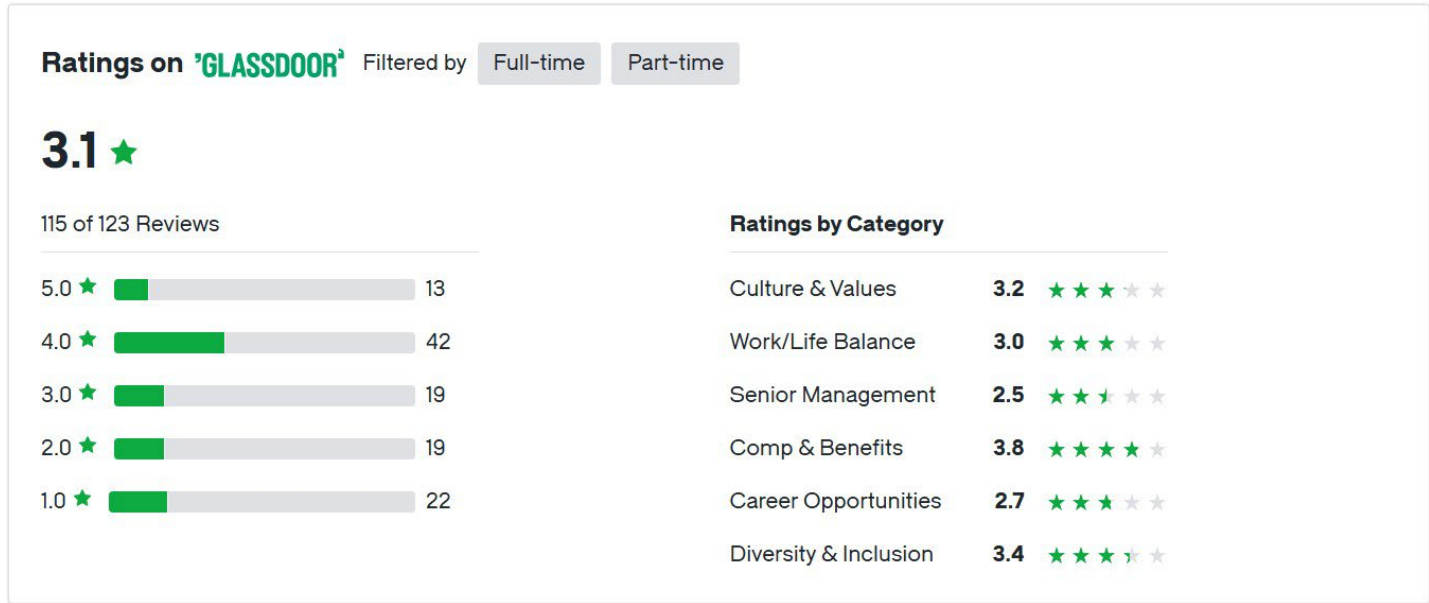
FACEBOOK OVERVIEW



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2026-2027\Q1\1. July 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT
FY 2026-2027 | July 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

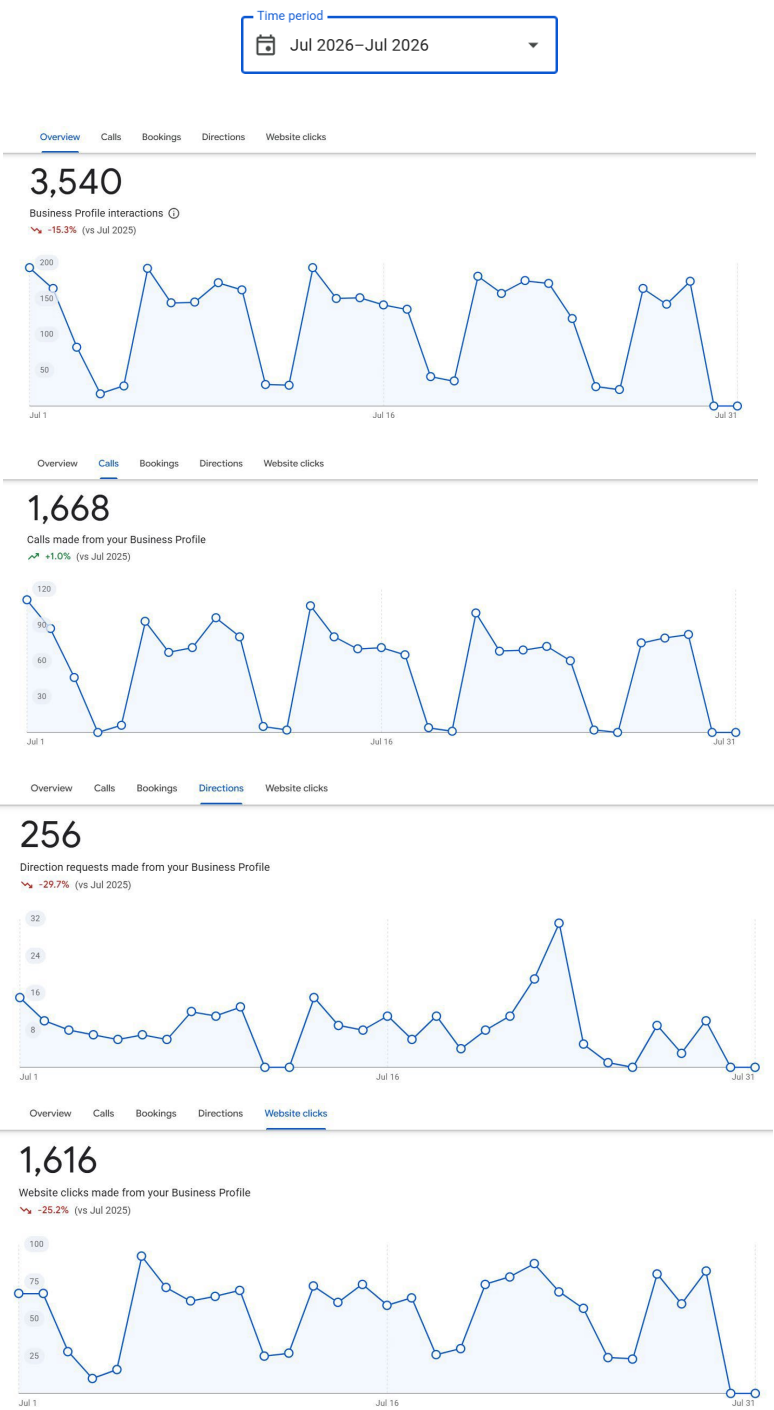
5 stars	11%
4 stars	37%
3 stars	17%
2 stars	17%
1 star	19%

All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2026-2027\Q1\1. July 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

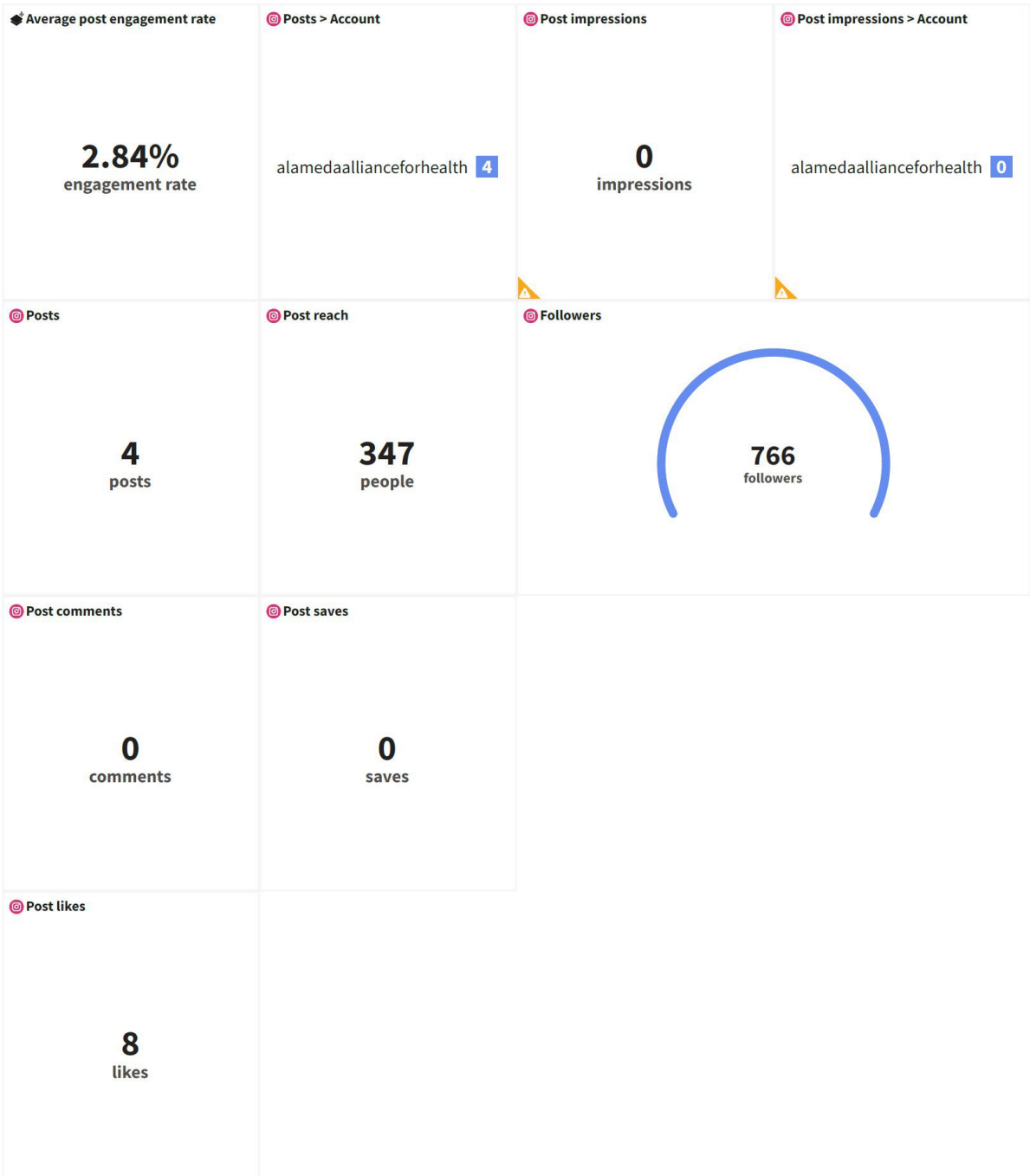
FY 2026-2027 | July 2026

GOOGLE OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2026-2027\Q1\1. July 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT
FY 2026-2027 | July 2026
INSTAGRAM OVERVIEW:

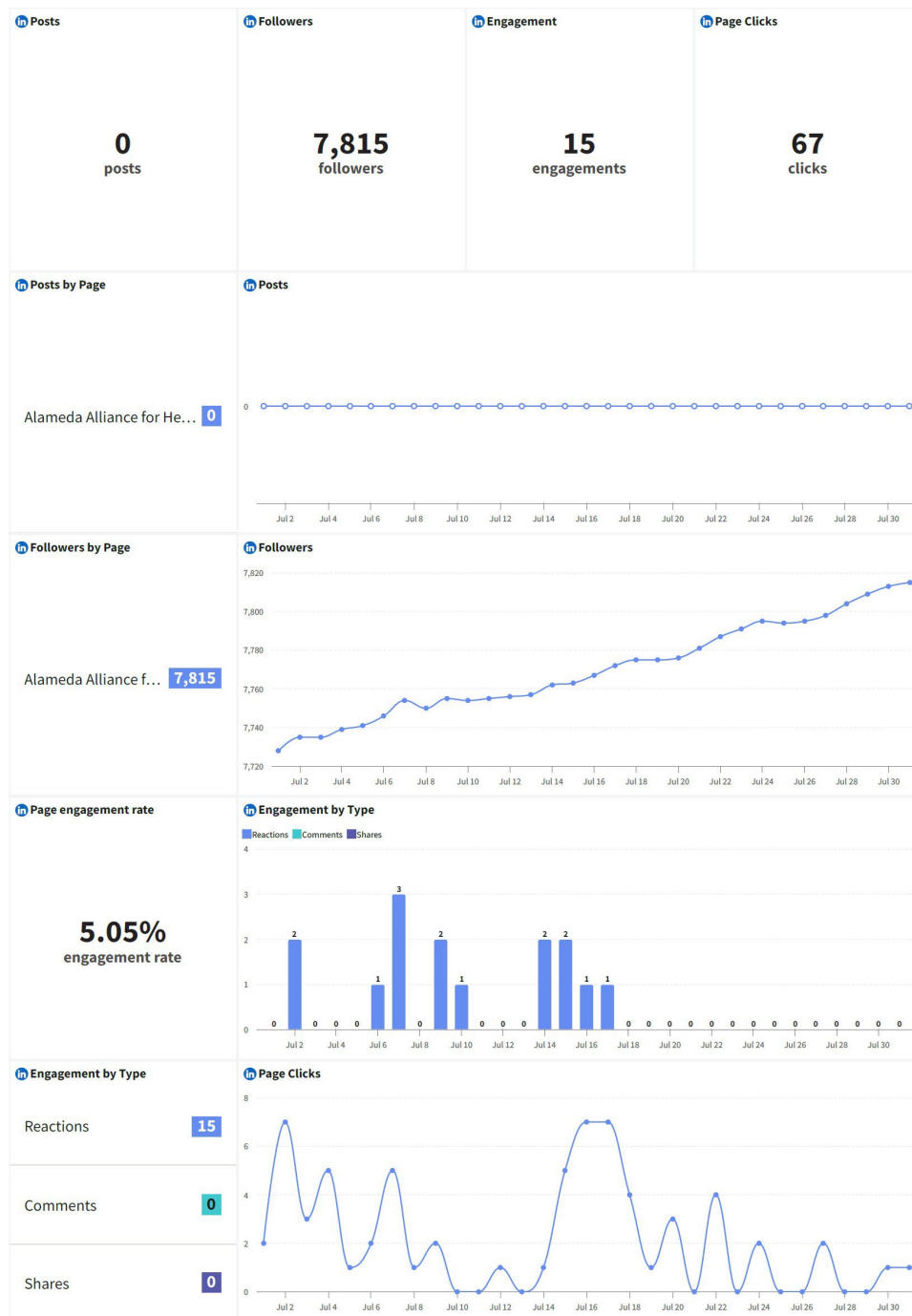


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ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2026-2027 | July 2026

LINKEDIN OVERVIEW



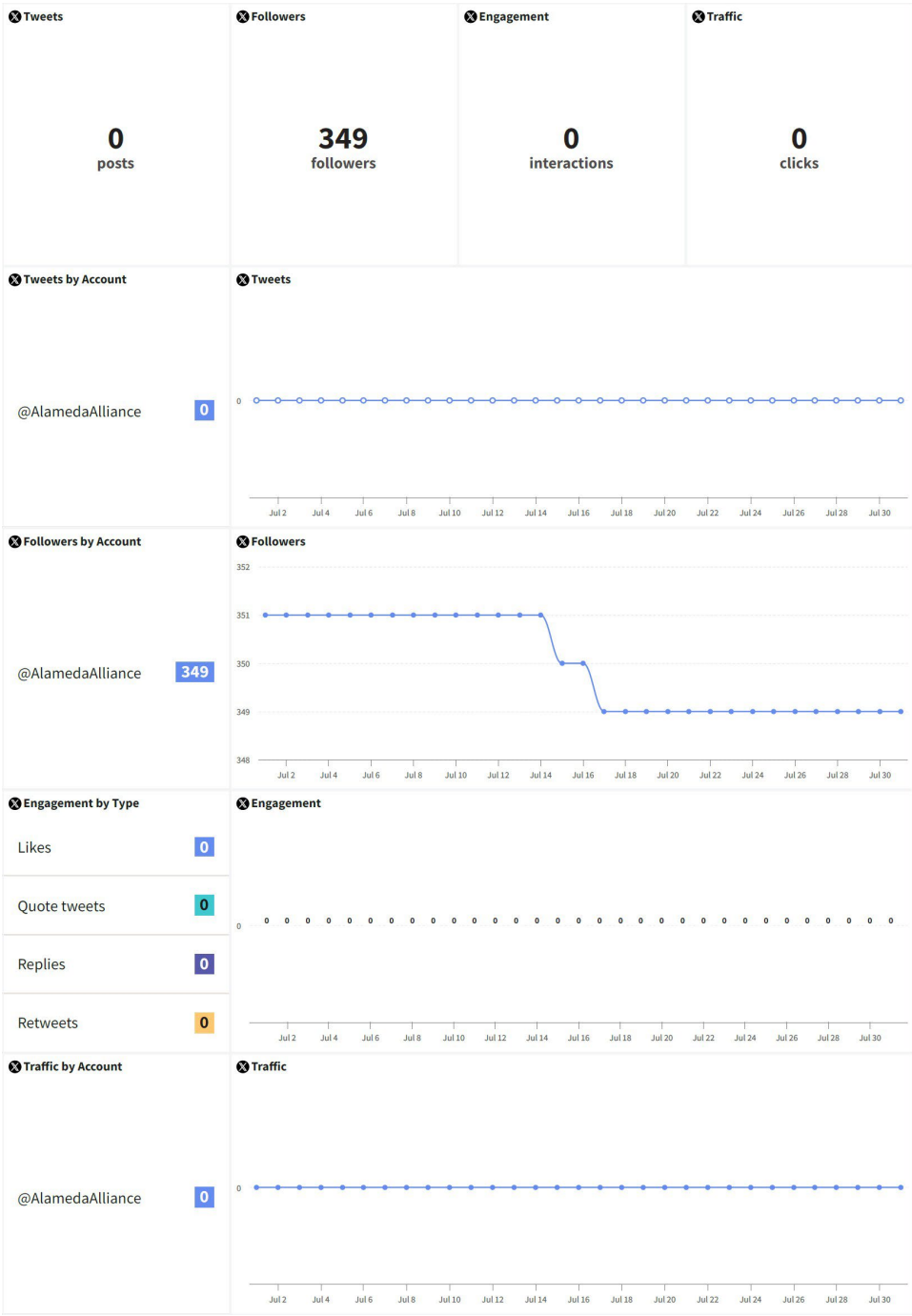
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X (previously TWITTER) OVERVIEW

COMMUNICATIONS & OUTREACH DEPARTMENT – SM & WA FY 2026 – 2027 | July 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2026-2027 | July 2026

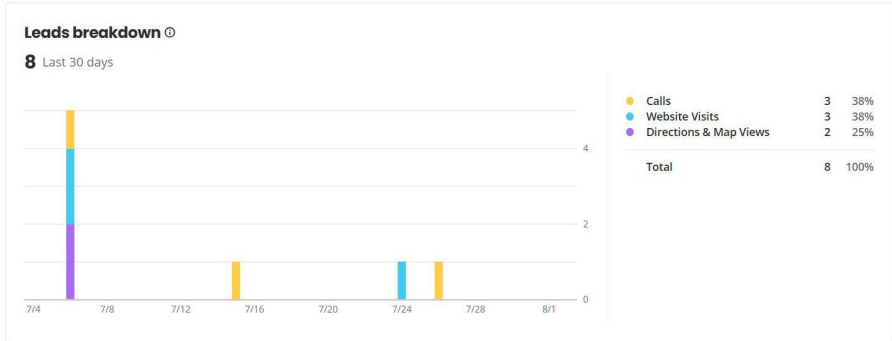
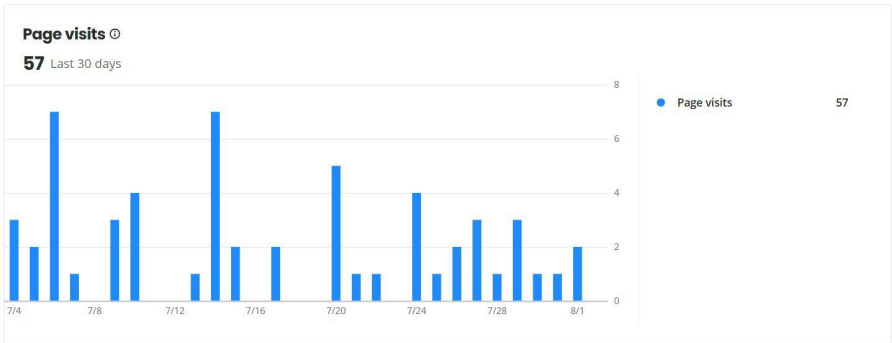
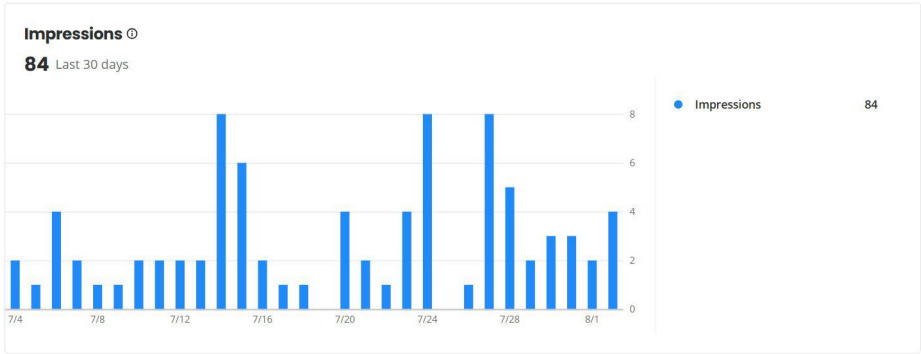
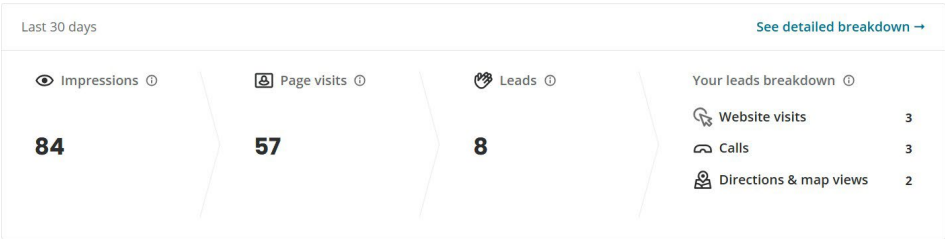


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YELP OVERVIEW

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

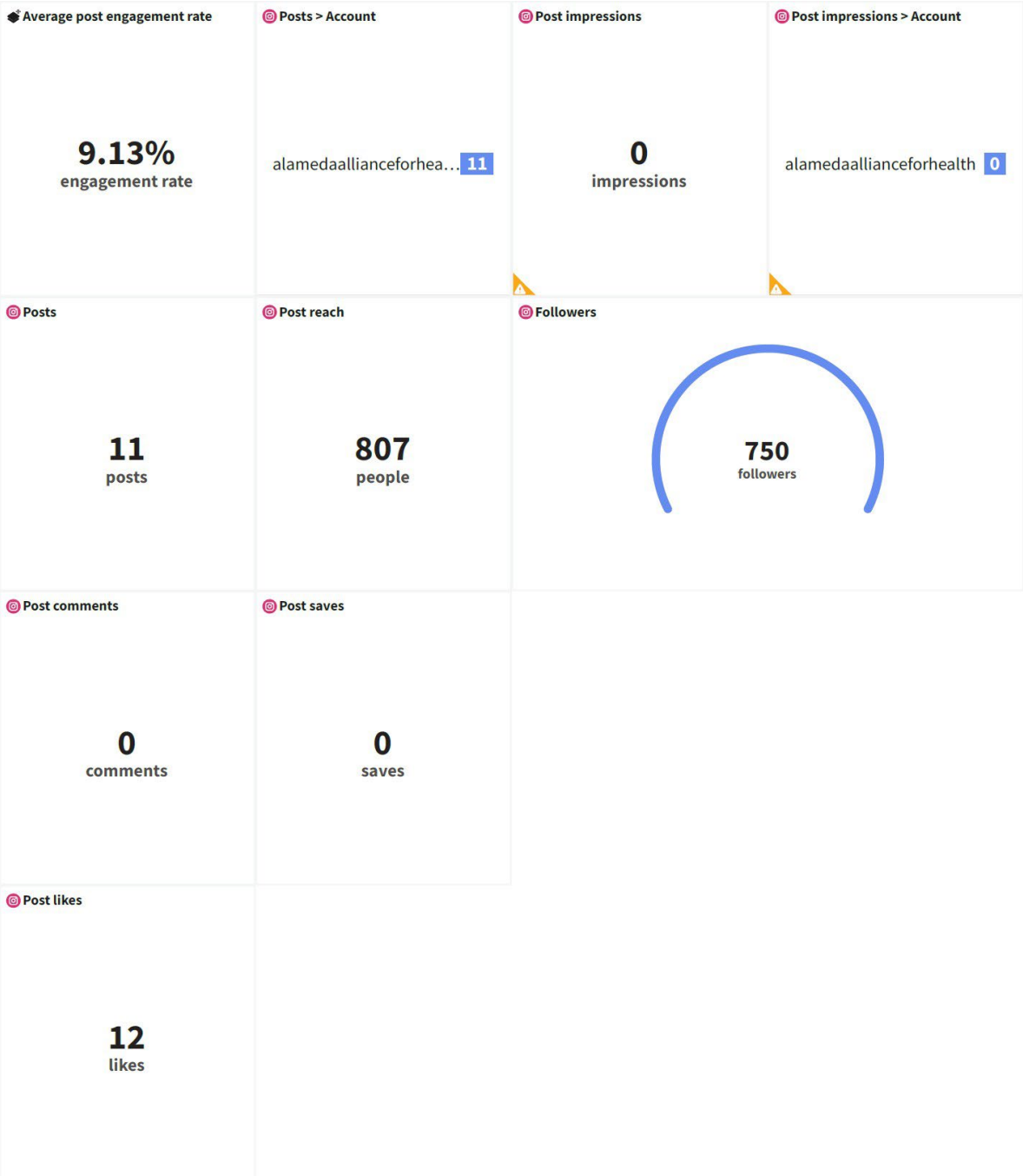
FY 2026-2027 | July 2026



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2026-2027\Q1\1. July 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT
FY 2025-2026 | June 2026

INSTAGRAM OVERVIEW:

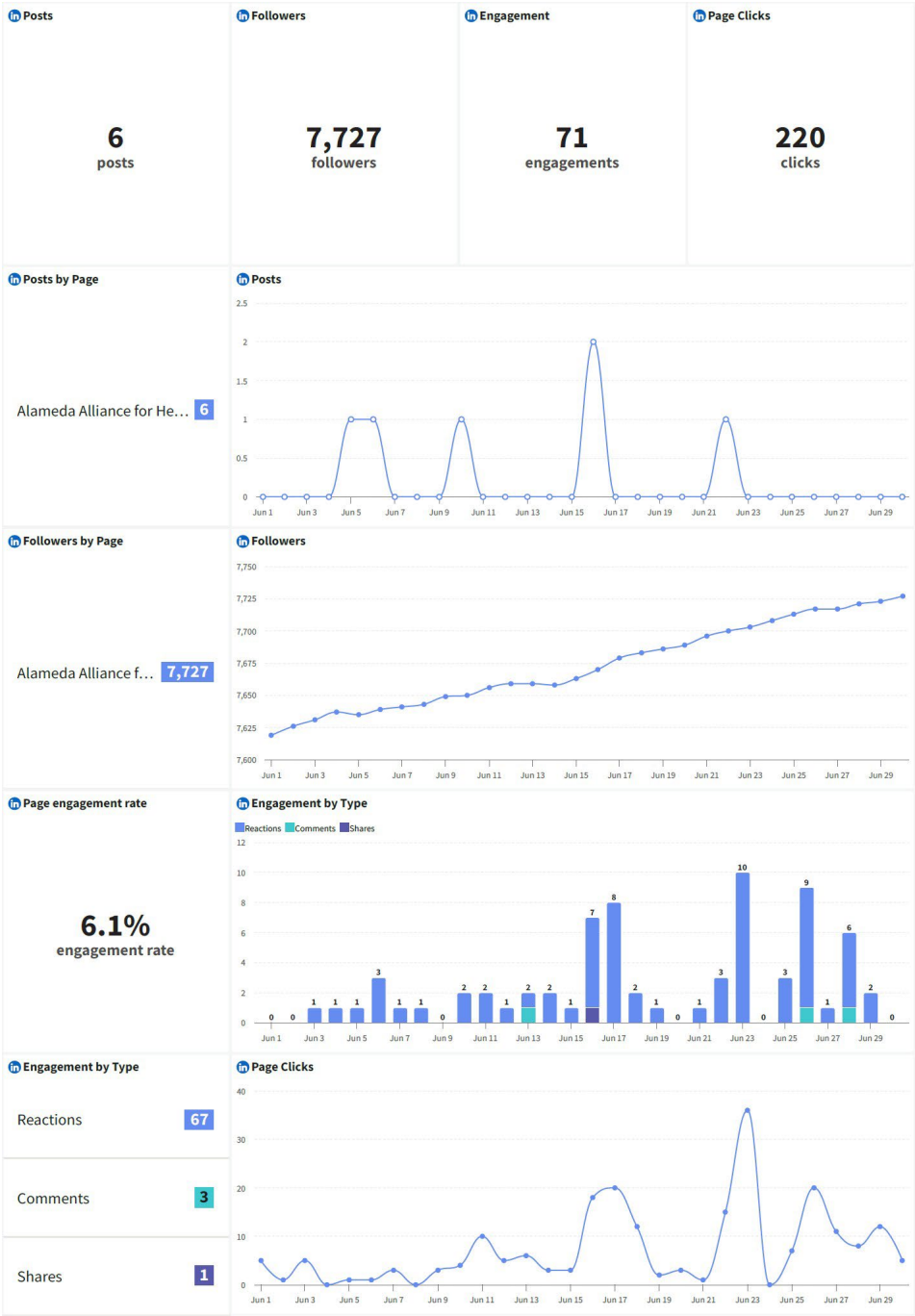


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ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | June 2026

LINKEDIN OVERVIEW

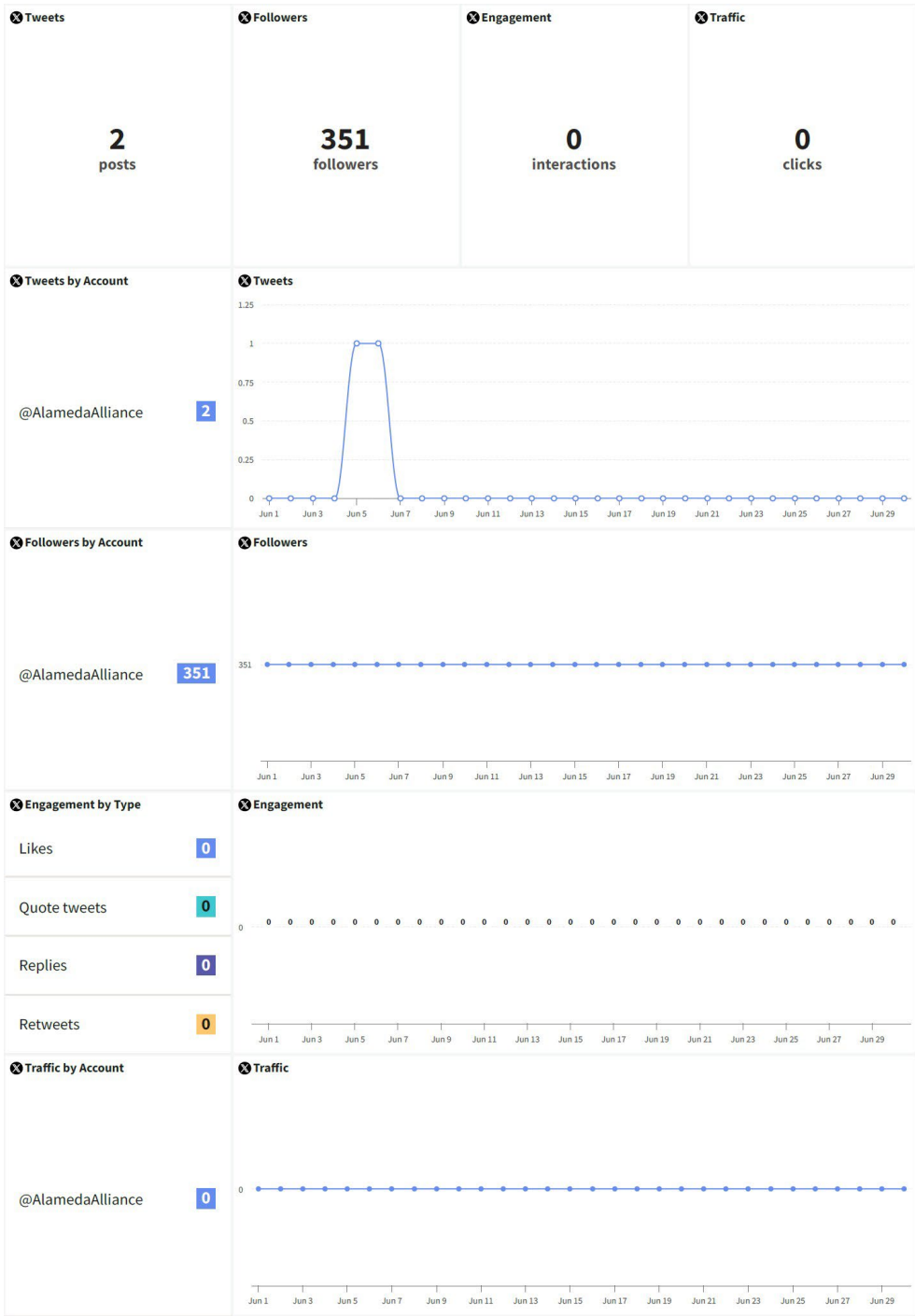


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ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | June 2026

X (previously TWITTER) OVERVIEW

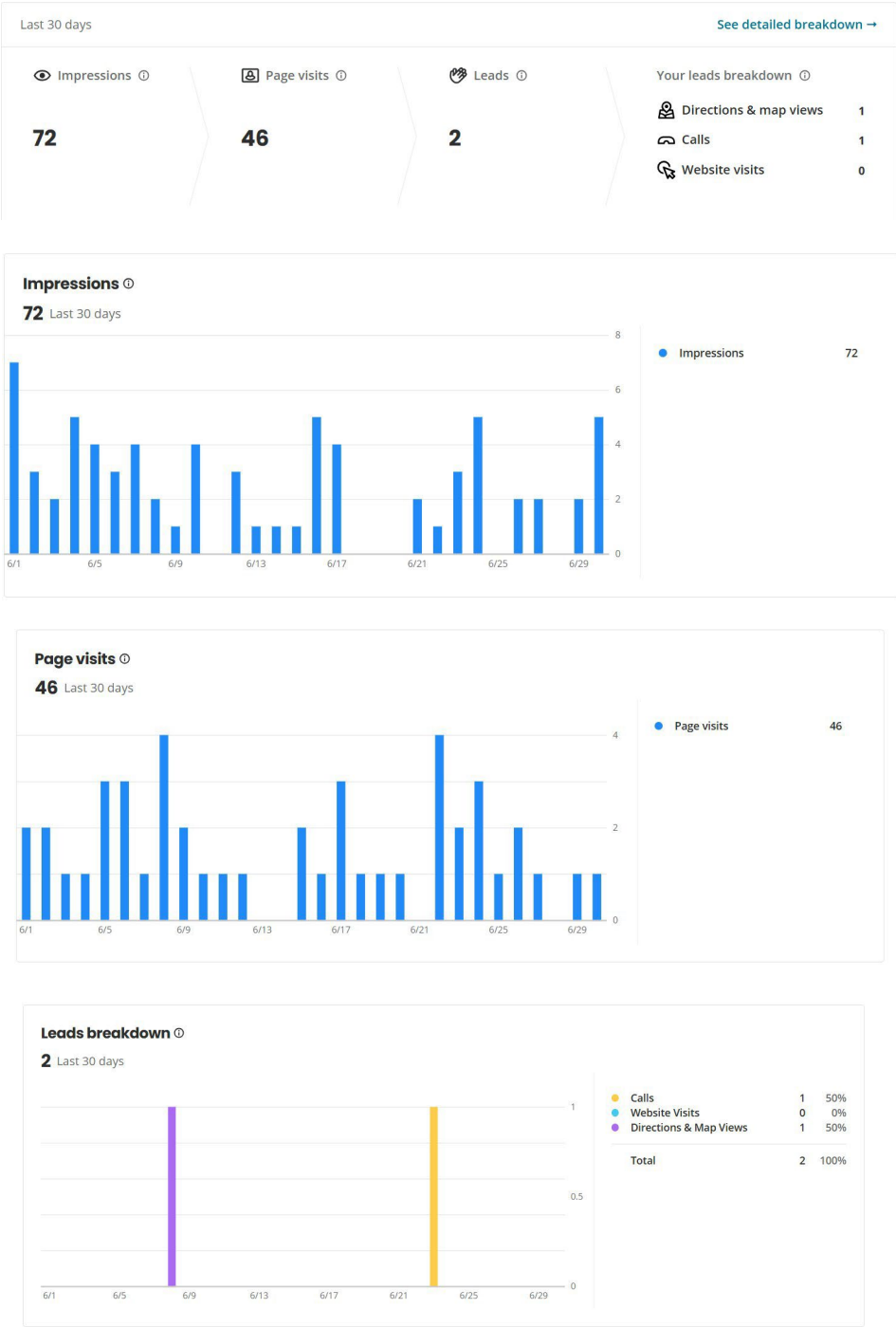


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ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | June 2026

YELP OVERVIEW



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Integrated Planning

Beau Hennemann

To: Alameda Alliance for Health Board of Governors

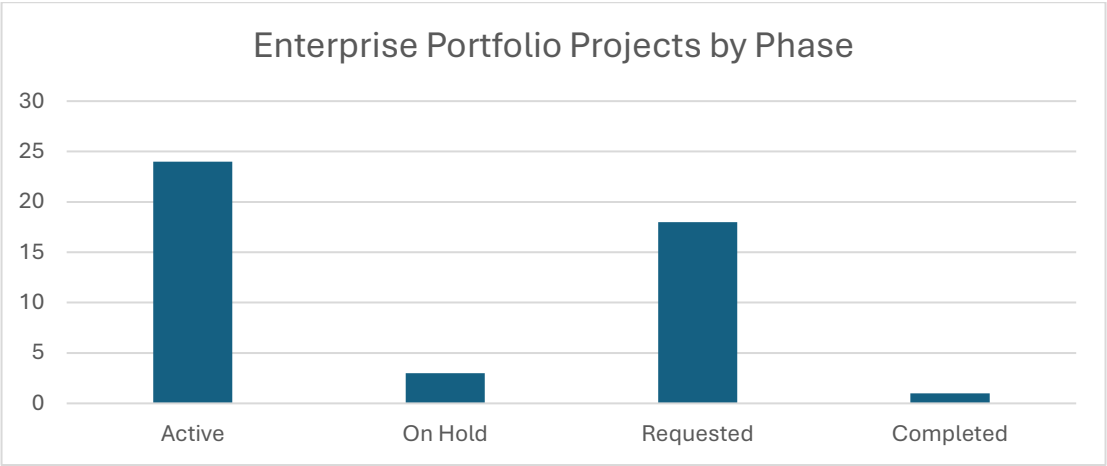
From: Sasikumar Karaiyan, Chief Information Officer & Chief Security Officer

Date: August 14th, 2026

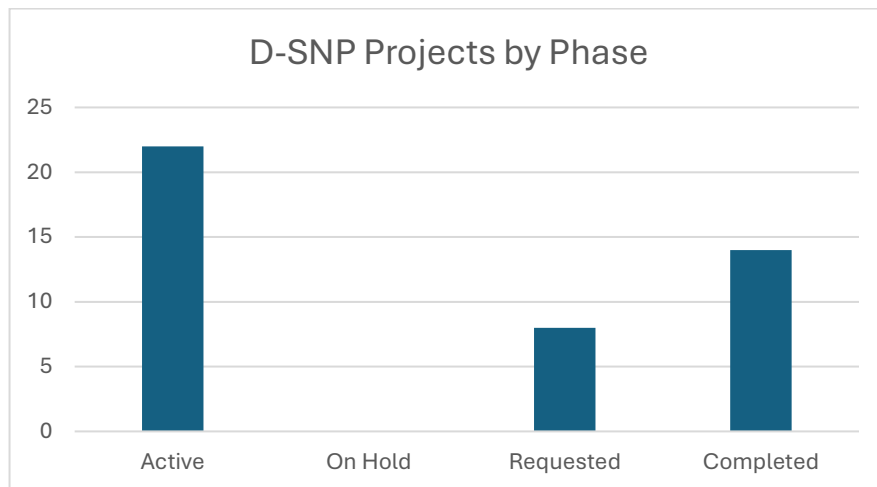
Subject: Integrated Planning Division Report – July 2026 Activities

Integrated Planning Division

- Enterprise Portfolio
 - 45 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
 - 24 Active projects (discovery, initiation, planning, execution, warranty)
 - 3 On Hold projects
 - 18 Requested and Approved Projects
 - 1 Completed Projects (Fiscal YTD)



- D-SNP Portfolio
 - 30 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
 - 22 Active projects (discovery, initiation, planning, execution, warranty)
 - 0 On Hold
 - 8 Requested Projects
 - 14 Completed Projects (Fiscal YTD)



- **Enterprise Portfolio (Active Projects) for all Lines of Business (includes projects in Initiation, Planning, and Execution)**
 - (CMS-0057-F) Interoperability and Prior Authorization Final Rule (TDX ID 5816)
 - Project Phase: *Planning
 - Project Health: **Yellow
 - ISSUE: P2P API: Ambiguous Member Consent Requirements
 - ISSUE: P2P API: Alliance as former Payer - For members with SUD (i.e. protected) data, is an ASCMI consent form required?
 - ISSUE: P2P API: Alliance as former Payer - Proposed member matching scheme may be insufficient
 - High Level Milestones (Completed in July):
 - Fit Gap Analysis (FGA) Sessions with Edifecs/Cotiviti have completed
 - High Level Milestones (In Flight in July):
 - Final FGA approval of all four (4) APIs
 - Delivery of Spark for PAS endpoints to Edifecs/Cotiviti
 - Delivery of Patient Access content to FHIR Repository
 - 2026 PBM Transition – PerformRx to MedImpact (TDX 14906)
 - Project Phase: *Planning
 - Project Health: **Green
 - High Level Milestones (Completed in July):
 - Business Requirements Document (BRD) completed
 - High Level Milestones (In Flight in July):
 - Technical requirements documentation, including file library and crosswalk of current eligibility and claims files with new MedImpact layouts
 - Completion of information questionnaires and continued progress of program design phase with MedImpact
 - Initiation of transition planning with current PBM, PerformRx
 - Contracting with MedImpact is in progress
 - Project charter revisions and approvals
 - Pharmacy Operational Workflow review and revisions
 - AOR Workflow Optimization and Systems Integration (TDX 11260)

- Project Phase: *Executing
- Project Health: **Green
- High Level Milestones (Completed in July):
 - QA Testing (IT)
- High Level Milestones (In Flight in July):
 - Development of UAT Test Plan
 - Vendor engagement to align on AOR data file testing
- Community Supports (CS) Policy Guide 04.30.25 Changes
 - Project Phase: *Executing
 - Project Health: **Green
 - High Level Milestones (Completed in July):
 - Continued Requirement Sessions
 - Completed UAT Testing of CR-07194 (T2051 with modifier U6)
 - Updated contracts for EBI and Omatachi and sent for signature
 - High Level Milestones (In Flight in July):
 - Testing CR-07209 New PEPM Rate Changes
 - Complete Requirements
 - Approval Final BRD
- CYBHI Statewide Multi-Payer School-Linked Fee Schedule (TDX ID 4186)
 - Project Phase: *Executing
 - Project Health: **Yellow
 - BAA executed 6/26/26
 - Schedule delayed due to late BAA, impacting project health
 - Risk 4736: BAA - A fully executed BAA is required before AAH can proceed with the transfer of member data; a test file was scheduled for submission to Carelon on 4/20. Without the BAA, this will delay project efforts.
 - High Level Milestones (Completed in July):
 - Monthly Eligibility File delivered to Carelon
 - High Level Milestones (In Flight in July):
 - Carelon ingested monthly file and began configuration of test file for endpoint mapping
 - Carelon has moved the file into test development region to map fields for their review
 - Carelon internal testing of file
 - AAH IT team to deliver updated/corrected test file to Carelon
 - Carelon will review, fix and retest file when received
- D-SNP: 1A Contracting & Credentialing (TDX ID 6924)
 - Project Phase: *Executing
 - Project Health: **Green
 - High Level Milestones (Completed in July):
 - Text to Speech (TTS) application found and approved by IT
 - The following languages have been recorded for TTS:
 - Farsi, English, Cantonese, Mandarin, Vietnamese
 - Spanish in progress
 - Provider Contract Termination UM Utilization Report
 - Requirements for contents and data fields

- Determination around when to begin development of report was dependent upon requirements stated above
- High Level Milestones (In Flight in July):
 - Validation of TTS recordings
 - QA test cases developed
 - UAT test cases developed and reviewed with the Business
- D-SNP: 2D Chronic Care Improvement Program (CCIP) (TDX ID 6936)
 - Project Phase: *Executing
 - Project Health: **Green
 - High Level Milestones (Completed in July):
 - None
 - High Level Milestones (In Flight in July):
 - Identification of additional Care Plan Elements and Assessments that will be needed for the CCIP Program
 - Developing the CCIP Plan to present to internal committees in August
- D-SNP: 6G Organizational Training (TDX ID 6908)
 - Project Phase: *Executing
 - Project Health: **Yellow
 - TDX Risk 5029 – Limited Internal SME Capability for SCROM Training Development and Video Editing
 - Mitigation Plan: Med Ops has received budget approval for an L&D Program Manager. If we are unable to identify a candidate with Articulate experience, the team will use Ispring
 - TDX Risk 5028 – Loss of Training Edits or Updates Due to Expiring Consulting Contract
 - Mitigation Plan: Purchase and maintain licenses for Articulate, Synthesia
 - High Level Milestones (Completed in July):
 - Completed SCROM File Conversation for Case Management
 - Completed HR Testing for UM Modules 1-8
 - High Level Milestones (In Flight in July):
 - Continued HR Testing of UM Modules
 - Training Team Update HR Testing Feedback
 - Start HR Testing of Case Management
- D-SNP: CHCN Delegation (TDX 14333)
 - Project Phase: *Initiating
 - Project Health: **Yellow
 - TDX Issue 5003: D-SNP Delegation scope has not been finalized, CHCN executive team is discussing
 - Mitigation Plan: AAH will proceed under the assumption that the areas AAH is recommending for delegation will be delegated
 - TDX Issue 4801: CHCN has one (1) outstanding CAP for the Medical LOB from 2025
 - Mitigation Plan: AAH Compliance team is working with CHCN to be resolved by 8/31/26

- TDX Risk 4790: CHCN is currently going through a core system upgrade for the Medi-Cal LOB which is scheduled to be completed in February 2027. This will need to be completed before starting their D-SNP IT Implementation.
 - Mitigation Plan: AAH has requested CHCN to ask vendor for the requirements they will need and estimated duration for a D-SNP Implementation
 - High Level Milestones (Completed in July):
 - Alignment on the deliverables and timelines for the pre-delegation audit
 - Alignment on the existing business issues with CHCN that will need to be resolved or an agreed path to resolution by 8/31
 - High Level Milestones (In Flight in July):
 - Finalized Draft D-SNP Delegation Amendment and DoFR
- D-SNP: Provider Exclusions Project (TDX 15452)
 - Project Phase: *Executing
 - Project Health: **Green
 - High Level Milestones (Completed in July):
 - Member Letter edited and shall be refiled with CMS due to deviation of content from model template – internal review of content in progress
 - Requirements sessions are in process for Exclusion Lists
 - Determination if Provider Repository Module is needed
 - Dependency: Process flow of proposed module must be completed for IT to determine feasibility and level of effort for this component
 - High Level Milestones (In Flight in July):
 - Policy Development and Editing in progress for multiple business areas
- DHCS APL 25-015 Data Sharing and Quality Rate Production (TDX ID 14146)
 - Project Phase: *Executing
 - Project Health: **Green
 - High Level Milestones (Completed in July):
 - Final Review of IT Workflows
 - Confirmed with Compliance we do not need draft APL 26-xxx to close project
 - High Level Milestones (In Flight in July):
 - Project Closeout
- DHCS APL 26-004 Medi-Cal MCP Responsibilities for BH (TDX 15101)
 - Project Phase: *Executing
 - Project Health: **Yellow
 - The expanded scope of (15101) APL 26-004 is not yet fully merged into the project plan
 - High Level Milestones (Completed in July):
 - None
 - High Level Milestones (In Flight in July):
 - Meet with ACBH to review proposed MOU changes
- DMHC APL 25-021 Infertility and Fertility Services [SB 729] (TDX ID 14637)

- Project Phase: *Execution
- Project Health: **Yellow
 - TDX Issue 4820: Without DMHC billing guidance, AAH needs to create our own approach to billing for APL required services, including rates and codes
 - AAH has no historical data to pull from or billing/procedure codes associated with these services as they are not covered by Medi-Cal or Medicare
 - Outreach to sister plans for collaboration has not yet provided fruitful guidance.
 - TDX Issue 4941: Lack of Billing Structure/Reimbursement Methodology for providers is creating an impediment to contracting efforts with UCSF and increasing financial risk to the plan
 - Without a rate established, the potential cost to the health plan for this type of service is very high as AAH may have to resort to a percentage of billed charges.
- High Level Milestones (Completed in July):
 - BRD Approval
- High Level Milestones (In Flight in July):
 - Ongoing outreach to sister plans and other contacts at commercial plans for collaboration on rate development and procedure codes
 - Development of APL requires enrollee notices
 - EOC revisions based on DMHC redlines
 - Documentation of billing strategy and approach, as well as confirmed billing codes
 - Initiation of technical requirement refinement and development
- ECM Enhancement (TDX 15268)
 - Project Phase: *Executing
 - Project Health: **Yellow
 - TDX Risk 5038: Risk of not completing all the ECM Initiatives by the target date of 12/31/26 due to resource constraints and competing priorities
 - Mitigation Plan: Proactively plan the work and escalate blockers to leadership
 - High Level Milestones (Completed in July):
 - ECM Phase II (Provider Portal Referrals) Development completed
 - ECM Auto Authorizations for MIF/RTF BRD approved
 - ECM Billing and Provider billing future state design decisions made
 - ECM auto authorization termination business process flow completed
 - High Level Milestones (In Flight in July):
 - ECM Phase II (Provider Portal Referrals) QA, UAT, and deployment
 - Complete future state ECM Billing and Provider payment design
 - ECM auto authorization termination BRD finalization and approvals
- Member Correspondence (TDX ID 12697)
 - Project Phase: *Planning
 - Project Health: **Green
 - High Level Milestones (Completed in July):

- Completed Member Communications Inventory
 - Completed first iteration wireframes
- High Level Milestones (In Flight in July):
 - Complete requirements refinement
 - KP correspondence standard file template
- PY2027-D-SNP: Centralized Medicare Website Enhancement (TDX ID 14617)
 - Project Phase: *Initiating
 - Project Health: **Yellow
 - Issue: Medicare Ops will provide Images and Icons to C&O for Shopping and Enrollment & Member Resource Pages
 - Risk: CMS Model regulations are not due out until June or July
 - This risk can be closed as the mitigation plan is to submit C&O request, since we have received feedback from CMS
 - High Level Milestones (Completed in July):
 - Shopping & Enrollment Content Finalized
 - Initial Content Loaded into Test Environment
 - Approval of BRD
 - High Level Milestones (In Flight in July):
 - Complete Content Configuration in Test Environment
 - Member Resource Final C&O Approval
- PY2027-D-SNP Bid Strategy, Submission & Approval (TDX ID 14636)
 - Project Phase: *Executing
 - Project Health: **Green
 - High Level Milestones (Completed in July):
 - Submitted the CY2027 Agent/Broker Compensation Attestation
 - Completed preliminary review of CMS Part D benchmark results following CMS release on July 28th
 - Validated Milliman forecasted spend and confirmed budget remains within approved funding levels
 - High Level Milestones (In Flight in July):
 - Finalize CY2027 bid updates and CMS resubmission by August 6th CMS deadline
 - Continue monitoring CMS review ahead of expected bid and formulary approvals by the end of August
- PY2027-D-SNP CMS Marketing & Sales Readiness–AEP/OEP (TDX ID 14695)
 - Project Phase: *Initiating
 - Project Health: **Green
 - High Level Milestones (Completed in July):
 - Activated the project and finalized the business case in TDX
 - Developed the initial work breakdown structure and draft project plan
 - Clarified project scope and key handoffs with the Operational Readiness project
 - Established governance structure and developed the preliminary resource forecast for stakeholder review
 - High Level Milestones (In Flight in July):
 - Finalize named resources and estimated monthly hours for organizational capacity planning

- Following project charter approval, conduct the August 7th project kickoff and confirm workstream owners, deliverables, and timelines
 - Develop detailed plans for CMS-required integrated marketing materials, sales enablement, and enrollment readiness
- PY2027-D-SNP Operational Readiness – AEP/OEP (TDX ID 14696)
 - Project Phase: *Initiating
 - Project Health: **Green
 - High Level Milestones (Completed in July):
 - Activated the project and finalized the business case in TDX
 - Developed the initial work breakdown structure and draft project plan
 - Clarified project scope and key handoffs with the CMS Marketing and Sales Readiness project
 - Established governance structure and developed the preliminary resource forecast for stakeholder review
 - High Level Milestones (In Flight in July):
 - Finalize named resources and estimated monthly hours for organizational capacity planning
 - Following project charter approval, conduct the August 7th project kickoff and confirm workstream owners, deliverables, and timelines
 - Begin operational gap assessment and readiness planning across enrollment, systems, staffing, training, and downstream operations
- Receiving, Storing, and Retrieving SOGI Data (TDX ID 6623)
 - Project Phase: *Executing
 - Project Health: **Green
 - High Level Milestones (Completed in July):
 - Completed Updating Policy & Procedures
 - Race & Ethnicity
 - Language
 - Sexual Orientation
 - Disability Status
 - Presented P&Ps to IQIC
 - Completed Requirements Sessions
 - High Level Milestones (In Flight in July):
 - Final Approval of BRD
 - Drafted EXR Form and Submitted to C&S for Review
 - DHCS Approval of EXR Form
- sPayer Contracting Repository (TDX 1283)
 - Project Phase: *Planning
 - Project Health: **Yellow
 - TDX Risk: 5051 Project Hours – Reengagement
 - symplr reported there are 690 hours remaining out of 1,907 allocated; need to determine if this is sufficient time to implement the first phase of the project
 - High Level Milestones (Completed in July):
 - Kick Off Meeting 7/14/26
 - Discovery Timeline shared by vendor with AAH outlining activities July through beginning of September

- Timeline reviewed and shared with internal stakeholders; feedback provided to vendor who subsequently adjusted timeline as needed
- Reconciliation of timecards submitted by vendor to Alliance to align budget and hours remaining in project
- High Level Milestones (In Flight in July):
 - Mapping meetings
 - Symplr & Alliance PMs Connect Meetings began
 - Iteration 2 Data Delivered to AAH
 - AAH data validation begins



Compliance

Stephen A. Smythe

To: Alameda Alliance for Health Board of Governors

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

Date: August 14th, 2026

Subject: Compliance Division Report

Enterprise Audit Updates

- 2025 Department of Managed Health Care (DMHC) Routine Full Medical Survey
 - The Plan received the Department's final report on May 19th, 2026
 - On July 17th, 2026, as instructed in the Final Survey Report, the Plan submitted supplemental responses for deficiencies related to the Pharmacy Formulary and Concurrent Review Process to the Department. Efforts remain ongoing with the Plan stakeholders to address the twelve (12) open deficiencies identified in the Final Report.
- 2026 Department of Health Care Services (DHCS) Routine Audit
 - The Plan has completed its annual audit with DHCS. The Department reached out to the Plan on August 4th, 2026, to confirm the Plan's availability for the exit conference and to review the draft report. The tentative date is August 25th, 2026.
- 2026 Health Services Advisory Group (HSAG) Network Adequacy Validation (NAV) Audit
 - HSAG issued the NAV Audit Document Request Packet on May 11th, 2026, and conducted a Technical Assistance Webinar on May 12th, 2026. Following May 29th, 2026, Kick-Off Call, the Plan timely submitted the Information Systems Capabilities Assessment Tool (ISCAT), and all required pre-audit materials on June 18th, 2026. The Plan is preparing for the upcoming virtual review and system demonstration activities scheduled for August 20th, 2026.
- 2026 Health Services Advisory Group (HSAG) Encounter Data Validation (EDV) Audit
 - HSAG conducted the EDV Technical Assistance Webinar on June 1st, 2026, and distributed the EDV questionnaire and supporting materials on June 2nd,

2026. The Plan coordinated with internal SMEs and delegated entities to complete the required questionnaire and supporting documentation. The Plan completed its pre-audit submission and the online questionnaire on July 2nd, 2026.

- 2026 Health Equity Quality Performance CAP MY 2024
 - On July 1st, 2026, the Plan received DMHC's notification of deficiencies identified in the Measurement Year 2024 Health Equity and Quality Performance review. Twenty (20) benchmarks were evaluated and twelve (12) were found deficient, including repeat deficiencies in Breast Cancer Screening, Glycemic Status (2 measures), Controlling High Blood Pressure, Asthma Medication Ratio, Well-Child Visits (First 15 Months and 15-30 Months), Child and Adolescent Well-Care Visits, Plan All-Cause Readmissions, and the CAHPS Child Survey.
 - An internal kickoff was held on July 27th, 2026, to discuss the CAP and next steps with Plan stakeholders. The final Root Cause Analysis (RCA) and CAP are due to DMHC on September 28th, 2026.
- 2023 DHCS Focused Audit CAP Closure
 - On August 5th, 2026, DHCS formally closed Alameda Alliance for Health's Corrective Action Plan associated with the 2023 Focused Audit of Behavioral Health and Transportation Services. DHCS accepted all corrective actions and acknowledged the Plan's remediation efforts related to behavioral health care coordination, information sharing, substance use disorder referral processes, and transportation oversight. While the CAP is closed, DHCS noted these areas will continue to be evaluated during future audit activities to ensure sustained compliance with evolving regulatory requirements.

Compliance Program Activity

- Compliance Support of Pharmacy Benefit Manager Transition
 - On June 25th, 2026, the Compliance Department submitted a Material Modification e-filing related to the transition from PerformRx to MedImpact as the Plan's pharmacy benefit manager (PBM) to the Department of Managed Health Care (DMHC). The DMHC responded on July 16th, 2026, with an order of postponement and comments to which the Alliance must respond by August 15th, 2026. Compliance is coordinating with internal stakeholders and

MedImpact to obtain responses. Compliance has verbally informed DHCS and CMS of this change. Furthermore, Compliance continues to be active contributors to the enterprise-wide PBM transition work group.

- Unsatisfactory Immigration Status (UIS) Population Transition to Fee-for-Service (FFS)
 - California is implementing a federally required transition of Medi-Cal members with Unsatisfactory Immigration Status (UIS) from Managed Care to Medi-Cal Fee-for-Service (FFS), effective January 1, 2027. The transition will significantly change how the UIS population accesses care and may affect access to certain managed care services, including care management and Community Supports. Compliance is initiating a cross-functional project to support compliance with DHCS requirements related to continuity of care, data sharing, provider communications, member outreach, and operational readiness. The goal is to minimize disruption for impacted members.

Current efforts focus on project planning, regulatory deliverables, provider and member communication strategies, continuity-of-care planning, and data-sharing readiness. Teams are also evaluating impacts on vulnerable populations and identifying opportunities to collaborate with Alameda County programs, community clinics, and safety-net partners to support member transitions.

- Network Adequacy Submissions
 - Subcontractor Network Certification (SNC) - DHCS completed its review of the Plan's 2025 SNC Landscape Analysis and provided approval on December 30th, 2025. Subsequently, the Compliance Division submitted all required 2025 SNC Exhibits to DHCS on February 13th, 2026, consulting with internal resources to respond to DHCS' follow up inquiries to provide additional insight regarding delegate networks. The submitted exhibits and follow-up responses are pending DHCS' final review. Additionally, the Compliance Division submitted an inquiry to DHCS on June 30th, 2026. As of this date, DHCS has not provided a response. A follow-up email was subsequently sent advising that the Alliance remains awaiting clarification.
 - 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. Compliance worked with internal SMEs to provide comprehensive responses to follow-up inquiries received from DHCS, the most recent of which was submitted on May 19th, 2026. The submission and Compliance's responses are pending DHCS' final review.

- Legislative and Regulatory Implementation
 - DMHC published APL 25-020 Newly Enacted Statutes for the 2025 Legislative session on December 19th, 2025. This APL 25-020 provides guidance and outlines compliance requirements related to eleven (11) newly enacted statutes that are applicable to the Alliance. The Plan continues to await additional DMHC guidance on two statutes. On March 13th, 2026, the Plan submitted the initial e-Filing (20261070) to DMHC. The Plan submitted its response to the most recent comments on July 21st, 2026. DMHC is expected to provide responsive comments or close the filing by August 20th, 2026.
 - DMHC published APL 25-021 on December 30th, 2025. The APL provides guidance and outlines the Senate Bill (SB) 729 - Treatment for Infertility and Fertility Services compliance requirements. Although SB 729 is only applicable to Group Care, implementation of SB 729 is operationally complex, so implementation has been elevated to an enterprise-wide project. The project workgroup continues to meet on a weekly basis and is expecting to go-live by January 1st, 2027. DMHC approved all P&Ps related to SB 729 in the initial filing. The Alliance submitted comment responses on July 21st, 2026, and is awaiting additional comments or closure. The workgroup continues to develop the benefit matrix which informs updates to the 2026 Group Care Member Handbook.
- CY 2027 Integrated Materials – Regulatory Approval
 - For Exclusively Aligned Enrollment (EAE) Dual Eligible Special Needs Plans (D-SNPs), integrated materials are a set of unified, single-source documents that combine Medicare and Medicaid benefit information into one clear presentation for enrollees. These documents are referred to as “integrated materials.” All integrated materials must be submitted to CMS, DHCS and DMHC and approved well in advance of Open Enrollment, which begins on October 1st, 2026.

The Alliance is ahead of last year's timeline due to early strategic planning by the Medicare Operations Marketing team, proactive engagement with subject matter experts (SMEs) for input and approval, increased cross domain collaboration through regular meetings and regular communication and alignment with regulatory agencies.

Integrated Material	Submission Due Date	DMHC Approval Status	DHCS Approval Status	CMS Approval Status
Member Identification Card	07/13/26	<i>Approved</i>	<i>Approved</i>	<i>Approved</i>
ANOC — Annual Notice of Change	07/13/26	<i>Approved</i>	<i>Approved</i>	<i>Approved</i>
SOB - Summary of Benefits	07/13/26	<i>Pending</i>	<i>Approved</i>	<i>Approved</i>
Marketing Formulary	07/29/26	<i>Submission Not required</i>	<i>Pending</i>	<i>Pending</i>
Member Handbook / EOC- Evidence of Coverage	07/27/26	<i>Pending</i>	<i>Pending</i>	<i>Pending</i>
Provider Directory	07/29/26	<i>Submission Not required</i>	<i>Pending</i>	<i>Pending</i>

Privacy Office (The Privacy Office): Operational Updates

- Q2 2026 Privacy Team Executive Summary Report HIPAA Incidents submitted to Stephen Smythe Interim Chief Compliance & Privacy Officer for review and approval.
 - This report provides a comprehensive review of all privacy incidents investigated by Alameda Alliance's Privacy Office during Q2 2026. It evaluates incident volume, reporting timeliness, HIPAA risk assessments, regulatory reporting obligations, root causes, trends, corrective actions, and emerging privacy risks. The report also outlines strategic actions planned for Q3 to strengthen privacy controls and reduce future risk exposure.
 - Key Highlights: Strong Compliance Performance. The Privacy Office reviewed 39 reported incidents, of which 16 were confirmed privacy incidents. 100% of privacy incidents were reported within the required 24-hour timeframe. No incidents required reporting to DHCS, the State, or federal regulators. All Incidents Determined to be Non-Breach Events Following HIPAA-required risk

assessments, every Q2 incident was determined to have a low or very low probability of PHI compromise, resulting in zero reportable breaches.

- High-Impact Events Successfully Contained:
 - An unencrypted vendor email with potential impact of 78 members.
 - An encrypted email event with potential impact of 1,244 members.
 - An Authorized Representative (AOR) vendor feed issue with potential impact of approximately 11,891 members.
 - A personal-email transmission with potential impact of 500 members.
 - In each case, Privacy, IT, and operational teams implemented immediate containment and corrective actions, and no unauthorized access or misuse was identified.
- Strategic Focus: Increase privacy-by-design oversight for projects, vendor integrations, automated processes, and data-sharing activities.
- Q2 2026 Privacy Team Executive Summary Report HIPAA Incidents Referred Back to Covered Entities submitted to Stephen Smythe Interim Chief Compliance & Privacy Officer for review and approval.
 - This report supplements the Q2 Privacy Incident Report by focusing on privacy-related referrals involving external Covered Entities (CEs) and ECM providers, rather than Alliance-attributable HIPAA incidents. It was developed to provide Provider Relations and Quality leadership with visibility into recurring provider privacy concerns, identify trends, support provider oversight activities, and guide education and remediation efforts. These matters generally involved providers' own workforce, records, systems, or privacy practices and therefore are not investigated by Alameda Alliance as Alliance HIPAA incidents.
 - Key Highlights: Meaningful Reduction in Provider-Related Referrals. Q2 2026 recorded 15 CE/ECM-related referrals, compared to 24 referrals in Q1 2026, representing a 33% reduction in reported issues. Most Referrals Involved Provider PHI Transmission Practices. The most common issue category involved providers transmitting PHI through unsecured or unencrypted email communications. In each case, PHI reached the intended recipient. Provider education was provided regarding secure transmission practices.

- Additional Highlights: Provider Records, Disclosure, and Access Complaints emerged as a Significant Trend. Multiple member complaints involved: Access to medical records, Record accuracy concerns, Provider disclosure practices, Privacy concerns in clinical settings. Provider Relations and the Privacy Office will ensure that providers receive additional information and education on member access rights and minimum necessary standards.
- Q2 2026 Privacy Team Executive Summary Physical and Operational PHI Protection was submitted to Stephen Smythe Interim Chief Compliance & Privacy Officer for review and approval.
 - This report provides a summary of Q2 2026 physical privacy oversight activities conducted at the Alliance's 1240 South Loop Road facility. The review focused on evaluating the effectiveness of physical and operational safeguards designed to protect Protected Health Information (PHI) and Personally Identifiable Information (PII), including Privacy Rounds monitoring, workstation security, clean-desk practices, physical records management, visitor controls, secure storage, and warehouse access controls. The report also documents corrective actions, operational improvements, and overall physical privacy risk across the facility.
 - Results demonstrated strong compliance across monitored areas, including 100% workstation lock compliance, no identified PHI or PII exposures, effective physical access controls, and secure records management practices. Overall, the report reflects a low physical privacy risk environment and demonstrates the effectiveness of ongoing Privacy Rounds, Facilities partnership, and proactive monitoring activities.
- Privacy Program Q2 Record Requests
 - Record request volume remained stable during the first half of 2026, totaling 130 requests through June compared to 145 during the same period in 2025 (-10.3%). Overall, monthly request volume remains consistent with historical trends and continues to be managed to department guidelines.
- Privacy Program Q2 Guardianship and Legal Document Reviews
 - Guardianship/legal document review volume increased significantly in the first half of 2026, totaling 268 reviews compared to 195 during the same period in 2025, a 37.4% year-over-year increase. Q1 drove most of the increase, while Q2 remained elevated but moderated from the March peak.

- Privacy Program Q2 Positive HIPAA DLP Notifications
 - A positive HIPAA DLP notification is an automated alert generated when the Alliance's DLP system detects potential PHI in an outbound email, attachment, subject line, or meeting invite, and Privacy review confirms that PHI is actually present. The alert is typically triggered by identifiers such as member names, member IDs, dates of birth, claims data, diagnosis information, or other HIPAA-protected information. The DLP system automatically encrypts the message and notifies Privacy and IT Security for review.
 - Positive HIPAA notifications decreased 20% year-over-year through June (71 vs. 89).
- Privacy Program Q2 New Hires Trained
 - New hire training volume decreased in the first half of 2026, with 31 new hires trained compared to 61 during the same period in 2025.

Alameda Alliance Special Investigations Unit: Operational Updates

- Fraud, Waste, and Abuse Program Overview and Performance
 - The Special Investigations Unit (SIU) continued efforts to detect, investigate, and address potential fraud, waste, and abuse (FWA) across the organization, leveraging established reporting channels, investigative processes, and cross-functional collaboration to safeguard healthcare resources and support program integrity.
 - In July 2026, twenty-four (24) referrals were submitted to the SIU for assessment. Of these zero (0) were determined to involve potential FWA concerns.
 - The SIU successfully closed nine (9) investigations during the reporting period. Investigative findings did not identify evidence of potential fraud, waste, or abuse and the cases were closed following completion of the review process. Work continues on open cases requiring additional analysis, documentation review, and stakeholder coordination.
 - Cross-functional engagement remains an important component of the SIU's oversight approach, supporting identification of emerging risk areas and helping ensure investigative efforts remain aligned with organizational and regulatory priorities.

Enterprise Risk Management (ERM) and Operational Oversight Updates

- The Enterprise Risk Management (ERM) team continues to partner with leaders across the organization to assess and prioritize risks using the Alliance's developing risk taxonomy, risk assessment methodology, and COSO-based framework. Through ongoing risk calibration discussions, leadership is building a shared understanding of how risks are evaluated across the organization, helping establish a more consistent and enterprise-wide approach to risk-informed decision making.
- Internal Audit continues to execute the approved risk-based audit plan while advancing the organization's transition to a risk-focused audit model.
 - Four audits are currently underway, including Business Continuity Planning, Policies and Procedures Assessment, DSNP Claims Assessment, and the Medi-Cal Quality Program Validation.
 - Two DSNP-related audits, Risk Adjustment and Quality Improvement, have been deferred at management's request while key processes, data, and program components continue to be operationalized. In the interim, Internal Audit is partnering with leadership to perform targeted monitoring activities that support implementation readiness, provide ongoing oversight, and help ensure timely execution prior to future CMS regulatory review.
- To further strengthen risk management and internal control capabilities, ERM and Internal Audit completed the second quarterly Office Hours series. Sessions focused on common process gaps and mitigation strategies, root cause analysis, effective internal controls, and ERM fundamentals.
 - Participation remained strong, with 252 unique participants and 57 unique leaders attending both sessions.
 - The series generated 559 total topic attendance, including 118 participants who attended multiple sessions.
 - These education and outreach efforts continue to build organizational awareness of risk management principles, strengthen internal control knowledge, and support the ongoing maturity of the Alliance's Enterprise Risk Management and Internal Audit programs.

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 contract holders under HSC section 1374.21 and HSC section 1385.046.

2026 All Plan Letter (APL) List

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
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 non-grandfathered 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.

2026 All Plan Letter (APL) List

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
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.

2026 All Plan Letter (APL) List

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
10	3/25/2026	DHCS	26-005	Maternity Services for Pregnant and Postpartum Medi-Cal Members	MEDI-CAL	The purpose of this All Plan Letter (APL) is to consolidate and update guidance for Medi-Cal managed care plans (MCPs) on the maternity benefits that MCPs are required to provide to pregnant and postpartum Members. This omnibus APL supersedes APLs 00-012 and 18-022 and Policy Letters (PLs) 98-006, 98-010, and 12-003. This omnibus APL also retires APL 01-003 and PLs 98-001 and 02-004.
11	3/30/2026	DHCS	26-006	Skilled Nursing Facility Workforce Quality Incentive Program	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with instructions on the payment and data sharing process required for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for Rating Periods between January 1, 2023, and December 31, 2025. The Calendar Year (CY) 2023 Rating Period is referred to as Program Year (PY) 1, CY 2024 Rating Period as PY 2, and so forth.
12	4/8/2026	DMHC	26-006	AB 118: Part 2 - Compliance with Individual and Small Group Standardized Evidence of Coverage/Disclosure Form	N/A	Assembly Bill (AB) 118 (Ting, Chapter 42, Statutes of 2023) added Health and Safety Code section 1363.3 and revised Sections 1352.1, 1363, 1367.041, and 1367.24, effective January 1, 2025. Part 2 of the standardized EOC/DF will include the following template components: (1) Exclusions and Limitations, (2) Members' Rights and Responsibilities, and (3) Definitions, for use in health care service plan contracts in the individual and small group markets issued, amended, or renewed on or after January 1, 2027.
13	4/15/2026	DMHC	26-007	2026 Health Plan Annual Assessments	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide information to health care service plans (health

2026 All Plan Letter (APL) List

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
						plans) pertaining to the DMHC's fiscal year (FY) 2026-27 annual assessment.
14	4/24/2026	DHCS	26-007	Medi-Cal Managed Care Plan Guidance on Network Provider Agreements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, the MCP Contract, state law, APLs, and similar instructions.
15	5/12/2026	DHCS	26-008	Interoperability Final Rules, Including Prior Authorization Requirements	MEDI-CAL	To provide information to all Medi-Cal managed care plans (MCPs) regarding the Centers for Medicare and Medicaid Services' (CMS) interoperability requirements. This All Plan Letter (APL) supersedes APL 22-026.
16	5/12/2026	DMHC	26-008	Premium Rate Filing Review: Small Group Geographic Rating Practice	N/A	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide additional information as part of premium rate review submission to health care service plans (health plans) pertaining to the small group geographic rating practices to comply with the requirements of 45 Code of Federal Regulations (CFR) § 147.102(a)(1)(ii)(B).
17	5/26/2026	DMHC	26-009	State of Emergency Due to Orange County Chemical Incident	N/A	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to remind health care service plans of the requirements of Health and Safety Code section 1368.7 and to provide related DMHC filing instructions.

2026 All Plan Letter (APL) List

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
18	5/26/2026	DMHC	26-010	Pharmacy Benefit Manager Licensure	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Licensee Letter (ALL) to inform pharmacy benefit managers (PBMs) of the requirements of Assembly Bill 116 (Committee on Budget, Ch. 21, Stats. 2025) and Senate Bill 41 (Wiener, Ch. 605, Stats. 2025). Specifically, this ALL addresses the licensure requirements of PBMs in Article 6.1, including the requirements that all PBMs be licensed by January 1, 2027.
19	6/1/2026	DMHC	26-011	Compliance with Senate Bill 306 (2025) - First Data Call	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide notice to health care service plans (health plans) of compliance requirements with Senate Bill (SB) 306 (Becker, 2025), which added section 1367.025 to the California Health and Safety Code.
20	6/1/2026	DHCS	26-009	Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age of 21	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify Medi-Cal managed care plan (MCP) obligations to provide case management services to Members under the age of 21 for whom Private Duty Nursing (PDN) services have been authorized pursuant to the federally mandated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) available under Medi-Cal.
21	6/10/2026	DHCS	26-010	Skilled Nursing Facilities - Long Term Care Benefit Under Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) on the Skilled Nursing Facility (SNF) Long-Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including coverage for Medi-Cal members under managed care.

2026 All Plan Letter (APL) List

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
22	6/10/2026	DHCS	26-011	Subacute Care Facilities – Long-Term Care Benefit Under Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) on the Subacute Care Facility Long-Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including coverage for Medi-Cal members under managed care.
23	6/10/2026	DHCS	26-012	Intermediate Care Facilities For Individuals With Developmental Disabilities – Long-Term Care Benefit Under Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) for the Long-Term Care (LTC) Intermediate Care Facility/Home for Individuals with Developmental Disabilities services provisions of the California Advancing and Innovating Medi-Cal (CalAIM) benefit standardization initiative for Medi-Cal managed care Members. This APL contains requirements related to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes.
24	6/23/2026	DHCS	26-013	H.R. 1 – Federal Payment to Prohibited Entities – Important Update: End of One-Year Restriction on Federal Payments	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide updated guidance to Medi-Cal managed care plans (MCPs) on the handling of payments to Medi-Cal Providers who were impacted by Section 71113 of H.R. 1 (Public Law No: 119-21) between the dates of July 4, 2025, and July 3, 2026. This update is specific to claims or Encounters with Dates of Service (DOS) on or after July 4, 2026.

2026 All Plan Letter (APL) List

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
25	7/1/2026	DHCS	26-014	Annual Cognitive Assessment	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) about the provision of the annual Medi-Cal cognitive health assessment to eligible Members who are 65 years of age or older and who do not have Medicare coverage. This APL supersedes APL 22-025 and reflects statutory changes chaptered on June 30, 2025 (Assembly Bill 116, Committee on Budget, Chapter 21, Statutes of 2025), which amended section 14132.171 of the Welfare and Institutions Code (W&I) to remove the cognitive health assessment training requirement. (Supersedes APL 22-025)
26	7/14/2026	DHCS	26-015	Immunization Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify requirements related to the provision of immunization services. (Supersedes APL 24-008)



Health Care Services

Donna Carey, MD

To: Alameda Alliance for Health Board of Governors

From: Dr. Donna White Carey, Chief Medical Officer

Date: August 14th, 2026

Subject: Health Care Services (HCS) Report

Credentialing Committee

- At the Peer Review and Credentialing (PRCC) meetings held on July 21, 2026, there were one hundred and one hundred and sixty-one (161) initial network providers approved; one (1) primary care provider, ten (10) specialists, twenty-three (23) ancillary providers, ten (10) midlevel providers, and one hundred and seventeen (117) behavioral health providers.
- Additionally, sixty (60) providers were re-credentialed at this meeting; five (5) primary care providers, fourteen (14) specialists, one (1) ancillary provider, nine (9) midlevel providers, and thirty-one (31) behavioral health providers.
- The report shows 433 facilities that are currently credentialed.

Utilization Management: Outpatient

- The prior authorization and benefits grid revision was completed, and the searchable code tool is now posted on the external website. The goal was to create a more provider-friendly reference document to delineate code-specific authorization rules. The searchable code tool was updated on June 25th to enable providers to see if codes are covered or non-covered codes. The benefit will be maintained monthly in alignment with DHCS Medi-Cal TAR and non-standard benefit code list articles to ensure ongoing accuracy and compliance. OP processed a total of 4,119 authorizations for the month of June. We also processed 467 CCS referrals, of which 129 cases were submitted to our regional CCS office for review (49 approved, 28 denied, 47 pending). CBAS 12 New CEDT, 7 Discharge, 2 ERS, 42 renewals.
- Overall OP Turnaround times exceeded the threshold of 99.5% for the month of July 2026. The OP UM team, in collaboration with the MDs, continue to explore process improvements to streamline efficiency and reduce missed TATs.
- The top 5 categories remain unchanged TQ, Radiology, Home Health, Outpatient Rehab and Outpatient Facility. These 5 categories represent ~75% of this volume. The highest overall category for Denials is Out of Network Genetic testing.

- The Home Health pilot launched in July 2025 continues to be effective, reducing the number of manual reviews for selected HH services and diagnoses. Currently, 9 providers are utilizing the process for their initial home health requests. The pilot is being monitored and will be expanded in the future.
- The number of D-SNP authorizations created continue to rise as April was the first month that the 90-day Continuity of Care provisions were lifted for the original D-SNP members. There were 40 Outpatient D-SNP Authorizations created July 2026.

Total Outpatient Authorization Volumes						
	May 2026 Approvals	May 2026 Denials	June 2026 Approvals	June 2026 Denials	July 2026 Approvals	July 2026 Denials
Medi-Cal	N/A	N/A	N/A	N/A	3401	526
IHSS	N/A	N/A	N/A	N/A	132	22
D-SNP	N/A	N/A	N/A	N/A	36	4
Overall	3,054	427	3,141	396	3,569	550

Source: #02569_AuthTAT_Summary- Authorization volume breakdown per LOB began in June 2026

Outpatient Authorization Denial Rates			
Denial Rate Type	May 2026	June 2026	July 2026
Denial Rate Excluding Partial Denials	2.7%	3.0%	4.9%
Partial Denial Rate	0.3%	0.2%	0.3%
Overall Denial Rate	3.0%	3.2%	5.7%

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

Outpatient Turn Around Time Compliance (benchmark: 95%)			
Line of Business	May 2026	May 2026	June 2026
Overall	98.5%	99.7%	99.8%
Medi-Cal	99.7%	99.3%	99.5%
IHSS	98.6%	100%	100%
D-SNP	97.2%	100%	100%

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 slightly from 3,526 in June 2026, to 3,565 in July.
- 49 D-SNP Authorizations were processed by the Inpatient Department in July.

- Inpatient overall average LOS increased from 5.5 in May to 5.6 in June Admits per thousand also decreased slightly from 50.6 in May to 50.1 in June. While days per thousand -increased from 275.8 in May to 281.8 in June.
- IP overall denial rate decreased slightly from 2.0% in May to 1.9% in June.
- IP Auth TAT –100% overall continues to surpass 95% benchmark across all lines of business in July 2026.
- External hospital rounds are ongoing with UCSF, Stanford, Alameda Health System, Kindred LTACH, Kentfield LTACH, Washington, Eden, Alta Bates, and Summit, to review members' current active admissions discuss UM issues, address discharge barriers, offer other opportunities for supporting throughput and appropriate discharge.
- Alameda Alliance IP UM RN onsite nurse pilot program completed its 6th month at Washington Hospital. Data shows decrease in readmission rates for Washington Hospital by 0.2% FYE 2025 to FYE 2026. Preliminary data also suggests significant decrease in length of stay: 5.8 in the first 2 quarters of 2025 vs 5.0 in the first two quarters of 2026. Report outs in the coming next months, with confirmed data after 3-month claims lag. The IP UM Onsite RN meets with members in the ED and on the inpatient floors, interacting with hospital care management staff and providers to ensure appropriate care coordination, follow ups, and discharge authorizations are in place.

Total Inpatient Authorization Volumes						
	May 2026 Approvals	May 2026 Denials	June 2026 Approvals	June 2026 Denials	July 2026 Approvals	July 2026 Denials
Medi-Cal	N/A	N/A	3,403	57	3424	62
IHSS	N/A	N/A	39	0	30	0
D-SNP	N/A	N/A	25	1	48	1
Overall	3,484	73	3,467	58	3502	63

Source: #02569_AuthTAT_Summary

Authorization breakdown per LOB began in June 2026

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	April 2026	May 2026	June 2026
Authorized LOS	5.6	5.5	5.6
Admits/1,000	53.7	50.6	50.1
Days/1,000	302.4	275.8	281.8

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

Inpatient Authorization Denial Rates			
Denial Rate Type	May 2026	June 2026	July 2026
Full Denials Rate	1.2%	1.3%	1.0%
Partial Denials	2.1%	1.7%	1.0%
All Types of Denials	3.3%	3.0%	2.0%

Source: #01292_AllAuthDenialsRate

Inpatient Turn Around Time Compliance (benchmark: 95%)			
Line of Business	May 2026	June 2026	July 2026
Overall	100%	100%	100%
Medi-Cal	100%	100%	100%
IHSS	100%	100%	100%
D-SNP	94%	100%	100%

Utilization Management: Long-Term Care

- LTC census during July 2026 was 2309 members. This is a decrease of –7.2% (180 members) from May 2026.

Totals	May 2026	June 2026	July 2026
Medi-Cal	2489	2442	2309
D-SNP	2	2	2

- Month to Month, the admissions and length of stays seem to decrease from April 2026 - June 2026 of 90%, 80%, 67% respectively. Some of this could be due to a lag in claims data being available. NOTE: there were no admissions for D-SNP members in LTC

Medi-Cal Totals	April 2026	May 2026	June 2026
Admissions	128	142	80
Days	752	764	829
Readmissions	29	42	32

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.
- LTC Provider Office Hours were completed for SNF and ICF/DD facilities in July 2026 – this is a quarterly forum for providers to ask questions related to operational processes (including claims, authorizations, and appeals)
- Having virtual rounds with AHS, San Leandro, Kyakameena, Elmwood, Jones Convalescent and Eden LTC facilities to coordinate on complex cases

- LTC Team continues to meet individually with multiple facilities to discuss collaboration with discharge planning and submitting proper documentation for requests.
- Quarterly rounds with Regional Center of Easy Bay to discuss any ICF/DD members.
- Continued internal Long Term Care rounds to discuss members coming into and leaving a long-term care setting.
- Social Workers continue visiting LTC facilities in person, on a monthly and quarterly basis depending on census, to assist with discharge planning and access to other resources. The team continues referrals to TCS and other internal/external programs to provide wraparound support to members preparing to discharge from an LTC custodial facility.
- LTSS Liaison is visiting and meeting with facilities to discuss any claims issues and educating on processes.
- The LTC Manager position is vacant effective 03/29/26.
- The LTC Director position is vacant effective 05/01/26.
- Authorization processing turn-around time (TAT) has remained at 99%, which is exceeding the threshold of 95%.

Total Medi-Cal LTC Authorization Volume			
Authorization Status	May 2026	June2026	July2026
Approvals	758	844	783
Partial Approvals	0	0	0
Denials	41	59	41
Total	799	903	824

Source: #02569_AuthTAT_Summary

*Numbers change month-over-month based on the void and copy process to adjust authorizations for bed holds

Total D-SNP LTC Authorization Volume			
Authorization Status	May 2026	June 2026	July 2026
Approvals	1	0	0
Partial Approvals	0	0	0
Denials	0	0	1
Total	1	0	1

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	May 2026	June 2026	July 2026
Medi-Cal	99%	99%	99%
D-SNP	100%	N/A	100%

Source: #02569_AuthTAT_Summary

Behavioral Health

- In July, the Behavioral Health Department processed 626 authorizations within TAT requirements. Denials remain low across service types.

BH Authorization Volume				
	26-Apr	26-May	26-June	26-July
Approvals	748	712	626	619
Partial Approval	0	0	0	0
Denials	9	7	7	7
Total	757	719	633	626

MH TAT				
<i>Goal ≥95%</i>	26-Apr	26-May	26-Jun	26-Jul
Determination TAT%	100%	98%	98%	98%
Notification TAT%	98%	98%	97%	99%

BHT/ABA TAT				
<i>Goal ≥95%</i>	26-Apr	26-May	26-Jun	26-Jul
Determination TAT%	100%	98%	98%	94%
Notification TAT%	100%	95%	98%	99%

BH Denial Rates				
	<i>Goal ≤ 5%</i>			
Year/Month	26-Apr	26-May	26-June	26-July
	1.50%*	<1%	<1%	1.1%

*corrected data from <1% to 1.5%

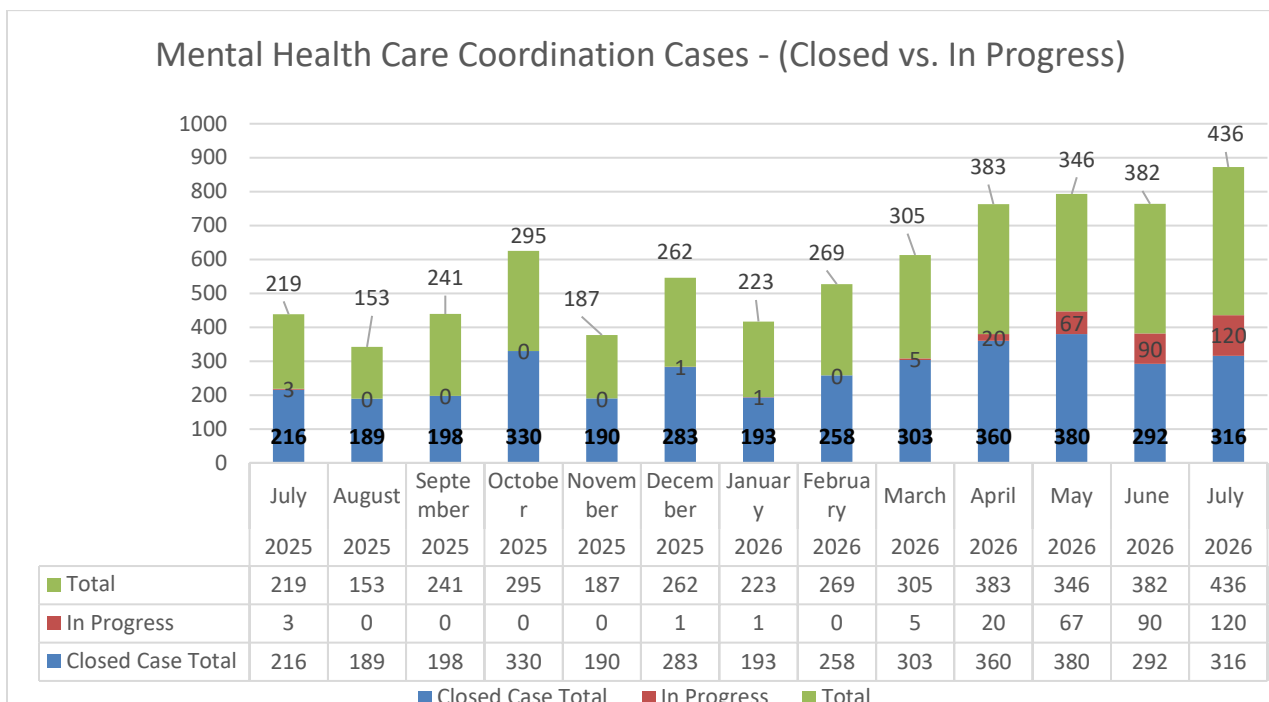
Mental Health Care Coordination

- 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.

	26-Apr	26-May	26-June	26-July
Youth Screenings	62	75	70	48
Adult Screenings	122	149	118	117
Incoming ACBH Referrals	159	91	164	154
Outgoing Referrals to ACBH	32	43	6	43
Transition of Care Tools to ACBH	1	1	2	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. The MH Care Coordination team continues to close a high number of cases per month.



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.

BHT/ABA Case Coordination (Closed vs. In Progress)			
Year -Month	Cases Closed	Cases In Progress	Total Cases
202507	882	42	Total Cases 924
202508	642	36	678
202509	714	51	765
202510	903	42	945
202511	615	48	663
202512	630	66	696
202601	795	102	897
202602	633	180	813
202603	600	198	798
202604	795	435	1230
202605	873	612	1485
202606	867	474	1341
202607	258	817	1075

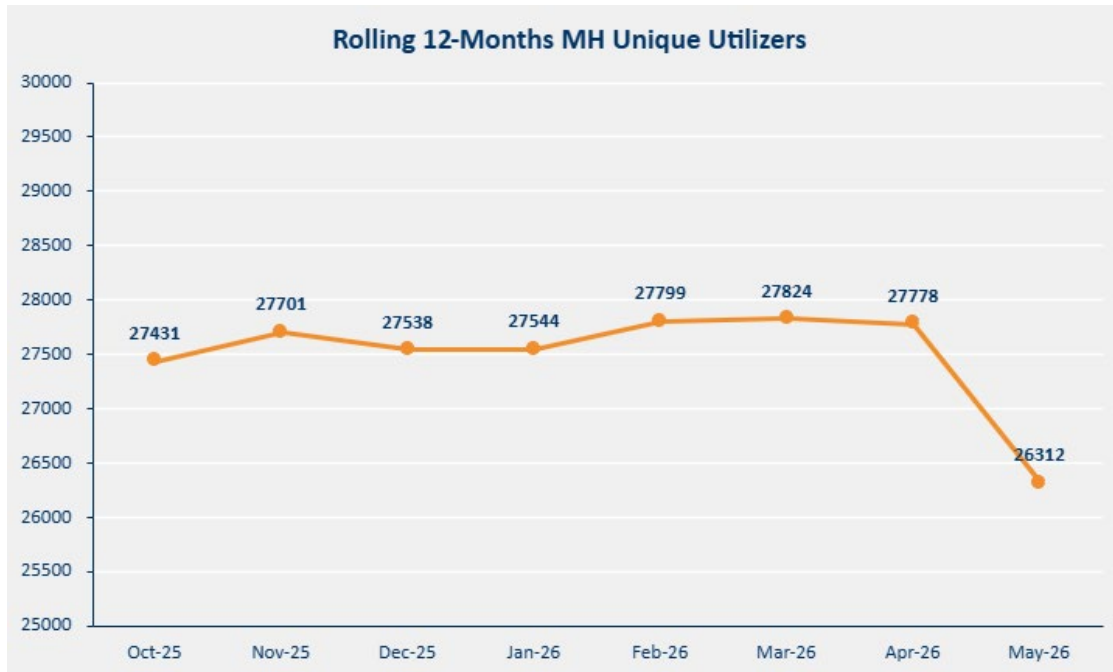
Source: 14665_BH_Cases

Case numbers in progress are high for July 2026 at 817 vs. 258 closed cases. This is a result of a vacant staff position which was filled 8/3/26.

Behavioral Health Unique Utilizers

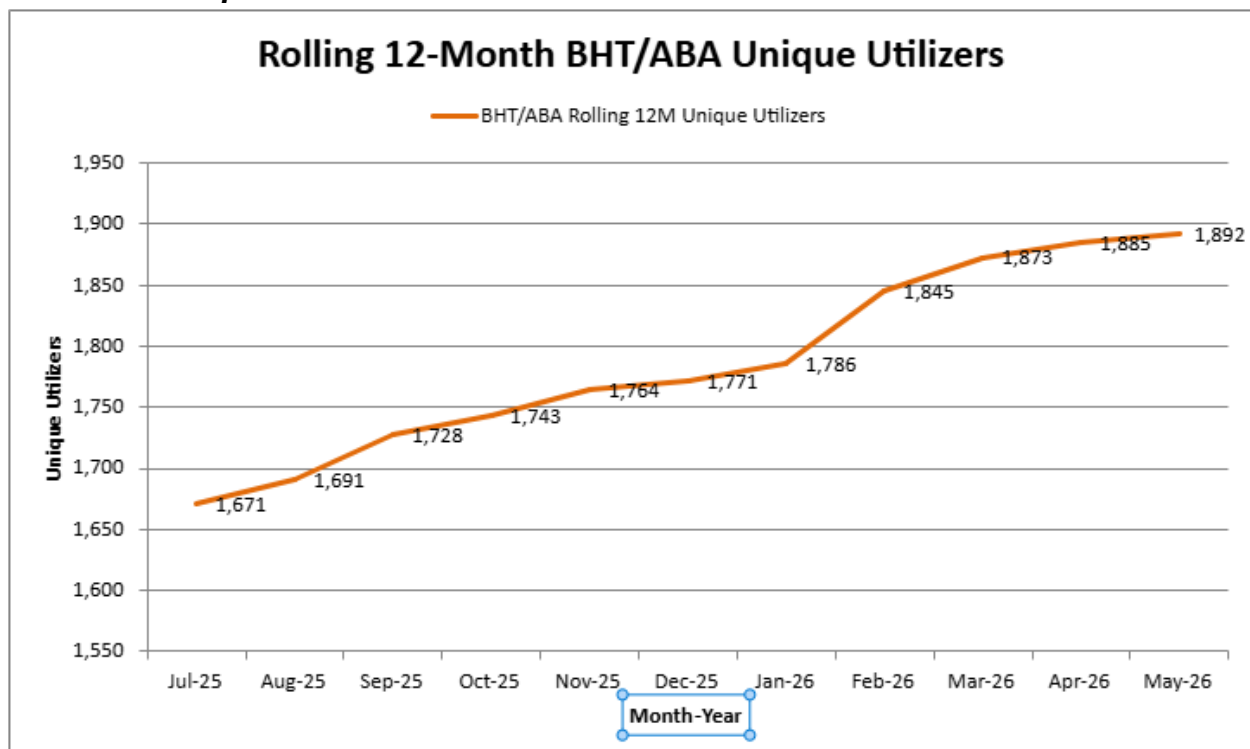
- Removing barriers to accessing BHT/ABA and MH services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.

Mental Health Unique Utilizers:



- Data is based on claims and reflects rolling 12 months with a 2-month claim lag.
- The May 2026 drop in unique utilizers may represent a claims lag beyond 2 months, or be tied to changes in membership volume. Plan: Continue to monitor for trends.

BHT/ABA Unique Utilizers:

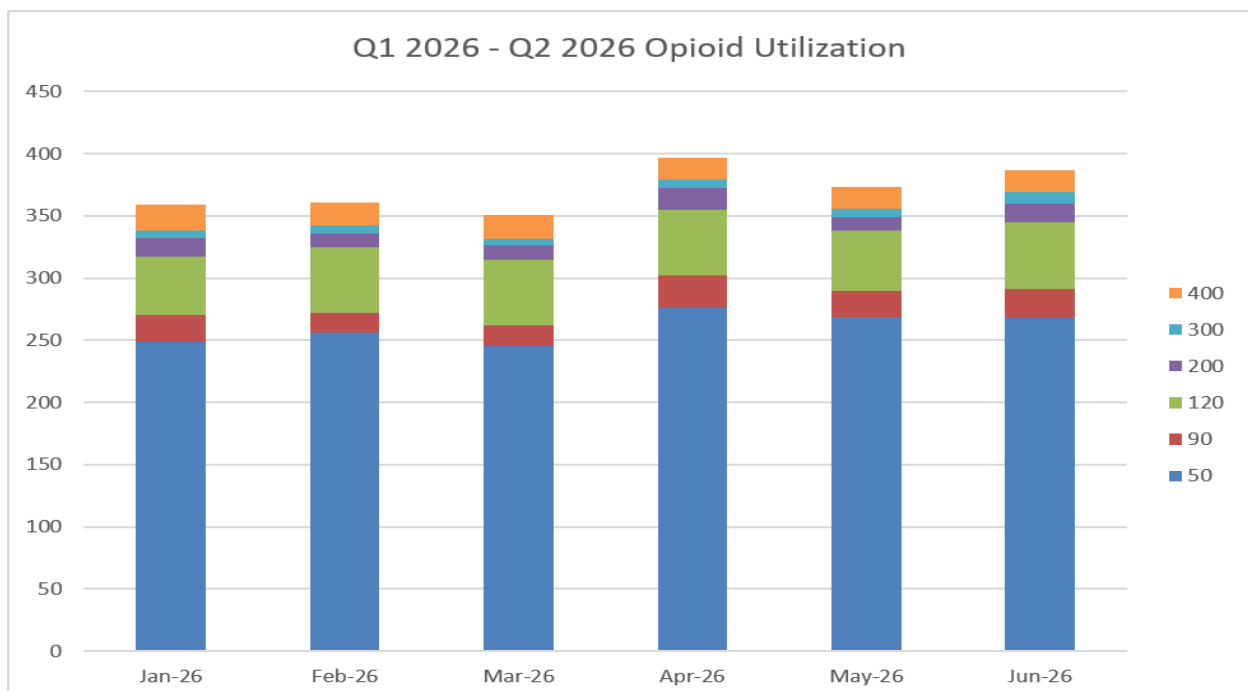


Source: PBI 14621 BHT Utilization Report

- Unique utilizers continue to rise representing a 13.2% increase in BHT/ABA utilizers from July 2025 to June 2026.
- Data is based on claims. June 2026 utilization numbers reflect a 2-month claim lag.

Pharmacy

- The Pharmacy Transitional Care Services (TCS) program has screened 21 **Heart Failure** cases, 34 **Sepsis** cases, and received 0 **direct referral** for the month of July 2026.
- Pharmacy is collaborating with population health, QI, and disease management on creating clinical programs for HEDIS measures for high blood pressure, asthma, and diabetes.
- The Pharmacy Department continues to monitor members on use of opioids. We send bi-annual mailings to at risk members and their providers. Impacted members receive handouts on medication assisted treatment for opioid dependence, an opioid safety guide, and alternative pain management strategies. Their assigned PCPs receive guides to benzodiazepine and opioid tapering, formulary alternatives to opioids, and opioid dependence treatment approaches.
- We measure the use of opioid medications using Morphine Milligram Equivalents (MME). Utilization less than 90 MME slightly increased (+9.4%, 23 member increase), while greater than 400 MME slightly decreased from March to June (-10%, 2 member decrease).



Q2 2026

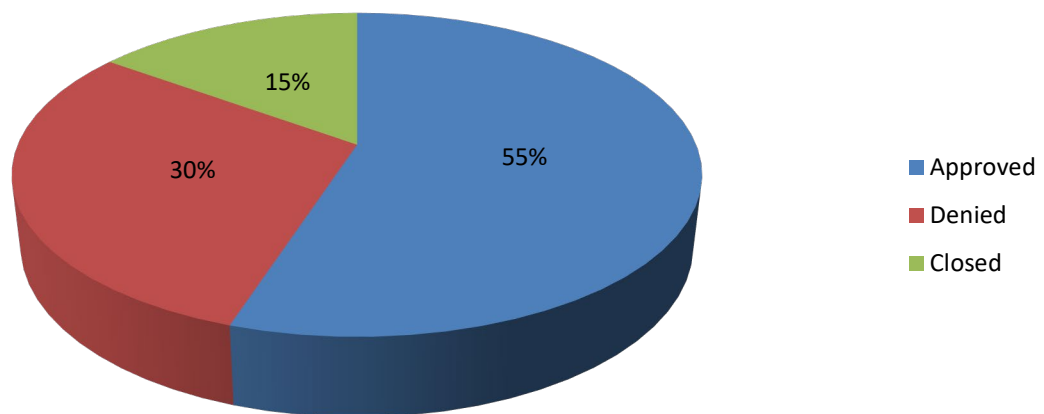
MME	IHSS	MCAL	Total
April			397
50	12	264	276
90	6	20	26
120	4	49	53
200	1	16	17
300		7	7
400		18	18
May			373
50	9	260	269
90	3	18	21
120	4	44	48
200	1	10	11
300		7	7
400	1	16	17
June			387
50	15	253	268
90	4	19	23
120	4	50	54
200		15	15
300		9	9
400		18	18

DSNP Prior Authorization July 2026

Summary Table

<u>Decisions</u>	<u>Number of PAs Processed</u>
<u>Approved</u>	<u>11</u>
<u>Denied</u>	<u>6</u>
<u>Closed</u>	<u>3</u>
<u>Total</u>	<u>20</u>

July 2026 Coverage Determination by Decision Types



24/72 Hour TAT Compliance

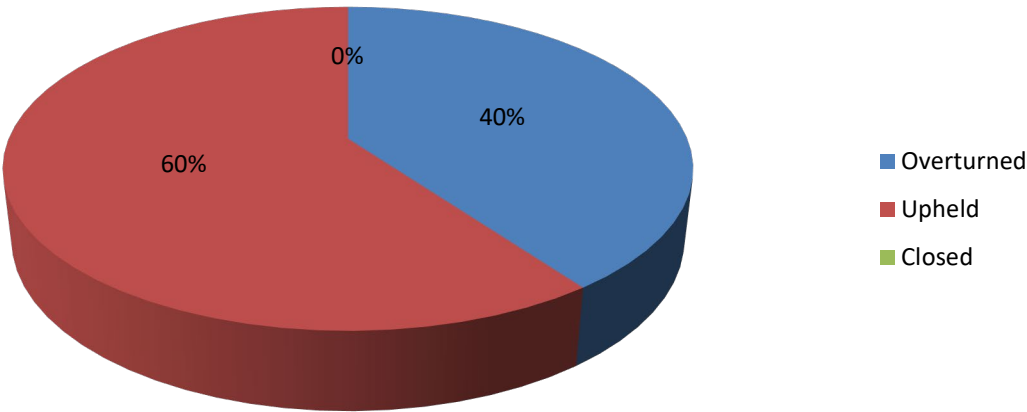
	<u>Number of Coverage Determinations</u>	<u>Percentage of Coverage Determinations</u>
<u>Compliant</u>	<u>20</u>	<u>100%</u>
<u>Non-Compliant</u>	<u>0</u>	<u>0%</u>
<u>Total</u>	<u>20</u>	<u>100%</u>

DSNP Prior Authorization Appeals & Redeterminations July 2026

Summary Table

Decisions	Number of PAs Processed
Overturned	2
Upheld	3
Closed	0
Total	5

**July 2026 Redeterminations
by Decision Types**

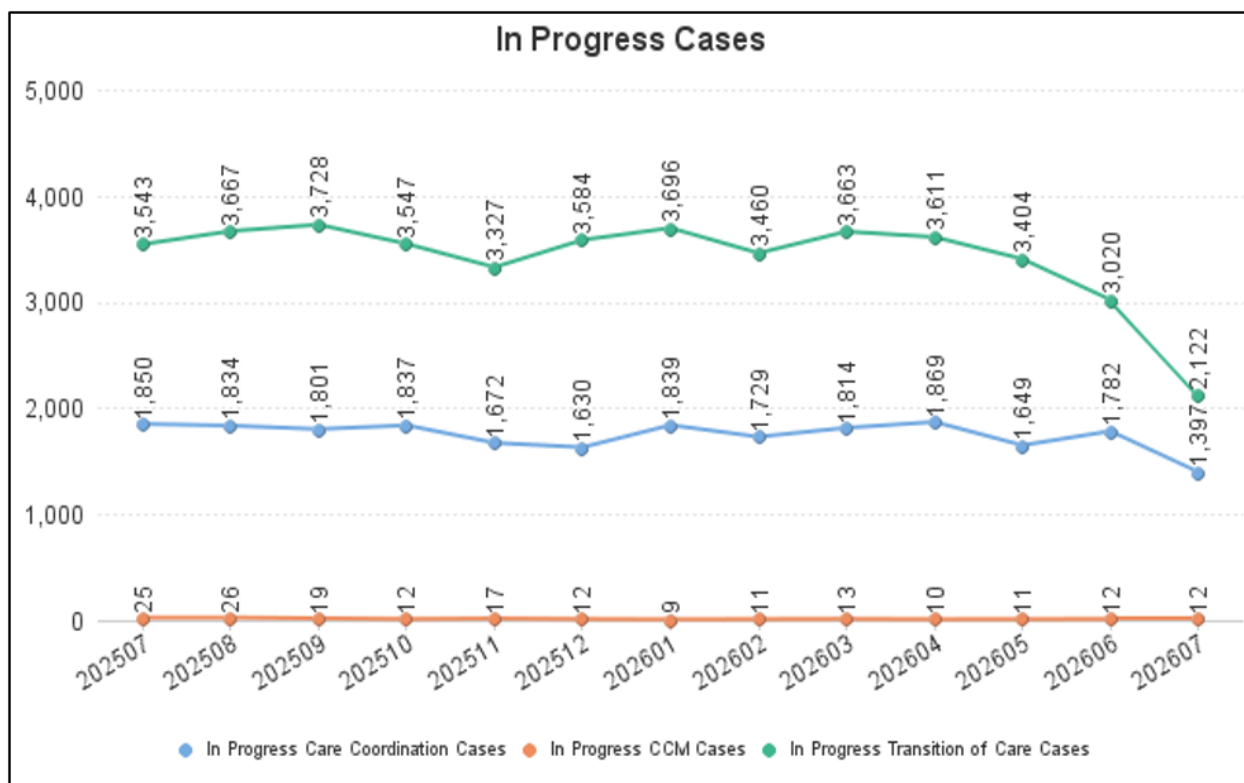


72/168 Hour TAT Compliance

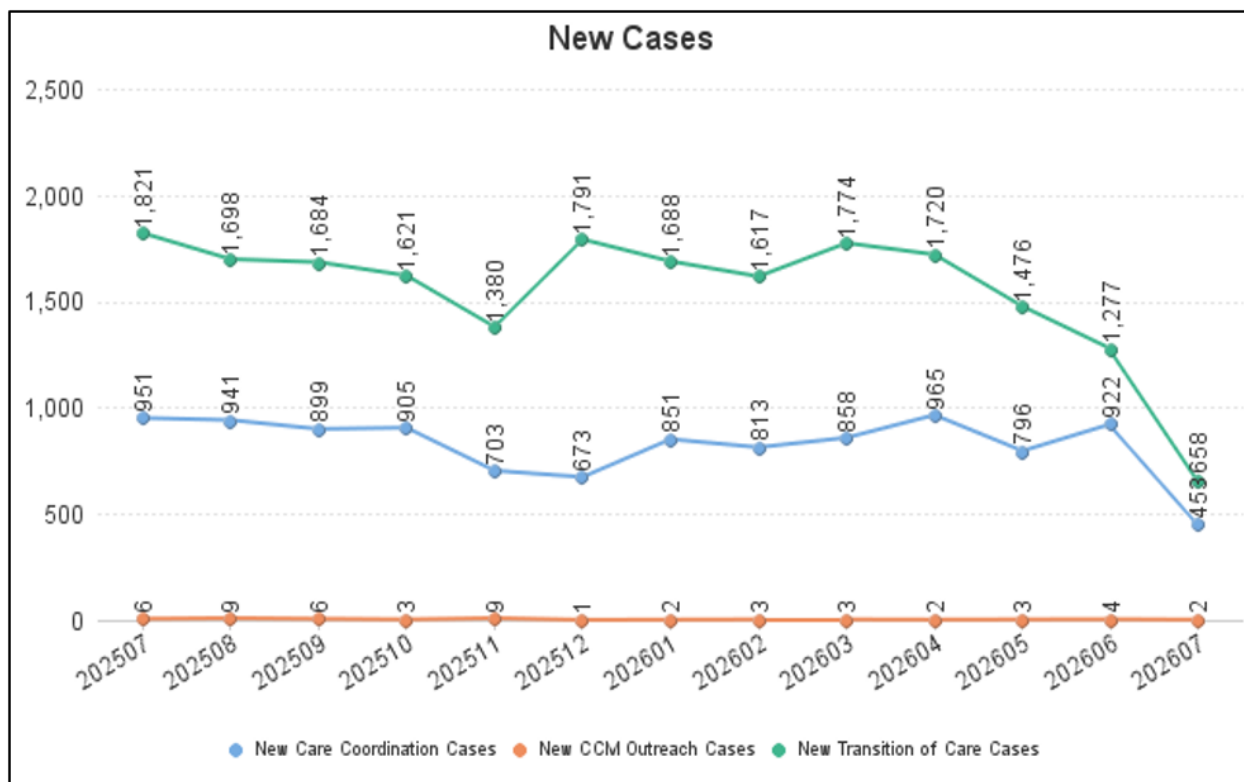
	Number of Redeterminations	Percentage of Redeterminations
Compliant	5	100%
Non-Compliant	0	0%
Total	5	100%

Case and Disease Management

- D-SNP case management is live. The Case Management (CM) team is engaging D-SNP members in completing HRA assessments, building care plans and supporting members to help meet their needs.
- The CM team continues to assist the high volume of members needing Transitional Care Services (TCS) as they transition from one level of care to another. This includes outreaching members who are still hospitalized and following up post-discharge to help meet the members' needs. The CM team has partnered with an in-person provider, Upward Health for the adult high-risk TCS population that went live 6/1/26.
- 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.

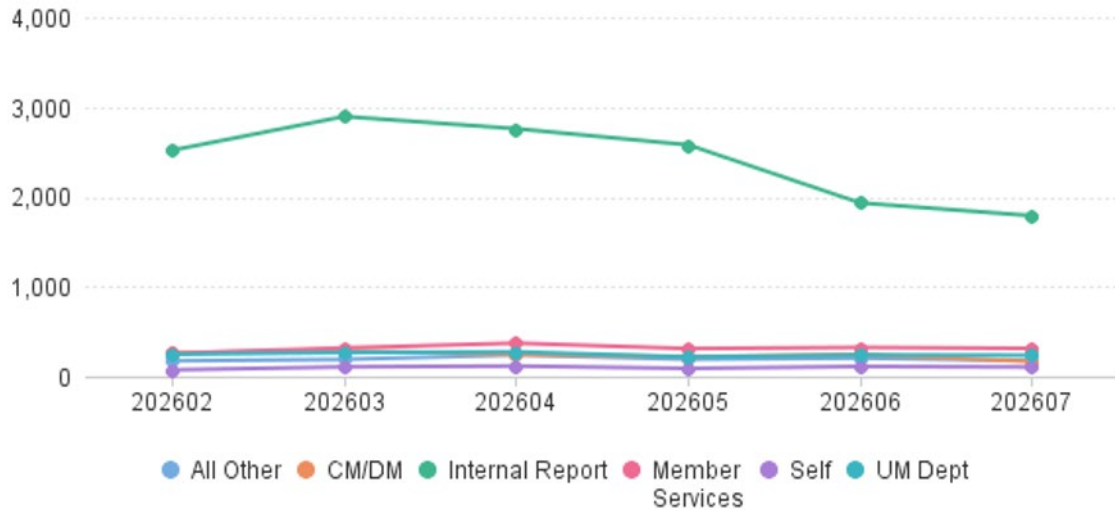


Source: #03342 TruCare Caseload



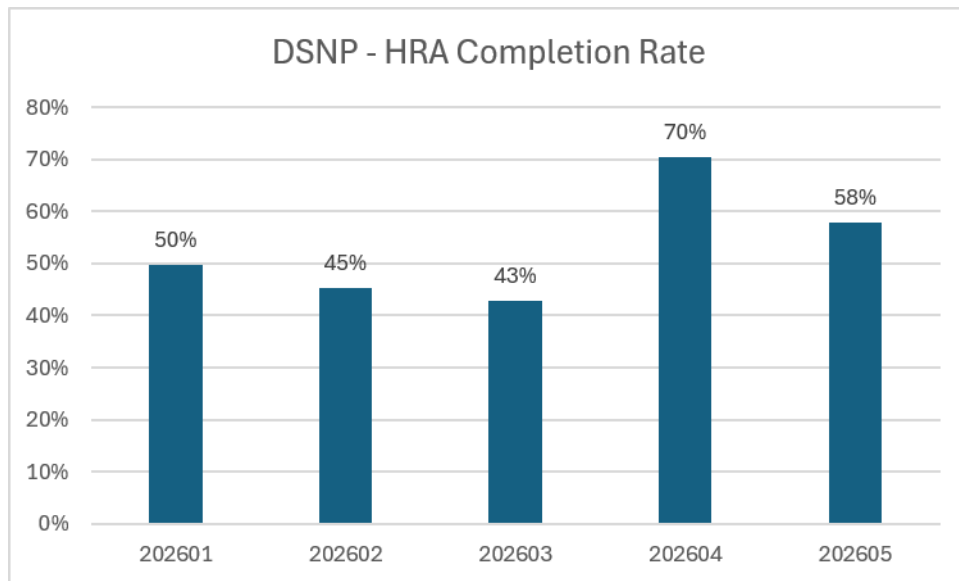
Source: #03342 TruCare Caseload

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

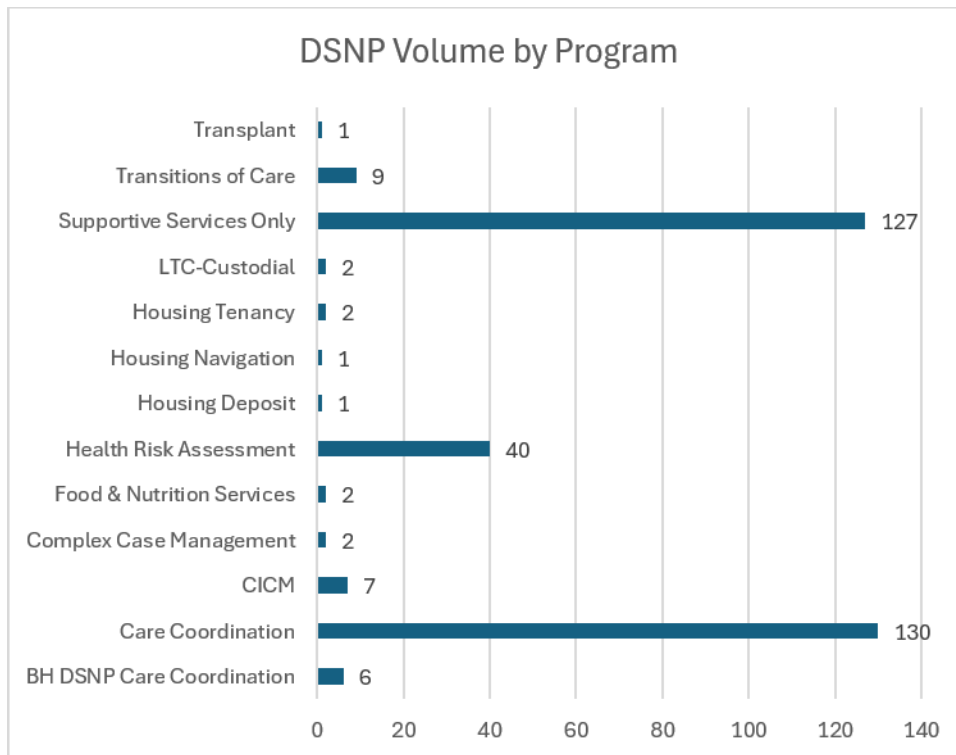
Source: #03881 Case and Disease Management Dashboard -



*Note: HRA's due 90 days from enrollment, so members who enrolled 6/1/26 or later still be outreached

Source: #00835 HRA Dashboard

DSNP CM Volume by Program Type



Source: #17175 CM DSNP Aging

Definitions:

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

CalAIM

Enhanced Case Management

- All Populations of Focus are live:
 - Homeless children/youth and adults
 - High Utilizer children/youth and adults
 - SMI/SUD children/youth and adults
 - Children/Youth Transitioning from a Youth Correction Facility
 - Adults Transitioning from Incarceration
 - Adults Living in the Community and At Risk for Long-Term Care Institutionalization
 - Children/Youth Enrolled in CCS with Additional Needs Beyond the CCS Condition
 - Children/Youth Involved in Child Welfare
 - Children/Youth and Adults Who are Pregnant or Postpartum
- With DSNP live, the ECM team is working closely with the ECM providers to assist with Continuity of Care for these members and confirm the Alliance is meeting the new requirements associated with DSNP requirements for California Integrated Care Management (CICM).
- The ECM team is collaborating with IT and IPD to automate creation of authorization shells, provide auto authorizations where possible, and centralize ECM referrals. This will improve referral processing and authorization determination decisions with improved turnaround times. Additionally, this will free up ECM staff to work on other areas of ECM (i.e. graduating or assisting with stepping members down to a lower level of care, clinical audits, additional support to Provider frontline staff to improve effectiveness of care plan outcomes and, further advance the growth of ECM especially in key POF areas that are underdeveloped like Birth Equity).
- Efforts to expand the ECM provider network have resumed. The screening panel reviews provider applications based on capacity to serve targeted Populations of Focus, demonstrated operational excellence in programming, and quality benchmarks.
- The ECM team continues to build rapport with the ECM providers, meeting to discuss specific cases and work with the ECM providers to assist with moving members through the ECM program by addressing care plan barriers and offering support and services ECM providers may not be aware of. This has led to more collaboration and community referrals to additional resources. Additional meetings are scheduled with ECM providers for individual case conferences as needed. Clinical Operations meetings that support ECM provider leadership and processes continue. These meetings further support the relationship between the ECM provider and AAH, to

better understand the barriers ECM providers experience to moving members through the ECM care continuum appropriately and with a higher level of quality of care.

- ECM and CS teams have begun a collaborative meeting to confirm communication is occurring between Community Supports providers and ECM lead care managers. The collaboration further enhances coordination of care, ensuring non-duplicative services and members receive appropriate services to meet their needs. One new area where collaboration is happening is in preparing for Transitional Rent, ensuring smooth transitions into ECM as necessary.
- The ECM team is wrapping up the Spring Audit of the ECM providers. The ECM team continues to meet with Compliance to address findings and develop best practices for consistent communication with the providers to monitor improvements.
- The ECM team continues the ECM Training Academy. The trainings began in April and occur monthly throughout the year. Topics include ECM referrals and documentation for reauthorizations, nonjudgemental language and care, and more. July focused on Dementia Care.

	April 2026		May 2026		June 2026	
ECM Providers	Outreach	Enrolled	Outreach	Enrolled	Outreach	Enrolled
ACBH	-	13	-	13	-	13
Alameda Health System (AHS)	28	250	11	258	11	261
Bay Area Community Services (BACS)	29	245	40	264	29	273
California Cardiovascular Consultants	-	129	-	130	-	131
California Children's Services (CCS)	12	60	6	59	7	61
CHCN	225	1,410	107	1,401	58	1,379
East Bay Innovations (EBI)	14	168	9	174	6	182
Full Circle	-	218	-	221	-	227
Institute on Aging	182	266	195	282	182	291
La Familia	47	33	35	33	-	32
MedZed	1,777	1,619	1,780	288	139	1,880
Pair Team	1	1,958	-	1952	8	1,879
Roots Community Health Center (includes Street Medicine)	-	590	1	578	1	593
Seneca Family Services	54	58	48	57	9	54
Star Nursing	-	-	-	-	-	-
Titanium Health Care	648	1,932	821	2,038	625	2,124
Tiburcio Vasquez Health Center (Street Medicine)	-	125	-	121	-	123
BACH (Street Medicine)	-	73	-	66	-	67
Lifelong (Street Medicine)	1	404	-	388	-	383

Community Supports (CS)

- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance offers the following Community Supports:
 - Housing Navigation
 - Housing Deposits
 - Tenancy Sustaining Services
 - Medical Respite
 - Medically Tailored/Supportive Meals
 - Asthma Remediation
 - (Caregiver) Respite Services
 - Personal Care & Homemaker Services
 - Environmental Accessibility Adaptations (Home Modifications)
 - Assisted Living Facility Transition
 - Community or Home Transition Services
 - Transitional Rent
- The Alliance is working to identify gaps in current service capacity and member access to Community Supports; this will inform future targeted efforts for CS network expansion.
- AAH CS staff continue to meet with CS providers to work through logistical issues as they arise, including referral management, claims payment and member throughput. AAH is also working with CS providers, in coordination with DHCS, to clarify any policy or operational questions that may inform potential refinement of processes.
- LTSS Director position vacant as of 5/1/26.
- Oversight of Community Supports providers continues through the provider audit process.
- Draft DHCS Community Support Policy Guides Volume 1 and 2 released for public comment on July 20th, 2026. Expected finalized DHCS Community Support Policy Guides in Fall of 2026.

Community Supports	Services Authorized in May 2026	Services Authorized in June 2026	Services Authorized in July 2026
Housing Navigation	1078	1046	950
Housing Deposits	421	399	338
Housing Tenancy	1956	1973	1885
Asthma Remediation	151	155	142
Medically	1433	1401	1224
Medical Respite	49	43	38
Transition to Home	3	2	1

Nursing Facility	3	3	3
Home Modifications	15	13	10
Personal Care and	32	29	19
Caregiver Respite	1	1	1
Transitional Rent	36	43	45
Total	5,178	5,111	4,656

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

- There was an increase in the amount of authorization requests by 15% from May 2026 to June 2026. There was a 23% decrease from June 2026 to July 2026. Total decrease in the amount of authorizations from May 2026 to July 2026 is 11%.

Total Medi-Cal CS Authorization Volume			
Authorization Status	May 2026	June 2026	July 2026
Approvals	880	1014	768
Partial Approvals	0	0	0
Denials	77	83	82
Total	958	1097	850

Total D-SNP CS Authorization Volume			
Authorization Status	May 2026	June 2026	July 2026
Approvals	1	1	1
Partial Approvals	0	0	0
Denials	0	0	0
Total	1	1	1

Source: #02569_AuthTAT_Summary

- Authorization processing turn-around time (TAT) for Medi-Cal has remained between 98%-99%, which is exceeding the threshold of 95%. D-SNP TAT remains at 100%.

CS Turn Around Time Compliance (benchmark: 95%)			
Line of Business	May 2026	June 2026	July 2026
Medi-Cal	98%	98%	99%
D-SNP	100%	100%	100%

Source: #02569_AuthTAT_Summary

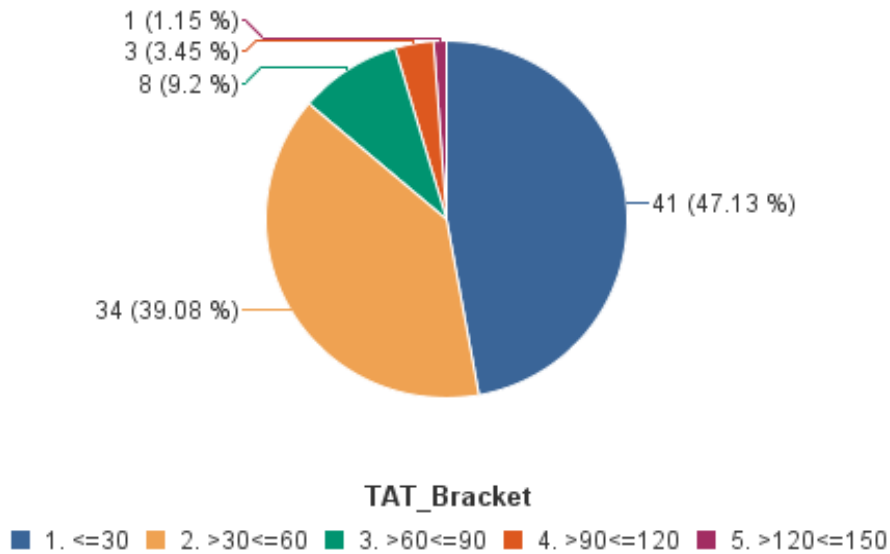
Quality

- There was an increase of PQIs closed compared to last month by 44% (from 100 to 177 cases). As of July 31, 2026, the turnaround time (TAT) for Potential Quality Issues (PQI) is 100% closed within 150 days which exceeded the standard of 95% case closure rate. The majority of the cases were closed within 90 days (95%), a 7% increase compared to last month. The TAT at which PQI cases are being

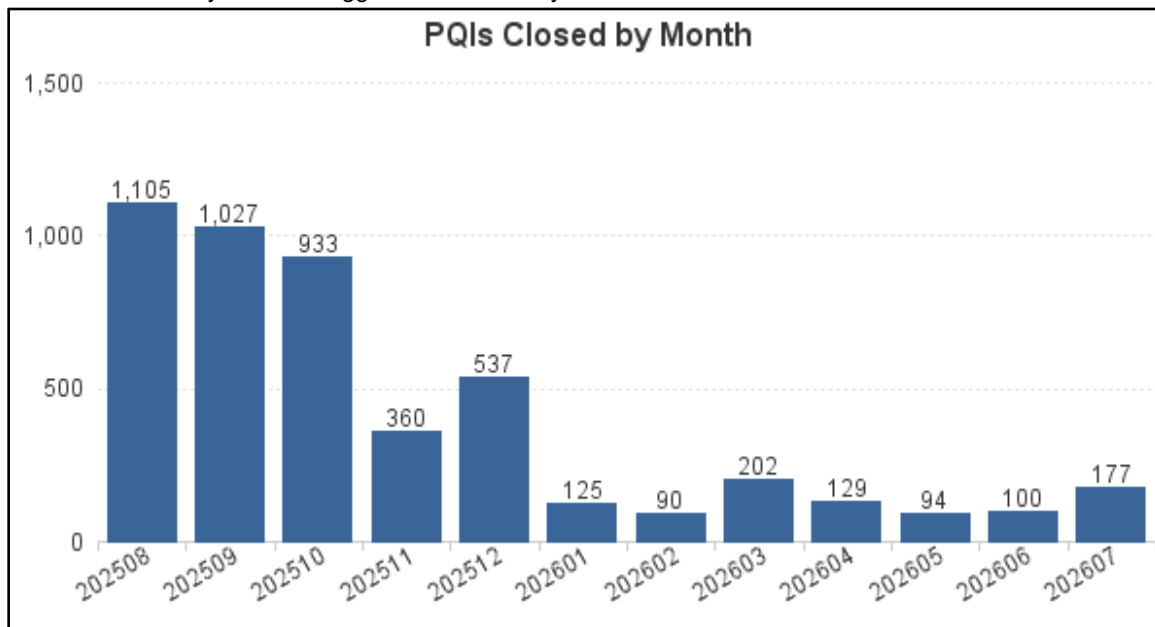
leveled and closed with final MD recommendations was met for the last 3 consecutive months.

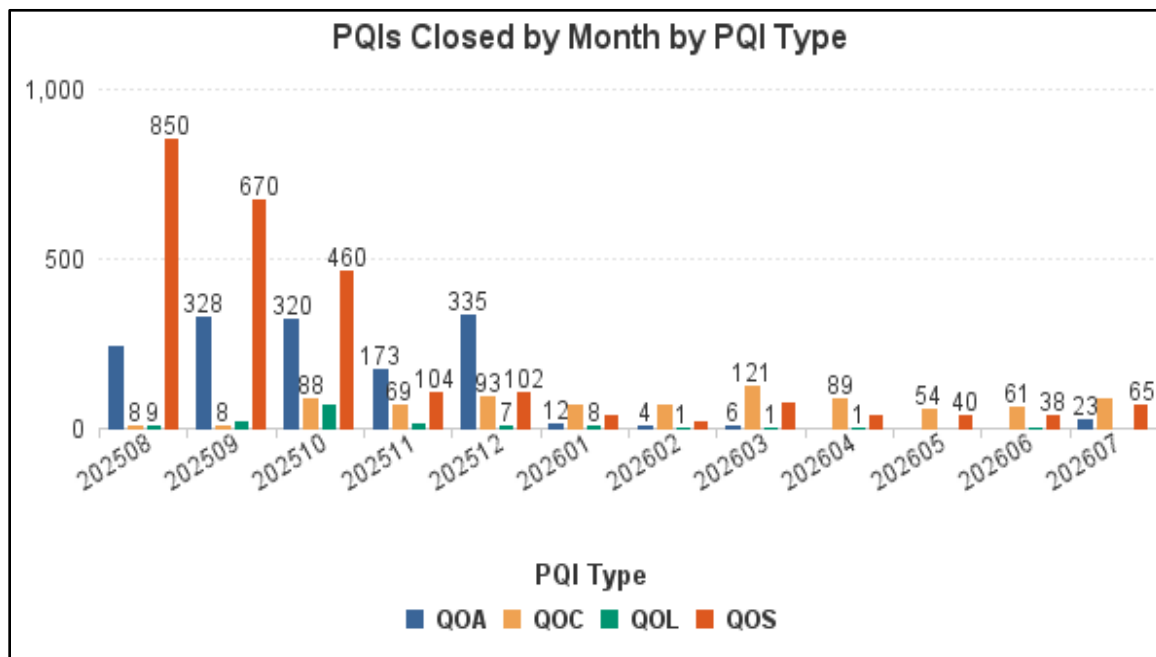
- Starting in July 2026, to strengthen the Provider Preventable Conditions (PPC) process, a letter will be sent to providers to notify them of a substantiated PPC and obligations to report to DHCS. The Alliance will continue to share PQI trends, including PPCs, at the Joint Operating Meetings.

PQI Aging Report as of 07/31/2026 N= 87



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





Provider Satisfaction Survey:

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

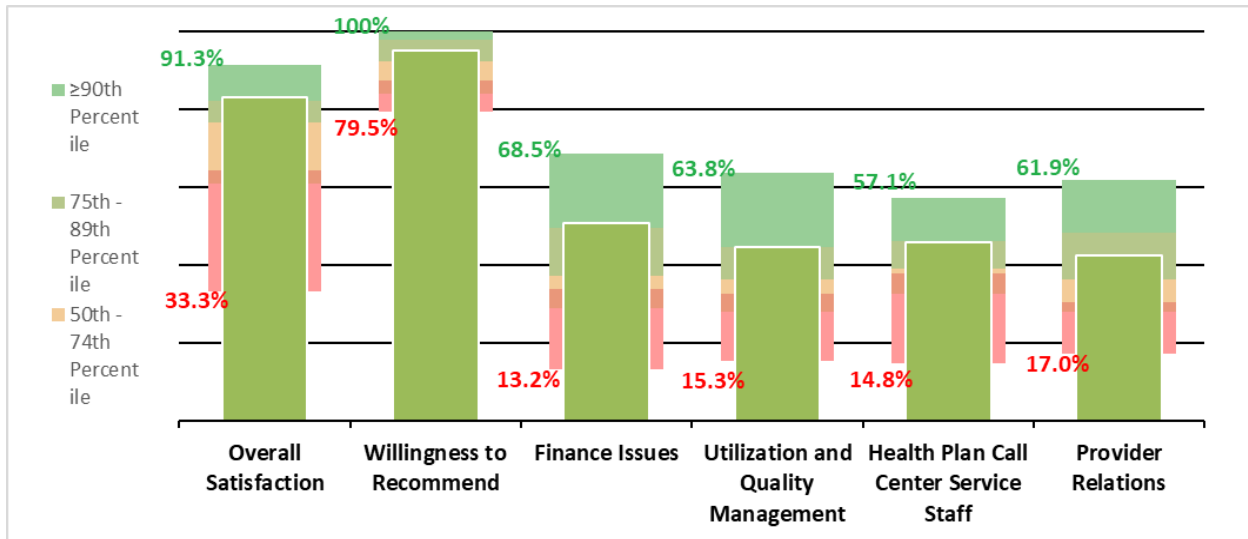
Provider Satisfaction Composite Scores

Composite	MY 2025 Result	Variance Compared to Previous Year	Variance Compared to PG Commercial Benchmark BoB	MY 2024 Result	MY 2023 Result
Overall Satisfaction	83.1%	Higher	Significantly Higher	80.7%	78.4%
All Other Plans (Comparative Rating)	62.9%	Lower	Significantly Higher	64.1%	55.3%
Finance Issues (Claims)	50.6%	Lower	Significantly Higher	56.3%	49.0%
Utilization and Quality Management	44.7%	Lower	Significantly Higher	50.4%	47.5%

Network/Coordination of Care	33.5%	Higher	N/A	27.0%	41.7%
Pharmacy	33.7%	Lower	N/A	35.6%	38.1%
Health Plan Call Center Service Staff	45.7%	Lower	Significantly Higher	50.9%	49.2%
Provider Relations	42.3%	Lower	Significantly Higher	52.6%	61.8%

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

Comparison Relative to PG Book of Business



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

Red bar = AAH performing below the 25th percentile

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

Key Drivers of Overall Satisfaction with Health Plan

Power: Promote and leverage Strengths (Top 5 Listed)

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

- Procedures for obtaining pre-certification/referral/authorization information
- Accuracy of claims processing

Opportunities: Focus resources on improving processes

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

Community Health Strategy (CHS) – July 2026

Community Health Strategy advances health equity by strengthening the connection between healthcare and community. Through trusted partnerships, Community Health Workers and community-based organizations improve access, address social drivers of health, and create coordinated, person-centered care that improves health outcomes for Alameda Alliance members.

Staffing Updates:

- No updates at this time.

July Program Summary:

During July, CHS focused on several key initiative designs to strength benefit operations, streamline provider engagement, and expand community partnerships across Alameda County.

CHS advanced efforts to standardize and automate the CHW benefit exhaust review process within the TruCare platform. Currently, when CHW claims exceed the standard 12-unit benefit threshold, the Claims team provides CHS with a manual report identifying members who may require additional services. CHS then reviews each case to determine whether the CHW provider has submitted a care plan documenting medical necessity for continued services. To improve efficiency, consistency, and program oversight, CHS is partnering with the TruCare Steering Committee to develop a standardized assessment and workflow within TruCare that will support a more automated review process for CHW services that exceed the standard benefit limit.

CHS continued provider network expansion efforts through outreach and engagement with local health jurisdictions (LHJs), community-based organizations (CBOs), and other community partners. Through a landscape analysis, the team is developing a strategic outreach approach that leverages FindHelp community resource data, along with insights from organizations that have previously engaged with ECM and CS programs, to prioritize outreach and identify potential CHW partners.

As part of this effort, CHS will prioritize engagement with organizations serving pregnant and postpartum populations to support the department's goal of developing a Maternal Health Equity Program. By better understanding community-based service models and identifying organizations with expertise in maternal health, CHS aims to strengthen partnerships that address disparities in maternal outcomes, improve member engagement, and expand access to culturally responsive care and support services. These efforts will help cultivate future partnerships that advance health equity and increase access to CHW services across Alameda County.

CHS initiated a comprehensive refresh of the CHW benefit website. This work includes updating provider-facing resources, enhancing educational materials, and creating a centralized provider directory designed to serve as a consistent referral pathway for members, providers, and community partners seeking Community Health Worker services.

CHS initiated a comprehensive refresh of the CHW Benefit website to improve access to resources for providers, community partners, members, and internal teams. Updates include the addition and revision of key program materials such as the CHW Provider Notification Templates, CHS Entity Interest Form, CHS Capacity Building Form, CHW Attestation Form, and CHW Care Plan Form. These enhancements are intended to streamline provider onboarding, support ongoing program participation, and improve access to standardized CHW program resources.

In partnership with Provider Services (PS), CHS is also working to incorporate contracted CHW providers into the Alliance Provider Directory. This enhancement will create a centralized referral pathway that allows members, community organizations, providers, and internal Alliance teams to identify and connect eligible members with CHW providers offering CHW services throughout Alameda County.

To strengthen partnerships and deepen understanding of community-based service delivery models, CHS is conducting site visits with emerging and existing Community Health Worker providers. One upcoming visit includes Love Never Fails (LNF), a newly contracted Community Health Worker provider that supports youth and adults impacted by human trafficking and exploitation. The organization provides violence prevention services, reentry support, survivor advocacy, homelessness support, and long-term stabilization services through community-based interventions designed to address complex social and health needs.

CHS also plans to visit the Vietnamese American Community Center of the East Bay (VACCCEB) to better understand programs serving Alameda County residents and explore opportunities to strengthen community partnerships that support health equity, member engagement, and access to culturally responsive services for the Asian population.

Quality In the Community: Community Health Worker-Led Interventions

CHS partnered with the Quality Improvement (QI) team to support referrals for the Fatty Liver Disease pilot. Through this collaboration, CHS received referral lists identifying members diagnosed with fatty liver disease who also have diabetes and hypertension, as well as members who demonstrate challenges with medication adherence for diabetes and hypertension management. The pilot supports quality improvement efforts tied to key HEDIS measures, including CBP and GSD, by connecting eligible members with CHW-led education, engagement, and care coordination services.

CHS is also partnering with the Long-Term Care Services (LTCS) and Community Supports (CS) teams to co-design a Housing as Health pilot focused on supporting members as they transition between levels of care. Through ongoing discovery and planning sessions, CHS is working with LTCS and CS partners to better understand challenges and barriers members may experience during care transitions, including

transitions between healthcare settings, community-based services, and housing-related supports. The pilot seeks to identify opportunities for CHWs to provide navigation, coordination, and member support during these critical transition points, helping improve continuity of care and reduce barriers to successful community integration.

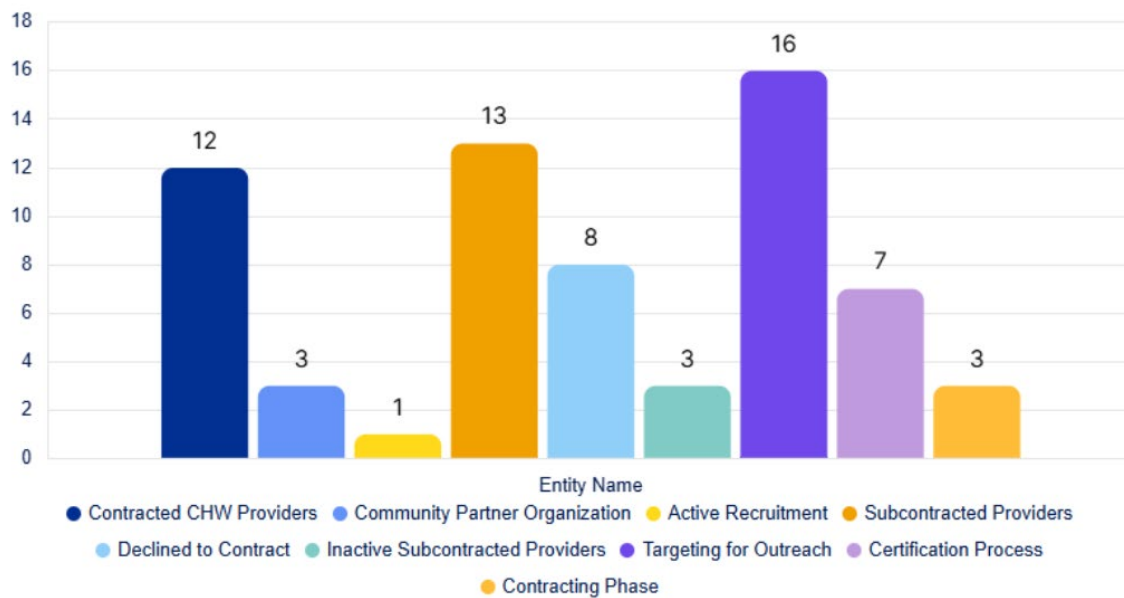
CHS Provider Recruitment and Community Partnership Development

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

During July, CHS advanced several provider partnerships across various stages of the CHW onboarding pipeline. Ascension Health will successfully complete contracting activities and became a contracted CHW provider effective August 2026. One Love Center for Health and Clarity Pediatrics Medical Group has also advanced from the pre-contracting/SLT approval phase into contract negotiations. City of Berkeley, East Bay Innovations, Hume Behavioral Health, and Kingdom Builders Transitional Housing Program are currently progressing through the CHW certification process and readiness activities. Collectively, these efforts support Alameda Alliance's strategic priorities related to provider network expansion, reducing health inequities, strengthening access to care, improving member engagement, and increasing the availability of community-based services for populations experiencing disproportionate disparities.

CHS Provider Recruitment Snapshot

CHW Recruitment Efforts - YTD



As of July 2026, the CHS provider network includes twenty-five (25) contracted providers, consisting of:

- Twelve (12) directly contracted organizations
- Thirteen (13) subcontracted entities.
- One (1) organization actively assessing readiness to pursue certification and contracting.
- Seven (7) organizations are currently engaged in the CHW certification process.
- Three (3) organizations are currently onboarding.
- Eight (8) organizations deemed ineligible or electing not to proceed year-to-date.
- Three new (3) organizations requested CHW Capacity Building
- Sixteen (16) organizations targeted for recruitment/outreach

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

Looking Ahead

Looking ahead, CHS will continue expanding the CHW provider network through targeted outreach to community-based organizations, local health jurisdictions, and organizations serving maternal and postpartum populations to support the development of the Alliance’s maternal health equity program. The team will advance the implementation of CHW-led interventions and further develop operational infrastructure through TruCare enhancements and website modernization. CHS remains focused on building sustainable community partnerships, strengthening data-informed decision making, and advancing innovative models that connect members to culturally responsive, community-based services that improve health outcomes and reduce health inequities across Alameda County.

Interpreter Services

Interpreter Services Annual Overview

- In 2025, over 124,000 interpreter services (in-person, telephonic, and video) were provided across 127 languages.
- Top 10 languages requested in 2025 included threshold languages, American Sign Language, Mam, and other languages. See table 1 below.

Table 1. Top 10 Languages Requested by Modality, 2025

Alliance Wellness/ D-SNP	Medi-Cal and Group Care
Spanish	Spanish
Chinese Cantonese	Chinese Cantonese

Chinese Mandarin	Vietnamese
Vietnamese	Chinese Mandarin
Tagalog	Mam
Arabic	Arabic
Hindi	Dari
Punjabi	Farsi
French	Punjabi
Turkish	Hindi

- 2026 Q1, we saw an 18% increase over 2025 Q1, with a 99% fulfillment rate for Medi-Cal and Group Care and 100% fulfillment rate for Alliance Wellness/D-SNP, exceeding our 95% target.
- 78% of interpreter services utilized in 2026 Q1 were on-demand (Phone 96%, Video 4%); 22% were prescheduled (In-person 88%, Video 10%, and Phone 2%).
- See table 2 below for the top 10 languages requested in 2026 Q1 by line of business (LOB).

Table 2. Top 10 Languages Requests, 2026 Q1

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

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

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

- Adult scores improved throughout 2025, while child scores remained strong for favorable responses to the Member Satisfaction Survey, CG-CAHPS question: *“Were you able to communicate with your doctor and clinic staff in your preferred language?”*
- There is an opportunity to further increase awareness and use of qualified interpreter services, while recognizing member cultural and personal preferences.
- Overall, we met or exceeded our workplan goal: 81% of Adult members and 92% of Child members who needed interpreter services reported receiving a qualified non-family interpreter.

Table 3. Favorable Responses, CG-CAHPS, 2025

2025 Workplan Goal: 81% of Adult members and 92% of Child members who needed interpreter services reported receiving a qualified non-family interpreter.

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

Quality Improvement: Population Health Management (PHM)

- Completed the annual update of the Alliance population health assessment, evaluation of 2025 PHM Strategy, and NCQA-compliant 2026 PHM Strategy in May 2026. QIHEC approved the documents on May 8, 2026
- Began engagement with PHM consultant HealthBegins. From March to August 2026, HealthBegins will guide Alliance PHM and QI teams in utilizing their Equity-Focused Upstream Quality Improvement Approach to move from data analysis to actionable program roadmaps for two priority HEDIS measures, Well-Child Visits in the First 15 Months of Life (W15) and Controlling High Blood Pressure (CBP). W15 will use a comprehensive approach with three stakeholder sessions, while CBP will use an accelerated approach with one stakeholder session.
- DHCS released new technical specifications and resumed quarterly submissions of PHM KPIs starting January 2026, which had been on hold since November 2023. The KPIs are listed in the table below with the most recent submitted rates in April 2026 (lookback period 1/1/2025-12/31/2025):

	Acronym	Measure	April 2026 submission
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1	EDPC	Members Utilizing Emergency Department Care More than Primary Care	7.3%
2	ENPC	Members Engaged in Primary Care	44.0%
3	ENPC-A	Members Engaged in Primary Care at Assigned Primary Care Site	36.0%
4a	CCME Rate A	Complex Care Management Enrollment	5.9%
4b	CCME Rate B	Note: Rate B looks at the subset of members from Rate A who were not enrolled in CCM in the last measurement period and thus identifies new enrollment into CCM.	0.8%
5	CMHRD	Care Management for High-Risk Members after Discharge	20.4%
6	FUAH	Follow-Up Ambulatory Visit after Hospital Discharge	32.8%



Information Technology

Sasikumar Karaiyan

To: Alameda Alliance for Health Board of Governors
From: Sasi Karaiyan, Chief Information & Security Officer
Date: August 14th, 2026
Subject: Information Technology Report

Enrollment

- July membership decreased by 2,923 members, representing a 0.79% month-over-month change. PCP assignment patterns remained balanced at 53% auto-assigned and 47% member-selected. All 48 DHCS, CMS, and Public Authority files were processed successfully with no issues or downtime.

Provider & Member Portals

- In June 2026, the Provider Portal's top five most-used pages recorded 2.50-million-page views, a 3.7% increase from May, while Member Portal's top five most-used pages recorded 12,521 page views. Providers submitted 6,429 authorizations through the portal, members submitted 12 grievances, and active portal account totaled 6,898 providers and 3,433 members.

*Portal metrics are reported in arrears and reflect the period from June 2025 - June 2026.

Call Center Metrics

- Call center systems remained stable in July, with 100% availability and no service interruptions. The Alliance received 13,717 member calls and 10,718 provider calls, while Alliance Wellness extended-hours support handled 80 calls during evening, weekend, and holiday hours.

Encounter Data

- In the month of July 2026, the Alliance submitted 147 encounter files to the Department of Health Care Services (DHCS) with a total of 499,559 encounters.
- In the month of July 2026, the Alliance submitted 1,152 encounters to the Centers for Medicare Services (CMS) for D-SNP members.

Workflow Automation

- To enhance Claim TAT, our IT Configuration team has identified three key process improvement opportunities that could increase our claims auto-adjudication rate from 85% to 92%.

Alliance is introducing agentic AI to automate portions of the manual claims processing workflow. In June, the IT Configuration team identified a use case and completed the design, development, and testing phases. The pilot successfully passed the end to end process.

Once the pilot is complete, we will outline the implementation strategy to deliver at least 10 claims workflows by the end of December 2026.

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

Our next 3 months plan is to complete the Navex integrate the PolicyTech documents workflow from AAH to Readily platform.

- Alliance has kicked off AI-driven automation to transform software development by enhancing developer productivity, improving code quality, and accelerating delivery across the full software development lifecycle (SDLC) from design and development to deployment, quality assurance, and maintenance. This initiative includes capabilities such as automated code generation, DevOps and Continuous Integration/Delivery (CI/CD) automation, as well as code reviews and testing. The AI transformation is planned as a 12-month level of effort.
- Alliance developed a high-accuracy (Optical Character Recognition) OCR using OpenAI, automating image interpretation and text extraction from faxes and user prompts, now integrated into key workflows.
 - Change Management end-to-end process redesign is underway.
 - 10+ Health Care Services workflow processes are in the pipeline for automation in CY2026 which includes Health Ed Wellness, Behavioral Health care - Autism evaluation form etc.
- The enterprise-wide Speech-to-Text implementation is complete. The Alliance has onboarded 10 users, improving operational efficiency across the process.

Claims – HEALTHsuite Application

- The Alliance received 380,205 claims in the month of July 2026.
- For the MediCal and Group Care lines of business, a total of 440,698 claims finalized, out of which 369,350 claims auto adjudicated, setting the auto-adjudication rate at 83.8%.

- The D-SNP line handled 1184 finalized claims during the period, out of which 608 were auto adjudicated, resulting in a 51.4% auto-adjudication rate.
- HEALTHsuite Upgrade is scheduled for the weekend of August 14th, 2026.
- Actively exploring AI-led solutions to boost claims auto-adjudication percentages and improve processing accuracy.

Quality Suite Application

- High level dashboard of cases for the month of July 2026:
 - G&A cases received in the month - 2390
 - Exempt Grievances received in the month - 2082
 - PQI cases received in the month - 97
 - PDR cases received in the month - 2785
- QS Automation Roadmap - This initiative aims to enhance the application for faster turnaround times and improved quality metrics. The following high impact automation is in progress.
 - Automating the QA Process - High impact project focused on automating the QA Process. The current manual process needs to be replaced with an automated solution. This is essential to reduce repetitive tasks and allow the QA team to focus on the quality of work. This process will support the coordinator score card for performance as well.

TruCare

- The TruCare application, running version 25.2.1.2 alongside CareWebQI version 17.3 and MCG Health content version 29.1, maintained 99.9% uptime while receiving and processing 24,347 intake authorizations in July 2026, supporting timely care coordination and authorization management.
- OCR technology has streamlined the processing of key operational documents—including Pre-Service Authorizations, Home Health requests, Face Sheets, and Interpreter service requests - improving accuracy, reducing manual effort, and accelerating turnaround times. In July, the solution processed 2,967 prior authorization requests, 212 pre-service authorization form (DSNP & MCAL) 21 home health requests, 3,450 face sheets, and 314 interpreter service requests, enhancing operational efficiency and supporting timely member care.
- The fax infrastructure continues to support critical authorization workflows, provider communications, regulatory compliance, and care coordination activities across the organization. In July 2026, approximately 39,233 outbound faxes were transmitted to providers for authorization approvals, denials, and other required communications, while 27,644 inbound faxes were received from providers and hospitals to support prior authorization requests and clinical documentation intake, including face sheets.

Electronic File Exchange and System Performance

- File transfer and integration applications—AppXTender, Automate, Docunect, and ECS—maintained 99.9% uptime while processing approximately 756,671 total files in July, including 745,806 inbound and 10,865 outbound transactions that supported critical business, clinical, and partner integration processes.

Change Management

- Change Management activity remained strong in July 2026, with 104 Change Requests (CRs) submitted and 87 CRs closed. While submissions exceeded closures, the gap narrowed compared to previous months, reflecting continued efforts to manage incoming demand and maintain delivery performance.
- Normal CRs represented the largest share of activity, with 55 submitted and 48 closed, followed by FastTrack CRs, which increased to 43 submissions and 34 closures, indicating growing demand for expedited changes. Emergency CRs remained low, with 6 submitted and 5 closed, demonstrating effective management of high-priority requests.

IT Service Desk

- 1,640 Service Desk tickets were opened in July 2026, a 10.77% decrease from June (1,838) but 27.63% higher than the previous 4-month average of 1,285 (March–June).
- 1,636 Service Desk tickets were closed in July 2026, a 14.39% decrease from June (1,911) but 26.06% higher than the previous 4-month average of 1,297.75 (March–June).

IT Security Program

- As part of the broader IT Security Program execution (4-year roadmap), Security efforts to improve posture continue through various means – P&P, frameworks, operational streamlining, projects, and compliance.
- Operational progress includes (1) AI blocking SOP going through validation testing (2) completed email authentication hardening - DMARC (3) remediation continues on annual Security Risk Assessment and Penetration Test findings.
- Authentication Pattern initiative – (1) data collection into IT Glue continues to see progress through organic means (2) notification workflow in final phase of validation testing.
- Network Micro-segmentation project completed policy/rule enforcement on non-production TruCare and HealthSuite assets.

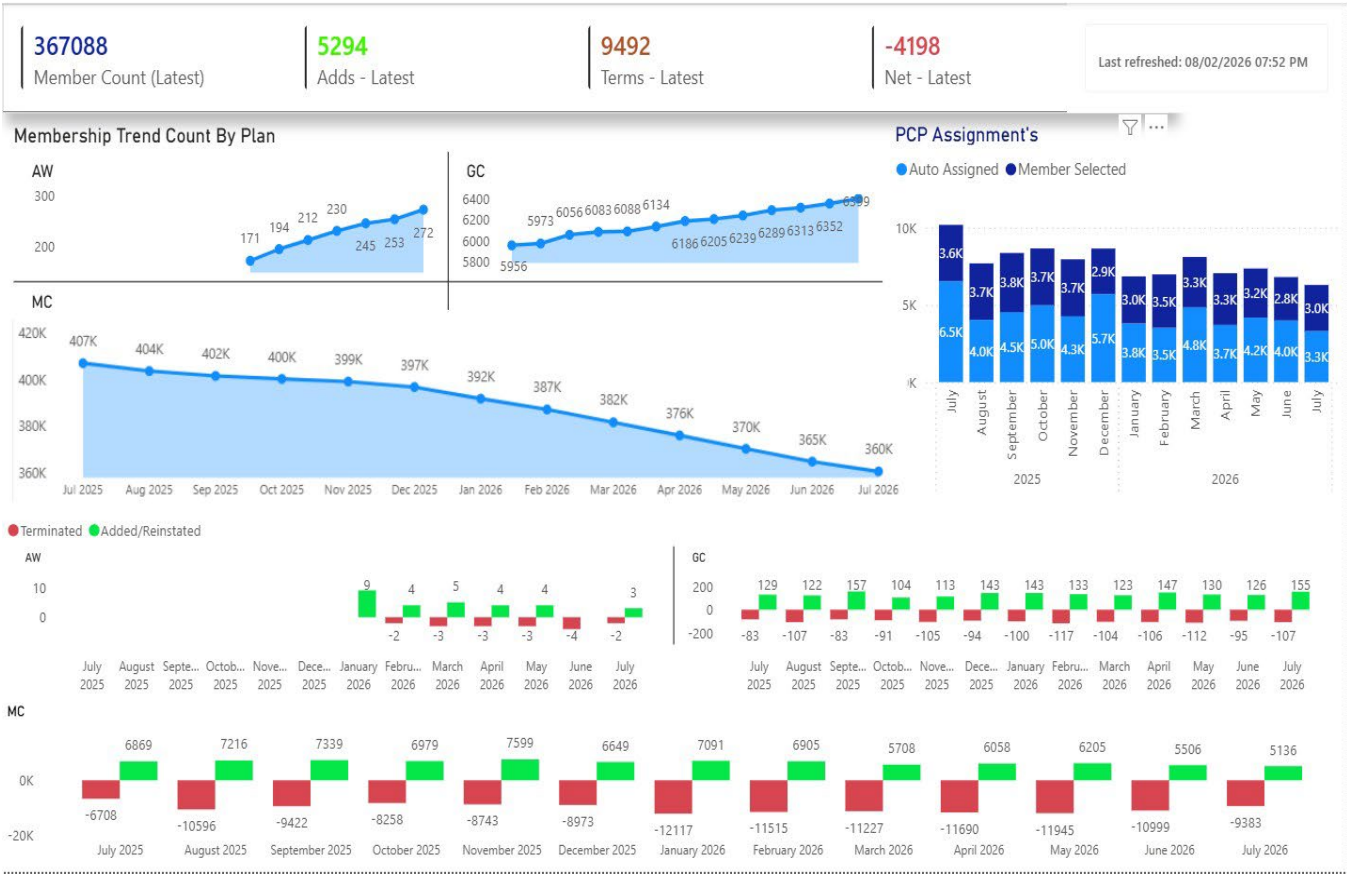
Information Technology

Supporting Documents

Enrollment

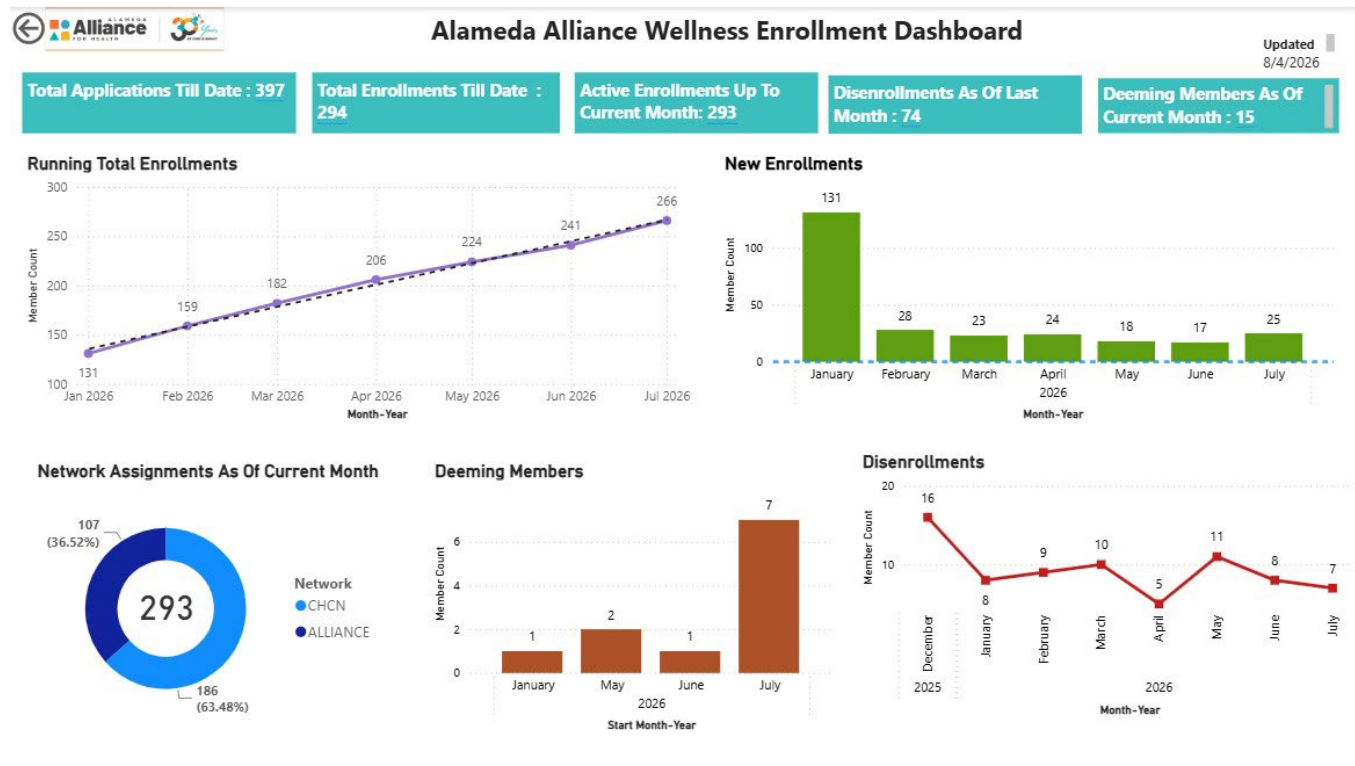
Membership Trend & PCP Assignments

July 2026 membership totaled 367,088, a decrease of 2,923 members (0.79%) from June. During the month, 5,294 members were added and 9,492 members were disenrolled. Of PCP assignments completed in July, 53% were auto-assigned and 47% were member-selected.



Alliance Wellness Enrollment Activity

July 2026 Alliance Wellness enrollments totaled 266 active members. During the month, 25 new enrollments, 7 disenrollments, and 7 deeming members were recorded.

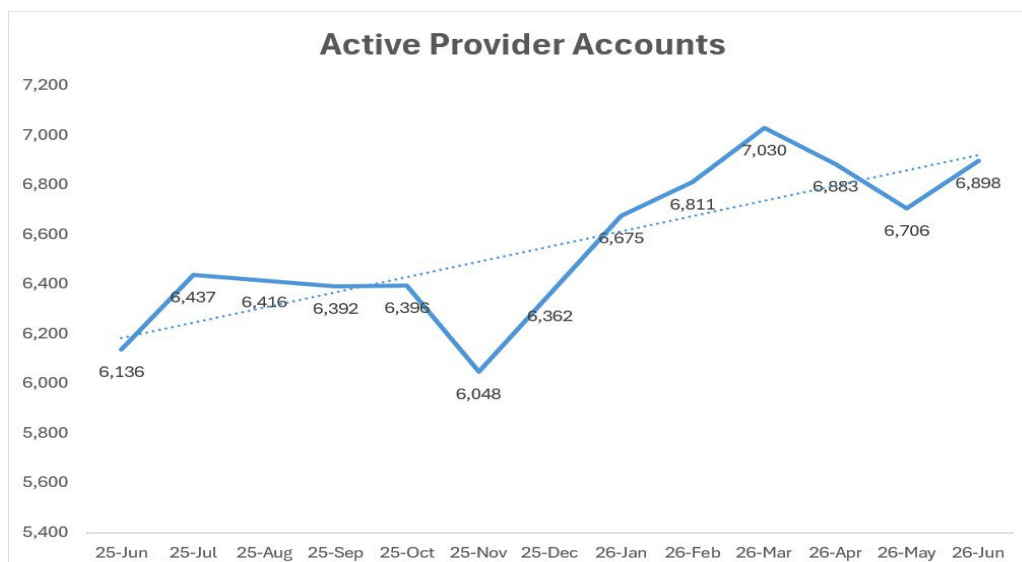


Provider & Member Portals

*Portal metrics are reported in arrears and reflect the period from June 2025 - June 2026.

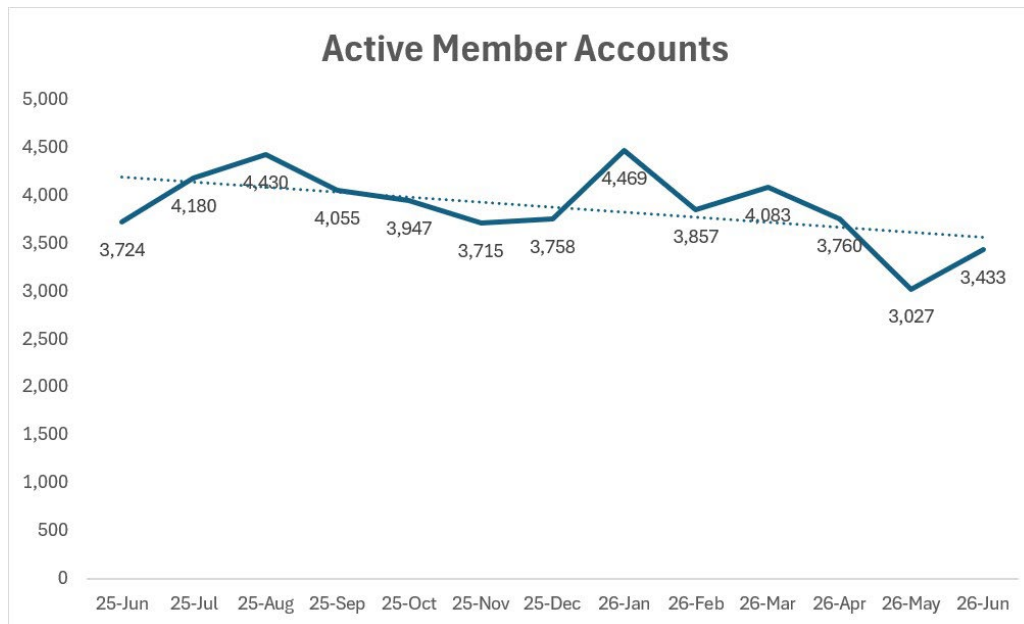
Provider Portal Users

Active provider accounts increased by 192 accounts (2.9%), from 6,706 to 6,898 over the reporting period.



Member Portal Users

Active member accounts increased from 3,027 to 3,433, an increase of 406 accounts (13.4%) over the reporting period.



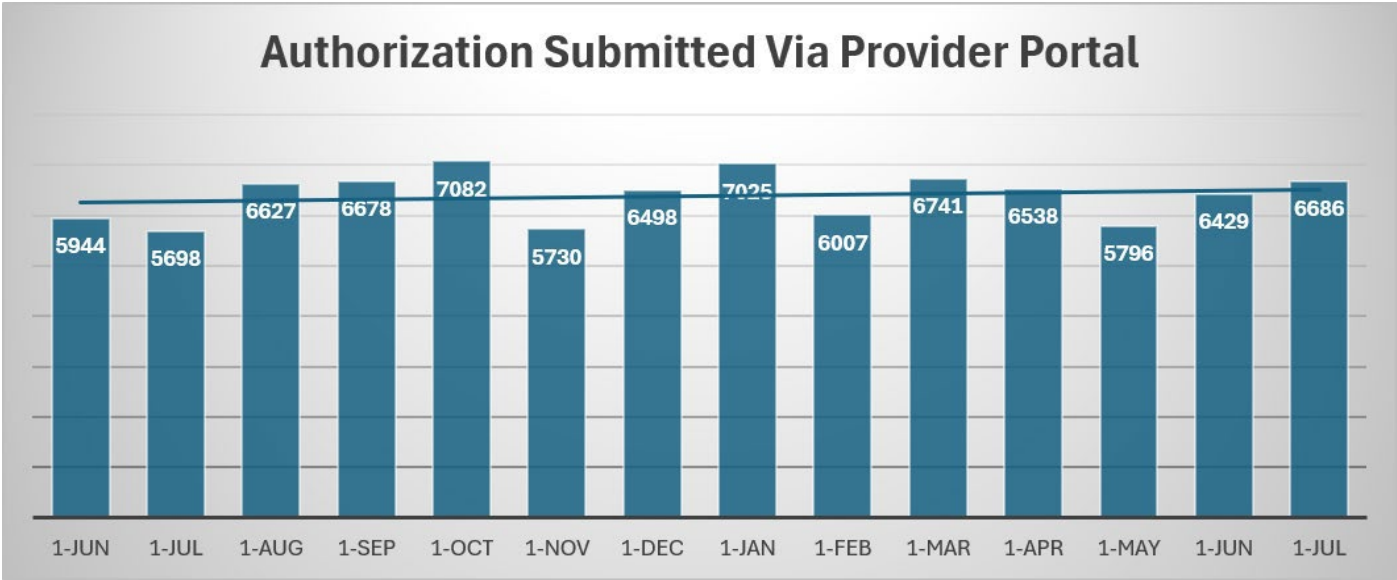
Provider & Member Portal top 5 pages viewed

The most-viewed provider portal page, Member Eligibility, recorded 2,154,772 page views in June, an increase of 65,374 views (3.1%) from May. The most-viewed member portal page, ID Card, recorded 4,318 page views, an increase of 933 views (27.6%) from May.

Portal	Page	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Provider	Member eligibility	1,504,728	1,585,727	1,690,469	1,755,600	1,856,262	1,842,582	2,080,703	2,170,351	1,664,301	1,886,751	2,006,389	2,080,398	2,145,772
	Claim Status	284,525	296,663	262,537	270,631	279,789	233,977	267,656	254,452	247,939	255,575	241,762	314,492	327,081
	Authorization status	8,237	9,556	10,237	10,574	11,381	9,103	10,845	11,322	10,422	11,741	11,140	10,051	11,365
	Submit authorizations	7,096	8,638	7,676	7,965	9,874	6,653	8,109	8,561	7,433	8,257	7,981	7,308	8,810
	Submit professional claims	6,011	6,175	7,035	6,304	6,444	5,246	6,025	6,198	6,357	7,379	6,621	6,557	6,622
	Total	1,810,597	1,906,759	1,977,954	2,051,074	2,163,750	2,097,561	2,373,338	2,450,884	1,936,452	2,169,703	2,273,893	2,418,806	2,499,650
Member	ID Card	4,558	5,781	6,175	5,082	4,824	4,436	4,082	4,771	3,953	4,046	3,960	3,385	4,318
	Member Eligibility	5,231	5,620	5,781	5,555	4,903	4,775	4,312	4,421	3,377	3,643	3,173	2,810	3,011
	Provider Directory	3,305	3,533	3,905	3,650	3,229	3,152	2,862	4,051	2,691	3,092	2,667	2,153	2,544
	Select/ Change PCP	2,249	2,100	2,390	2,363	1,990	1,830	1,887	2,337	1,568	1,882	1,569	1,370	1,374
	My Claims Services	1,535	1,592	1,571	1,623	1,606	1,355	1,451	1,589	1,418	1,524	1,371	1,329	1,274
	Total	16,878	18,626	19,822	18,273	16,552	15,548	14,594	17,169	13,007	14,187	12,740	11,047	12,521

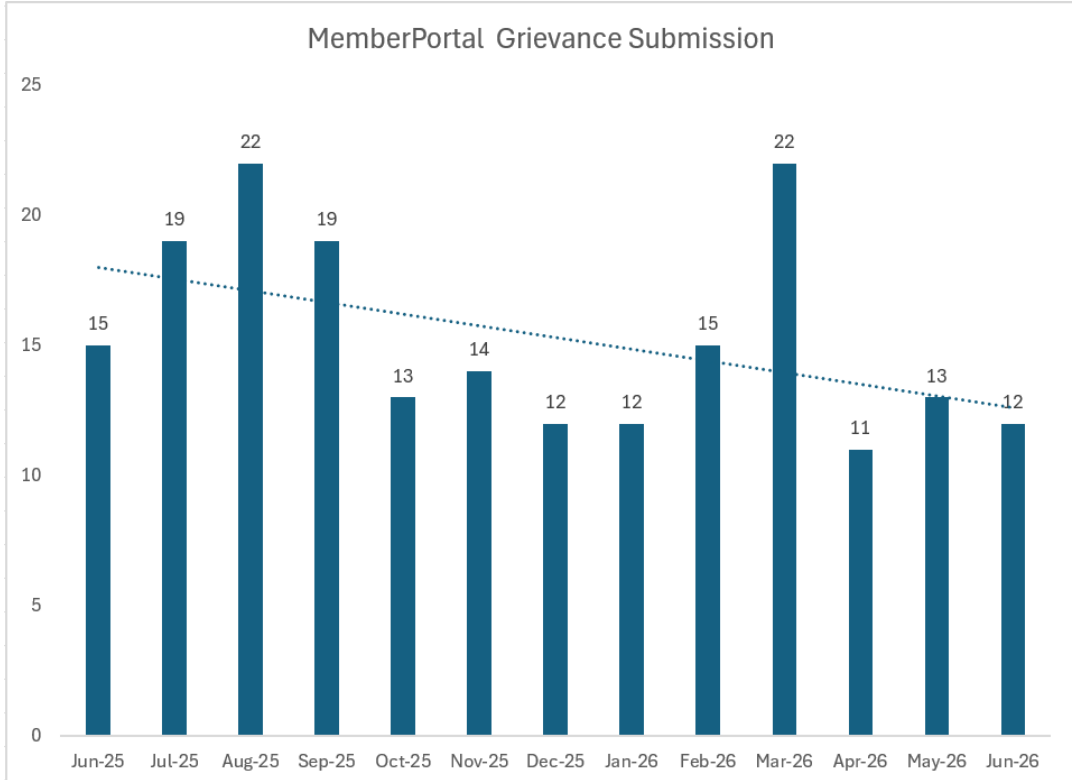
Provider Authorizations (Portal Submissions)

Submissions increased 4.0% from May 2026 to June 2026, with monthly volumes remaining relatively consistent throughout the reporting period.



Member Grievances (Portal Submissions)

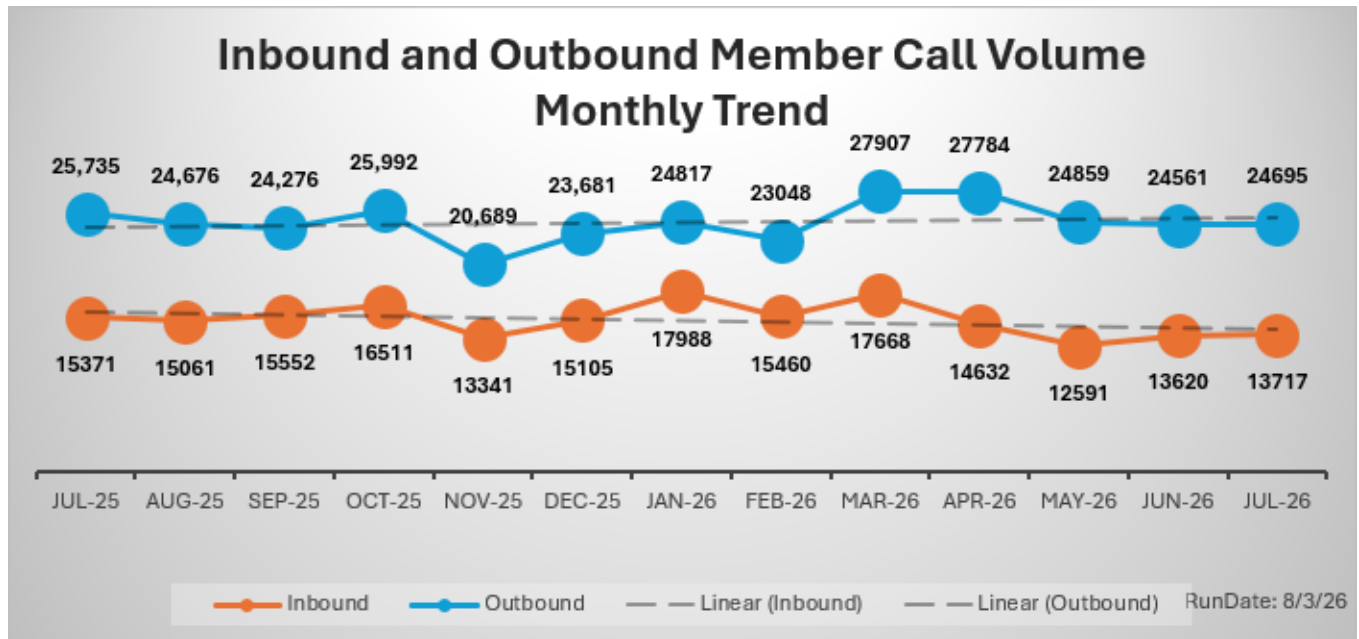
Member Portal grievance submission decreased from 15 in June 2025 to 12 in June 2026, a decrease of 3 submissions (20.0%) over the reporting period.



Call Center Metrics

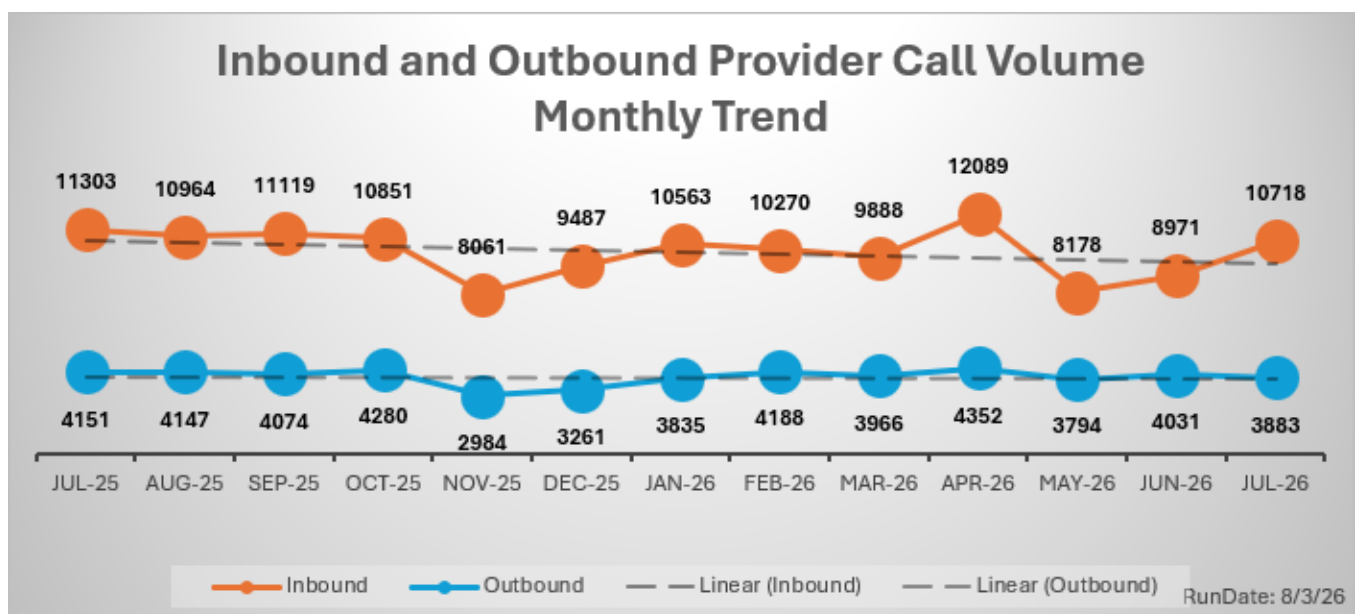
Member Call Utilization

Member call utilization remained stable with no outages or downtime. During July 2026, member-facing call center applications supported 13,717 inbound and 24,695 outbound calls. Compared with June 2026, inbound calls increased by 0.7% and outbound calls increased by 0.5%.



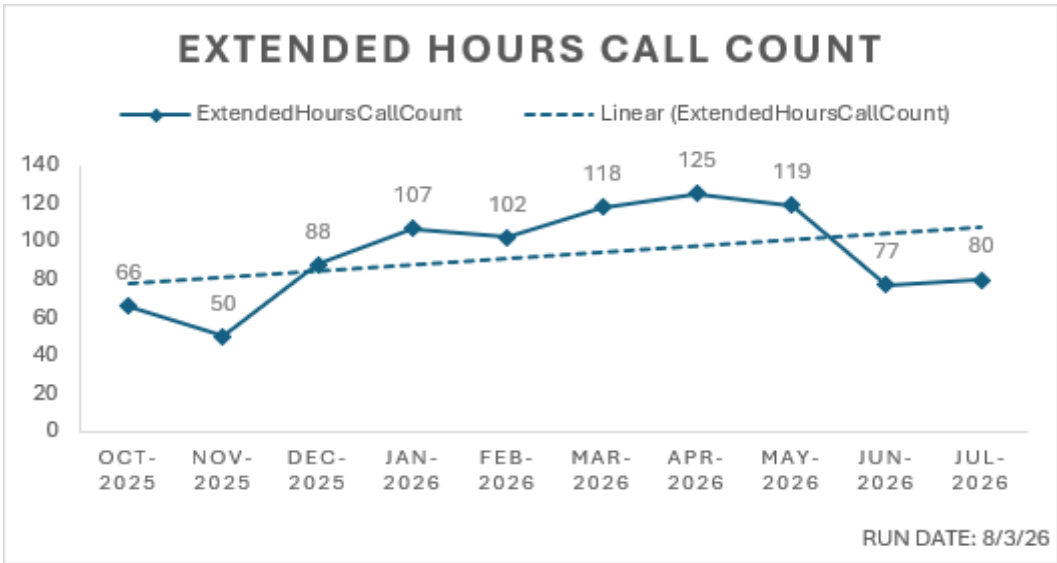
Provider Call Utilization

Provider call utilization remained stable with no application outages or downtime. During July 2026, provider-facing call center applications supported 10,718 inbound and 3,583 outbound calls. Compared with June 2026, inbound calls increased by 19.5% and outbound calls decreased by 11.1%.



Alliance Wellness Extended Hours Utilization

Alliance Wellness extended hours utilization reflects member calls on weekdays from 5–8 p.m., weekends from 8 a.m.–8 p.m., and holidays, excluding Thanksgiving and Christmas. A total of 80 extended-hours calls were received in July 2026, compared with 77 in June 2026.

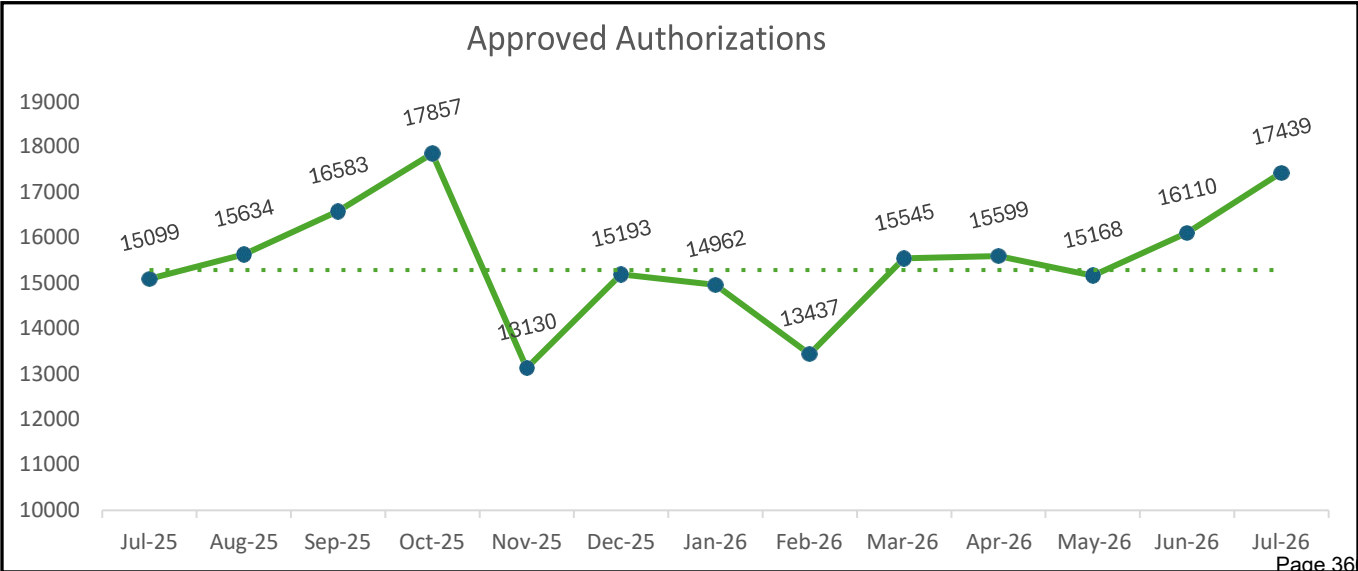


Authorizations

Over a 13-month period, approved authorizations averaged 15,520 monthly cases, peaking at 17,857 in October 2025 before stabilizing between 13,130 and 17,439. Auto-approved authorizations averaged 8,195 cases monthly, representing a 52.8% average automation rate that peaked 59.1% in July 2026. Denied authorizations averaged 758 cases monthly, peaking at 1,180 in June 2026 following an upward climb that began in early spring.

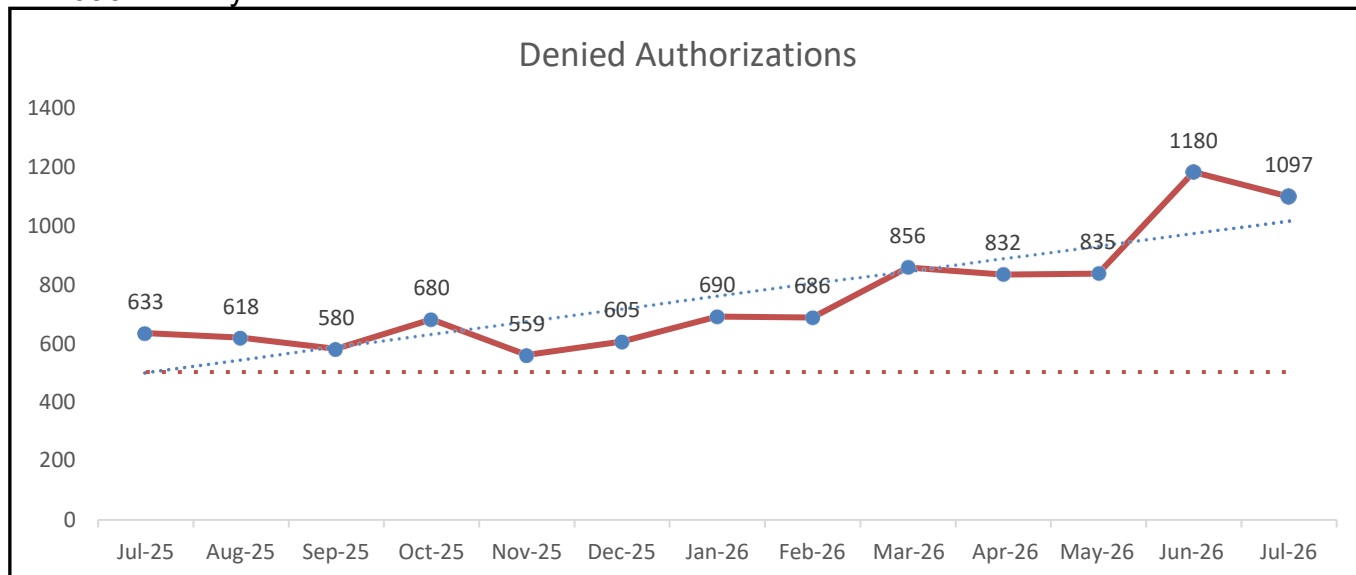
Approved Authorizations:

Authorizations averaged 15,520 monthly over the 13-month period. Volumes peaked significantly in October 2025 at 17,858 approvals before dropping the following month. Since then, demand has normalized into a predictable operational baseline ranging between 13,130 and 17,439 monthly cases.



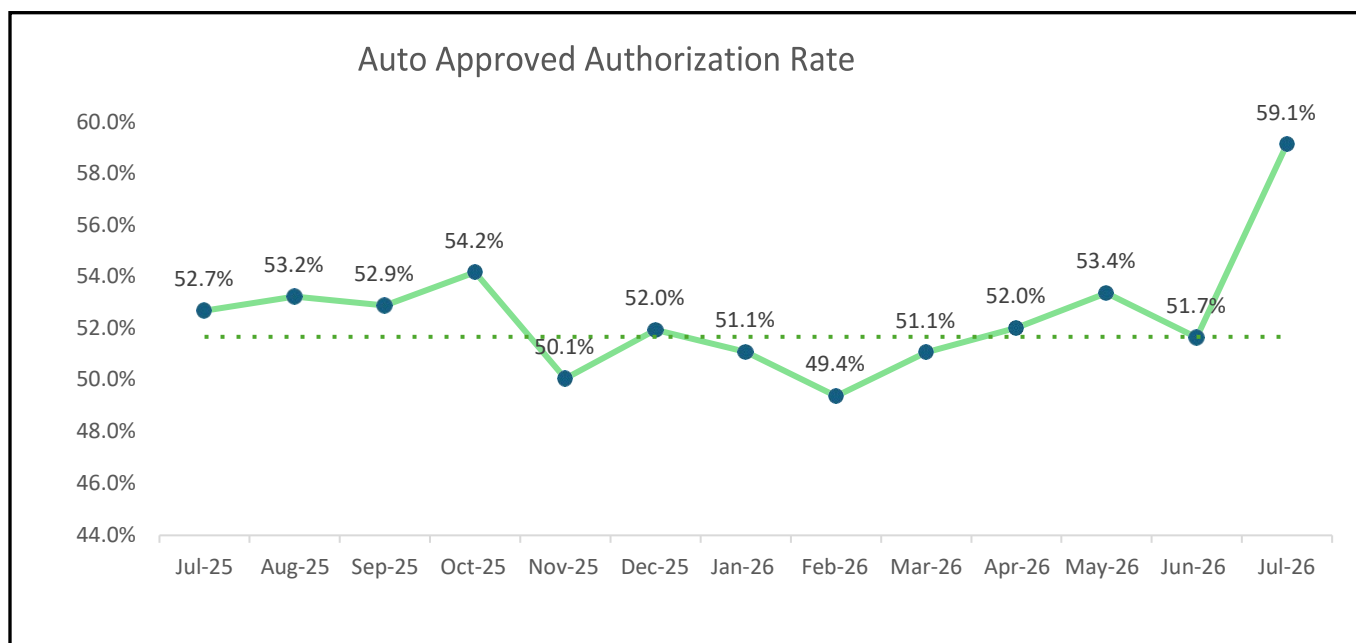
Denied Authorizations:

Denied authorizations averaged 758 cases monthly over the 13-month period. Volumes hit a peak in June 2026, reaching 1,180 denials, following an upward trend that began in early spring. Prior to this upward climb, denial metrics fluctuated within a lower baseline range between 559 and 690 monthly cases.



Auto Approved Authorization Rate:

The auto-approval rate remained highly stable over the 13-month period, processing an average of 52.8% of all approved authorizations. System automation peaked at 59.1% in July 2026, while consistently streamlining at least half of the total case volume month-over-month.



OCR-Based Form Processing and Automation

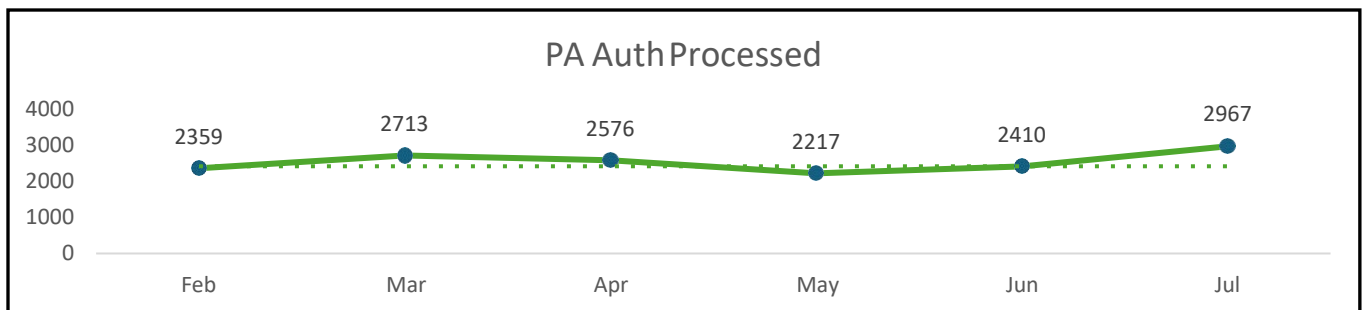
To improve operational efficiency, reduce manual effort, and minimize data-entry errors, the Alliance has implemented Optical Character Recognition (OCR) technology for the automated processing of key authorization and enrollment forms. OCR enables faster document intake, data extraction, and workflow routing, resulting in shorter processing times and improved accuracy.

Forms currently processed using OCR technology include:

- Pre-Service Authorization (D-SNP and Medi-Cal)
- PA Authorization (alternative to DocuStream)
- Home Health Authorization
- FaceSheets
- Interpreter Service Requests
- Palliative Care Authorization
- Community Support Authorization Request
- Post-Acute Authorization Request

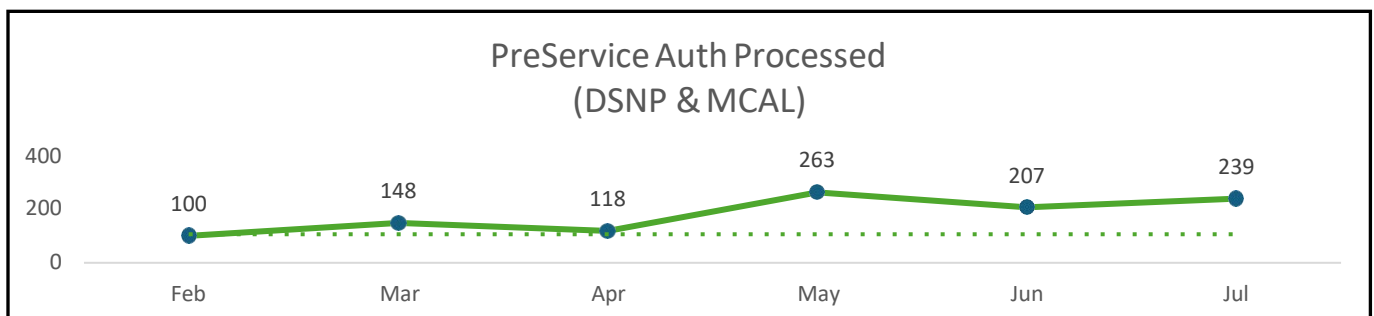
PA Authorization (alternative to DocuStream):

PA Auth processing transitioned from DocuStream to OCR beginning in February, supporting the broader objective of improving processing efficiency, reducing manual touchpoints, and minimizing errors. From February through July, monthly PA Auth volumes ranged between 2,217 and 2,967, reflecting ongoing operational processing through the new OCR workflow.



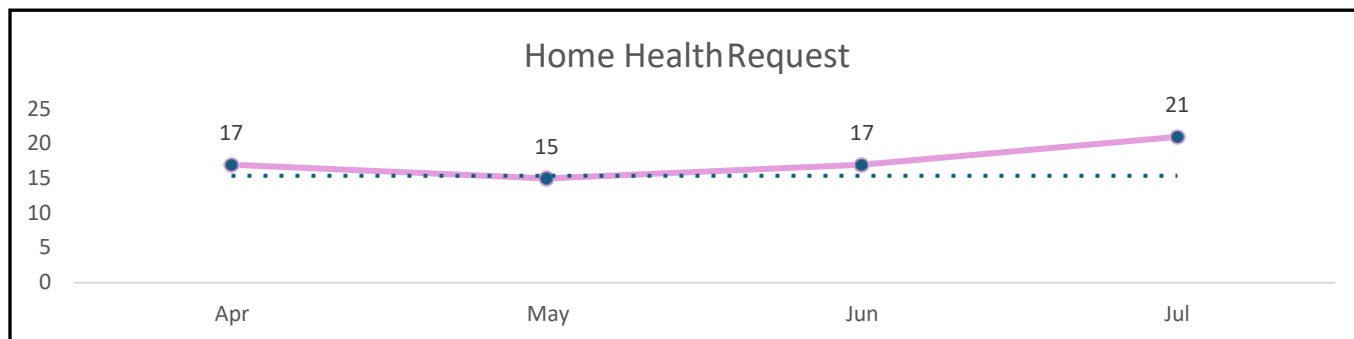
Pre-Service Auth:

Pre-Service Auth processing for DSNP and MCAL maintained consistent activity from February through July. During this six-month period, monthly volumes reached a low of 100 in February and peaked at 263 in May.



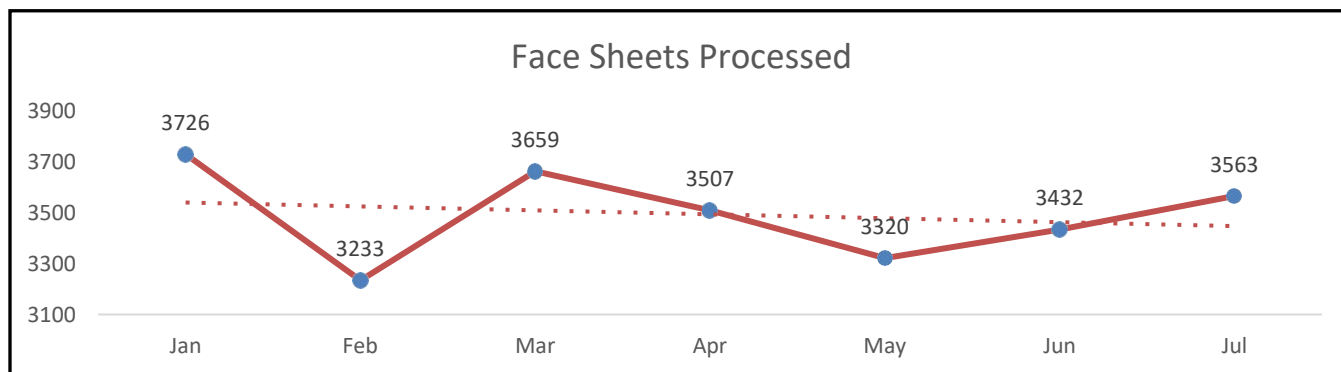
Home Health Request:

Home health request processing transitioned to OCR in April 2026, maintaining stable volume levels through July with monthly requests ranging between 15 and 21.



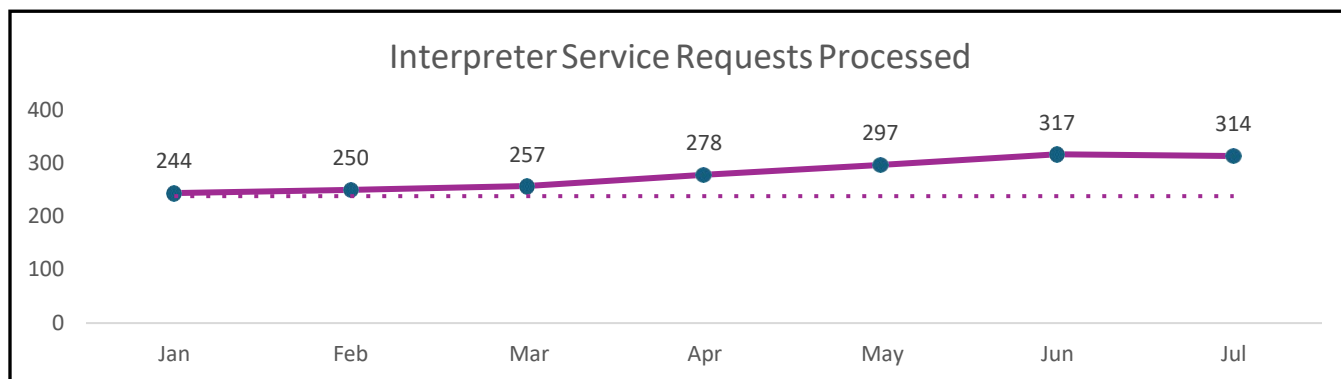
Face Sheet:

Monthly face sheet processing volumes remained stable from January through July, ranging between 3,233 and 3,726 with an average of 3,492 per month.



Interpreter Service Requests:

Monthly interpreter service requests grew steadily from January through July, rising from 244 to 314 requests with an average of 280 per month, totaling 1,957 overall.

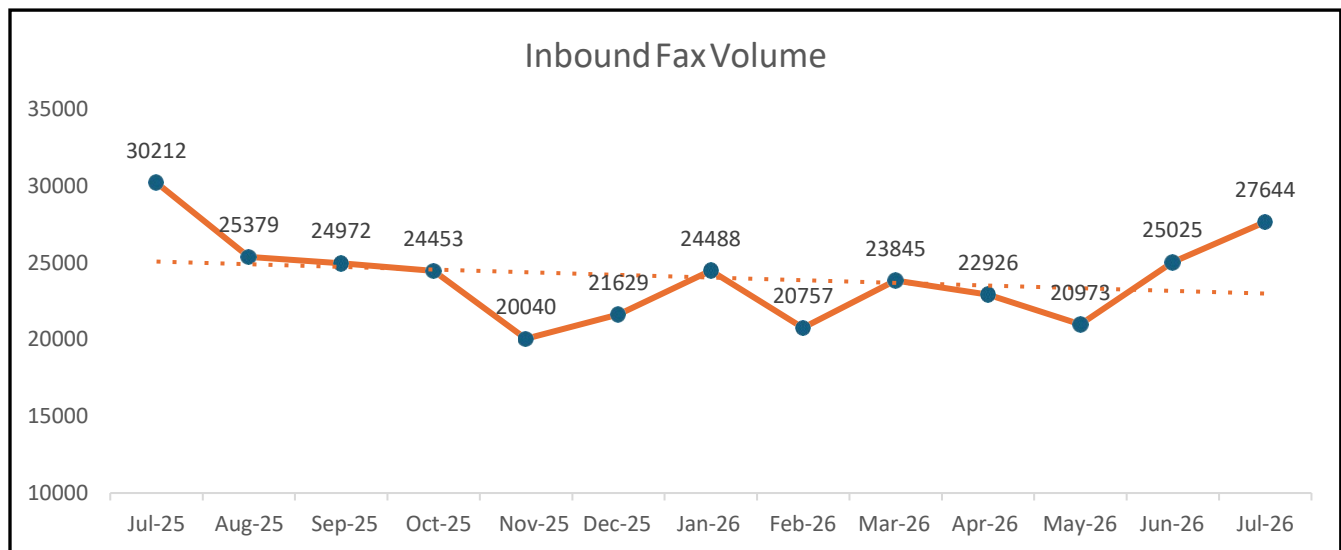


Fax-Based Authorization and Provider Communication

Fax services remain a critical communication channel supporting authorization processing, provider engagement, clinical documentation intake, and regulatory compliance across the organization.

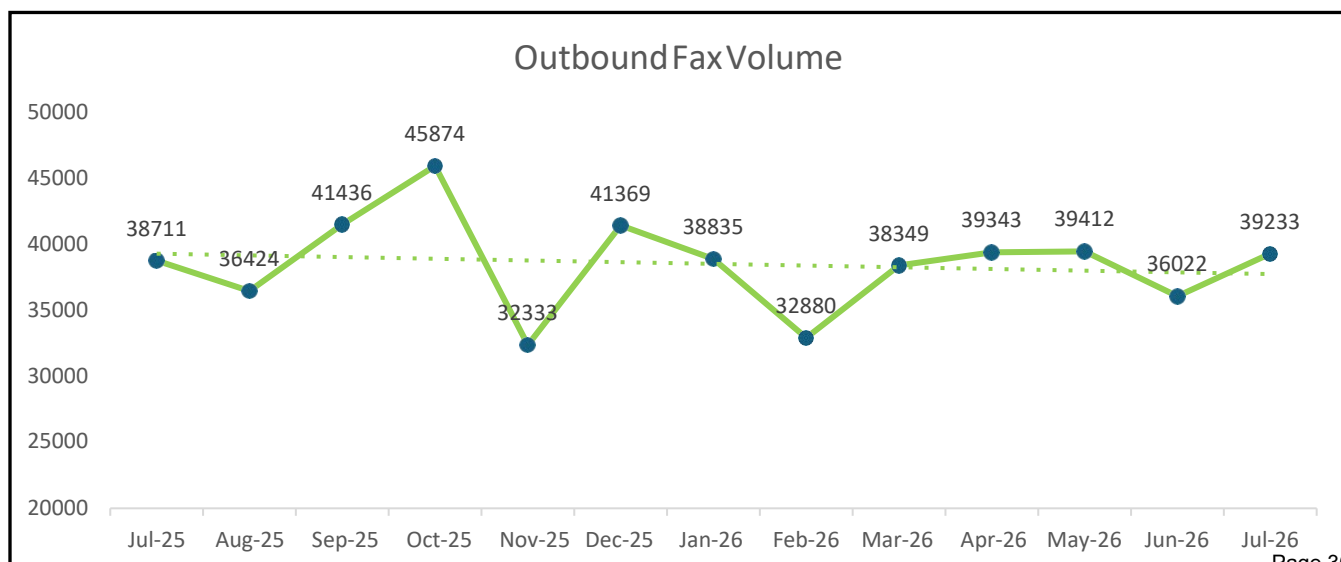
Inbound Fax Processing for Prior Authorization Support:

Inbound faxes averaged 24,318 monthly over the 13-month period. Volume peaked significantly in July 2025 at 30,212 transmissions before settling into a consistent operational pattern. Since then, the communication channel has maintained a highly stable baseline, with volume tracking between 20,040 and 27,644 faxes each month.



Outbound Fax Delivery for Authorization Decisions:

Outbound faxes averaged 38,402 monthly over the 13-month period. Volume climbed steadily through the summer and fall, reaching a maximum throughput of 45,874 transmissions in October 2025. Following this high-demand period, outbound traffic maintained a highly consistent and reliable operational range, generally tracking between 32,333 and 41,436 faxes per month.

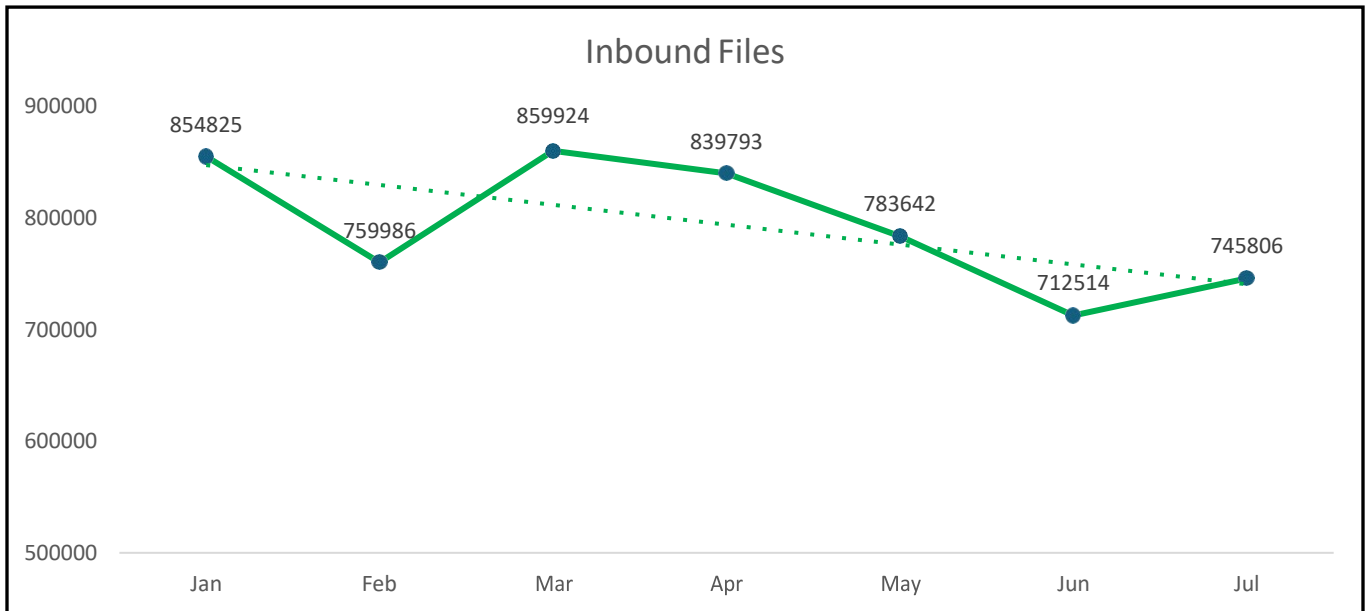


Monthly Inbound and Outbound file processing

From January through July, file processing averaged approximately 803,919 total files per month, with inbound files representing most of the activity each month. Overall volume remained strong across the period, reaching its highest level in March with 870,262 total files, supported by consistent inbound processing and elevated outbound file activity.

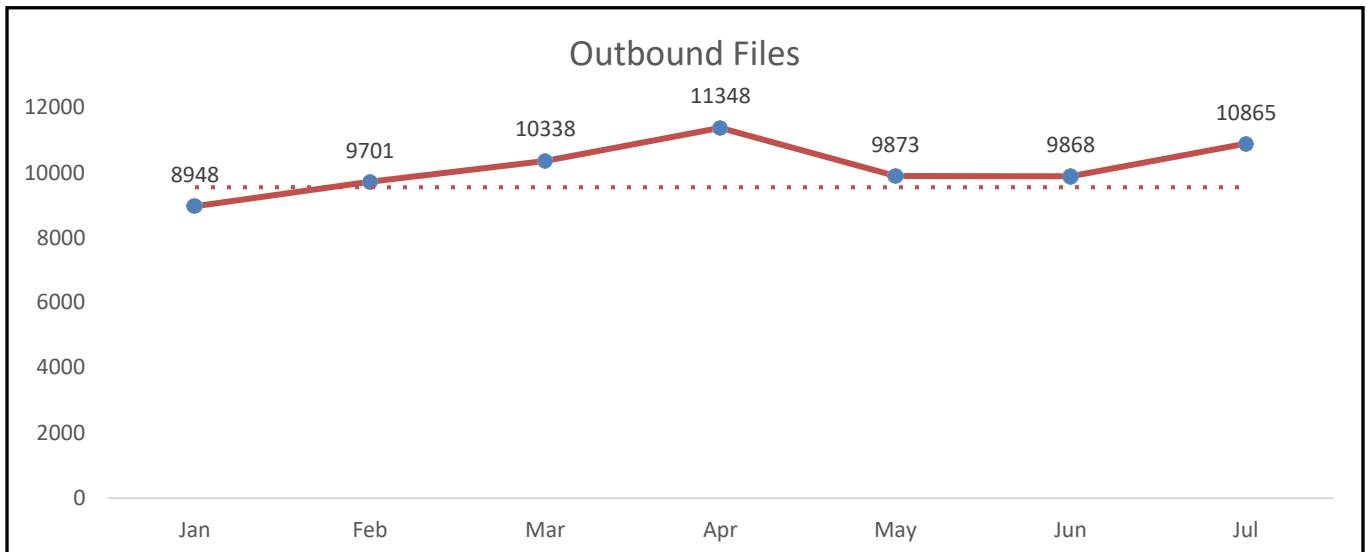
Inbound files processing:

Inbound file processing averaged approximately 793,784 files per month from January through July, with steady activity across the period and the highest volume recorded in March at 859,924 files, while June marked the lowest operational volume at 712,514



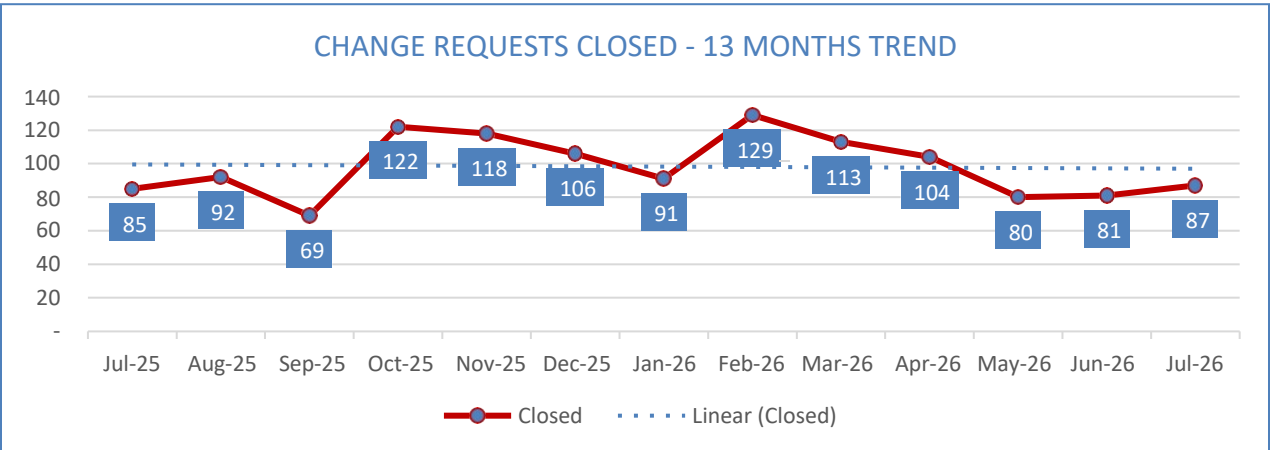
Outbound file processing:

Outbound file processing averaged approximately 10,134 files per month from January through July, consistently representing the smaller share of total file activity. Volume grew progressively early in the year, reaching its highest throughput in April at 11,348 files.

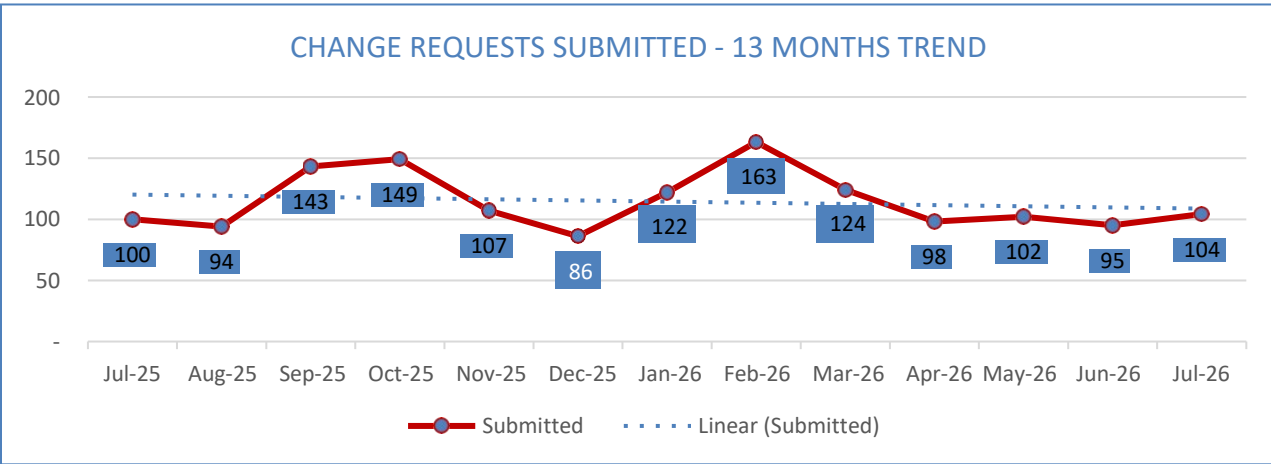


Change Management Key Performance Indicator (KPI)

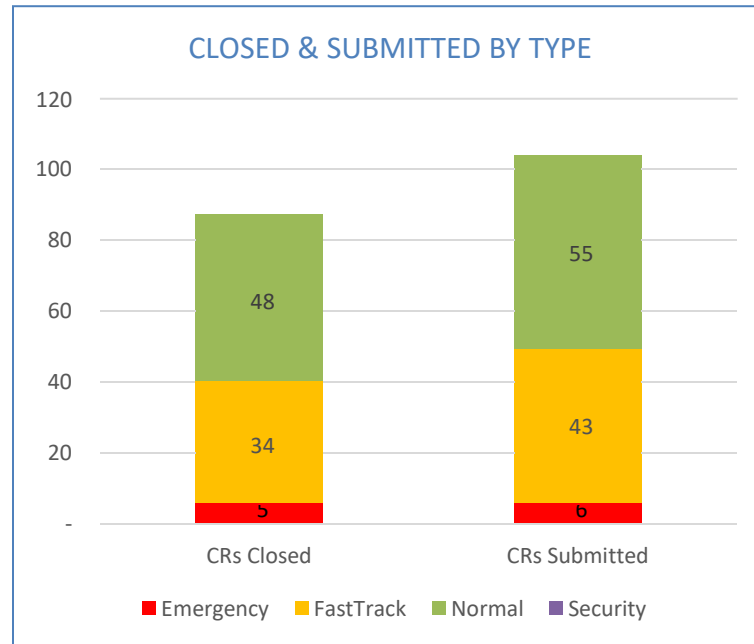
- Change Management activity remained strong in July 2026, with 104 Change Requests (CRs) submitted and 87 CRs closed, reflecting continued business demand and steady operational performance. As a result, 151 CRs remained active at month-end, with aging requests continuing to be an area of focus, including 85 open for more than 30 days, 60 over 60 days, 40 over 90 days, and 5 open for more than one year.
- Over the past 13 months, 1,277 Change Requests (CRs) were closed, averaging approximately 98 closures per month, demonstrating consistent Change Management throughput and support for ongoing business initiatives. Closure volumes fluctuated throughout the period, reaching a low of 69 closures in September 2025 before rebounding strongly to a peak of 129 closures in February 2026.



- Over the past 13 months, 1,577 Change Requests (CRs) have been submitted, averaging approximately 121 submissions per month, reflecting sustained demand for change management services across the organization. Submission volumes fluctuated throughout the period, reaching a peak of 163 submissions in February 2026 and a low of 86 submissions in December 2025.



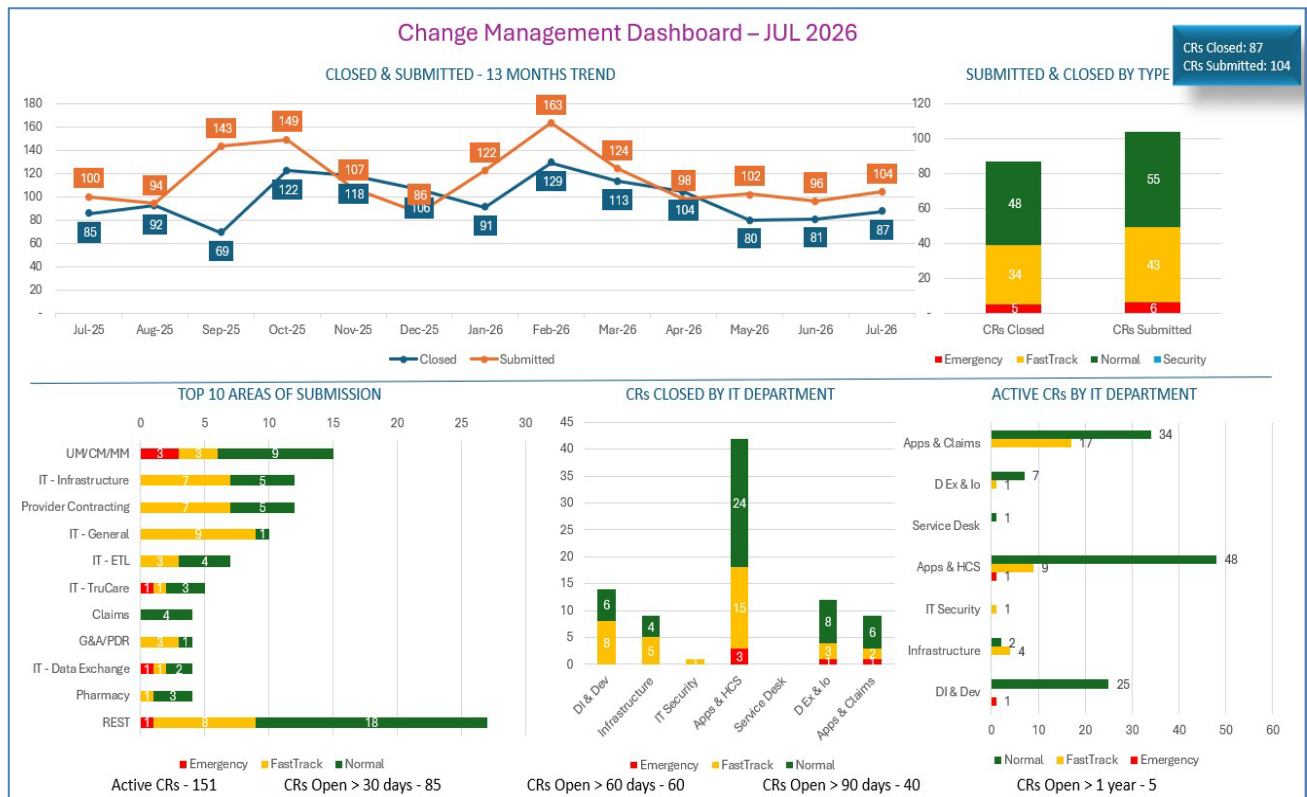
- In July 2026, a total of 104 Change Requests (CRs) were submitted and 87 were closed, reflecting continued demand for change management services. Normal CRs accounted for the largest share of activity, with 55 submitted and 48 closed, followed by FastTrack CRs with 43 submitted and 34 closed. Emergency CRs remained low and well managed, with 6 submissions and 5 closures.



- A total of 87 CRs were closed in July 2026, consisting of 48 Normal (55%), 34 FastTrack (39%), and 5 Emergency (6%) changes. Closure activity was led by Apps & HCS with 42 CRs (48% of total closures), followed by Data Integration (14) and Data Exchange (12), demonstrating strong delivery across key business and technology teams.
- Emergency changes were limited and primarily handled by Apps & HCS (3), with additional support from Data Exchange (1) and Apps & Claims (1). Most departments focused on delivering Normal and FastTrack changes, reflecting a continued emphasis on planned and expedited change execution.

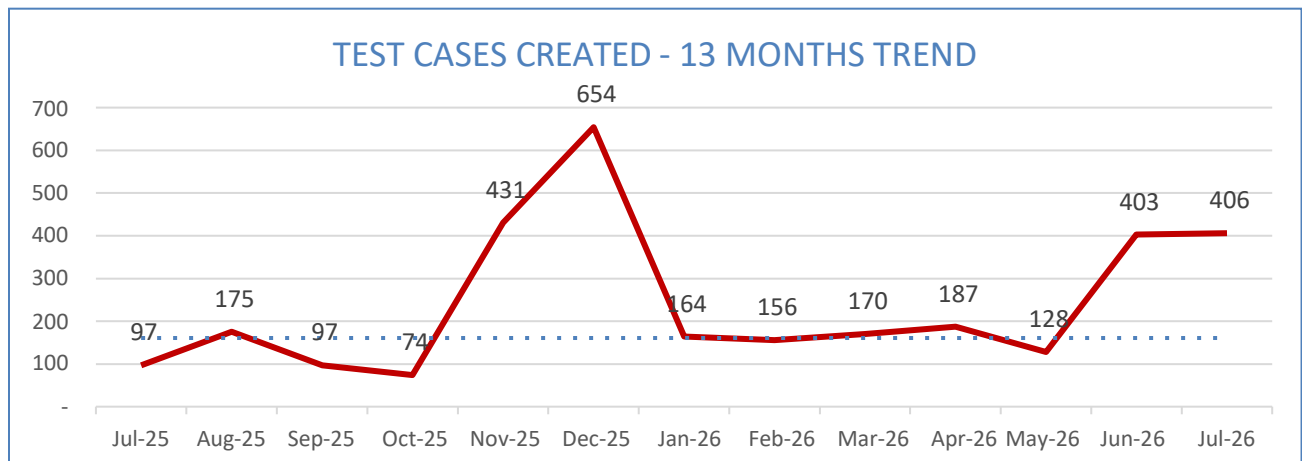
Change Requests Closed in July 2026 (Percentage of Emergency CRs closed by IT Department)					
	CRs Closed			TOTAL	% of Emergency CRs
	<u>Emergency</u>	<u>Fast Track</u>	<u>Normal</u>		<u>%</u>
Data Integration	-	8	6	14	
Infrastructure	-	5	4	9	
IT Security	-	1	-	1	
Apps & HCS	3	15	24	42	7%
Service Desk	-	-	-	-	
Data Exchange	1	3	8	12	8%
Apps & Claims	1	2	6	9	11%
	5	34	48	87	6%

- July 2026 Change Management Dashboard**

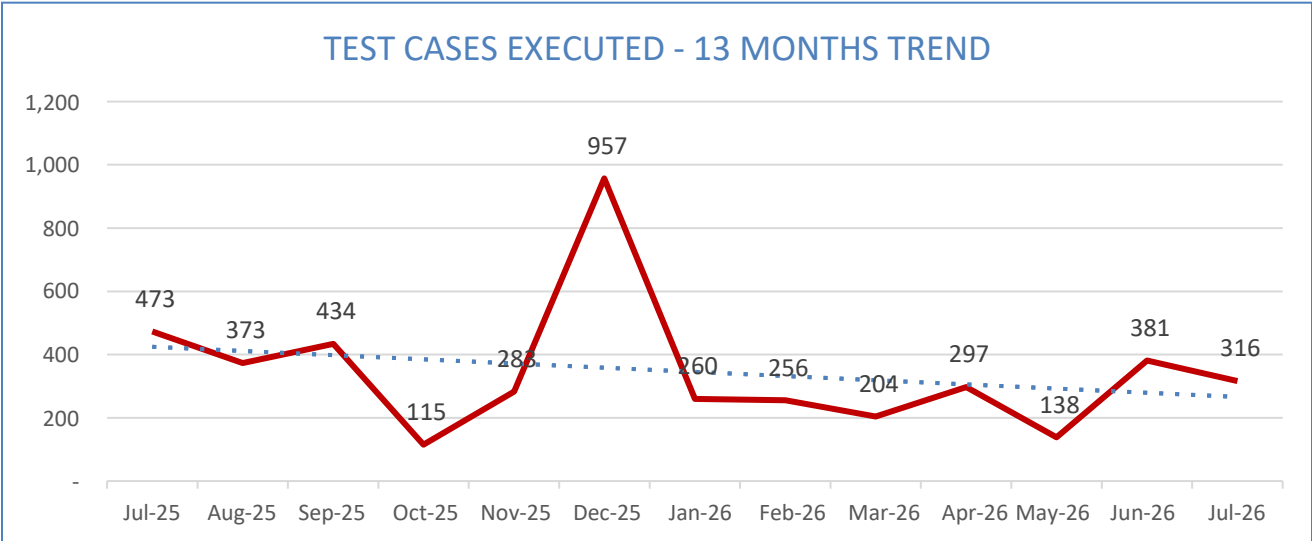


IT Quality Assurance

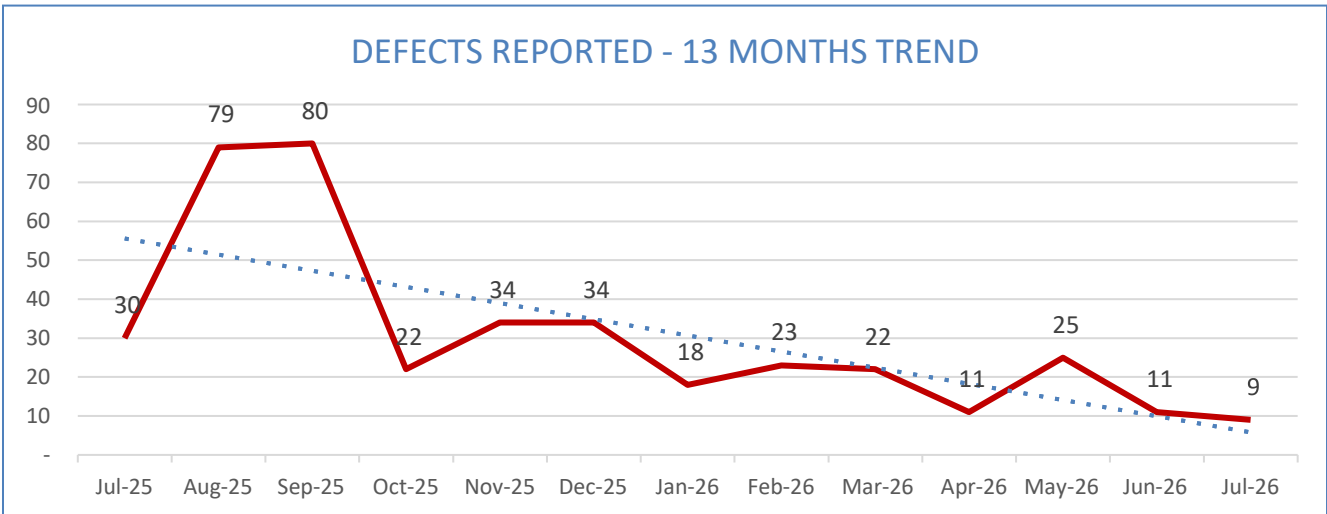
- Test case creation: Over the past 13 months, the QA team created 3,542 test cases, averaging approximately 272 test cases per month, demonstrating a strong commitment to expanding test coverage and supporting project delivery. Test case creation peaked in November 2025 (431) and December 2025 (654), driven by the D-SNP project, which required significant test design and validation efforts.
- Following a period of moderate activity during early 2026, test case creation increased substantially in June (403) and July 2026 (406), reflecting renewed testing efforts in support of ongoing initiatives and release activities.



- **Test case Execution:** Over the past 13 months, the QA team executed 4,487 test cases, averaging approximately 345 test executions per month. Test execution activity peaked in December 2025 (957 executions), driven by extensive testing efforts supporting the D-SNP project. Following lower execution volumes during the first half of 2026, testing activity increased to 381 executions in June 2026 and remained strong with 316 executions in July 2026.



- **Defects Reported:** Over the past 13 months, 398 defects were identified, averaging approximately 31 defects per month. Defect volumes peaked in August 2025 (79) and September 2025 (80), primarily driven by testing activities associated with D-SNP project. Since then, defect counts have generally trended downward, reaching the lowest level in July 2026 with 9 defects.



- **Key Initiatives for the Next Two Quarters:** The following section outlines the team's priority initiatives planned for the next two quarters, highlighting key focus areas that will support operational efficiency, quality improvement, and continued process maturity.

Initiative	Status	Estimated Completion	Notes
Modernize Change Management (Process Improvement)	On Track	12/31/2026	Redesign the Change Management framework to streamline processes, improve stakeholder adoption, and establish a sustainable, self-governing operating model with shared accountability between Delivery and Change Management teams.
AppEnhancer (ApplicationXTender) Upgrade	Completed	7/31/2026	100% of Configuration completed.
TruCare Correspondence in AppXTender	On Track	10/31/2026	Initial development and discovery phase. KP dependency.
TruCare Environment Sync up	On Track	8/31/2026	40% Completed
Letters Enclosure Automation	On Track	8/30/2026	60% Completed
Call Center Test Automation	On Track	12/31/2026	Complete Production smoke test suite and regression test suite for Call Center
Katalon - Procurement and standardize	On Track	9/30/2026	Procure the tool, train the team and implement Katalon for TruCare/EREx application
QA/Testing Dashboard	On Track	9/30/2026	Automated QA / Testing Dashboard to be published
Delphix – Upgrade to version 27.0.0.0	Not Started	12/31/2026	Upgrade Delphix from version 2026.2 to version 27.0.0.0
SFTP Archiving Strategy	On Track	9/30/2026	70% completed
Letters – Correspondence Metatag	On Track	9/30/2026	40% Completed
Enrollment - End to End test automation	On Track	3/31/2027	Activity to start in August 2026. End to End regression test scripts to be delivered as part of this initiative
CM Dashboard automation	Not Started	12/31/2026	This will be initiated in Q2 2026-27
OKTA Single sign on (check all the applications)	Not Started	12/31/2026	This will be initiated in Q2 2026-27
Member Correspondence	On Track	12/31/2026	Initial development and discovery phase.
Liaison ECS/Delta Upgrade	Not Started	12/31/2026	This initiative will be started in Q2 2026-27
ABA and BH Referral Form Automation	On Track	12/31/2026	20% Completed
Metrics and Dashboards	On Track	12/31/2026	Refining and enhancing reporting sections
Inbound 834 Eligibility Process Improvement	On Track	1/31/2027	The 834-enhancement project is advancing through detailed review of member- matching logic, exception scenarios, and business rules to reduce manual review efforts and improve enrollment accuracy.
Call Center Modernization	On Track	4/30/2027	The Call Center vendor selection process is progressing as planned, with the top three vendors identified and moving forward in the final evaluation phase.
Claims End to End test automation	Not Started	6/30/2027	This initiative will be started in Q2 2026-27
Provider Data End to End test automation	Not Started	6/30/2027	End to end test automation is planned to start after the application is stabilized
Automate Upgrade	Not Started	6/30/2027	This initiative will be started in Q3 2026-27

IT Workflow Automation

Past 60 days accomplishments

- **Enclosure Updates:** Used a semi-automation solution to cut the time needed to update enclosures for 1,000+ TruCare letters from 80 hours down to under 10 minutes, replacing a slow, manual process.
- **Letter Setup:** Used the same semi-automation solution to reduce setup time for 300+ letter templates from 30–60 minutes down to under 5 minutes per letter, successfully handling difficult layouts like right-to-left Farsi text.
- **Document Review:** Used an OCR solution to identify authorizations and clinical documents from face sheets, saving 250 hours over the last two months by replacing a fully manual review process.
- **Duplicate Face Sheet Detection:** Used an OCR solution to automatically identify duplicate face sheets, saving approximately 75 hours each month by replacing a fully manual review process.
- **By automating provider portal referral intake and creating authorization shells directly in TruCare,** this solution eliminated manual data entry to secure strict DHCS compliance, improve data accuracy, and enable the system to scale without increasing headcount. Approximately 80 hours of saving per month.
- **ApplicationXTender Upgrade:** Completed the system upgrade for ApplicationXTender to enhance file processing performance, maintain platform support, and secure integration stability
- **Over the last 60 days, Membership & PCP automations processed approximately 11,700 records,** saving an estimated 200 hours of manual work for the Enrollment team.

Next 90 days Plan:

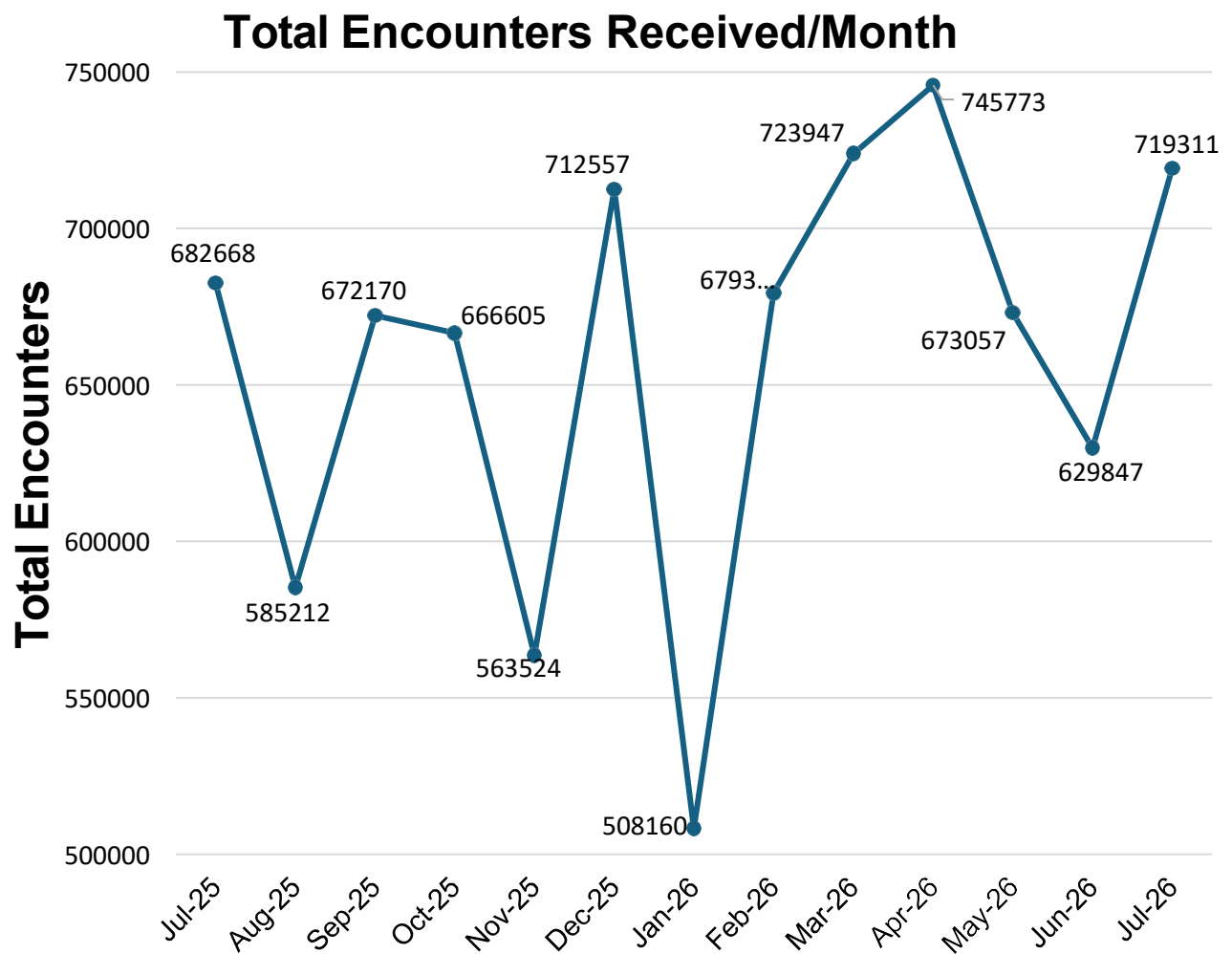
- **Letters Enclosure Automation:** Transition the current semi-automated process into a fully automated solution across all letter categories, eliminating manual intervention and maximizing processing speed.
- **Letters – Correspondence Metatag:** Implement programmatic meta tagging across remaining letter templates to standardize layouts and speed up the configuration process.
- **TruCare Environment Sync:** Standardize environment synchronization. TruCare platforms to better manage the software development life cycle (SDLC) and ensure testing consistency.
- **SFTP Archiving Strategy:** Establish a structured SFTP archiving strategy to optimize data storage, improve file retrieval times, and maintain long-term compliance standards.
- **Call Center Modernization:** Following the receipt of RFP responses on June 1, 2026, the initiative is on track to finalize its vendor selection by September 2026, which will establish the timeline for project kick-off, development, and production deployment.
- **Based on the current automation trend, these automations are projected to process approximately 17,500 records and save nearly 290 hours of manual work over the next 90 days**

Encounter Data from Trading Partners 2026

- **AHS:** July weekly files (9,529 records) were received on time.
- **BACH:** July monthly files (0 records) were received on time.
- **BACS:** July monthly files (255 records) were received on time.
- **CFMG:** July weekly files (17,465 records) were received on time.
- **CHCN:** July weekly files (133,429 records) were received on time.
- **CHME:** July monthly files (8,795 records) were received on time.
- **Docustream:** July monthly files (467 records) were received on time.
- **EBI:** July monthly files (1,619 records) were received on time.
- **FULLCIR:** July monthly files (1,096 records) were received on time.
- **HCSA:** July monthly files (5,876 records) were received on time.
- **IOA:** July monthly files (1,433 records) were received on time.
- **LAFAM:** July monthly files (82 records) were received on time.
- **LIFE:** July monthly files (278 records) were received on time.
- **Logisticare:** July weekly files (63,205 records) were received on time.
- **Magellan:** July monthly files (539,139 records) were received on time.
- **March Vision:** July monthly files (392 records) were received on time.
- **MED:** July monthly files (2,018 records) were received on time.
- **PAIRTEAM:** July monthly files (8,028 records) were received on time.
- **Quest:** July weekly files (17,997 records) were received on time.
- **SENECA:** July monthly files (747 records) were received on time.
- **SERENE:** July monthly files (0 records) were received on time.
- **STAR:** July monthly files (297 records) were received on time.
- **TITANIUM:** July monthly files (5,035 records) were received on time.
- **TVHC:** July monthly files (87 records) were received on time.
- **VSP:** July monthly files (6,172 records) were received on time.

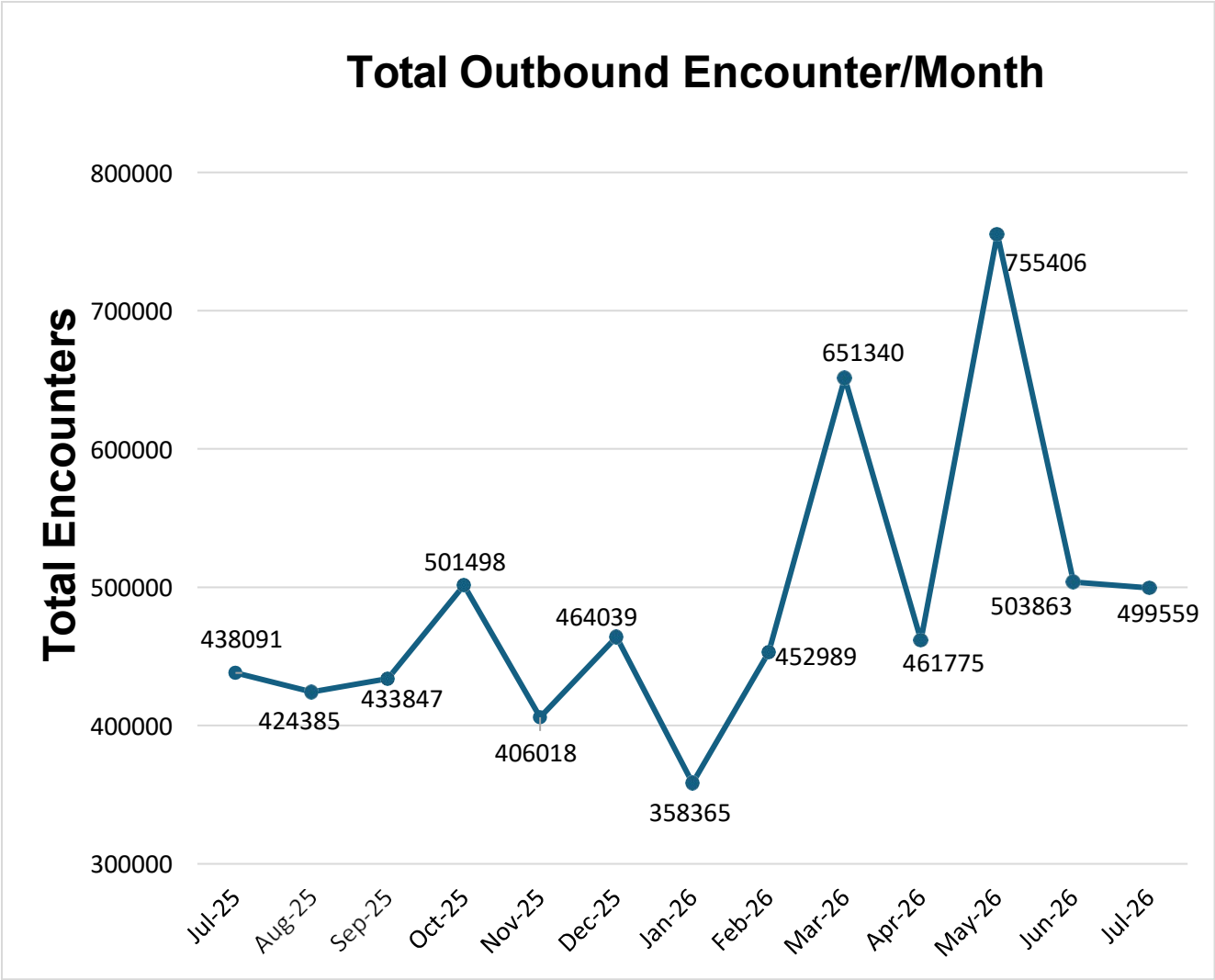
Trading Partner Encounter Inbound Submission History

TradingPartnerName	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
AHS	7880	10257	8455	9267	11333	8671	8345	10599	9835	8399	9261	11371	9529
BACH	172	172	180	181	0	0	0	0	0	0	0	0	0
BACS	81	82	100	102	114	109	196	140	359	409	248	278	255
CFMG	13266	13336	20280	15705	20083	16647	10692	22313	17563	13461	18591	11152	17465
CHCN	125697	132885	170744	152102	138524	153899	104101	193474	177607	178392	147494	187040	133429
CHME	8115	8368	8228	7938	9119	7579	8492	8597	7129	6348	7571	8785	8795
Docustream	1215	704	423	829	322	0	1568	852	1292	420	164	276	467
EBI	2946	1940	1800	1823	1922	1683	1856	1690	1910	1825	1881	1627	1619
FULLCIR	3266	3972	5006	2176	168	1358	462	3150	2698	1077	1641	1718	1096
HCSA	2671	2453	2930	172	2481	2876	2532	3008	3496	4888	5710	6705	5876
Health Suite	429170	326685	348285	415003	296717	413349	291556	381022	396919	452453	381440	338080	435009
IOA	1851	635	1377	1683	0	3095	1697	1672	1660	1485	1570	1717	1433
LAFAM	85	83	74	87	247	84	87	85	72	78	86	77	82
LIFE	388	541	245	290	330	361	250	229	255	281	293	258	278
Logisticare	38834	34040	62760	15649	36206	59563	34215	16237	62637	38508	40646	16373	63205
March Vision	6914	7877	8374	9295	9338	7336	10116	2845	2702	2040	1197	983	392
MED	2722	1246	1172	1468	1299	2894	1443	1434	912	5462	5381	7430	2018
PAIRTEAM	15956	14426	9446	9972	7871	10633	7419	5779	14368	8550	6195	5637	8028
Quest	18000	22500	18001	18001	22500	18004	18001	22499	18000	18002	22501	17998	17997
SENECA	76	0	188	66	0	123	360	206	932	395	407	632	747
SERENE	581	0	0	0	0	0	0	0	0	0	0	0	0
STAR	0	0	0	0	0	0	0	0	0	0	0	127	297
TITANIUM	2782	3010	4102	4796	4950	4244	4746	3536	3558	3300	4824	6119	5035
TVHC	0	0	0	0	0	49	26	0	43	0	0	52	87
VSP	0	0	0	0	0	0	0	0	0	0	15956	5412	6172
TOTAL	682668	585212	672170	666605	563524	712557	508160	679367	723947	745773	673057	629847	719311



Trading Partner Encounter Outbound Submission History

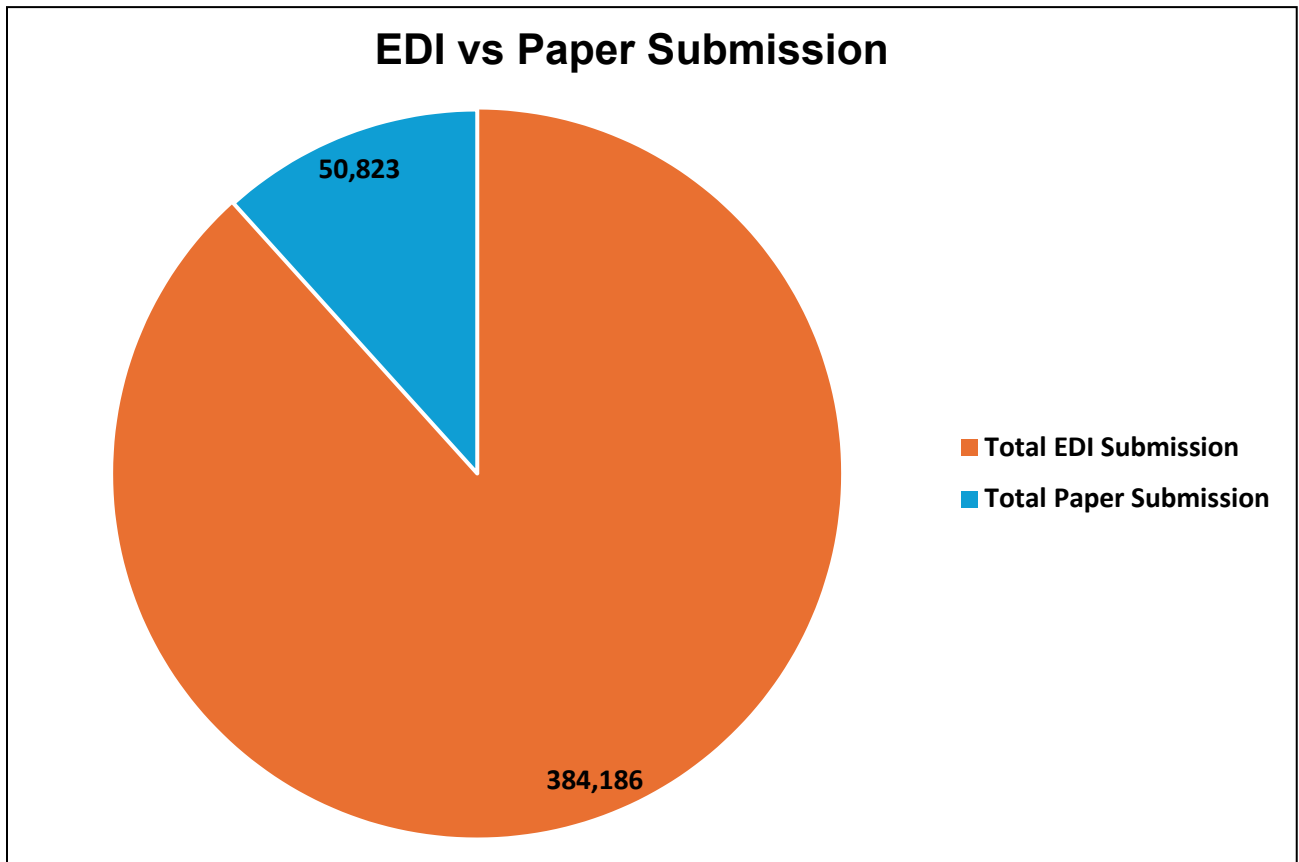
TradingPartnerName	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
AHS	7038	10166	8358	9125	11095	8218	8090	10555	9316	8363	9211	10082	7347
BACH	138	0	147	139	0	0	0	0	0	0	0	0	0
BACS	60	52	82	77	86	79	96	112	178	332	186	247	241
CFMG	9238	9252	10764	11978	11518	13611	7425	13874	17300	10228	12177	9867	9782
CHCN	106648	92163	89837	133350	93935	101887	69962	121092	119747	127177	98429	102319	117420
CHME	7991	8232	8090	7822	8407	7470	7697	8191	6682	6170	7386	8386	8596
Docustream	381	192	131	247	99	0	338	307	496	148	69	92	89
EBI	1885	1745	1634	1718	1834	1600	1770	1610	1869	1777	1827	1553	1552
FULLCIR	2889	3407	2713	1748	89	1081	165	2479	2226	634	1121	923	837
HCSA	2637	2430	2871	149	2462	2840	2505	2979	3451	4832	5661	6637	5819
Health Suite	222783	228707	236163	253075	207026	228028	188845	245896	390092	230072	534368	306039	250117
IOA	1732	551	1176	1304	0	2911	1617	1474	1108	1338	1178	1360	1134
LAFAM	80	76	69	84	93	83	87	82	64	73	75	64	59
LIFE	122	142	152	111	222	175	140	119	144	157	188	144	142
Logisticare	38763	33974	36968	41267	36150	59480	34166	16213	62539	38458	40564	16326	63128
March Vision	3888	4183	4724	5103	4847	3696	6051	1272	518	312	119	292	73
MED	2471	1124	974	1103	1160	1547	1360	1344	65	5010	1482	4756	1804
PAIRTEAM	9364	8386	8229	7901	5824	6500	6777	5157	11205	6835	4360	3413	3802
Quest	16774	16903	16855	20951	16810	20937	16905	16777	20859	16724	16798	20753	16565
SENECA	63	0	164	19	0	109	319	190	174	168	92	106	564
SERENE	569	0	0	0	0	0	0	0	0	0	0	0	0
STAR	0	0	0	0	0	0	0	0	0	0	0	94	44
TITANIUM	2577	2700	3746	4227	4361	3772	4039	3266	3293	2967	4242	5014	4497
TVHC	0	0	0	0	0	15	11	0	14	0	0	36	45
VSP	0	0	0	0	0	0	0	0	0	0	15873	5360	5902
TOTAL	438091	424385	433847	501498	406018	464039	358365	452989	651340	461775	755406	503863	499559



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
26-JUL	384,186	50,823	435,009

Key: EDI – Electronic Data Interchange



Onboarding EDI Providers – Updates

July 2026 EDI Claims:

A total of 3665 new EDI submitters has been added since October 2015, with 46 added in July 2026.

The total number of EDI submitters is 4405 providers.

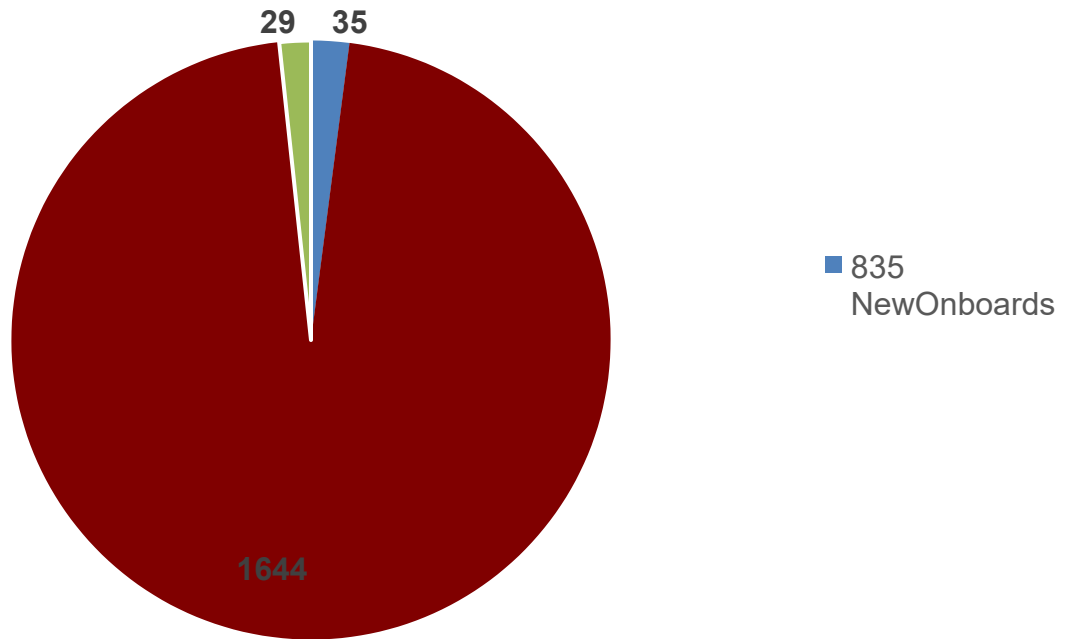
July 2026 EDI Remittances (ERA):

A total of 1726 new ERA receivers have been added since October 2015, with 29 added in July 2026.

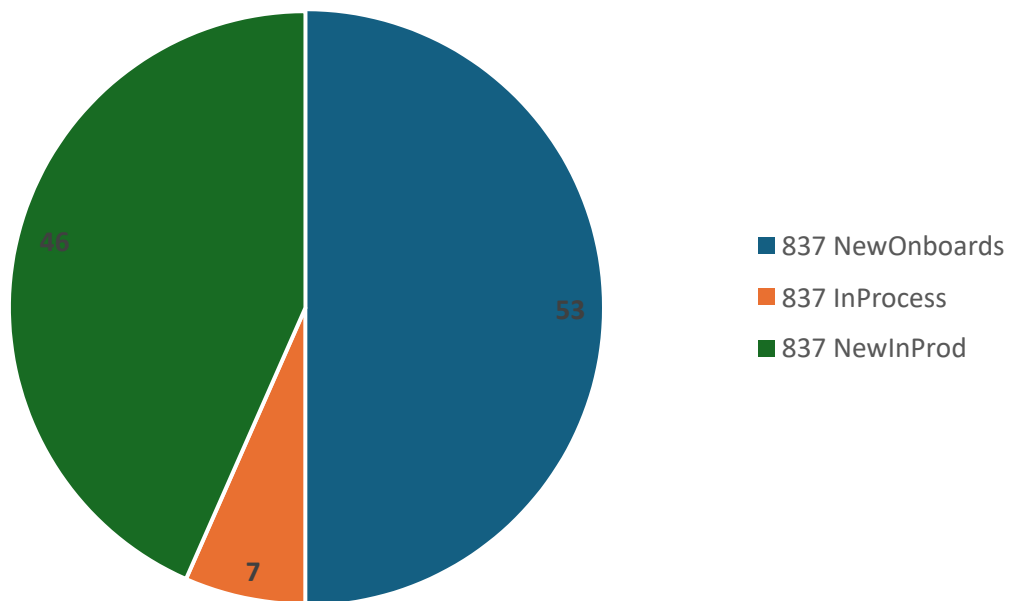
The total number of ERA receivers is 1742 providers.

YearMonth	837 NewOnboards	837 InProcess	837 NewInProd	837 TotalInProd	835 NewOnboards	835 InProcess	835 NewInProd	835 TotalInProd
May-25	47	3	44	3765	77	1402	45	1410
Jun-25	52	25	27	3792	62	1445	19	1429
Jul-25	52	0	52	3844	60	1487	18	1447
Aug-25	35	19	16	3860	37	1502	22	1469
Sep-25	92	6	86	3946	65	1516	51	1520
Oct-25	76	11	65	4011	42	1528	30	1550
Nov-25	41	7	34	4045	26	1536	18	1568
Dec-25	50	0	50	4045	32	1549	19	1587
Jan-26	48	0	48	4143	32	1555	26	1613
Feb-26	35	8	27	4170	18	1563	10	1623
Mar-26	53	0	53	4223	18	1581	5	1628
Apr-26	67	1	66	4289	50	1602	29	1657
May-26	41	0	41	4330	50	1622	30	1687
Jun-26	36	7	29	4359	42	1638	26	1713
Jul-26	53	7	46	4405	35	1644	29	1742

835 EDI Receivers



837 EDI Submitters



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 July 2026.

FILE TYPE	TOTAL COUNT	YEAR MONTH
837 I Files	28	Jul-26
837 P Files	119	Jul-26
Total Files	147	

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	LagPercent	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	93%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	99%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	94%	65%
Timeliness-% Within Lag Time - Professional 0-180 days	99%	80%

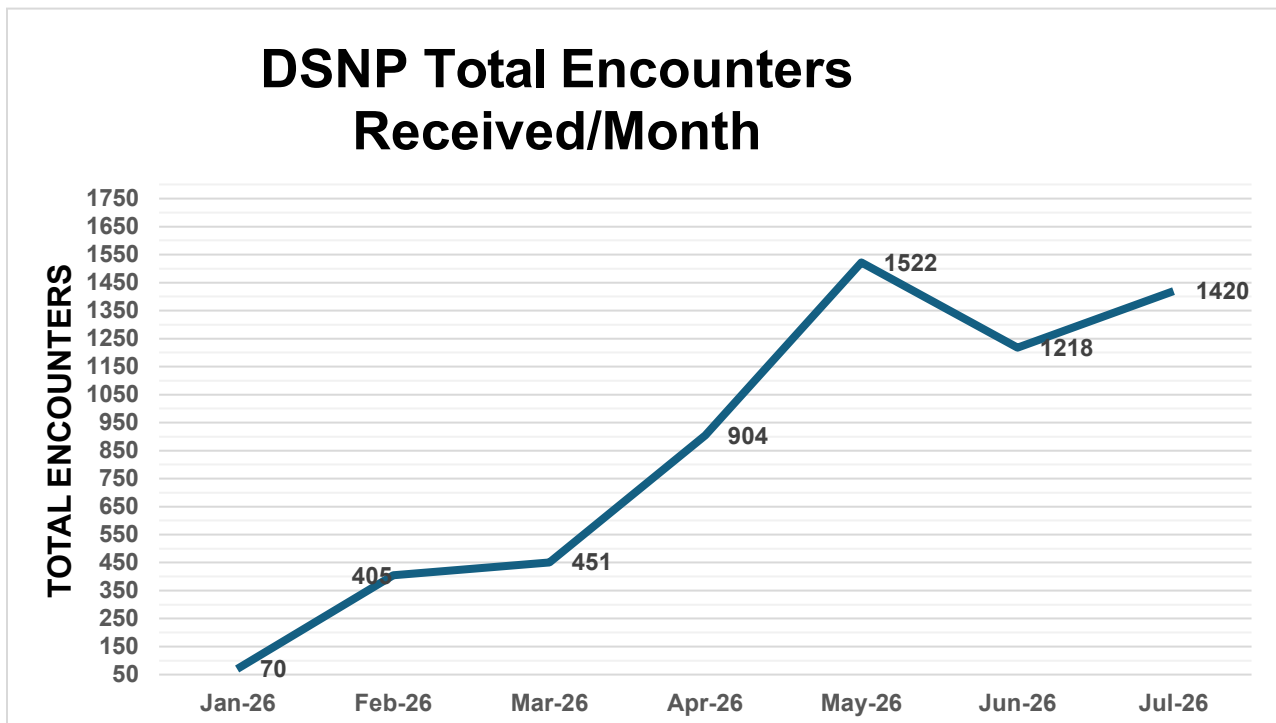
*Note, the Number of Encounters comes from: Total at bottom of this chart.

DSNP Encounter Data from Trading Partners

- **CHME:** July monthly files (44 records) were received on time.
- **Nations Flex Card:** July monthly files (180 records) were received on time.
- **Nations Hearing:** July monthly files (2 records) were received on time.
- **Vision Service Plan:** July monthly files (8 records) were received on time.

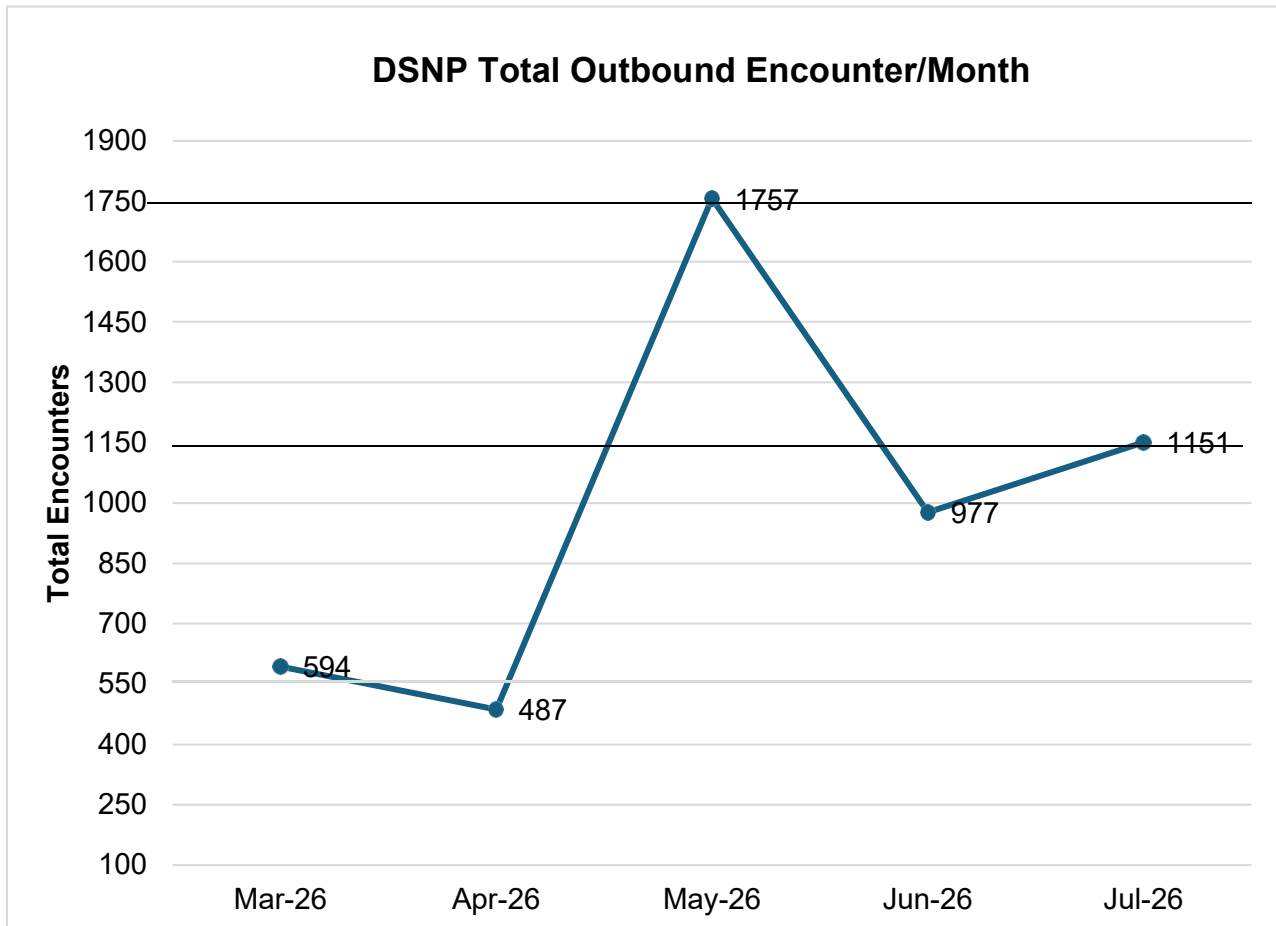
DSNP Trading Partner Encounter Inbound Submission History

TradingPartnerName	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
CHME		10	11	29	31	46	44
HealthSuite	70	395	440	875	918	959	1186
Nations Benefits					545	209	182
Vision Service Plan					28	4	8
TOTAL	70	405	451	904	1522	1218	1420



DSNP Trading Partner Encounter Outbound Submission History

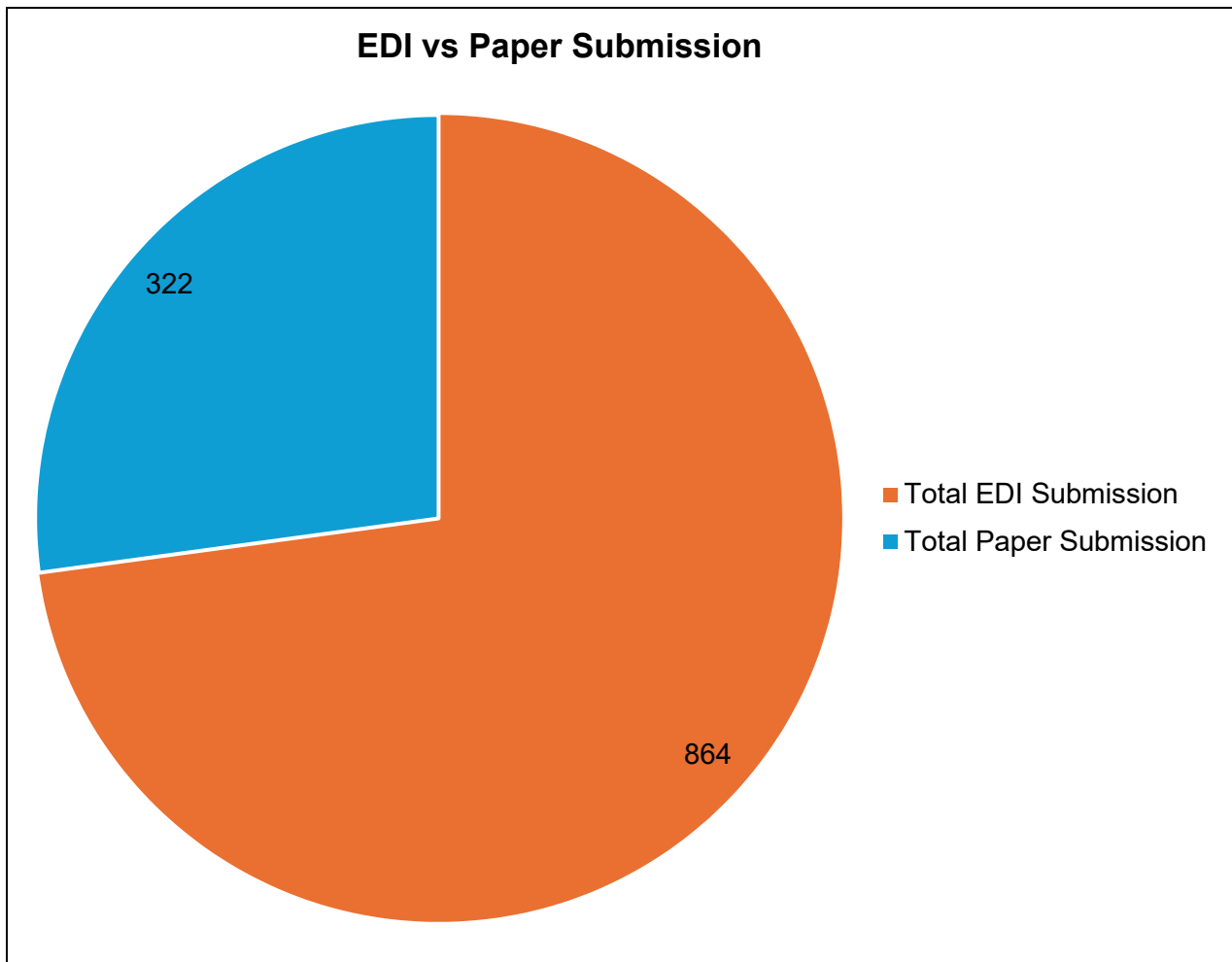
TradingPartnerName	Mar-26	Apr-26	May-26	Jun-26	Jul-26
CHME	20	29	29	40	41
HealthSuite	574	458	1155	725	920
Nations Flex Card			542	208	180
Nations Hearing			3		2
Vision Service Plan			28	4	8
TOTAL	594	487	1757	977	1151



DSNP HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
26-JUL	864	322	1,186

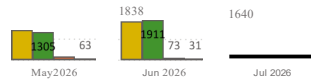
Key: EDI – Electronic Data Interchange



SERVICE DESK DASHBOARD

Jul y 2026

Track-It Tickets



Q Tickets Received . Tickets Closed . Tickets Open . Tickets Overdue

Laptops Issued

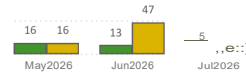


ewarranty Not Expired Q Warranty Expired

Top Updates During Month

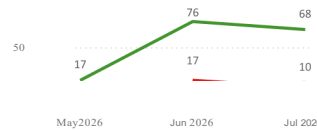
Category	Item	Version
Driver	Intel - Extension - 9.0.11911.64898	
Driver	Intel Bluetooth Driver Update	
Driver	Intel ComputeAccelerator Driver Update	32.0.100.4778
Driver	Intel Display Driver Update	32.0.101.8826
Driver	Intel Extension Driver Update	32.0.100.4778
Driver	Intel Extension Driver Update	32.0.101.8826
Driver	Intel SoftwareComponent Driver Update	1.0.0.2.48
Driver	LenovoFirmwareDriver Update	1.43.0.0
Driver	LenovoSystem Driver Update	10.17.2606.3

Onboard and Offboard



onboard Q Offboard

Laptops Deployed, In Stock, Decommissioned

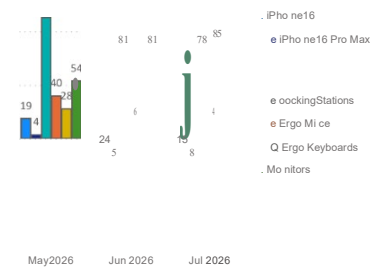


Deployed In Stock Decommissioned

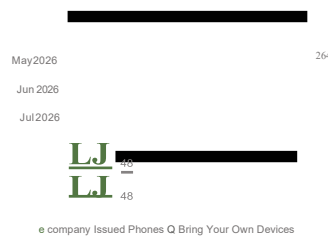
Top Track-It Ticket Trends During Month

Category	Tickets Received
IT Service Desk - Troubleshoot -> Access->Website	34
IT Service Desk - Request ->Access->Termination	37
ITServiceDesk-Request->Hardware->Laptop	37
IT Service Desk - Request ->Access->Title and Access Change	39
IT Service Desk - Request ->Access->Weekly Status Updates	47
IT Service Desk - Request	51
IT Service Desk - Troubleshoot->Software->Fin esse	52
IT Service Desk - Troubleshoot->Hardware->Laptop	59
IT Service Desk - Troubleshoot->Conference Rooms	77
ITServiceDesk - Request->Software->Email	83
ITServiceDesk - Request->Access->Information	178

Equipment in Stock



Mobile Devices



company Issued Phones Q Bring Your Own Devices

Executive Security Summary

Overall Posture: MODERATE RISK (AMBER)
Risk Trend:  (decreasing)

Top Risks

- Network Segmentation (flat network)
- Critical database excessive permissions security gap
- Shadow IT (Azure, Network) - vis

Key Progress

- Network Micro-Segmentation – enforcing policy on Active Directory and backup services (last piece)
- AI governance strategy (DLP) being fine-tuned
- Cert. Mgmt. notification workflow established

Risk Trends (90 Days – Activity Based ▲ in Exposure)

- Azure Cloud Defender alerts
- AI governance
- Vulnerability visibility on endpoints and DB

Next 30-Day Priorities

- Network Micro-Segmentation project completion
- Cert. Mgmt. SOP and validation
- Wrap up 2025 SRA findings
- Wrap up 2025 Pen test findings

Support to/from Leadership

- 360* dashboard
- Asserting IT Security review and approval into workflows (Security Architecture Review Board – SARB and part of Server Core's request intake)
- Alignment on security ownership – link [1](#)

Risk Register

Risk	Likelihood	Impact	Residual (after controls)	Risk Trend	Owner	Status
Penetration test findings (2025)	Low	High	Low		Various	WIP
Security Risk Assessment (2025)	Medium	Medium	Low		Various	WIP
Cert. Mgmt. - process/renewal/enrollment/revamp	Medium	High	Medium		Various	Completed
Network / Firewall - audit/access (part of SRA)	Medium	High	Low		Aman	WIP - will coordinate with Gobi
AI	Medium	High	Low		ITSec	Fine-tuning security controls
Access & Permissions (RBAC) – new employees / lateral post changes, etc.	High	Medium	Low		ITSec	Validating w/ SD
 Endpoint – vuln data	Medium	High	Low		Service Desk	Assign to SD as project
Endpoint – malware events	Medium	Medium	Low		Service Desk	Assign to SD as a daily task
Network Micro-Segmentation	Medium	High	Low		ITSec	WIP
Azure/M365 (general)	Medium	High	Medium		Various	Strategizing



Analytics

Tiffany Cheang

To: Alameda Alliance for Health Board of Governors

From: Tiffany Cheang, Chief Analytics Officer

Date: August 14th, 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: May 2025 – Apr 2026 dates of service

Prior reporting period: May 2024 – Apr 2025 dates of service

(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 13.1% of members account for 89.8% of total costs.
- In comparison, the Prior reporting period was lower at 11.7% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
- The SPD/LTC (non duals) and ACA OE categories of aid slightly increased to account for 53.6% of the members, with SPD/LTCs accounting for 17.7% and ACA OE's at 35.8%.
- The percent of members with costs $\geq$ \$30K slightly increased from 3.1% to 3.3%.
- Of those members with costs $\geq$ \$100K, the percentage of total members has slightly increased to 1.1%.
 - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 29.0%.
- 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 13.1% is more concentrated in the 45-66 year old category (33.2%) compared to the overall population (20.6%).

Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis

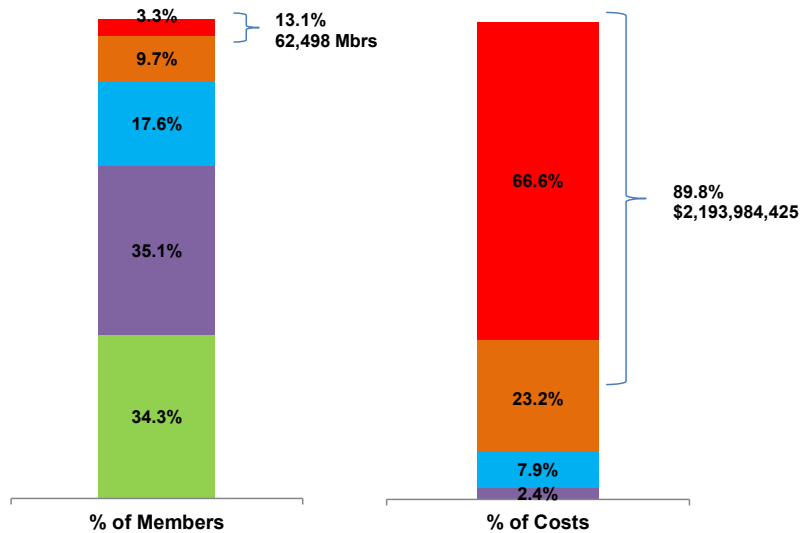
Lines of Business: MCAL, IHSS; Excludes Kaiser Members

Dates of Service: May 2025 - Apr 2026

Note: Data incomplete due to claims lag

Run Date: 07/28/2026

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
\$30K+	15,980	3.3%	\$ 1,626,881,803	66.6%
\$5K - \$30K	46,518	9.7%	\$ 567,102,622	23.2%
\$1K - \$5K	84,179	17.6%	\$ 192,410,262	7.9%
< \$1K	167,947	35.1%	\$ 57,480,094	2.4%
\$0	164,204	34.3%	\$ -	0.0%
Totals	478,828	100.0%	\$ 2,443,874,781	100.0%

Top 13.1% of Members = 89.8% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
\$100K+	5,068	1.1%	\$ 1,045,801,862	42.8%
\$75K to \$100K	1,877	0.4%	\$ 163,172,246	6.7%
\$50K to \$75K	3,082	0.6%	\$ 188,193,668	7.7%
\$40K to \$50K	2,348	0.5%	\$ 104,953,835	4.3%
\$30K to \$40K	3,605	0.8%	\$ 124,760,191	5.1%
SubTotal	15,980	3.3%	\$ 1,626,881,803	66.6%
\$20K to \$30K	6,507	1.4%	\$ 158,437,689	6.5%
\$10K to \$20K	17,815	3.7%	\$ 250,547,756	10.3%
\$5K to \$10K	22,196	4.6%	\$ 158,117,178	6.5%
SubTotal	46,518	9.7%	\$ 567,102,622	23.2%
Total	62,498	13.1%	\$ 2,193,984,425	89.8%

Enrollment Status	Members	Total Costs
Still Enrolled as of Apr 2026	381,388	\$ 2,206,949,198
Dis-Enrolled During Year	97,440	\$ 236,925,582
Totals	478,828	\$ 2,443,874,781

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

13.1% of Members = 89.8% of Costs

Lines of Business: MCAL, IHSS; Excludes Kaiser Members

Dates of Service: May 2025 - Apr 2026

Note: Data incomplete due to claims lag

Run Date: 07/28/2026

13.1% of Members = 89.8% of Costs

17.7% of members are SPD/LTCs and account for 24.4% of costs.

35.8% of members are ACA OE and account for 33.9% of costs.

9.0% of members disenrolled as of Apr 2026 and account for 9.7% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Members	% of Members
IHSS	IHSS	245	1,011	1,256	2.0%
MCAL	MCAL - ADULT	1,429	8,213	9,642	15.4%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	875	4,190	5,065	8.1%
	MCAL - ACA OE	5,220	17,174	22,394	35.8%
	MCAL - DUALS	-	-	-	0.0%
	MCAL - SPD-LTC	3,917	7,159	11,076	17.7%
	MCAL - SPD-LTC/Full Dual	2,563	4,833	7,396	11.8%
D-SNP	DSNP	13	54	67	0.1%
Not Eligible	Not Eligible	1,718	3,884	5,602	9.0%
Total		15,980	46,518	62,498	100.0%

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Costs	% of Costs
IHSS	IHSS	\$ 23,509,428	\$ 12,100,301	\$ 35,609,729	1.6%
MCAL	MCAL - ADULT	\$ 130,985,368	\$ 100,766,812	\$ 231,752,180	10.6%
	MCAL - BCCTP	\$ -	\$ -	\$ -	0.0%
	MCAL - CHILD	\$ 63,307,234	\$ 46,649,148	\$ 109,956,381	5.0%
	MCAL - ACA OE	\$ 532,655,173	\$ 210,765,445	\$ 743,420,619	33.9%
	MCAL - DUALS	\$ -	\$ -	\$ -	0.0%
	MCAL - SPD-LTC	\$ 441,983,084	\$ 92,803,600	\$ 534,786,683	24.4%
	MCAL - SPD-LTC/Full Dual	\$ 266,213,244	\$ 56,875,220	\$ 323,088,464	14.7%
D-SNP	DSNP	\$ 1,208,691	\$ 618,817	\$ 1,827,508	0.1%
Not Eligible	Not Eligible	\$ 167,019,581	\$ 46,523,280	\$ 213,542,860	9.7%
Total		\$ 1,626,881,803	\$ 567,102,622	\$ 2,193,984,425	100.0%

% of Total Costs By Service Type

% of Total Costs By Service Type				Breakout by Service Type/Location						
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
\$100K+	4%	0%	1%	16%	34%	2%	10%	3%	1%	34%
\$75K to \$100K	4%	0%	1%	21%	23%	3%	6%	5%	4%	37%
\$50K to \$75K	5%	0%	2%	27%	25%	5%	7%	8%	3%	25%
\$40K to \$50K	6%	0%	2%	34%	22%	8%	6%	9%	1%	21%
\$30K to \$40K	9%	0%	3%	33%	21%	12%	6%	8%	1%	19%
\$20K to \$30K	2%	1%	6%	35%	21%	6%	9%	9%	1%	19%
\$10K to \$20K	0%	0%	10%	36%	21%	7%	9%	11%	1%	16%
\$5K to \$10K	1%	0%	4%	32%	10%	11%	13%	15%	1%	19%
Total	4%	0%	3%	24%	27%	4%	9%	6%	2%	28%

Notes:

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

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

26.1% of members are SPD/LTCs and account for 29.1% of costs.

28.2% of members are ACA OE and account for 32.1% of costs.

9.1% of members disenrolled as of Apr 2026 and account for 9.3% of costs.

Member Breakout by LOB

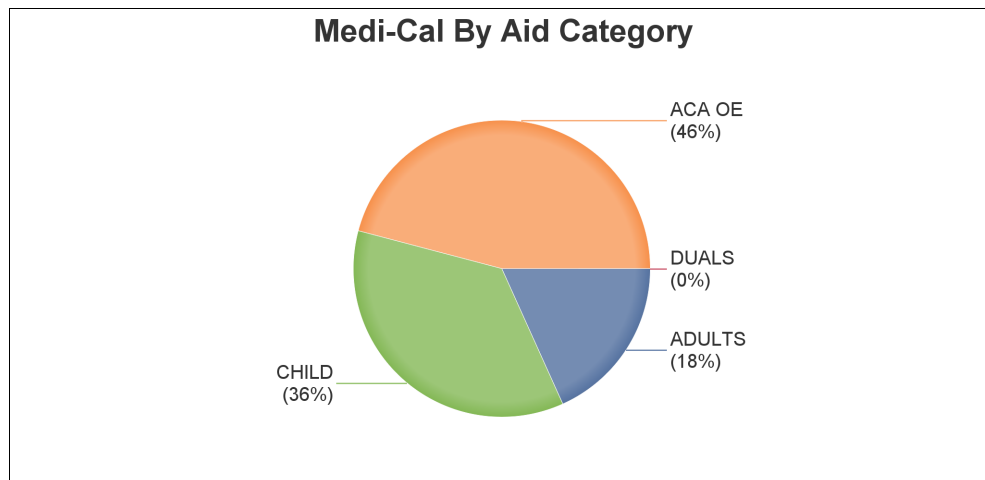
LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	58	1.1%
MCAL	MCAL - ADULT	315	6.2%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	92	1.8%
	MCAL - ACA OE	1,427	28.2%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,321	26.1%
	MCAL - SPD-LTC/Full Dual	1,390	27.4%
D-SNP	DSNP	3	0.1%
Not Eligible	Not Eligible	462	9.1%
Total		5,068	100.0%

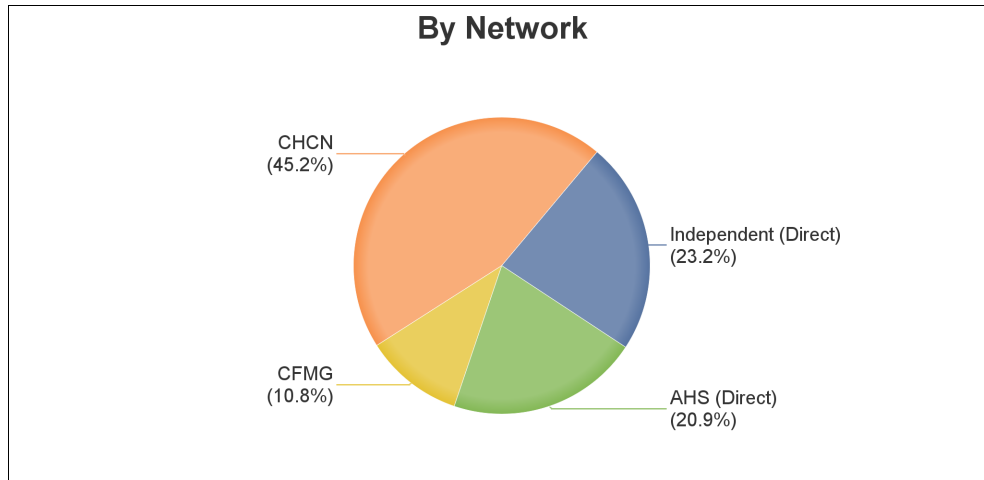
Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	\$ 13,973,458	1.3%
MCAL	MCAL - ADULT	\$ 74,305,109	7.1%
	MCAL - BCCTP	\$ -	0.0%
	MCAL - CHILD	\$ 26,048,729	2.5%
	MCAL - ACA OE	\$ 336,146,346	32.1%
	MCAL - DUALS	\$ -	0.0%
	MCAL - SPD-LTC	\$ 303,866,812	29.1%
	MCAL - SPD-LTC/Full Dual	\$ 193,911,179	18.5%
D-SNP	DSNP	\$ 704,563	0.1%
Not Eligible	Not Eligible	\$ 96,845,667	9.3%
Total		\$ 1,045,801,862	100.0%

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

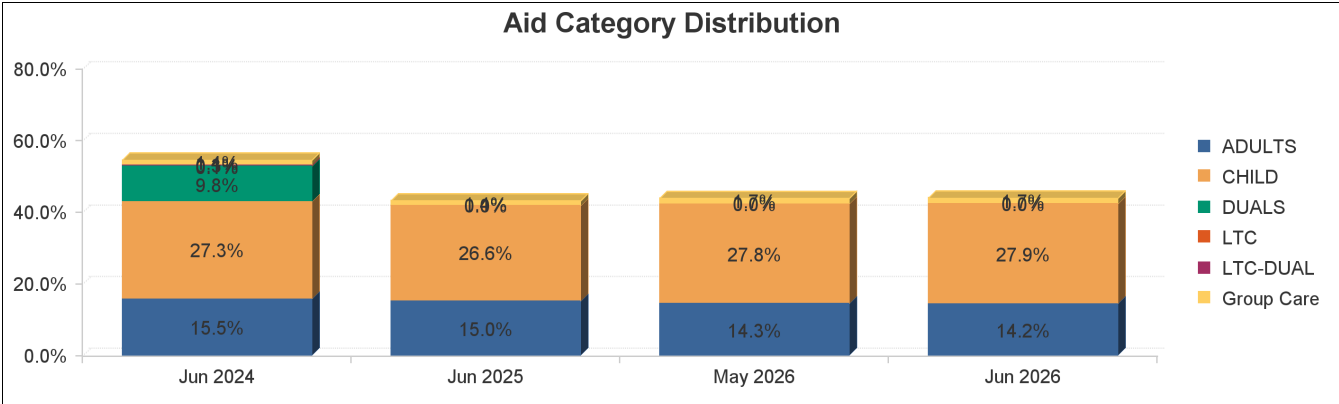
Category of Aid Trend						
Category of Aid	Jun 2026	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	52,663	14%	10,704	12,532	1	29,426
CHILD	103,377	28%	9,362	13,585	36,920	43,510
SPD	0	0%	0	0	0	0
ACA OE	132,326	36%	24,606	41,844	1,402	64,474
DUALS	9	0%	9	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	27,360	8%	7,841	4,934	1,532	13,053
SPD-LTC/Full Dual	47,882	13%	30,847	3,397	1	13,637
Other	0		0	0	0	0
Medi-Cal	363,617		83,369	76,292	39,856	164,100
Group Care	6,350		2,262	1,169	0	2,919
D-SNP	253		80	26	0	147
Total	370,220	100%	85,711	77,487	39,856	167,166
Other %	0.0%		0.0%	0.0%	0.0%	0.0%
Medi-Cal %	98.2%		97.3%	98.5%	100.0%	98.2%
Group Care %	1.7%		2.6%	1.5%	0.0%	1.7%
D-SNP %	0.1%		0.1%	0.0%	0.0%	0.1%
Network Distribution			23.2%	20.9%	10.8%	45.2%
			% Direct:	44%	% Delegated:	56%



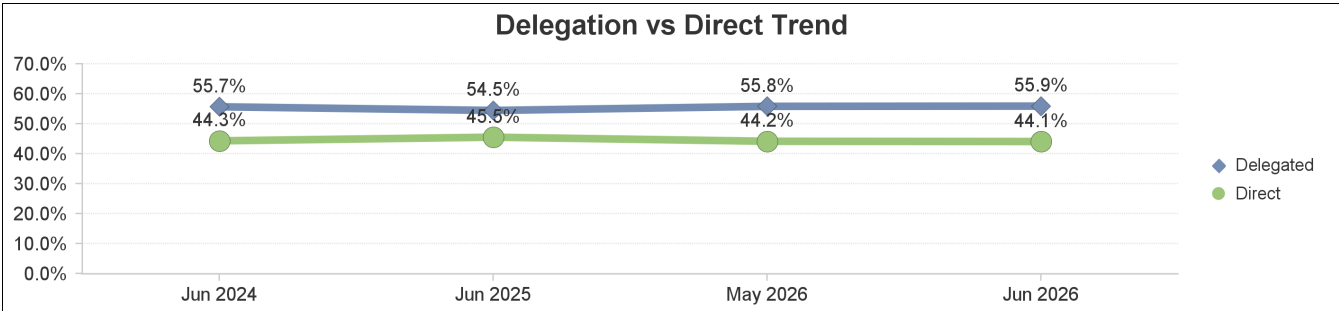


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend											
Category of Aid	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026
ADULTS	62,786	61,699	53,740	52,663	15.5%	15.0%	14.3%	14.2%	-1.8%	-17.2%	-2.0%
CHILD	110,164	109,640	104,137	103,377	27.3%	26.6%	27.8%	27.9%	-0.5%	-6.1%	-0.7%
SPD	34,935	0	0	0	8.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ACA OE	149,359	155,176	134,907	132,326	37.0%	37.7%	36.0%	35.7%	3.7%	-17.3%	-2.0%
DUALS	39,789	1	5	9	9.8%	0.0%	0.0%	0.0%	#####	88.9%	44.4%
LTC	224	0	0	0	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LTC-DUAL	1,250	0	0	0	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SPD-LTC	0	29,750	27,794	27,360	0.0%	7.2%	7.4%	7.4%	100.0%	-8.7%	-1.6%
SPD-LTC/ Full Dual	0	49,304	47,866	47,882	0.0%	12.0%	12.8%	12.9%	100.0%	-3.0%	0.0%
Other	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medi-Cal	398,507	405,570	368,449	363,617	98.6%	98.6%	98.3%	98.2%	1.7%	-11.5%	-1.3%
Group Care	5,658	5,910	6,311	6,350	1.4%	1.4%	1.7%	1.7%	4.3%	6.9%	0.6%
D-SNP	0	0	245	253	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%
Total	404,165	411,480	375,005	370,220	100.0%	100.0%	100.0%	100.0%	1.8%	-11.2%	-1.3%

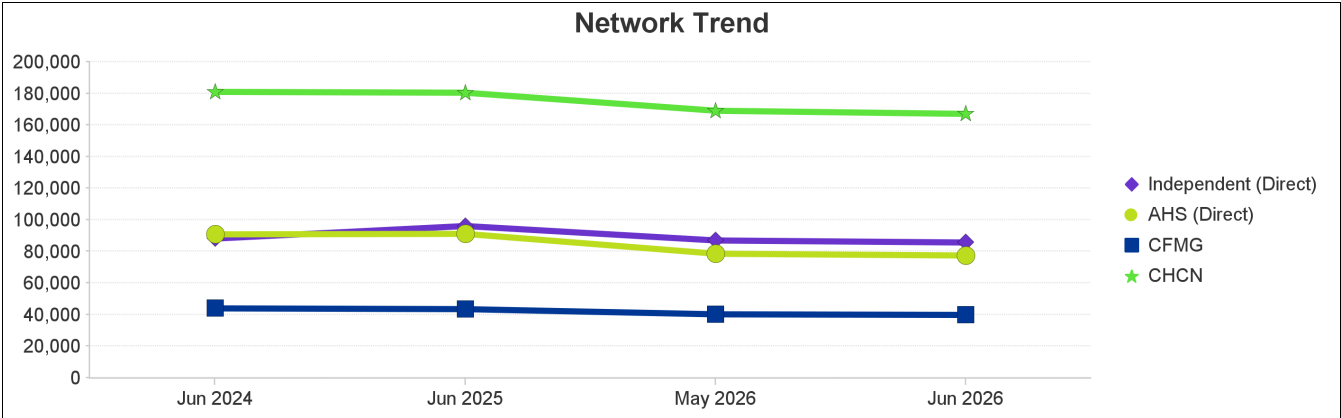


Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026
Delegated	225,091	224,102	209,395	207,022	55.7%	54.5%	55.8%	55.9%	-0.4%	-8.3%	-1.1%
Direct	179,074	187,378	165,610	163,198	44.3%	45.5%	44.2%	44.1%	4.4%	-14.9%	-1.5%
Total	404,165	411,480	375,005	370,220	100.0%	100.0%	100.0%	100.0%	1.8%	-11.2%	-1.3%



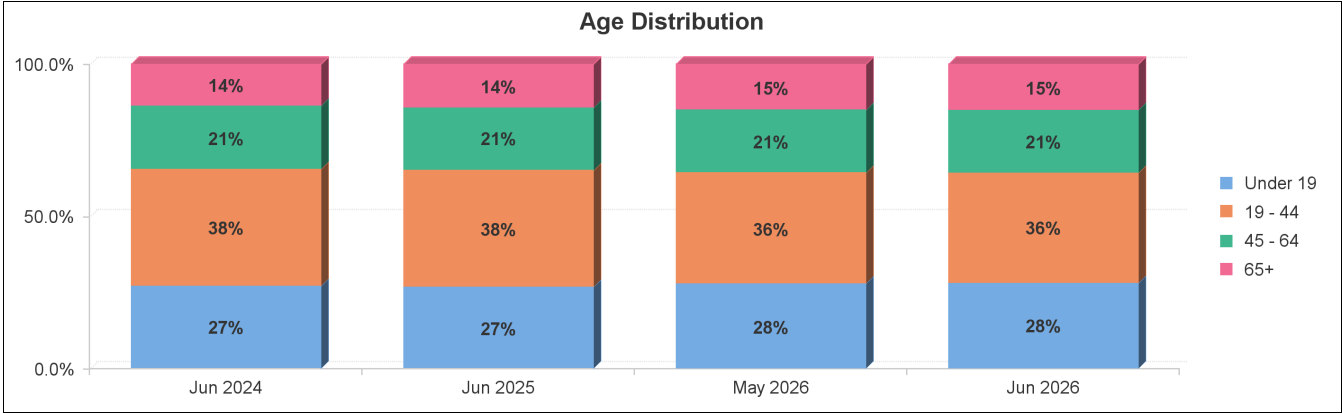
Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Network Trend											
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026
Independent (Direct)	88,206	96,173	87,006	85,711	21.8%	23.4%	23.2%	23.2%	8.3%	-12.3%	-1.5%
AHS (Direct)	90,868	91,205	78,604	77,487	22.5%	22.2%	21.0%	20.9%	0.4%	-17.7%	-1.4%
CFMG	43,991	43,522	40,238	39,856	10.9%	10.6%	10.7%	10.8%	-1.1%	-9.2%	-1.0%
CHCN	181,100	180,580	169,157	167,166	44.8%	43.9%	45.1%	45.2%	-0.3%	-8.1%	-1.2%
KAISER	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	404,165	411,480	375,005	370,220	100.0%	100.0%	100.0%	100.0%	1.8%	-11.2%	-1.3%

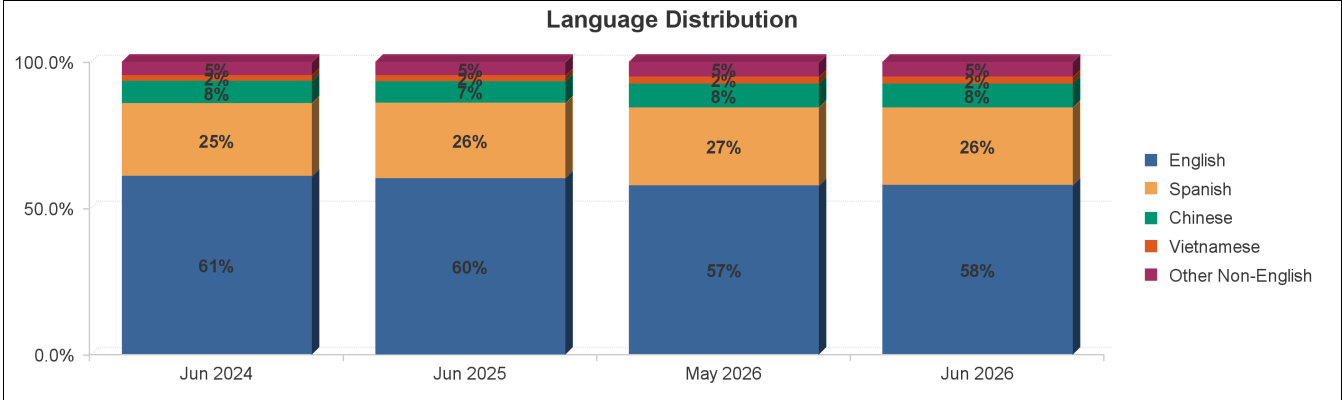


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Age Category Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026
Under 19	108,701	109,396	103,989	103,159	27%	27%	28%	28%	1%	-6%	-1%
19 - 44	155,198	157,686	136,512	133,894	38%	38%	36%	36%	2%	-18%	-2%
45 - 64	83,870	84,758	77,090	76,166	21%	21%	21%	21%	1%	-11%	-1%
65+	56,396	59,640	57,169	56,748	14%	14%	15%	15%	5%	-5%	-1%
Total	404,165	411,480	374,760	369,967	100%	100%	100%	100%	2%	-11%	-1%

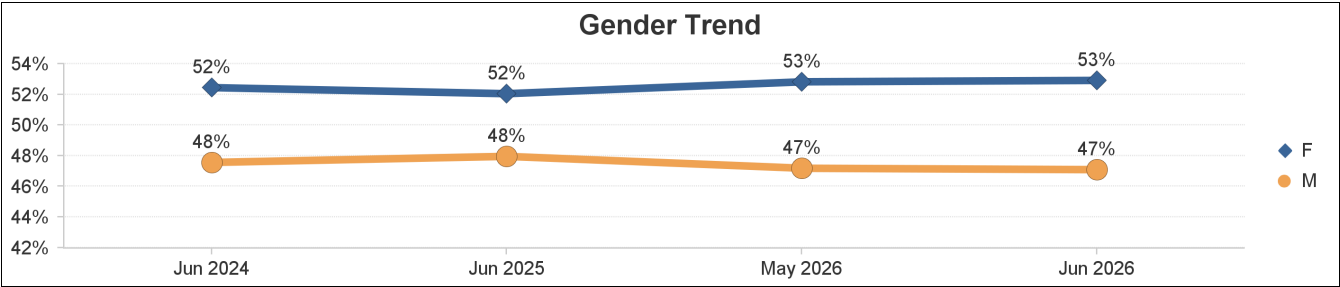


Language Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026
English	245,593	247,110	215,572	213,402	61%	60%	57%	58%	1%	-16%	-1%
Spanish	100,576	105,889	100,122	98,042	25%	26%	27%	26%	5%	-8%	-2%
Chinese	30,660	30,503	30,532	30,269	8%	7%	8%	8%	-1%	-1%	-1%
Vietnamese	8,386	8,135	8,689	8,647	2%	2%	2%	2%	-3%	6%	0%
Other Non-English	18,950	19,843	19,845	19,607	5%	5%	5%	5%	5%	-1%	-1%
Total	404,165	411,480	374,760	369,967	100%	100%	100%	100%	2%	-11%	-1%

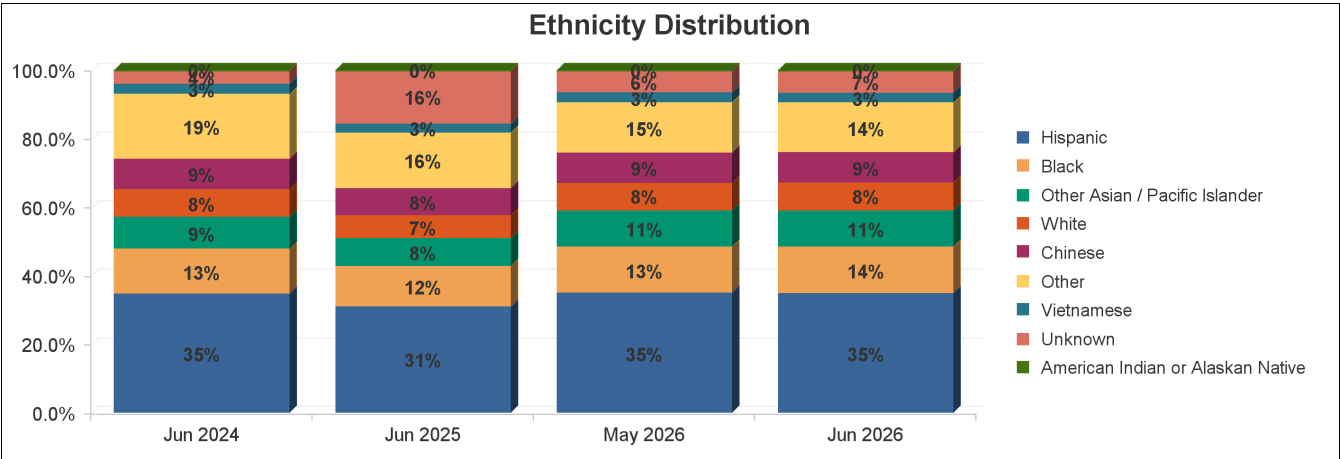


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Gender Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026
F	211,959	214,154	198,088	195,898	52%	52%	53%	53%	1%	-9%	-1%
M	192,206	197,326	176,917	174,322	48%	48%	47%	47%	3%	-13%	-1%
Total	404,165	411,480	375,005	370,220	100%	100%	100%	100%	2%	-11%	-1%



Ethnicity Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024	Jun 2025	May 2026	Jun 2026	Jun 2024 to Jun 2025	Jun 2025 to Jun 2026	May 2026 to Jun 2026
Hispanic	139,887	127,002	131,004	128,769	35%	31%	35%	35%	-10%	1%	-2%
Black	53,044	48,489	50,300	50,123	13%	12%	13%	14%	-9%	3%	0%
Other Asian / Pacific Islander	37,615	33,457	39,472	39,082	9%	8%	11%	11%	-12%	14%	-1%
White	32,738	27,820	30,366	30,171	8%	7%	8%	8%	-18%	8%	-1%
Chinese	35,855	32,481	33,098	32,764	9%	8%	9%	9%	-10%	1%	-1%
Other	76,430	66,579	54,939	53,712	19%	16%	15%	15%	-15%	-24%	-2%
Vietnamese	11,893	10,610	10,768	10,679	3%	3%	3%	3%	-12%	1%	-1%
Unknown	15,906	64,320	24,326	24,199	4%	16%	6%	7%	75%	-166%	-1%
American Indian or Alaskan Native	797	722	732	721	0%	0%	0%	0%	-10%	-1%	-2%
Total	404,165	411,480	375,005	370,220	100%	100%	100%	100%	2%	-11%	-1%



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

Medi-Cal By City						
City	Jun 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	144,272	40%	21,538	36,570	15,719	70,445
HAYWARD	46,596	13%	10,985	12,312	5,236	18,063
FREMONT	34,865	10%	14,902	5,498	1,876	12,589
SAN LEANDRO	22,955	6%	6,170	3,617	2,878	10,290
UNION CITY	13,175	4%	5,375	2,199	741	4,860
ALAMEDA	12,695	3%	3,144	2,312	1,982	5,257
BERKELEY	14,750	4%	3,153	2,390	1,644	7,563
LIVERMORE	11,997	3%	1,940	320	1,959	7,778
NEWARK	8,315	2%	2,677	3,210	418	2,010
CASTRO VALLEY	10,264	3%	2,978	1,531	1,636	4,119
SAN LORENZO	5,529	2%	1,145	1,227	643	2,514
PLEASANTON	7,437	2%	2,265	256	784	4,132
DUBLIN	7,248	2%	2,486	268	843	3,651
EMERYVILLE	2,875	1%	533	638	502	1,202
ALBANY	2,299	1%	402	272	528	1,097
PIEDMONT	398	0%	86	147	58	107
SUNOL	80	0%	31	8	6	35
ANTIOCH	34	0%	12	10	4	8
Other	17,833	5%	3,547	3,507	2,399	8,380
Total	363,617	100%	83,369	76,292	39,856	164,100

Group Care By City						
City	Jun 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,883	30%	332	426	0	1,125
HAYWARD	729	11%	336	195	0	198
FREMONT	730	11%	455	89	0	186
SAN LEANDRO	698	11%	275	105	0	318
UNION CITY	295	5%	173	52	0	70
ALAMEDA	322	5%	95	39	0	188
BERKELEY	161	3%	40	19	0	102
LIVERMORE	101	2%	28	1	0	72
NEWARK	160	3%	90	41	0	29
CASTRO VALLEY	226	4%	95	37	0	94
SAN LORENZO	187	3%	59	45	0	83
PLEASANTON	78	1%	27	3	0	48
DUBLIN	137	2%	50	5	0	82
EMERYVILLE	46	1%	10	10	0	26
ALBANY	26	0%	9	4	0	13
PIEDMONT	4	0%	0	1	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	7	5	0	12
Other	542	9%	180	92	0	270
Total	6,350	100%	2,262	1,169	0	2,919

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

D-SNP By City						
City	Jun 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	93	37%	20	9	0	64
HAYWARD	30	12%	11	3	0	16
FREMONT	19	8%	12	0	0	7
SAN LEANDRO	17	7%	5	5	0	7
UNION CITY	5	2%	3	0	0	2
ALAMEDA	18	7%	4	5	0	9
BERKELEY	16	6%	1	0	0	15
LIVERMORE	12	5%	2	1	0	9
NEWARK	7	3%	6	1	0	0
CASTRO VALLEY	3	1%	2	1	0	0
SAN LORENZO	5	2%	3	0	0	2
PLEASANTON	5	2%	3	0	0	2
DUBLIN	7	3%	0	0	0	7
EMERYVILLE	3	1%	1	0	0	2
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	13	5%	7	1	0	5
Sum:			2,262	1,169	0	2,919

Total By City						
City	Jun 2026	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	146,155	39%	21,870	36,996	15,719	71,570
HAYWARD	47,325	13%	11,321	12,507	5,236	18,261
FREMONT	35,595	10%	15,357	5,587	1,876	12,775
SAN LEANDRO	23,653	6%	6,445	3,722	2,878	10,608
UNION CITY	13,470	4%	5,548	2,251	741	4,930
ALAMEDA	13,017	4%	3,239	2,351	1,982	5,445
BERKELEY	14,911	4%	3,193	2,409	1,644	7,665
LIVERMORE	12,098	3%	1,968	321	1,959	7,850
NEWARK	8,475	2%	2,767	3,251	418	2,039
CASTRO VALLEY	10,490	3%	3,073	1,568	1,636	4,213
SAN LORENZO	5,716	2%	1,204	1,272	643	2,597
PLEASANTON	7,515	2%	2,292	259	784	4,180
DUBLIN	7,385	2%	2,536	273	843	3,733
EMERYVILLE	2,921	1%	543	648	502	1,228
ALBANY	2,325	1%	411	276	528	1,110
PIEDMONT	402	0%	86	148	58	110
SUNOL	81	0%	32	8	6	35

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

ANTIOCH	58	0%	19	15	4	20
Other	18,375	5%	3,727	3,599	2,399	8,650
Total	369,967	100%	85,631	77,461	39,856	167,019



Human Resources

Anastacia Swift

To: Alameda Alliance for Health Board of Governors

From: Anastacia Swift, Chief Human Resources Officer

Date: August 14th, 2026

Subject: Human Resources Report

Staffing

- As of August 1st, 2026, the Alliance had 631 full time employees and 0 part time employee.
- On August 1st, 2026, the Alliance had 17 open positions in which 4 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 13 positions open to date. The Alliance is actively recruiting for the remaining 13 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by division:

Division	Open Position August 1 st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	3	2	1
Operations	12	2	10
Healthcare Analytics	0	0	0
Information Technology	0	0	0
Finance	0	0	0
Compliance	1	0	1
Human Resources	1	0	1
Executive	0	0	0
Total	17	4	13

- Our current recruitment rate is 3%.

Employee Recognition

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

5 years:

- Anna F (Member Services)
- Mark H (Healthcare Analytics)

6 years:

- Daniel L (Healthcare Analytics)
- Andrew L (Claims)

7 years:

- Alan Z (Claims)

8 years:

- Trina C (Claims)
- Cathy C (Grievance and Appeals)
- Nancy T (Grievance and Appeals)

9 years:

- Jasmine C (Provider Services)
- Rubeen S (Member Services)

10 years:

- Cindy D (Credentialing)
- Roberta R (Privacy & SIU)

11 years:

- Matthew W (Executive)

12 years:

- Evelyn W (Long-Term Services and Support)

13 years:

- Jennifer R (Utilization Management)
- Julia K (Healthcare Analytics)

15 years:

- Lorraine V (Claims)

16 years:

- Daniel M (IT Infrastructure)