ALAMEDA Alliance FOR HEALTH

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Board of Governors

PACKET

FEBRUARY 14th, 2025

ALAMEDA Alliance FOR HEALTH

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EXECUTIVE SUMMARY APPENDIX

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

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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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CEO Update

Matthew Woodruff

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

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

Date: **February 14th, 2025**

Subject: **CEO Report**

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

	December	YTD
Medi-Cal	($6.4M)	($92.3M)
Group Care	($336K)	($237K)
Medicare	($1.9M)	($4.6M)
Total	($8.6M)	($97.2M)

  - **Revenue was $163.0 million in December 2024 and $1.0 billion Year-to-Date (YTD)**.
    - Medical expenses were $164.6 million in December and $1.1 billion for the fiscal year-to-date; the medical loss ratio is 101.0% for the month and 105.7% for the fiscal year-to-date.
    - Administrative expenses were $9.4 million in December and $57.7 million for the fiscal year-to-date; the administrative loss ratio is 5.8% of net revenue for the month and 5.7% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 204% of the required DMHC minimum, representing $80.6 million in excess TNE.
  - **Total enrollment in December 2024 was 412,226**, an increase of 5,348 Medi-Cal members compared to November 2024.

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

- **Alliance Updates:**
  - **Demographics**
    - Please see the attached PowerPoint describing the demographics of the Alliance employees.

- **Medicare Overview**
    - **D-SNP Readiness**
        - Alameda Alliance for Health (AAH) Medicare Advantage (MA) Duals Eligible Special Needs Plan (D-SNP) will begin serving members on January 1st, 2026. Currently, there are 17 different departmental workstreams and a total of 112 projects, of which 57 are active, 51 requested, and 4 are on hold.
        - The plan name will be called “Alameda Alliance Wellness (HMO D-SNP).” Model of Care (MOC) is complete, and the Health Risk Assessment Tool (HRAT) is complete.
        - Teams are collaborating to complete the D-SNP application, which is scheduled for submittal to CMS on 2/12/2025. The leadership expects to meet the 2/12 deadline.
        - 107 Letters of Intent and 154 Medicare Amendments have been executed in order to meet CMS Network Adequacy.
        - Project kick off started with Nations for Sales System, Hearing, and FlexCard implementations. Stars Strategy has been kicked off and is underway.
        - Continuing to collaborate with IT in updating Core Claims / Medical Management Systems and identified 321 requirements collected within Microsoft List.

- **Department of Health Care Services**
    - The Alliance met with the Department on February 12, 2025. The department made a few points:
        1. Follow any regulations as written and be prepared in case there are changes
        2. They are not expecting any changes to funding in the calendar year 2025 but that could change

- **Meeting Recap**
    - A special finance meeting occurred on January 22, 2025, to discuss the updated budget, rates, and forecast.
    - An Executive committee of the Board was called on January 29, 2025, to discuss the updates in medical management and the strategic planning for the DSNP launch.
    - The Board held a strategic planning retreat on January 31, 2025, to finalize the Medicare decision and planning for future years. Follow-up actions and notes will be distributed in the coming weeks. Please fill out your surveys so the Alliance team can continue to improve our processes.

Demographics

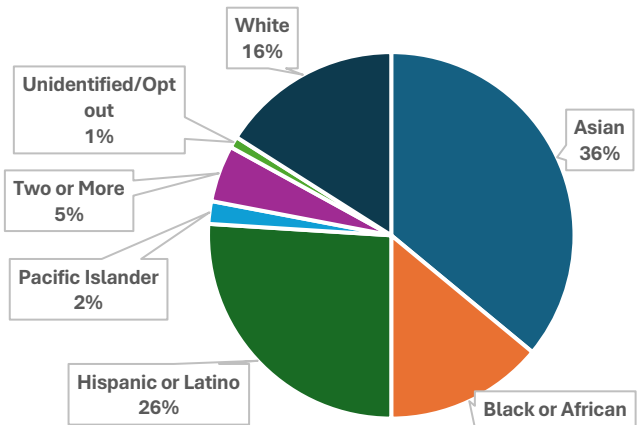
The purpose of this report is to conduct a comparative analysis of the demographic composition of Alameda Alliance for Health's workforce and the population distribution of Alameda Count. The primary focus of this comparison will be on key metrics, including race/ethnicity, gender, and age distribution.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

The demographic data for the county, including the total population and demographic breakdown, is sourced from Healthy Alameda County, which is sponsored by the Alameda County Public Health Department. This site serves as a central repository of information related to Alameda County, providing the most current data and over 250 community wellbeing indicators (Healthy Alameda County :: Demographics :: County :: Alameda). The information presented in this report was last updated in April 2024. Additionally, the data used for Alameda Alliance for Health was last updated in January 2025 and is collected and maintained monthly by the Human Resources Department internally.

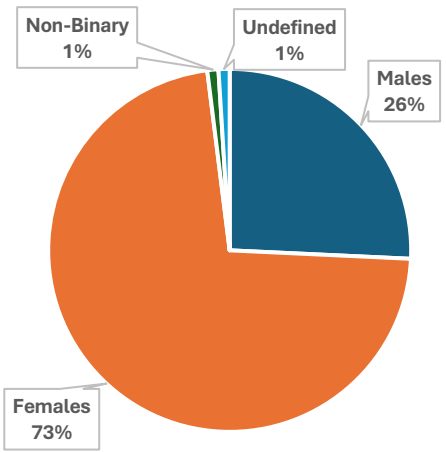
Category	**Alameda Alliance for Health** (Workforce information last updated January 2025)	**Alameda County** (Population Information last updated in April 2024)
Population/Total Employees	649	1,634,785
Race & Ethnicity		
Asian	36%	34.68%
Hispanic	26%	23.95%
White	16%	28.75%
Black/African American	14%	9.27%
Native Hawaiian/Pacific Islander	2%	0.85%
Two or More Races	5%	11.68%
Unidentified/Opt Out	1%	
Gender		
Male	26%	48.98%
Female	73%	51.02%
Non-Binary	>1%	0%
Undefined	>1%	0%
Age Distribution		
Under 25	>1%	12.47%
25-34	22%	14.34%
35-44	36%	15.89%
45-54	25%	13.44%
55-Older	17%	27.65%

AAH Employee Demographics Data Report January 2025

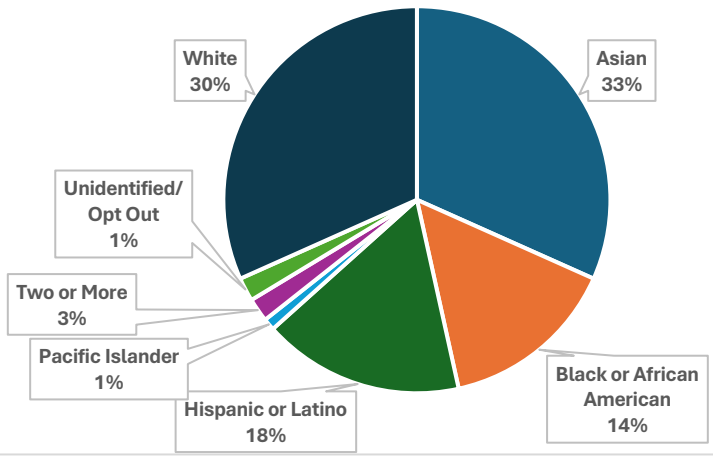
Employee Ethnicity - 649
January 2025



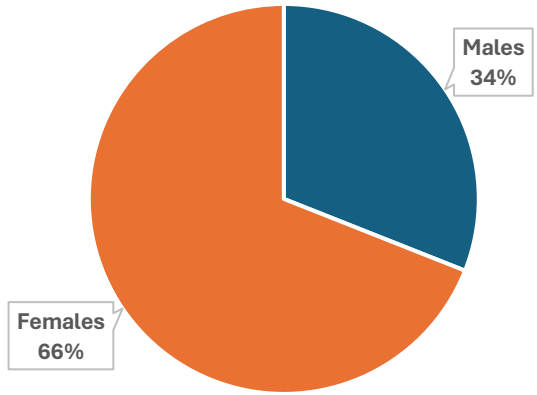
Employee Gender - 649
January 2025

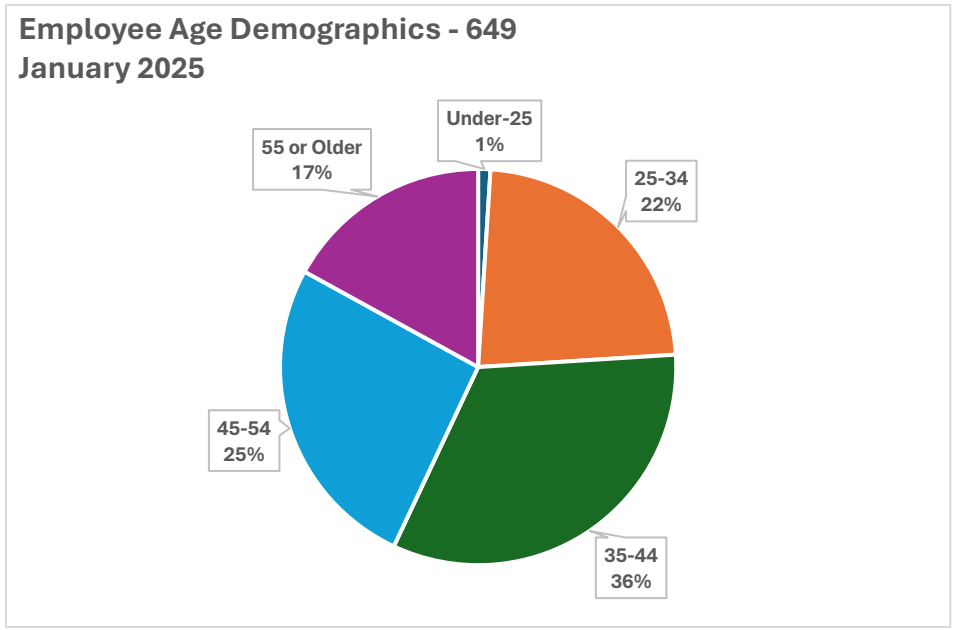


Managers Ethnicity - 130
January 2025



Managers Gender - 130
January 2025




Employee Age Demographics - 649
January 2025
Under-25
1%
25-34
22%
35-44
36%
45-54
25%
55 or Older
17%

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Legislative Tracking

2025 –2026 Legislative Tracking List

Legislative bills continue to emerge as we approach the February 21st deadline which will be the last day for new bills to be introduced by California legislators. Earlier this month, Governor Gavin Newsom approved $25 million for anticipated legal challenges against the Trump administration, and in late January, the Governor signed a $2.5 billion bipartisan relief package to Los Angeles for their wildfire recovery efforts.

The following is a list of state bills tracked by the Public Affairs and Compliance Departments. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership.

AB 4 **(Arambula D) Covered California expansion.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 2/3/2025-Referred to Com. on Health.

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

Summary: Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires the Exchange to apply for a federal waiver to allow persons otherwise not able to obtain coverage through the Exchange because of their immigration status to obtain coverage from the Exchange. This bill would delete that requirement and would instead require the Exchange, no sooner than January 1, 2027, and upon appropriation by the Legislature for this purpose, to administer a program to allow persons otherwise not able to obtain coverage by reason of immigration status to enroll in health insurance coverage in a manner as substantially similar to other Californians as feasible, consistent with federal guidance and given existing federal law and rules. The bill would require the Exchange to undertake outreach, marketing, and other efforts to ensure enrollment, which would begin on October 1, 2028. The bill would also require the Exchange to adopt an annual program design for each coverage year to implement the program, provide appropriate opportunities for stakeholders, including the Legislature, and the public to consult on the design of the program, and report to the Department of Finance and the Legislature on progress toward implementation, as specified. The bill would establish the Covered California for All Fund in the General Fund, to be administered by the Exchange, into which user fees, appropriations, and other funds would be deposited to be used upon appropriation to pay for the administration of the program.

AB 15 **(Gipson D) State government: immigration enforcement.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 2/3/2025-Referred to Coms. on PUB. S. and JUD.

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

Summary: Existing law, the California Values Act, prohibits a California law enforcement agency, defined as including both state and local agencies but excluding the Department of Corrections and Rehabilitation, from providing a person's release date or responding to a request for notification of a release date, unless that information is available to the public. The bill would prohibit the Department of Corrections and Rehabilitation from detaining on the basis of a hold request, providing an immigration authority with release date information, or responding to a notification request, transferring to an immigration authority, or facilitating or assisting with a transfer request any individual who is eligible for release pursuant to specified provisions, including, among others, youth offender, elderly, and medical parole releases. This bill

contains other related provisions and other existing laws.

AB 29 **(Arambula D) Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 2/3/2025-Referred to Com. on Health.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires that Medi-Cal provider payments and payments for specified non-Medi-Cal programs be reduced by 10% for dates of service on and after June 1, 2011, and conditions implementation of those payment reductions on receipt of any necessary federal approvals. Existing law, for dates of service on and after July 1, 2022, authorizes the maintenance of the reimbursement rates or payments for specified services, including, among others, Adverse Childhood Experiences (ACEs) trauma screenings and specified providers, using General Fund or other state funds appropriated to the State Department of Health Care Services as the state share, at the payment levels in effect on December 31, 2021, as specified, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 that were implemented with funds from the Healthcare Treatment Fund, as specified. Existing law requires the department to develop the eligibility criteria, methodologies, and parameters for the payments and rate increases maintained, and would authorize revisions, as specified. This bill would require the department, as part of its above-described duties, to include (1)community-based organizations and local health jurisdictions that provide health services through community health workers and (2)doulas, that are enrolled Medi-Cal providers, as providers qualified to provide, and eligible to receive payments for, ACEs trauma screenings pursuant to the provisions described above. The bill would require the department to file a state plan amendment and seek any federal approvals it deems necessary to implement these provisions and condition implementation on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would also require the department to update its internet website and the ACEs Aware internet website to reflect the addition of the Medi-Cal providers described above as authorized to provide ACEs screenings.

AB 37 **(Elhawary D) Workforce development: mental health service providers: homelessness.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be heard in committee January 2.

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

Summary: Existing law establishes the California Workforce Development Board as the body responsible for assisting the Governor in the development, oversight, and continuous improvement of California's workforce investment system and the alignment of the education and workforce investment systems to the needs of the 21st century economy and workforce. This bill would state the intent of the Legislature to enact legislation relating to expanding the workforce of those who provide mental health services to "homeless persons" or "homeless people," as specified.

AB 40 **(Bonta D) Emergency services and care.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 2/3/2025-Referred to Com. on Health.

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

Summary: Existing law provides for the licensing and regulation of health facilities by the State Department of Public Health and makes a violation of those provisions a crime. 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 health facility to provide emergency services and

care upon request or when a person is in danger of loss of life or serious injury or illness, and requires a health care service plan to reimburse providers for emergency services and care. Existing law defines “emergency services and care” for these purposes to mean medical screening, examination, and evaluation by a physician and surgeon, or other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person’s license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility, among other things. This bill would additionally define “emergency services and care” for the above-described purposes to mean reproductive health services, including abortion. By expanding the applicability of a crime with respect to health facilities and health care service plans, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 45 **(Bauer-Kahan D) Privacy: health care data.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be heard in committee January 2.

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

Summary: Under the California Constitution, the state is prohibited from denying or interfering with an individual’s reproductive freedom in their most intimate decisions, including their fundamental right to choose to have an abortion. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a pregnant person’s right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the pregnant person. Existing law prohibits a person or business, as defined, from collecting, using, disclosing, or retaining the personal information of a person who is physically located at, or within a precise geolocation of, a family planning center, as defined, except as necessary to perform the services or provide the goods requested and not sold or shared. This bill would state the intent of the Legislature to enact legislation to make it unlawful to geofence an entity that provides in-person health care services and to prohibit health care providers from releasing medical research information related to an individual seeking or obtaining an abortion in response to a subpoena or request if that subpoena or request is based on another state’s laws that interfere with a person’s rights under the Reproductive Privacy Act. This bill contains other existing laws.

AB 49 **(Muratsuchi D) Schoolsites and day care centers: entry requirements: immigration enforcement.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be heard in committee January 2.

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

Summary: Existing law prohibits, except as required by state or federal law or as required to administer a state or federally supported educational program, school officials and employees of a school district, county office of education, or charter school from collecting information or documents regarding citizenship or immigration status of pupils or their family members. Existing law requires the superintendent of a school district, the superintendent of a county office of education, and the principal of a charter school, as applicable, to report to the respective governing board or body of the local educational agency in a timely manner any requests for information or access to a school site by an officer or employee of a law enforcement agency for the purpose of enforcing the immigration laws in a manner that ensures the confidentiality and privacy of any potentially identifying information. This bill would prohibit school officials and employees of a local educational agency from allowing an officer or employee of the United States Immigration and Customs Enforcement (ICE) to enter a school site for any purpose without providing valid identification, a written statement of purpose, and a valid judicial warrant, and receiving approval from the superintendent of the school district, the superintendent of the county office of education, or the principal of the charter school, or their designee, as applicable. The bill would require the local educational agency, if the officer or employee of ICE meets those requirements, to limit access to facilities where pupils are not present. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 50 **(Bonta D) Pharmacists: furnishing contraceptives.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be heard in committee January 2.

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

Summary: Existing law, the Pharmacy Law, establishes in the Department of Consumer Affairs the California State Board of Pharmacy to license and regulate the practice of pharmacy. Exiting law requires a pharmacist, when furnishing self-administered hormonal contraceptives, to follow specified standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. Existing law requires those standardized procedures or protocols to require that the patient use a self-screening tool that will identify related patient risk factors and that require the pharmacist to refer the patient for appropriate follow up care, as specified. Existing law requires the pharmacist to provide the recipient of the drug with a standardized factsheet that includes the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical followup, and other appropriate information. This bill would limit the application of those requirements to self-administered hormonal contraceptives that are prescription-only and would authorize a pharmacist to furnish over-the-counter contraceptives without following those standardized procedures or protocols. The bill would make related conforming changes. This bill would declare that it is to take effect immediately as an urgency statute.

AB 54 **(Krell D) Access to Safe Abortion Care Act.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be heard in committee January 2.

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

Summary: Existing law sets forth provisions under the California Constitution, regarding the fundamental right to choose to have an abortion. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a pregnant person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the pregnant person. This bill, the Access to Safe Abortion Care Act, would make legislative findings about medication abortion, with a focus on use of the drugs mifepristone and misoprostol. The bill would state the intent of the Legislature to enact legislation that would ensure access to medication abortion.

AB 55 **(Bonta D) Alternative birth centers: licensing and Medi-Cal reimbursement.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 2/3/2025-Referred to Com. on Health.

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

Summary: Existing law provides for the licensure and regulation of various types of clinics, including alternative birth centers, by the State Department of Public Health. Existing law defines an alternative birth center as a clinic that is not part of a hospital and that provides comprehensive perinatal services and delivery care to pregnant women who remain less than 24 hours at the facility. Existing law requires a licensed alternative birth center specialty clinic, and a licensed primary care clinic that provides services as an alternative birth center, to meet certain criteria. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth certain criteria for Medi-Cal reimbursement to alternative birth centers for facility-related delivery costs. Under existing law, as a criterion under both the licensing provisions and the Medi-Cal reimbursement provisions described above, the facility is required to be a provider of comprehensive perinatal services as defined in the Medi-Cal provisions. This bill would remove, under both sets of criteria, the certification condition of being a provider of comprehensive perinatal services as defined in the Medi-Cal provisions.

The bill would also make a technical change to an obsolete reference within a related provision.

AB 67 **(Bauer-Kahan D) Attorney General: Reproductive Privacy Act: enforcement.**
Current Text: Introduced: 12/4/2024 html pdf
Introduced: 12/4/2024
Status: 1/6/2025-Read first time.

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

Summary: Existing law, the Reproductive Privacy Act, prohibits a person from being subject to civil or criminal liability, or otherwise deprived of their rights, based on their actions or omissions with respect to their pregnancy or actual, potential, or alleged pregnancy outcome or based solely on their actions to aid or assist a woman or pregnant person who is exercising their reproductive rights as specified in the act. Existing law authorizes a party whose rights are protected by the Reproductive Privacy Act to bring a civil action against an offending state actor when those rights are interfered with by conduct or by statute, ordinance, or other state or local rule, regulation, or enactment in violation of the act, as specified, and require a court, upon a motion, to award reasonable attorneys' fees and costs to a prevailing plaintiff. This bill would authorize the Attorney General, if it appears to them that a person has engaged, or is about to engage, in any act or practice constituting a violation of the Reproductive Privacy Act, to bring an action in the name of the people of the State of California in the superior court to enjoin the acts or practices or to enforce compliance with the act, as specified. In this context, the bill would authorize the Attorney General to make public or private investigations, publish information concerning violation of the Reproductive Privacy Act, and subpoena witnesses, compel their attendance, take evidence, and require the production of documents or records that they deem relevant or material to the inquiry. This bill contains other related provisions.

AB 92 **(Gallagher R) Patient visitation.**
Current Text: Introduced: 1/6/2025 html pdf
Introduced: 1/6/2025
Status: 2/3/2025-Referred to Com. on Health.

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

Summary: Existing law provides for the licensure and regulation by the State Department of Public Health of health facilities, as defined. Existing law requires a health facility to allow a patient's domestic partner, the children of the patient's domestic partner, and the domestic partner of the patient's parent or child to visit unless no visitors are allowed, the facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of a facility, or the patient has indicated to the health facility staff that the patient does not want this person to visit. A violation of this provision is a misdemeanor. This bill, Dianne's Law, would require a health facility to allow specified persons to visit, including the patient's children and grandparents. The bill would require the health facility to develop alternate visitation protocols, if circumstances require the health facility to restrict visitor access to the facility due to health or safety concerns, that allow visitation to the greatest extent possible while maintaining patient, visitor, and staff health and safety. Notwithstanding the requirement mentioned above, the bill would prohibit a health facility from prohibiting in-person visitation in end-of-life situations unless the patient has indicated to the health facility staff that the patient does not want this person to visit, as specified, and would authorize a health facility to require visitors to adhere to personal protective equipment and testing protocols not greater than those required of facility staff for the duration of their visit. The bill would also require the facility to provide personal protective equipment and testing resources to each visitor for a patient in an end-of-life situation, to the extent that those resources have been made readily available to the facility by state or local entities for that purpose. By expanding an existing crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 96 **(Jackson D) Community health workers.**
Current Text: Introduced: 1/7/2025 html pdf
Introduced: 1/7/2025
Status: 2/3/2025-Referred to Com. on Health.

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

Summary: Existing law required the Department of Health Care Access and Information, on or before July 1, 2023, to develop and approve statewide requirements for community health worker certificate programs. Existing law defines "community health worker" for these purposes to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing law specifies that "community health worker" include Promotores, Promotores de Salud, Community Health Representatives, navigators, and other nonlicensed health workers with the qualifications developed by the department. This bill would also specify for these purposes that a "community health worker" includes a peer support specialist.

AB 220 **(Jackson D) Medi-Cal: subacute care services.**
Current Text: Introduced: 1/8/2025 html pdf
Introduced: 1/8/2025
Status: 2/3/2025-Referred to Com. on Health.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to establish a subacute care program in health facilities, as specified, to be available to patients in health facilities who meet subacute care criteria. Existing law requires that medical necessity for pediatric subacute care be substantiated by specified conditions. Existing regulations require a treatment authorization request for each admission to a subacute unit. This bill would require a health facility that provides pediatric subacute or adult subacute care services pursuant to these provisions to submit with a treatment authorization request, including an electronic treatment authorization request, a specified form when requesting authorization for subacute care services. The bill would prohibit a Medi-Cal managed care plan from developing or using its own criteria to substantiate medical necessity for pediatric subacute or adult subacute care services with a condition or standard not enumerated in those forms. The bill would require the department to develop and implement procedures, and authorize the department to impose sanctions, to ensure that a Medi-Cal managed care plan complies with these provisions.

AB 224 **(Bonta D) Health care coverage: essential health benefits.**
Current Text: Introduced: 1/9/2025 html pdf
Introduced: 1/9/2025
Status: 2/3/2025-Referred to Com. on Health.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified. This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.

AB 225 **(Bonta D) State hospitals for persons with mental health disorders: patient funds.**
Current Text: Introduced: 1/9/2025 html pdf
Introduced: 1/9/2025
Status: 2/3/2025-Referred to Com. on Health.

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

Summary: Existing law sets forth various functions and duties for the State Department of State Hospitals with respect to the administration of state institutions for the care and treatment of persons with mental health disorders. Existing law authorizes the Director of State Hospitals to deposit funds of patients in trust, as specified. Existing law also authorizes the hospital administrator, with the consent of the patient, to deposit the interest or increment on the funds of the patient in the state hospital in a special fund for each state hospital, designated the "Benefit Fund," and requires the hospital administrator to be the trustee of the fund. Existing law authorizes the hospital administrator, with the approval of the Director of State Hospitals, to expend moneys in the fund for the education or entertainment of the patients of the institution. Existing law requires that the hospital administrator take into consideration the recommendations of representatives of patient government and recommendations submitted by patient groups before expending any moneys in the fund. This bill would additionally authorize the funds to be expended for the welfare of the patients of the institution. The bill would require the hospital administrator of a state hospital to notify patients, patient governments, and patient groups, in writing, about any newly authorized expenditure options for the benefit fund, when applicable.

AB 228 **(Sanchez R) Pupil health: epinephrine delivery systems.**
Current Text: Introduced: 1/13/2025 html pdf
Introduced: 1/13/2025
Status: 2/3/2025-Referred to Com. on ED.

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

Summary: Existing law requires school districts, county offices of education, and charter schools to provide emergency epinephrine auto-injectors to school nurses or trained volunteer personnel and authorizes school nurses and trained personnel to use epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction, as provided. Existing law requires school districts, county offices of education, and charter schools to, among other things, store those emergency epinephrine auto-injectors in an accessible location upon need for emergency use and include that location in specified annual notices. Existing law authorizes a pupil to carry and self-administer prescription auto-injectable epinephrine if the school district receives specified written statements from a physician and surgeon or a physician assistant, and from the parent, foster parent, or guardian of the pupil, as specified. This bill would replace all references to epinephrine auto-injectors or auto-injectable epinephrine in the above-described provisions with references instead to epinephrine delivery systems, as defined, and would require school districts, county offices of education, and charter schools to instead provide at least one type of United States Food and Drug Administration-approved epinephrine delivery system, as specified. To the extent the bill would impose additional duties on local educational agencies, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 242 **(Boerner D) Genetic disease screening.**
Current Text: Introduced: 1/14/2025 html pdf
Introduced: 1/14/2025
Status: 1/15/2025-From printer. May be heard in committee February 14.

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

Summary: Existing law requires the State Department of Public Health to establish a program for the development, provision, and evaluation of genetic disease testing. This bill would require the department to expand statewide screening of newborns to include screening for Duchenne muscular dystrophy as soon as possible, but no later than January 1, 2027. By expanding the purposes for which moneys from the Genetic Disease Testing Fund (GDTF) may be expended, this bill would make an appropriation. This bill contains other existing laws.

AB 260 **(Aguiar-Curry D) Sexual and reproductive health care.**
Current Text: Introduced: 1/16/2025 html pdf
Introduced: 1/16/2025

Status: 1/17/2025-From printer. May be heard in committee February 16.

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

Summary: Existing law establishes the Department of Health Care Access and Information to oversee and administer various health programs. Existing law establishes the California Reproductive Health Equity Program within the department to ensure abortion and contraception services are affordable for and accessible to all patients and to provide financial support for safety net providers of these services. Existing law establishes the California Reproductive Health Service Corps within the department for the purposes of recruiting, training, and retaining a diverse workforce of reproductive health care professionals who will be part of reproductive health care teams to work in underserved areas. Existing law defines reproductive health, for purposes of the corps, to mean health services relating to abortion care, sexual health counseling, contraception, sexually transmitted infections, reproductive tract infections, HIV, gynecology, perinatal care, midwifery care, gender-affirming care, and gender-based violence prevention. This bill would state the intent of the Legislature to enact legislation to ensure that patients can continue to access care, including abortion, gender-affirming care, and other sexual and reproductive health care in California, and to allow patients to access care through asynchronous modes.

AB 277 **(Alanis R) Autism: behavioral technician certification.**
Current Text: Introduced: 1/21/2025 html pdf
Introduced: 1/21/2025
Status: 1/22/2025-From printer. May be heard in committee February 21.

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

Summary: Existing law authorizes the State Department of Developmental Services (DDS) to perform various duties relating to the prevention, diagnosis, and treatment of persons with intellectual and developmental disabilities, including disseminating educational information, providing advice, conducting educational and related work, organizing, establishing, and maintaining community mental health clinics and overseeing regional centers for people with developmental disabilities. Existing law requires the Department of Justice to maintain state summary criminal history information, as defined, and to furnish this information as required by statute to specified entities, including the agency or entity identified in a statute. Under existing law, the disclosure of state summary criminal history information to an unauthorized person is a crime. This bill would require DDS to establish a certification process for behavioral technicians, as defined, including, among others, qualified autism service providers. The bill would require the certification process to include, at a minimum, a criminal background check, except as specified. The bill would prohibit the department from certifying an individual who has been convicted of a crime involving a minor. The bill would require a behavioral technician to request certification from the department if their duties include, or would include, working with a patient who is under 18 years of age. The bill would prohibit a developmental center, facility, or program that provides services to a person who is under 18 years of age from employing a behavioral technician who is not certified by the department. By expanding the scope of the crime of unlawful disclosure of state summary criminal history information, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 278 **(Ransom D) Health care affordability.**
Current Text: Introduced: 1/21/2025 html pdf
Introduced: 1/21/2025
Status: 1/22/2025-From printer. May be heard in committee February 21.

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

Summary: Existing law establishes the Office of Health Care Affordability within the Department of Health Care Access and Information to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, and create a state strategy for controlling the cost of health care. Existing law establishes the Health Care Affordability Board to establish, among other things, a statewide health care cost target and the standards necessary to meet exemptions from health care cost targets or submitting data to the office. Existing law authorizes the office to establish advisory or technical committees, as necessary, in order to

support the board's decision making. This bill would require the board, on or before June 1, 2026, to establish a Patient Advocate Advisory Standing Committee, as specified, that is required to publicly meet, and receive public comments, at least 4 times annually. The bill would require the committee to include specified data from the meetings to the board as part of its annual report.

AB 280 **(Aguiar-Curry D) Health care coverage: provider directories.**
Current Text: Introduced: 1/21/2025 html pdf
Introduced: 1/21/2025
Status: 1/22/2025-From printer. May be heard in committee February 21.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: 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 health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a plan's or insurer's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2026, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2029. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. The bill would require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the out-of-network amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. The bill would require the health care service plan or the insurer, as applicable, to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 281 **(Gallagher R) Comprehensive sexual health education and human immunodeficiency virus (HIV) prevention education.**
Current Text: Introduced: 1/22/2025 html pdf
Introduced: 1/22/2025
Status: 1/23/2025-From printer. May be heard in committee February 22.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: The California Healthy Youth Act requires school districts, defined to include county boards of education, county superintendents of schools, the California School for the Deaf, the California School for the Blind, and charter schools, to ensure that all pupils in grades 7 to 12, inclusive, receive comprehensive sexual health education and human immunodeficiency virus (HIV) prevention education, as specified. The act authorizes a school district to provide that education earlier than grade 7 with age-appropriate and medically accurate information. The act requires each school district to notify parents and guardians of pupils about its plan to provide sexual health education and HIV prevention instruction for the upcoming school year and to inform them, among other things, that written and audiovisual educational materials used in this instruction are available for inspection. This bill would require a school district, as defined, to allow a pupil's parent or guardian to inspect any written or audiovisual educational material used in comprehensive sexual health education and HIV prevention education and would authorize a parent or guardian to make

copies of any written educational material that will be distributed to pupils, if it is not copyrighted and has been or will be presented by an outside consultant or guest speaker. The bill would authorize a school to charge up to $0.10 per page if a parent or guardian elects to make copies of this written educational material. The bill would also require a school district to inform parents and guardians of their right to make these copies and of the training in comprehensive sexual health education and HIV prevention education of each outside consultant or guest speaker providing this instruction. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 290 **(Bauer-Kahan D) Emergency services and care.**
Current Text: Introduced: 1/22/2025 html pdf
Introduced: 1/22/2025
Status: 1/23/2025-From printer. May be heard in committee February 22.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Existing law requires the State Department of Public Health (department) to license and regulate each health facility, defined to mean a facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, and includes, among others, a general acute care hospital and an acute psychiatric hospital. Existing law, the Unruh Civil Rights Act (Unruh Act), specifies that all persons within the jurisdiction of the state are free and equal, and no matter their sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, or immigration status are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind. Existing law requires a health facility that maintains and operates an emergency department to provide emergency services and care, as defined, to any person requesting the services or care for any condition in which the person is in danger of loss of life, or serious injury or illness, as specified. Existing law prohibits the provision of emergency services and care from being based on or affected by, among other characteristics, a person's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, or a characteristic identified in the Unruh Act, as specified. Existing law requires a hospital to adopt a policy prohibiting discrimination in the provision of emergency services and care, and to prohibit physicians and surgeons who serve on an "on-call" basis to the hospital's emergency room from refusing to respond to a call, based on the characteristics described above. If a hospital fails to timely adopt the required policies and protocols, in addition to denial or revocation of any of its licenses, existing law subjects the hospital to a fine not to exceed $1,000 for each day after 60 days' written notice from the department that the hospital's policies or protocols are inadequate, as specified. This bill would delete citizenship and preexisting medical condition, which are also similarly identified in the Unruh Act, from the list of characteristics prohibited from being considered with respect to the provision of emergency services and care. The bill would increase the fine for a hospital's failure to adopt the policies and protocols required for the provision of emergency services and care to $1,000,000 per day. This bill contains other related provisions and other existing laws.

AB 298 **(Bonta D) Health care coverage cost sharing.**
Current Text: Introduced: 1/23/2025 html pdf
Introduced: 1/23/2025
Status: 1/24/2025-From printer. May be heard in committee February 23.

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

Summary: 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's requirements a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services. This bill would prohibit a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2026, from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for services provided to an enrollee or insured under 21 years of age, except as otherwise specified. The bill would prohibit an individual or entity from billing or seeking reimbursement for services provided to an enrollee or insured under 21 years of age, except as otherwise specified. 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 contains other related provisions and other existing laws.

AB 302 **(Bauer-Kahan D) Confidentiality of Medical Information Act.**
Current Text: Introduced: 1/23/2025 html pdf
Introduced: 1/23/2025
Status: 1/24/2025-From printer. May be heard in committee February 23.

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

Summary: Existing law, the Confidentiality of Medical Information Act, prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information, as defined, regarding a patient of the provider of health care or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as prescribed. The act punishes a violation of its provisions that results in economic loss or personal injury to a patient as a misdemeanor. Existing law requires a provider of health care, a health care service plan, or a contractor to disclose medical information when specifically required by law or if the disclosure is compelled by, among other things, a court order or a search warrant lawfully issued to a governmental law enforcement agency. This bill would instead require a provider of health care, a health care service plan, or a contractor to disclose medical information when specifically required by California law. The bill would revise the disclosure requirement relating to a court order to require disclosure if compelled by a California state court pursuant to an order of that court or a court order from another state based on another state's law so long as that law does not interfere with California law, as specified. The bill would revise the disclosure requirement relating to a search warrant to require disclosure if compelled by a warrant from another state based on another state's law so long as that law does not interfere with California law. By narrowing the exceptions for disclosing medical information, and thereby expanding the crime of violating the act, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 309 **(Zbur D) Hypodermic needles and syringes.**
Current Text: Introduced: 1/23/2025 html pdf
Introduced: 1/23/2025
Status: 1/24/2025-From printer. May be heard in committee February 23.

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

Summary: Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists and pharmacies by the California State Board of Pharmacy. Existing law, until January 1, 2026, authorizes a physician or pharmacist to, without a prescription or permit, furnish hypodermic needles and syringes for human use to a person 18 years of age or older, and authorizes a person 18 years of age or older to, without a prescription or license, obtain hypodermic needles and syringes solely for personal use from a physician or pharmacist, as a public health measure, as specified. Existing law, until January 1, 2026, requires a pharmacy that furnishes nonprescription syringes to provide written information or verbal counseling to consumers, as specified, at the time of furnishing or sale of nonprescription hypodermic needles or syringes. Existing law, when no other penalty is provided, makes a knowing violation of the Pharmacy Law a misdemeanor and, in all other instances, makes a violation punishable as an infraction. This bill would delete the January 1, 2026, repeal date, thereby extending those provisions indefinitely, and would make other conforming changes. By indefinitely extending an existing requirement under the Pharmacy Law, the violation of which is a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 315 **(Bonta D) Medi-Cal: Home and Community-Based Alternatives Waiver.**
Current Text: Introduced: 1/23/2025 html pdf
Introduced: 1/23/2025
Status: 1/24/2025-From printer. May be heard in committee February 23.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is,

in part, governed and funded by federal Medicaid program provisions. Under existing law, home- and community-based services (HCBS) approved by the United States Department of Health and Human Services are covered for eligible individuals to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with certain federal provisions. Existing law authorizes the Director of Health Care Services to seek waivers for any or all approvable HCBS. Existing law sets forth provisions for the implementation of the Nursing Facility/Acute Hospital Transition and Diversion Waiver, which is the predecessor of the Home and Community-Based Alternatives (HCBA) Waiver, for purposes of providing care management services to individuals who are at risk of nursing facility or institutional placement. This bill would recast those provisions to refer to the HCBA Waiver. The bill would delete a provision authorizing the expansion of the number of waiver slots up to 5,000 additional slots and would instead require the enrollment of all eligible individuals who apply for the HCBA Waiver. The bill would require the department, by March 1, 2026, to seek any necessary amendments to the waiver to ensure that there is sufficient capacity to enroll all eligible individuals who are currently on a waiting list for the waiver, as specified. This bill contains other related provisions and other existing laws.

AB 322 **(Ward D) Pupil health: school-based health services and school-based mental health services.**
Current Text: Introduced: 1/24/2025 html pdf
Introduced: 1/24/2025
Status: 1/27/2025-Read first time.

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

Summary: Existing law establishes the State Department of Education in state government and vests the department with specified powers and duties relating to the state's public school system, including encouraging and assisting school districts to improve and monitor the health of their pupils. Existing law requires the department, as part of that assistance, to provide information and guidance to schools that request the information and guidance to establish "Health Days" to provide screenings for common health problems among pupils. This bill would require the department to include county offices of education and charter schools in the above-described provisions. The bill would require the department to encourage school districts, county offices of education, and charter schools to participate in programs that offer reimbursement for school-based health services and school-based mental health services, as provided.

AB 350 **(Bonta D) Health care coverage: fluoride treatments.**
Current Text: Introduced: 1/29/2025 html pdf
Introduced: 1/29/2025
Status: 1/30/2025-From printer. May be heard in committee March 1.

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

Summary: 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's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including certain dental services, that are rendered by Medi-Cal enrolled providers. Under existing law, silver diamine fluoride treatments are a covered benefit for eligible children 0 to 6 years of age, inclusive, as specified, and application of fluoride or other appropriate fluoride treatment is covered for children 17 years of age and under. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for the application of fluoride varnish in the primary care setting for children under 21 years of age. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill would make the application of fluoride or other appropriate fluoride treatment, including fluoride varnish, a covered benefit under the Medi-Cal program for children under 21 years of age. The bill would require the State Department of Health Care Services to establish and promulgate a policy governing billing and reimbursement for the application of fluoride varnish, as specified. This bill contains other related provisions and other existing laws.

AB 360 **(Papan D) Health care coverage for menopause.**
Current Text: Introduced: 1/30/2025 html pdf
Introduced: 1/30/2025
Status: 1/31/2025-From printer. May be heard in committee March 2.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies. This bill would state the intent of the Legislature to enact legislation relating to menopause that ensures patients experiencing menopause have access to health care providers who are well equipped to offer effective treatments and support and to promote greater awareness and education within the medical community to address gaps in care.

AB 371 **(Haney D) Dental coverage.**
Current Text: Introduced: 2/3/2025 html pdf
Introduced: 2/3/2025
Status: 2/4/2025-From printer. May be heard in committee March 6.

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

Summary: 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's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a contract between a plan or insurer and a dentist from requiring a dentist to accept an amount set by the plan or insurer as payment for dental care services provided to an enrollee or insured that are not covered services under the enrollee's contract or the insured's policy. Existing law requires a plan or insurer to make specified disclosures to an enrollee or insured regarding noncovered dental services. Existing law requires a health care service plan or health insurer to comply with specified timely access requirements. For a specified plan or insurer offering coverage for dental services, existing law requires urgent dental appointments to be offered within 72 hours of a request, nonurgent dental appointments to be offered within 36 business days of a request, and preventive dental care appointments to be offered within 40 business days of a request, as specified. Existing law requires a contract between a health care service plan and health care provider to ensure compliance with network adequacy standards and to require reporting by providers to plans to ensure compliance. Under existing law, a health care service plan is required to annually report to the Department of Managed Health Care on this compliance. Existing law authorizes the Department of Insurance to issue guidance to insurers regarding annual timely access and network reporting methodologies. If a health care service plan or health insurer pays a contracting dental provider directly for covered services, this bill would require the plan or insurer to pay a noncontracting dental provider directly for covered services if the noncontracting provider submits to the plan or insurer a written assignment of benefits form signed by the enrollee or insured. The bill would require the plan or insurer to provide a predetermination or prior authorization to the dental provider and to reimburse the provider for not less than that amount, except as specified. The bill would require the plan or insurer to notify the enrollee or insured that the provider was paid and that the out-of-network cost may count towards their annual or lifetime maximum. The bill would require a noncontracting dental provider to make specified disclosures to an enrollee or insured before accepting an assignment of benefits. This bill contains other related provisions and other existing laws.

AB 375 **(Nguyen D) Medical Practice Act: health care providers: qualified autism service paraprofessionals.**
Current Text: Introduced: 2/3/2025 html pdf
Introduced: 2/3/2025
Status: 2/4/2025-From printer. May be heard in committee March 6.

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

Summary: Existing law, the Medical Practice Act, establishes the Medical Board of California and charges it with administrative and enforcement duties related to the provision of medical services under the act. Existing law establishes requirements for the delivery of medical services, including via telehealth by specified health care providers. A violation of the act is a crime. Under existing law, a "health care provider," for purpose of the act, includes a qualified autism service provider or a qualified autism service professional that is certified by a national entity, as specified. This bill would expand that definition of "health care provider" to also include a qualified autism service paraprofessional. By expanding the scope of a crime under the act, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 384 **(Connolly D) Health care coverage: mental health and substance use disorders: inpatient admissions.**
Current Text: Introduced: 2/3/2025 html pdf
Introduced: 2/3/2025
Status: 2/4/2025-From printer. May be heard in committee March 6.

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

Summary: 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 health care service plan or health insurer to ensure that processes necessary to obtain covered health care services, including, but not limited to, prior authorization processes, are completed in a manner that assures the provision of covered health care services to an enrollee or insured in a timely manner appropriate for the enrollee's or insured's condition, as specified. This bill, the California Mental Health Protection Act, would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, that provides coverage for mental health and substance use disorders from requiring prior authorization (1) for an enrollee or insured to be admitted for medically necessary 24-hour care in inpatient settings for mental health and substance use disorders, as specified, and (2) for any medically necessary health care services provided to an enrollee or insured while admitted for that care. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, to assess administrative or civil penalties, as specified, for violations of 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. This bill contains other related provisions and other existing laws.

AB 403 **(Ortega D) Medi-Cal: community health worker services.**
Current Text: Introduced: 2/4/2025 html pdf
Introduced: 2/4/2025
Status: 2/5/2025-From printer. May be heard in committee March 7.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, community health worker (CHW) services are a covered Medi-Cal benefit subject to any necessary federal approvals. CHW is defined as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing law requires a Medi-Cal managed care plan to engage in outreach and education efforts to enrollees with regard to the CHW services benefit, as specified. Existing law requires the department to inform stakeholders about implementation of the benefit. This bill would require the department to annually review the above-described outreach and education efforts conducted by Medi-Cal managed care plans. The bill would require the department to annually conduct an analysis of the CHW services benefit, submit each analysis to the Legislature, and publish each analysis on the department's internet website, with the first analysis due July 1, 2027. This bill contains other related provisions and other existing laws.

AB 408 **(Berman D) Healing arts.**
Current Text: Introduced: 2/4/2025 html pdf

Introduced: 2/4/2025
Status: 2/5/2025-From printer. May be heard in committee March 7.

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

Summary: Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensing, regulation, and discipline of physicians and surgeons. This bill would state the intent of the Legislature to enact legislation to revise the authority of the Medical Board of California to establish a physician health and wellness program.

AB 412 **(Bauer-Kahan D) Generative artificial intelligence: training data: copyrighted materials.**
Current Text: Introduced: 2/4/2025 html pdf
Introduced: 2/4/2025
Status: 2/5/2025-From printer. May be heard in committee March 7.

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

Summary: Existing federal law, through copyright, provides authors of original works of authorship, as defined, with certain rights and protections. Existing federal law generally gives the owner of the copyright the right to reproduce the work in copies or phonorecords and the right to distribute copies or phonorecords of the work to the public. Existing law requires, on or before January 1, 2026, and before each time thereafter that a generative artificial intelligence system or service, as defined, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made available to Californians for use, regardless of whether the terms of that use include compensation, a developer of the system or service to post on the developer's internet website documentation, as specified, regarding the data used to train the generative artificial intelligence system or service. This bill would require a developer, before a generative artificial intelligence system or model is made publicly available to Californians for use, to, among other things, document any copyrighted materials used to train the system or model and document the copyright owner of that material. The bill would require a developer to provide a copyright owner with a comprehensive list of materials used to train the system or model for which the copyright owner holds the copyright within 7 days of receiving a written request from the copyright owner of the material, and would provide that each day following the 7-day period that a developer fails to provide a copyright owner with that list of materials constitutes a discrete violation. The bill would, if the written request is from a copyright owner of a material not used to train a generative artificial intelligence (GenAI) system or model, require a developer to notify the copyright owner within 30 days that no materials for which the copyright owner holds the copyright were used to train the GenAI system or model. The bill would authorize a copyright owner that is not provided with a list of materials or notified by a developer according to these provisions to bring a civil action against the developer for specified relief.

AB 416 **(Krell D) Involuntary commitment.**
Current Text: Introduced: 2/5/2025 html pdf
Introduced: 2/5/2025
Status: 2/6/2025-From printer. May be heard in committee March 8.

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

Summary: Existing law, the Lanterman-Petris-Short Act, authorizes the involuntary commitment and treatment of persons with specified mental disorders. Under the act, when a person, as a result of a mental health disorder, is a danger to self or others, or gravely disabled, the person may, upon probable cause, be taken into custody by specified individuals, including, among others, by a peace officer and a designated member of a mobile crisis team, and placed in a facility designated by the county and approved by the State Department of Health Care Services for up to 72 hours for evaluation and treatment. Existing law exempts specified individuals, including a peace officer responsible for the detainment of a person under these provisions from criminal and civil liability for an action by a person who is released at or before the end of the period for which they were detained. This bill would additionally authorize a person to be taken into custody, pursuant to those provisions, by an emergency physician, as defined. The bill would also exempt an emergency physician who is responsible for the detainment of a person under those provisions from criminal and civil liability, as specified.

AB 423 **(Davies R) Alcohol and drug recovery or treatment facilities: discharge and continuing care planning.**
Current Text: Introduced: 2/5/2025 html pdf
Introduced: 2/5/2025
Status: 2/6/2025-From printer. May be heard in committee March 8.

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

Summary: Existing law provides for the licensure and regulation of adult alcoholism or drug abuse recovery and treatment facilities by the State Department of Health Care Services. Existing law requires a licensee to provide recovery, treatment, or detoxification services. Existing law authorizes the department to adopt regulations requiring records and procedures that are appropriate for each of those services, including, among others, discharge and continuing care planning. This bill would instead require the department to adopt regulations requiring discharge and continuing care planning that are appropriate for each of the aforementioned services. The bill would require the department to adopt regulations requiring a licensee to, among other things, develop a plan to help the patient return to their home community at the conclusion of treatment, as specified, and schedule for the patient a follow-up meeting with a mental health or substance use disorder professional to occur no more than 7 days after discharge.

AB 432 **(Bauer-Kahan D) Menopause.**
Current Text: Introduced: 2/5/2025 html pdf
Introduced: 2/5/2025
Status: 2/6/2025-From printer. May be heard in committee March 8.

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

Summary: Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and requires the board to adopt and administer standards for the continuing education of those licensees. Existing law requires the board, in determining its continuing education requirements, to consider including a course in menopausal mental or physical health. This bill would instead require the board, in determining its continuing education requirements, to include a course in menopausal mental or physical health. The bill would require physicians who have a patient population composed of 25% or more of women to complete a mandatory continuing medical education course in perimenopause, menopause, and postmenopausal care. This bill contains other related provisions and other existing laws.

SB 7 **(McNerney D) Artificial intelligence.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 1/29/2025-Referred to Com. on RLS.

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

Summary: Existing law establishes within the Government Operations Agency the Department of Technology, which is supervised by the Director of Technology. Existing law authorizes the director and the department to exercise various powers in creating and managing the information technology policy of the state. This bill would declare the intent of the Legislature to enact legislation relating to artificial intelligence.

SB 12 **(Gonzalez D) State government: Immigrant and Refugee Affairs Agency: Office of Immigrant and Refugee Affairs.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 1/29/2025-Referred to Coms. on G.O. and JUD.

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

Summary: Existing law designates 8 agencies in state government and requires the secretary of an agency to be generally responsible for the sound fiscal management of each department, office, or other unit within the agency. Existing law further requires the secretary of an agency to, among other duties, continually seek to improve the organization structure, the operating policies, and the management information systems of each department, office, or other unit. This bill would establish the Immigrant and Refugee Affairs Agency as an agency within state government, to be headed by a secretary who is appointed by the Governor and subject to Senate confirmation. The bill would specify that the purpose of the agency is to reduce obstacles and enhance immigrant integration, as defined, into the social, cultural, economic, and civic life of the state. The bill would establish the Office of Immigrant and Refugee Affairs within the agency. The bill would declare the intent to incorporate existing and future programs created to assist immigrants and refugees into the office. The bill would transfer the property of any office, agency, or department that relates to functions transferred to the office by these provisions and would transfer the unencumbered balance of any appropriation and any other funds that are available for use in connection with any function transferred to the office. The bill would also provide that every officer and employee who is serving in the state civil service, as provided, and who is transferred to the office, shall retain the status position, and rights. The bill would create the Immigrant and Refugee Integration Fund within the State Treasury, and would make the moneys available in the fund available to the office upon appropriation by the Legislature. This bill contains other related provisions and other existing laws.

SB 27 **(Umberg D) Community Assistance, Recovery, and Empowerment (CARE) Court Program.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 1/29/2025-Referred to Com. on JUD.

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

Summary: Existing law, the Community Assistance, Recovery, and Empowerment (CARE) Act, authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan and implement services, to be provided by county behavioral health agencies, to provide behavioral health care, including stabilization medication, housing, and other enumerated services, to adults who are currently experiencing a severe mental illness and have a diagnosis identified in the disorder class schizophrenia and other psychotic disorders, and who meet other specified criteria. Existing law authorizes a specified individual to commence the CARE process, known as the original petitioner. Existing law authorizes the court to dismiss a case without prejudice when the court finds that a petitioner has not made a prima facie showing that they qualify for the CARE process. Existing law requires the court to take prescribed actions if it finds that a prima facie showing has been made, including, but not limited to, setting the matter for an initial appearance on the petition. This bill would allow the court to conduct the initial appearance on the petition at the same time as the prima facie determination if specified requirements are met. This bill would declare that it is to take effect immediately as an urgency statute.

SB 32 **(Weber Pierson D) Public health: maternity ward closures.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 1/29/2025-Referred to Com. on RLS.

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

Summary: Existing law establishes the licensure and regulation of health facilities by the State Department of Public Health, including, among others, general acute care hospitals. This bill would express the intent of the Legislature to enact legislation to address maternity ward closures.

SB 40 **(Wiener D) Health care coverage: insulin.**
Current Text: Introduced: 12/3/2024 html pdf
Introduced: 12/3/2024
Status: 1/29/2025-Referred to Com. on HEALTH.

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

Summary: 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's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin if it is determined to be medically necessary. This bill would generally prohibit a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2026, from imposing a copayment of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug, except as specified. On and after January 1, 2026, the bill would prohibit a health care service plan or disability insurer from imposing step therapy protocols as a prerequisite to authorizing coverage of insulin. 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 contains other related provisions and other existing laws.

SB 41 **(Wiener D) Pharmacy benefits.**
Current Text: Introduced: 12/3/2024 html pdf
Introduced: 12/3/2024
Status: 1/29/2025-Referred to Coms. on HEALTH and JUD.

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

Summary: 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 pharmacy benefit manager under contract with a health care service plan to, among other things, register with the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would additionally require a pharmacy benefit manager to apply for and obtain a license from the Department of Insurance to operate as a pharmacy benefit manager no later than January 1, 2027. The bill would establish application qualifications and requirements, and would require initial license and renewal fees to be collected into the newly created Pharmacy Benefit Manager Account in the Insurance Fund to be available to the department for use, upon appropriation by the Legislature, as specified, for costs related to licensing and regulating pharmacy benefit managers. The bill would impose specified duties on pharmacy benefit managers and requirements for pharmacy benefit manager services and pharmacy benefit manager contracts, including requiring a pharmacy benefit manager to file specified reports with the department, the contents of which are not to be disclosed to the public. The bill would require the department, at specified intervals, to submit reports to the Legislature based on the reports submitted by pharmacy benefit managers, and would require the department to post the reports on the department's internet website. This bill would make a violation of these provisions subject to specified civil penalties. The bill would create the Pharmacy Benefit Manager Fines and Penalties Account in the General Fund, into which fines and administrative penalties would be deposited. This bill contains other related provisions and other existing laws.

SB 53 **(Wiener D) Artificial intelligence: frontier models.**
Current Text: Introduced: 1/7/2025 html pdf
Introduced: 1/7/2025
Status: 1/29/2025-Referred to Com. on RLS.

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

Summary: Existing law requires the Department of Technology to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. Existing law, the Generative Artificial Intelligence Accountability Act, among other things, requires the Department of Technology, under the guidance of the Government Operations Agency, the Office of Data and Innovation, and the Department of Human Resources, to update the report to the Governor, as required by Executive Order No. N-12-23, as prescribed, and requires the Office of Emergency Services to perform, as appropriate, a risk analysis of potential threats

posed by the use of generative AI to California's critical infrastructure, including those that could lead to mass casualty events. This bill would declare the intent of the Legislature to enact legislation that would establish safeguards for the development of AI frontier models and that would build state capacity for the use of AI, that may include, but is not limited to, the findings of the Joint California Policy Working Group on AI Frontier Models established by the Governor. This bill contains other existing laws.

SB 62 **(Menjivar D) Health care coverage: essential health benefits.**
Current Text: Introduced: 1/9/2025 html pdf
Introduced: 1/9/2025
Status: 1/29/2025-Referred to Com. on HEALTH.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified. This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.

SB 81 **(Arreguín D) Health facilities: information sharing.**
Current Text: Introduced: 1/17/2025 html pdf
Introduced: 1/17/2025
Status: 1/29/2025-Referred to Com. on RLS.

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

Summary: Existing law requires the State Department of Public Health to license and regulate each health facility, defined to mean a facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, and to which persons are admitted for a 24-hour stay or longer, and includes, among others, a general acute care hospital, an acute psychiatric hospital, and a skilled nursing facility. Existing law, the Confidentiality of Medical Information Act, prohibits a health care provider, a contractor, or a health care service plan from disclosing medical information, as defined, regarding a patient of the provider or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as specified. This bill would state the intent of the Legislature to enact legislation to prohibit health facilities from collaborating with, providing access to, or providing information, including patient data or records, about patients to, immigration authorities.

SB 85 **(Umberg D) Patient access to health records.**
Current Text: Introduced: 1/21/2025 html pdf
Introduced: 1/21/2025
Status: 1/29/2025-Referred to Com. on RLS.

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

Summary: 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 persons 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, nonsubstantive changes to those findings and declarations.

SB 242 **(Blakespear D) Medicare supplement coverage: open enrollment periods.**

Current Text: Introduced: 1/30/2025 html pdf

Introduced: 1/30/2025

Status: 2/3/2025-From printer. May be acted upon on or after March 2.

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

Summary: Existing federal law provides for the Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Existing federal law specifies different parts of Medicare that cover specific services, such as Medicare Part B, which generally covers medically necessary services and supplies and preventive services. 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 federal law additionally provides for the issuance of Medicare supplement policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program for the hospital, medical, or surgical expenses of persons eligible for the Medicare Program, including coverage of Medicare deductible, copayment, or coinsurance amounts, as specified. Existing law, among other provisions, requires supplement benefit plans to be uniform in structure, language, designation, and format with the standard benefit plans, as prescribed. Existing law prohibits an issuer from denying or conditioning the offering or effectiveness of any Medicare supplement contract, policy, or certificate available for sale in this state, or discriminating in the pricing of a contract, policy, or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Existing law requires an issuer to make available specified Medicare supplement benefit plans to a qualifying applicant under those circumstances who is 64 years of age or younger who does not have end stage renal disease. This bill would delete the exclusion of otherwise qualified applicants who have end stage renal disease, thereby making the specified Medicare supplement benefit plans available to those individuals. The bill, on and after January 1, 2026, would prohibit an issuer of Medicare supplement coverage in this state from denying or conditioning the issuance or effectiveness of any Medicare supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for coverage is submitted during an open enrollment period, as specified in the bill. The bill would entitle an individual enrolled in Medicare Part B to a 90-day annual open enrollment period beginning on January 1 of each year, as specified, during which period the bill would require applications to be accepted for any Medicare supplement coverage available from an issuer, as specified. The bill would require the open enrollment period to be a guaranteed issue period.

SB 246 **(Grove R) Medi-Cal: graduate medical education payments.**

Current Text: Introduced: 1/30/2025 html pdf

Introduced: 1/30/2025

Status: 2/3/2025-From printer. May be acted upon on or after March 2.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department, subject to any necessary federal approvals and the availability of federal financial participation, to make Medi-Cal payments to designated public hospitals (DPHs) and their affiliated government entities, as defined, in recognition of the Medi-Cal managed care share of graduate medical education (GME) costs. Existing law requires that the payments consist of direct and indirect GME payments made in recognition and support of the direct costs incurred in the operation of GME programs and the increased operating and patient care costs associated with teaching programs, respectively. Under existing law, the nonfederal share of these payments consist of voluntary intergovernmental transfers (IGTs) of funds provided by DPHs or their affiliated government entities, or other eligible public entities, as specified. Under existing law, the continuously appropriated DPH GME Special Fund is established for these purposes. This bill would require the department, subject to any necessary federal approvals and the availability of federal financial participation, to make

additional Medi-Cal payments to district and municipal public hospitals (DMPHs), defined as nondesignated public hospitals, and to their affiliated government entities, in recognition of the Medi-Cal managed care share of GME costs. Under the bill, these payments would be made in a manner consistent with the methodology for GME payments to DPHs and their affiliated government entities and would consist of the above-described direct and indirect GME payment components. The bill would authorize the department to seek federal approval for other forms of GME payments to DMPHs and their affiliated government entities, as specified. This bill contains other related provisions and other existing laws.

SB 250 **(Ochoa Bogh R) Medi-Cal: provider directory: skilled nursing facilities.**
Current Text: Introduced: 1/30/2025 html pdf
Introduced: 1/30/2025
Status: 2/3/2025-From printer. May be acted upon on or after March 2.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal Medicaid law requires the state to publish an online directory of physicians and, at state option, other providers, as specified. Existing state law sets forth Medi-Cal managed care provisions relating to a Medi-Cal applicant or beneficiary being informed of the health care options available regarding methods of receiving Medi-Cal benefits, including through certain provider directories. The department has administratively created an online provider directory through an internet website known as Medi-Cal Managed Care Health Care Options. This bill would require, as part of the health care options information posted by the department, in the provider directory that lists accepted Medi-Cal managed care plans, through the Medi-Cal Managed Care Health Care Options internet website and any other applicable mechanisms, that the directory include skilled nursing facilities as one of the available searchable provider types. The bill would require that this provision be implemented in conjunction with implementation of the above-described provisions.

SB 257 **(Wahab D) Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act.**
Current Text: Introduced: 2/3/2025 html pdf
Introduced: 2/3/2025
Status: 2/4/2025-From printer. May be acted upon on or after March 6.

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

Summary: 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 disability insurers by the Department of Insurance. Existing law requires a health care service plan or disability insurer to allow an individual to enroll in or change their health benefit plan as a result of a specified triggering event. Existing law prohibits a health care service plan contract or disability insurance policy issued, amended, renewed, or delivered on or after July 1, 2003, from imposing a copayment or deductible for specified maternity services that exceeds the most common amount of the copayment or deductible imposed for services provided for other covered medical conditions. This bill, the Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act, would make pregnancy a triggering event for purposes of enrollment or changing a health benefit plan. The bill would prohibit a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2026, that provides coverage for maternity services or newborn and pediatric care services from taking specified actions based on the circumstances of conception, including denying, limiting, or seeking reimbursement for maternity services or newborn and pediatric care services because the enrollee or insured is acting as a gestational carrier. 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 contains other related provisions and other existing laws.

SB 278 **(Cabaldon D) Health data: HIV test results.**

Current Text: Introduced: 2/4/2025 html pdf
Introduced: 2/4/2025
Status: 2/5/2025-From printer. May be acted upon on or after March 7.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, public health records relating to human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), containing personally identifying information, that were developed or acquired by a state or local public health agency, or an agent of that agency, are generally confidential and are prohibited from being disclosed. Under existing, in the form of exceptions, certain disclosures of the information are authorized for the purpose of facilitating appropriate HIV/AIDS medical care and treatment, including disclosures by state or local public health agency staff to agency staff, the designated health care provider, or the HIV-positive person who is the subject of the record, as specified. This bill would additionally authorize specified staff to disclose the information to State Department of Health Care Services staff, followed by authorized disclosures to the Medi-cal managed care plan if applicable, the HIV-positive person who is the subject of the record, and the designated health care provider, for the purpose of proactively offering and coordinating care and treatment services to the person or for the purpose of administering quality improvement programs designed to improve HIV care for Medi-Cal beneficiaries. The bill would make a conforming change to a related provision regarding authorized disclosure of HIV test results for the purpose of administering quality improvement programs under Medi-Cal as described above.

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Financials

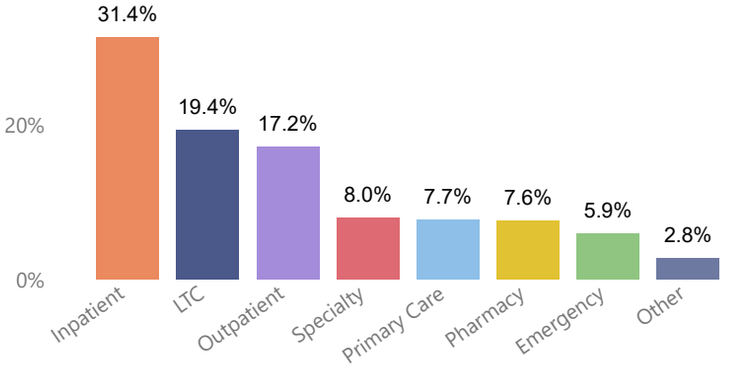
Income & Expenses

	DECEMBER 2024	FISCAL YTD
REVENUE	$ 227.5 M	$ 1.5 B
MEDICAL EXPENSE	$ (164.6) M	$ (1.1) B
ADMIN EXPENSE	$ (9.4) M	$ (57.7) M
OTHER/TAX	$ (62.0) M	$ (462.4) M
NET INCOME	$ (8.6) M	$ (97.2) M

Medical Loss % (Fiscal YTD)

105.7%

Medical Expenses



Liquid Reserves

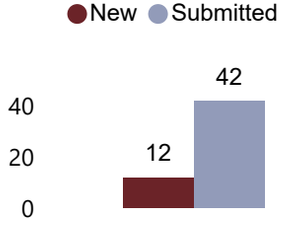
TNE %

203.8%

TNE $

$158.2M

Reinsurance Cases



Balance Sheet

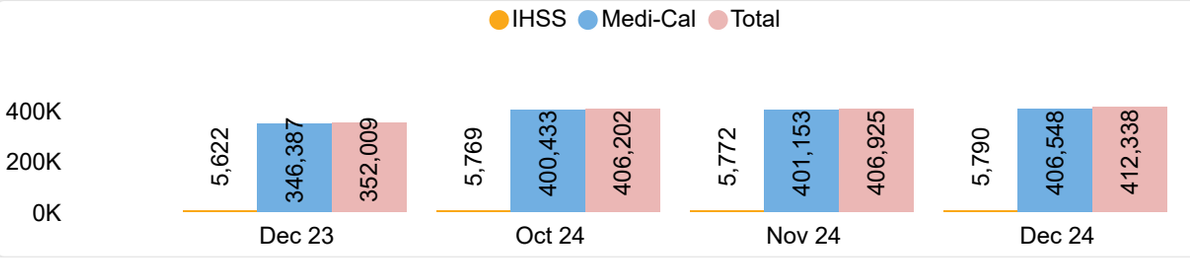
Cash Equivalents	$648.6M
Pass-Through Liabilities	$96.2M
Uncommitted Cash	$552.4M
Working Capital	$99.3M

Current Ratio

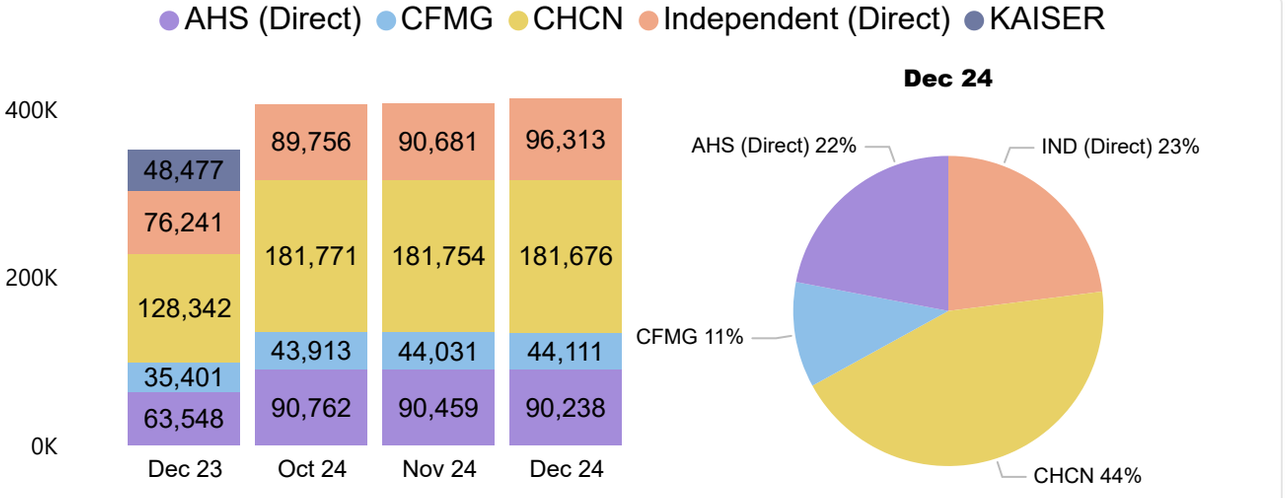
1.10

Membership

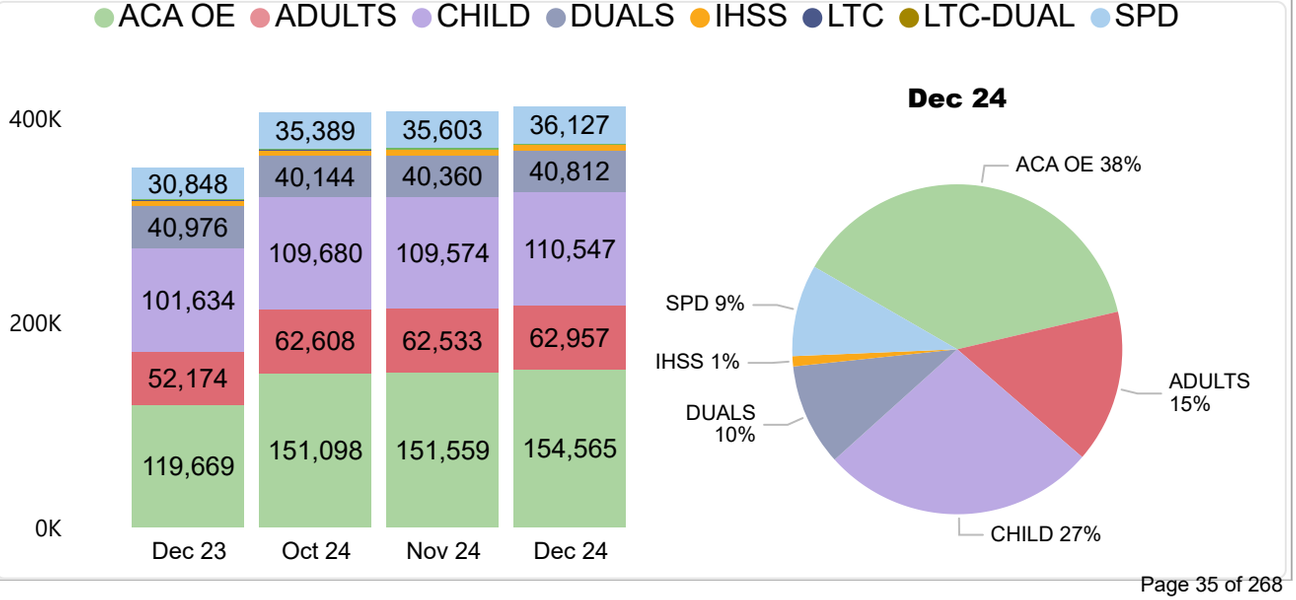
By Plan



By Network



By Category



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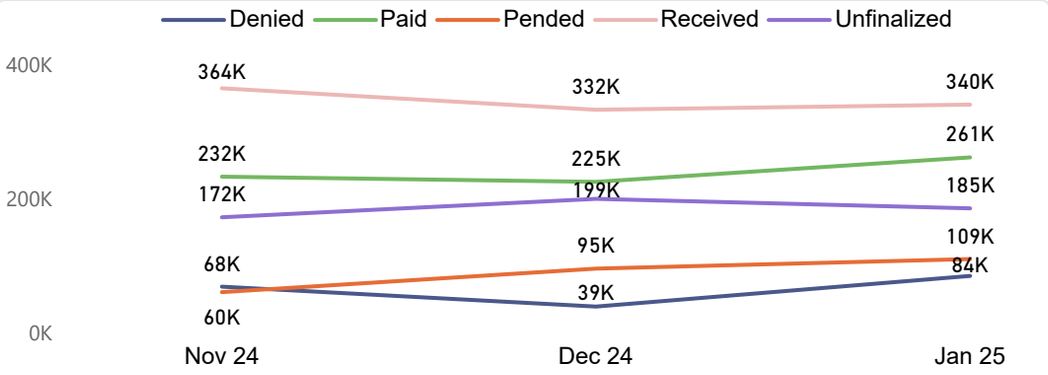
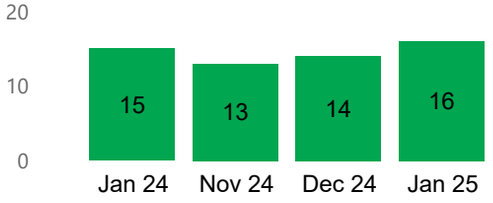
Claims

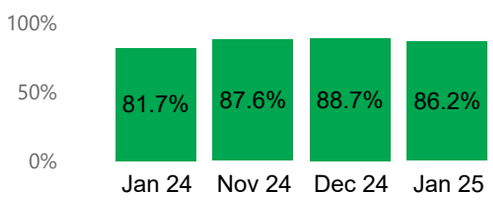
Claims Processing



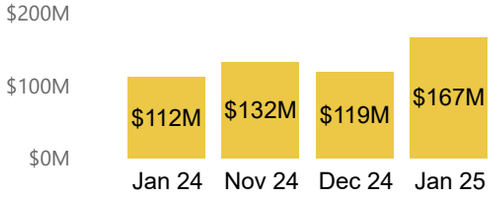
Average Payment TAT (Days)



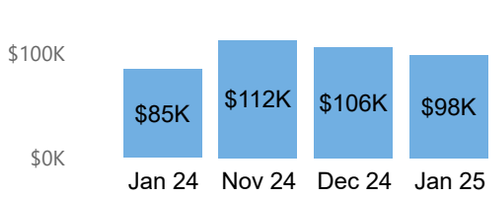
Auto Adjudication Rate (%)



Claims Paid ($)

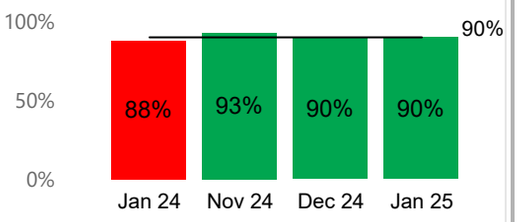


Interest Paid ($)

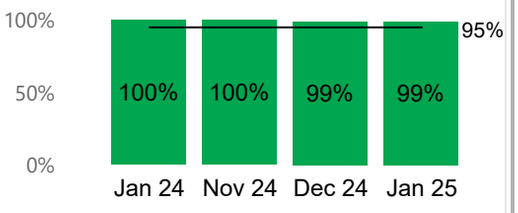


Claims Compliance

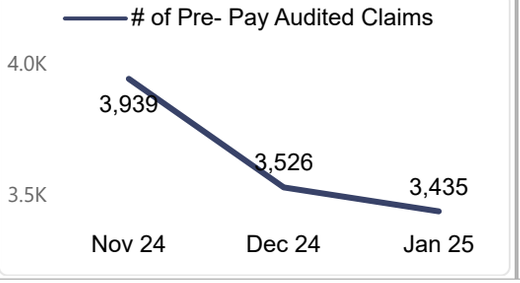
Processed 30 Cal Days (%)



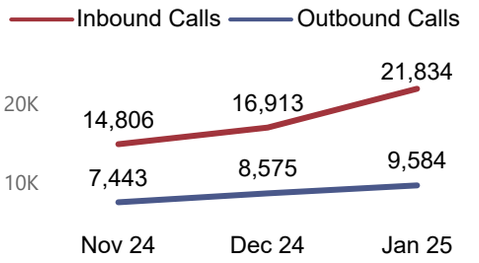
Processed 45 Work Days (%)



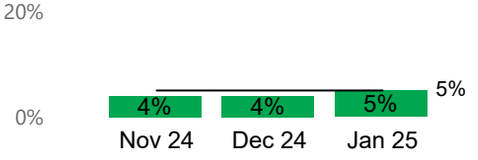
Claims Auditing



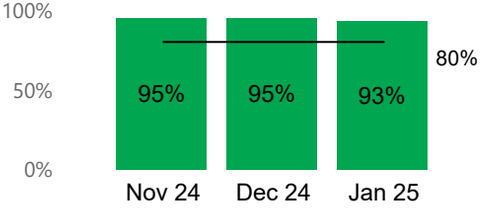
Member Services



Abandoned Call Rate (%)

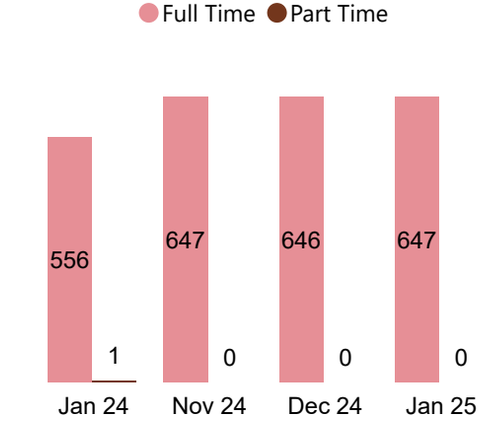


Calls Answered in 30 Seconds (%)

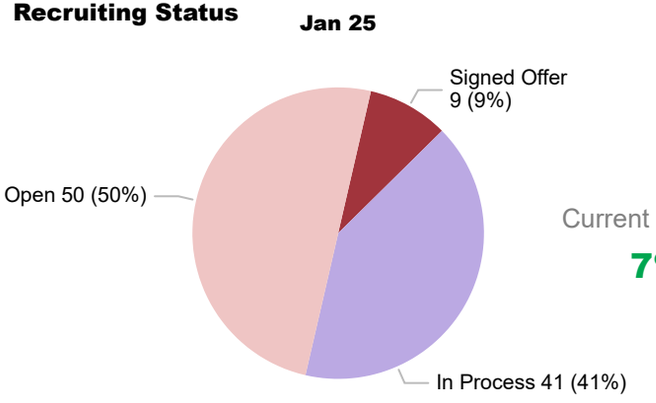


Average Call Times	Nov 24	Dec 24	Jan 25
Wait Time	00:12	00:14	00:16
Call Duration	07:13	07:33	07:34

Human Resources

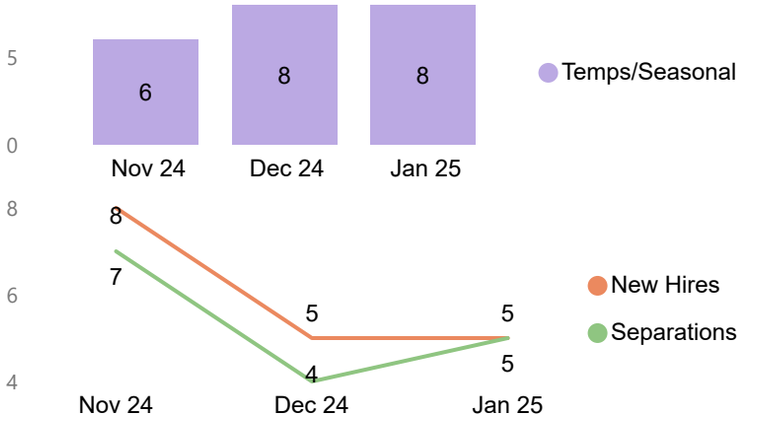


Recruiting Status Jan 25



Current Vacancy

7%



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Provider Services

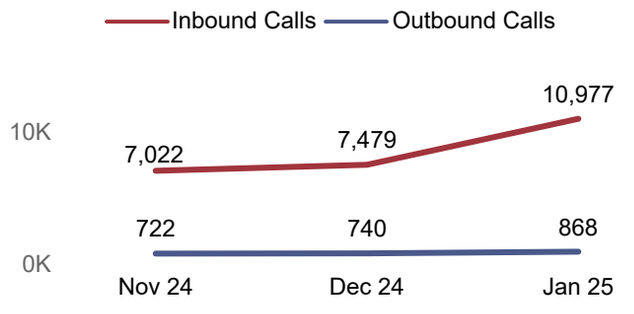
Provider Network

Hospital	17
Specialist	11,343
Primary Care Physician	792
Skilled Nursing Facility	105
Urgent Care	15
Health Centers (FQHCs and Non-FQHCs)	82
TOTAL	**12,354**

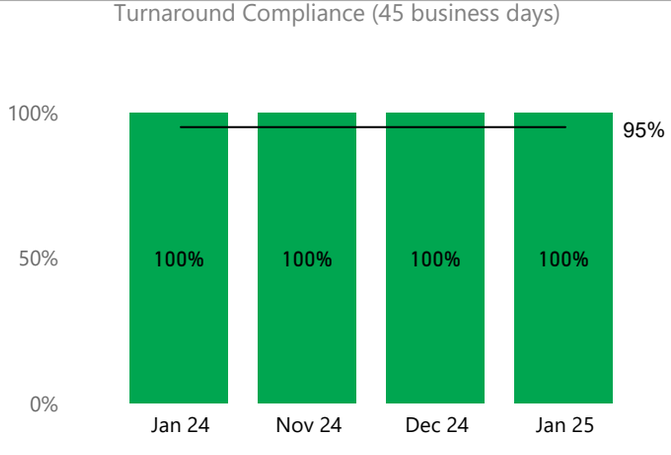
Provider Credentialing

4,420

Provider Call Center

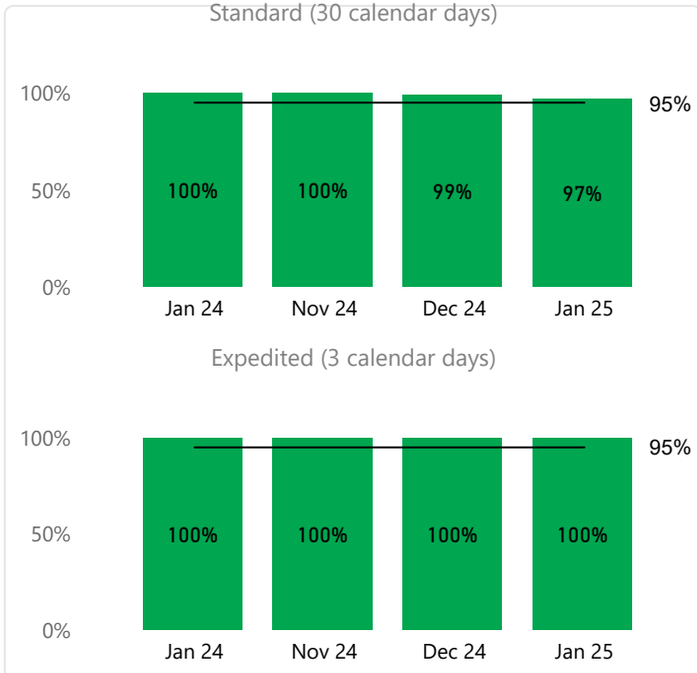


Provider Disputes & Resolutions

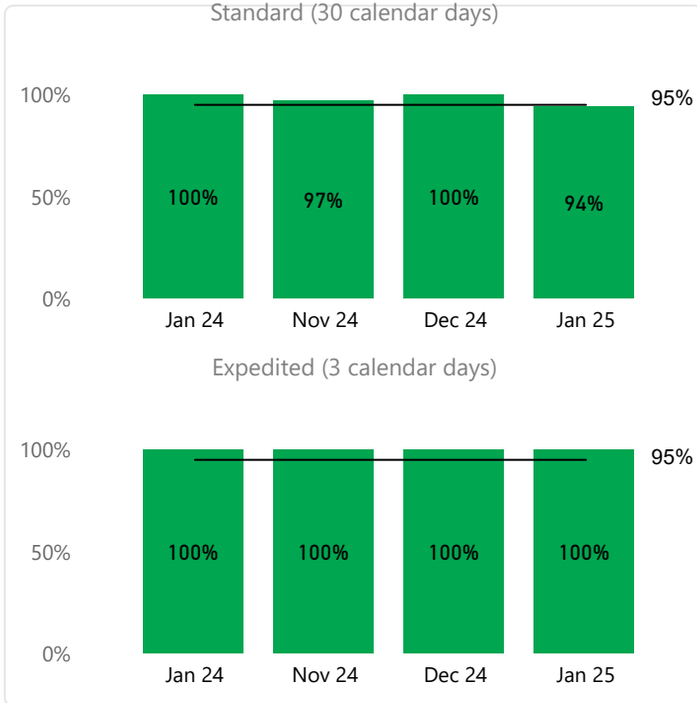


Compliance

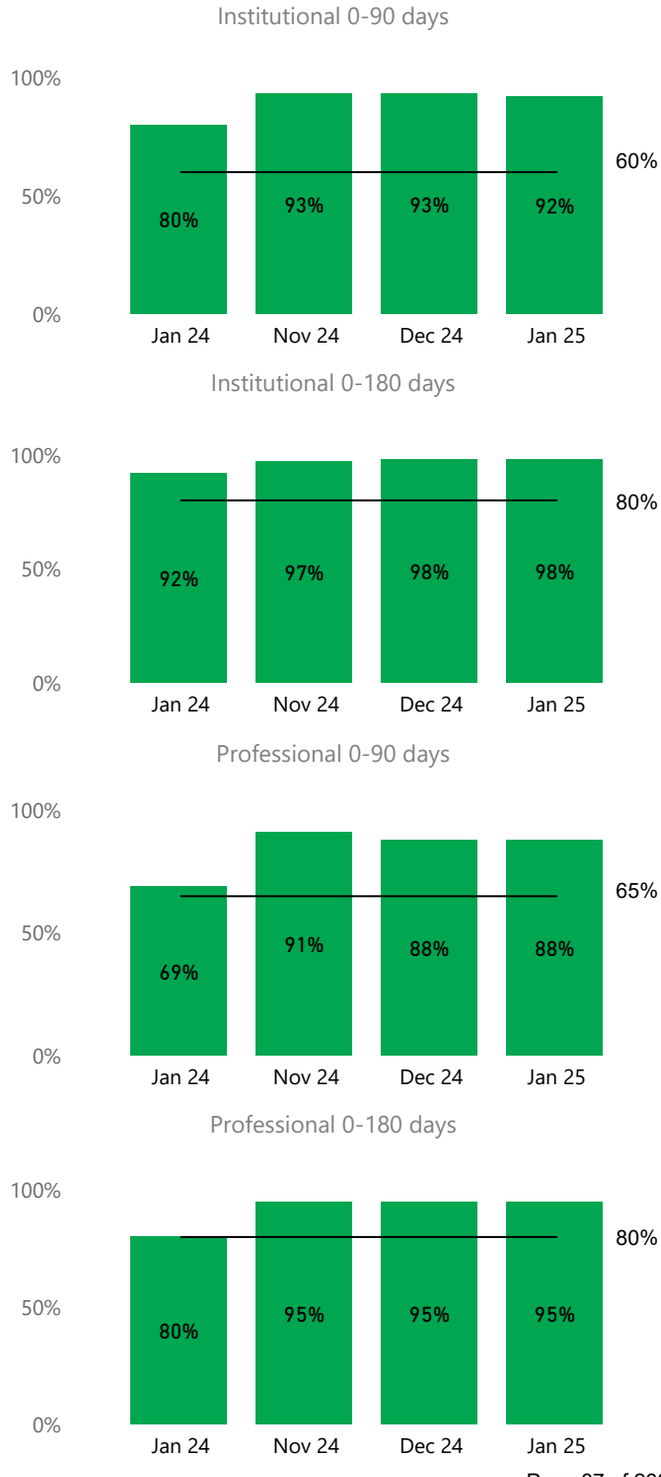
Member Grievances



Member Appeals



Encounter Data



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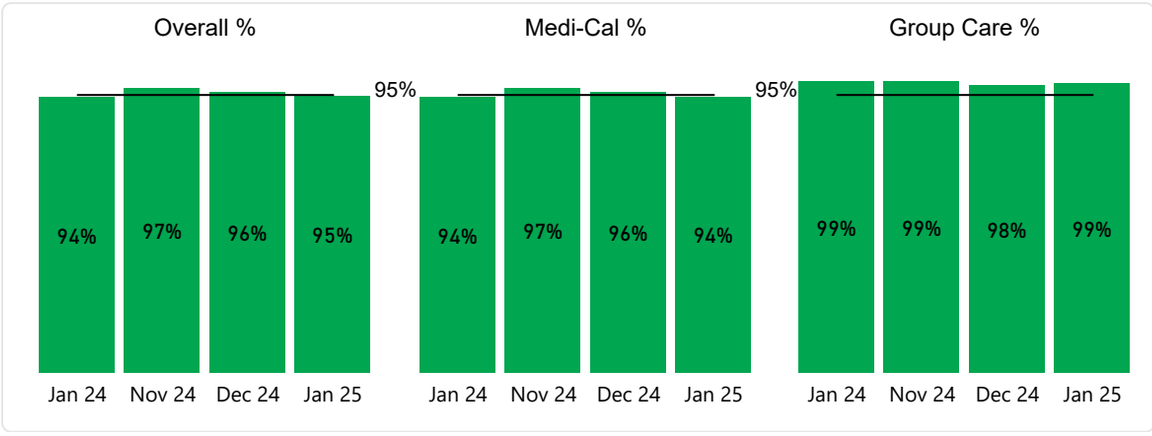
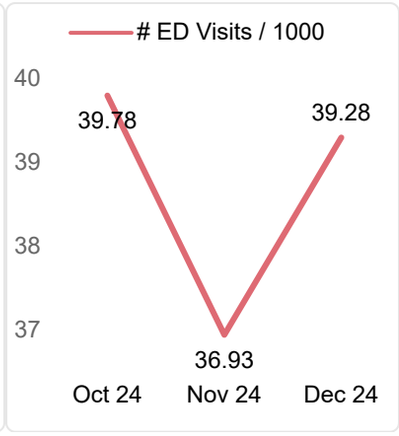
Health Care Services

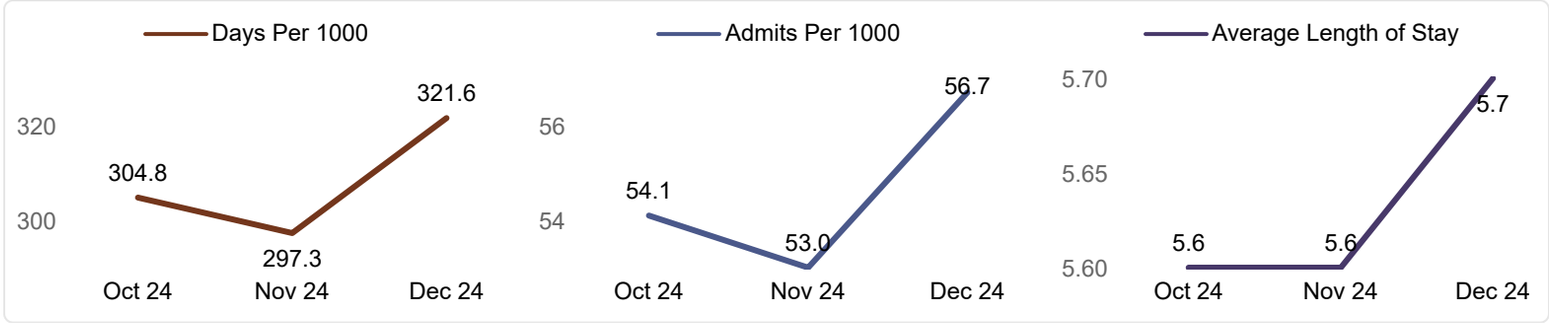
Authorization Turnaround



ED Utilization

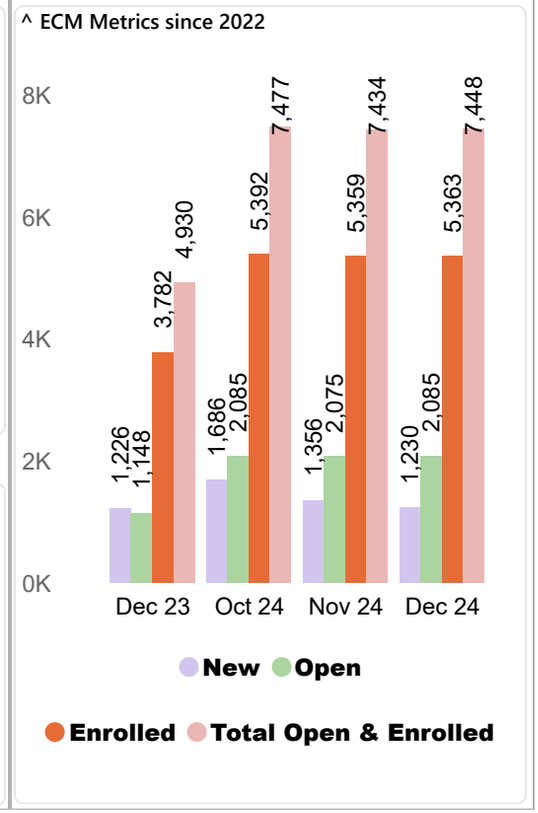


Inpatient Utilization

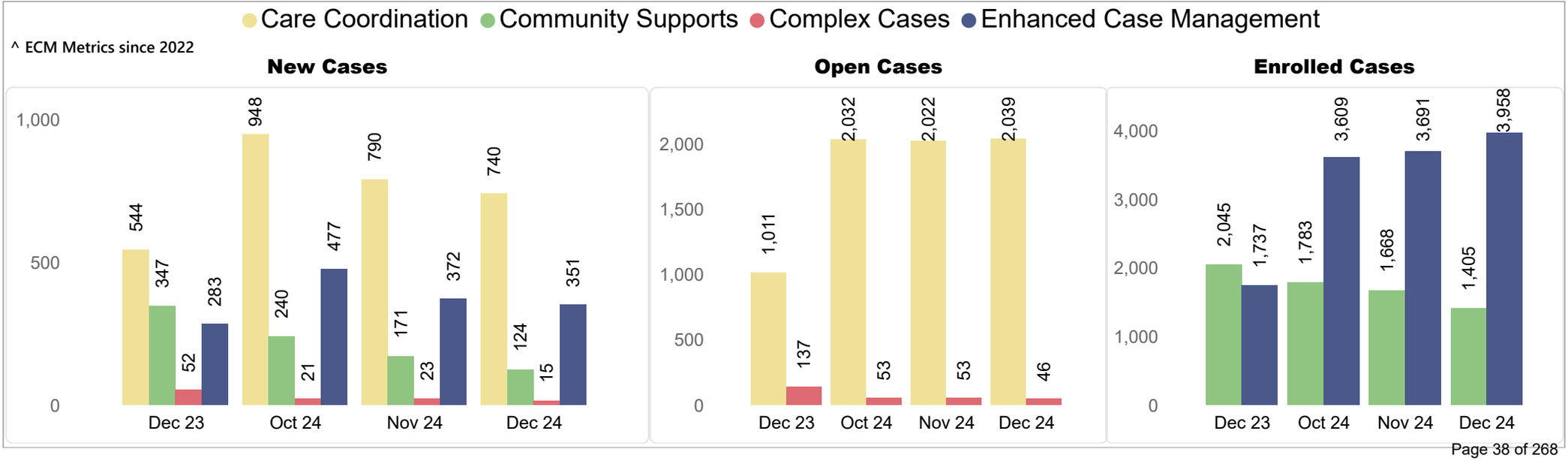


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Jan 24	Nov 24	Dec 24	Jan 25
HEALTHsuite System	100.0%	99.8%	100.0%	100.0%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Jan 24	Nov 24	Dec 24	Jan 25
Denial Rate Excluding Partial Denials (%)	3.6%	3.6%	3.5%	3.1%
Overall Denial Rate (%)	4.0%	3.9%	3.8%	3.5%
Partial Denial Rate (%)	0.3%	0.4%	0.3%	0.4%

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

Pharmacy Authorizations

Authorizations	Jan 24	Nov 24	Dec 24	Jan 25
Approved Prior Authorizations	30	34	43	49
Closed Prior Authorizations	107	85	26	23
Denied Prior Authorizations	43	62	73	77
Total Prior Authorizations	180	181	142	149

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

Finance

Gil Riojas

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

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

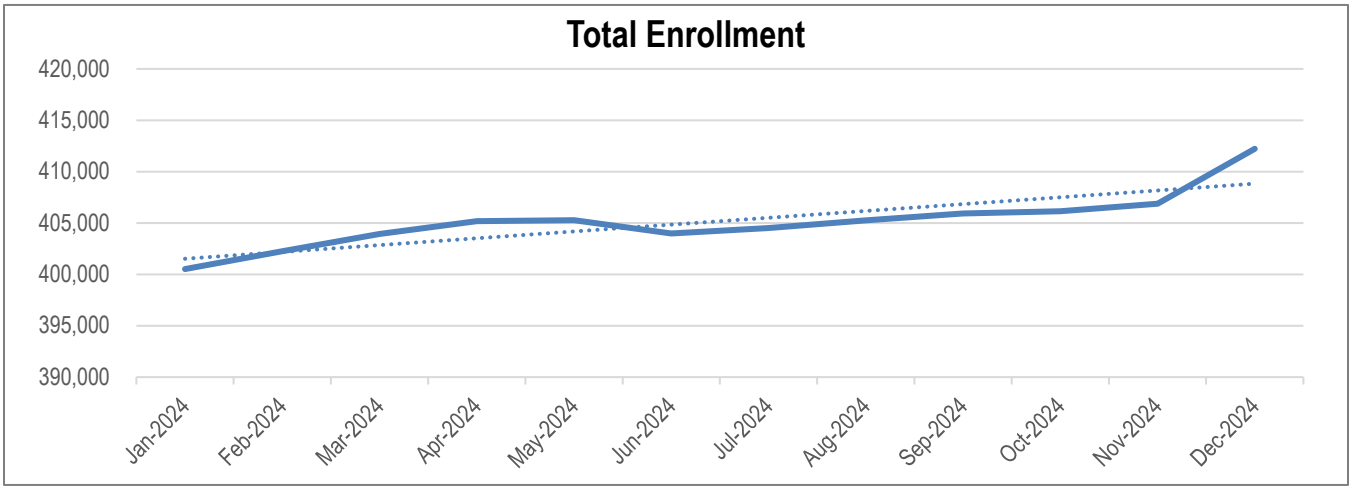
Date: **February 14th, 2025**

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

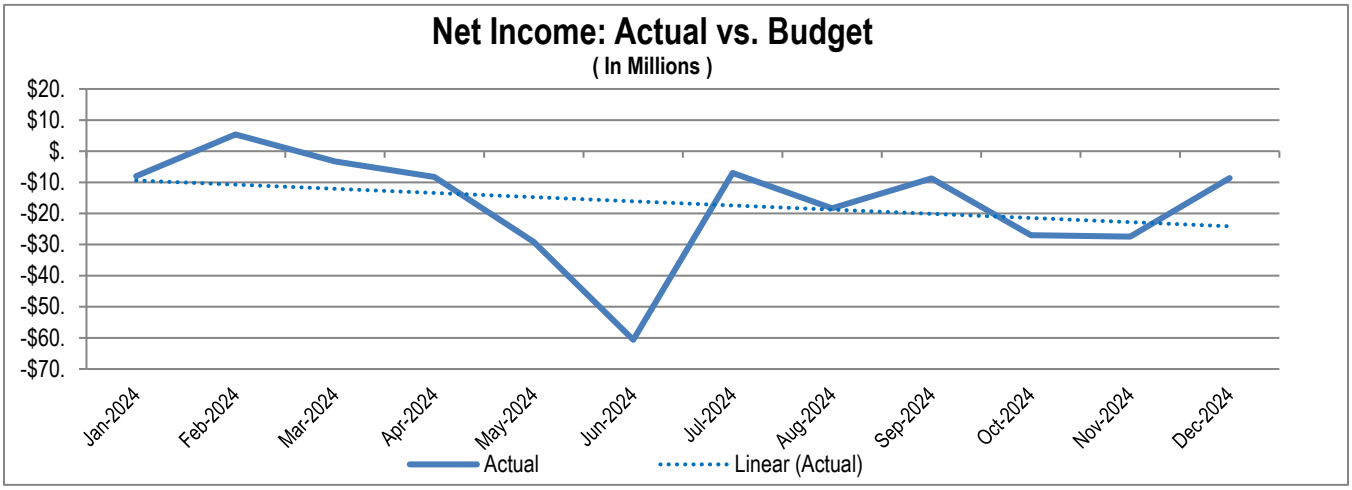
Executive Summary

For the month of December, the Alliance continued to see increases in enrollment, reaching 412,226 members. A Net Loss of $8.6 million was reported, and the Plan's Medical Expenses represented 101.0% of revenue. Alliance reserves decreased to 204% of required but continue to remain above minimum requirements.

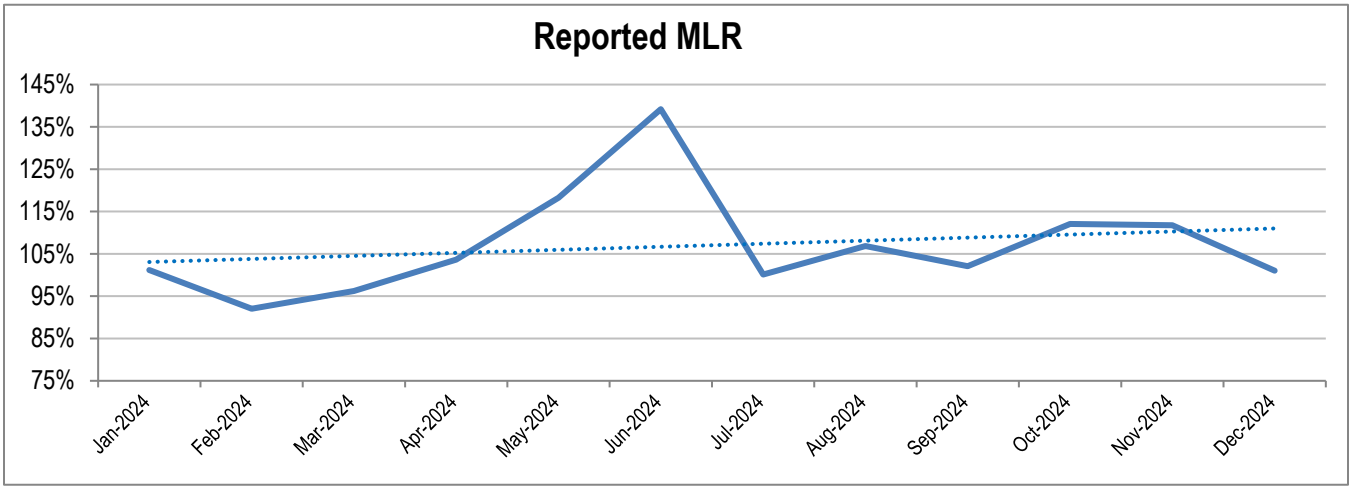
Enrollment – In December, Enrollment increased by 5,348 members.



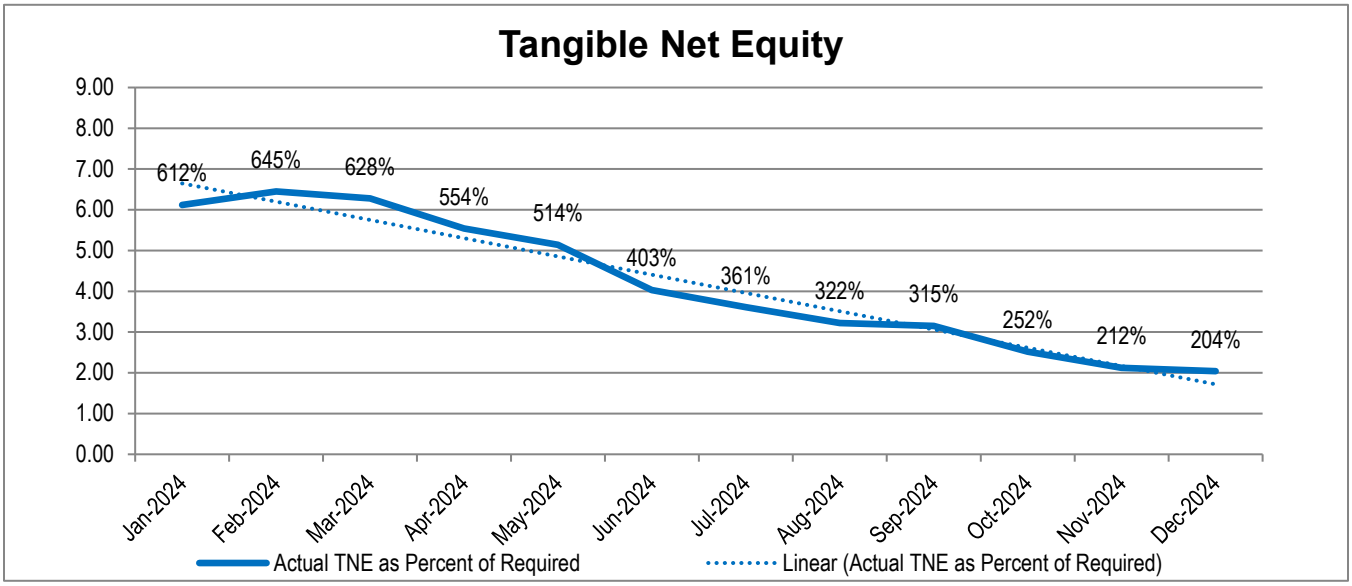
Net Income – For the month ended December 31st, 2024, actual Net Loss was $8.6 million vs. budgeted Net Loss of $26.8 million. For the fiscal YTD, actual Net Loss was $97.2 million vs. budgeted Net Loss of $97.8 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $163.0 million vs. budgeted Revenue of $137.1 million.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 101.0% for the month, and 105.7% for fiscal YTD. The major variances include unfavorable Primary Care, Outpatient, Inpatient/SNF, Ancillary FFS, Outpatient FFS, and Long-Term Care.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $77.6M in reserves, we reported $158.2M. Our overall TNE remains above DMHC requirements at 204%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date investments show a gain of $17.5M. Capital assets acquired so far are $530k.

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

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

Date: **February 14th, 2025**

Subject: **Finance Report – December 2024**

Executive Summary

- For the month ended December 31st, 2024, the Alliance had enrollment of 412,226 members, a Net Loss of $8.6 million and 204% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$227,458	$1,486,337
Medical Expense	164,647	1,063,464
Admin. Expense	9,438	57,654
MCO Tax Expense	64,497	479,901
Other Inc. / (Exp.)	2,481	17,522
Net Income	**($8,643)**	**($97,161)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	($6,413)	($92,280)
Group Care	(336)	(237)
Medicare	(1,893)	(4,643)
	($8,643)	**($97,161)**

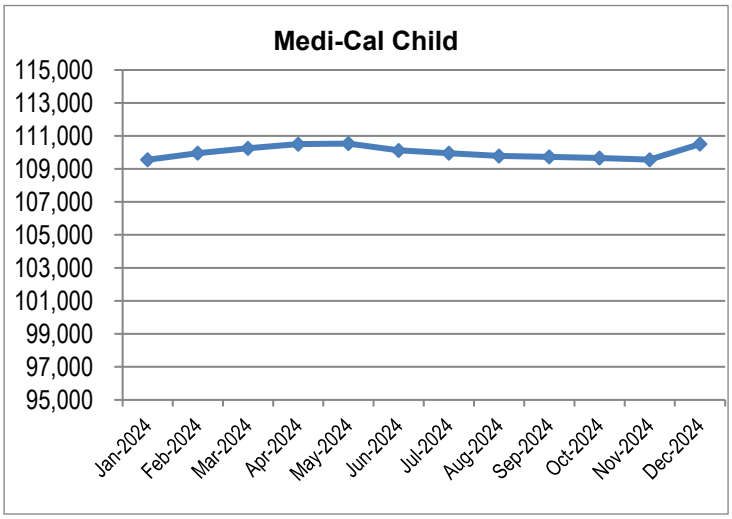
Enrollment

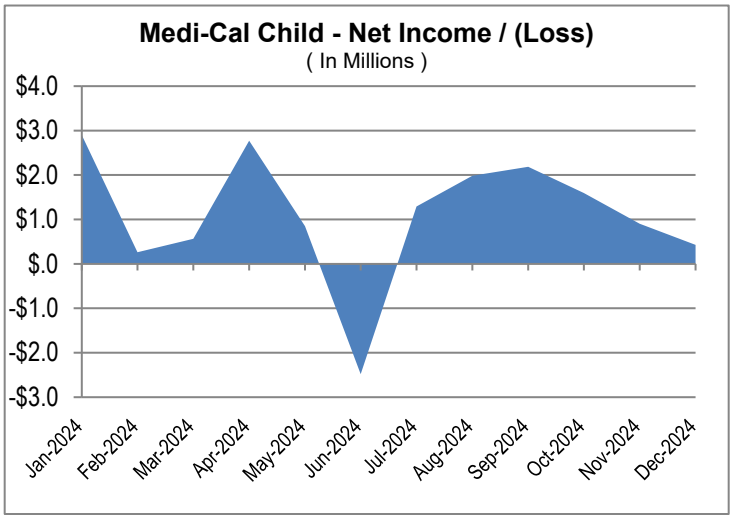
- Total enrollment increased by 5,348 members since November 2024.
- Total enrollment increased by 8,236 members since June 2024.

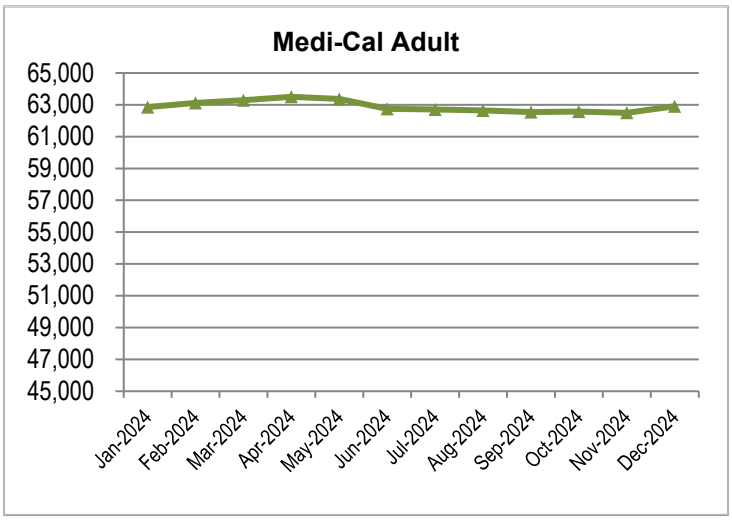
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

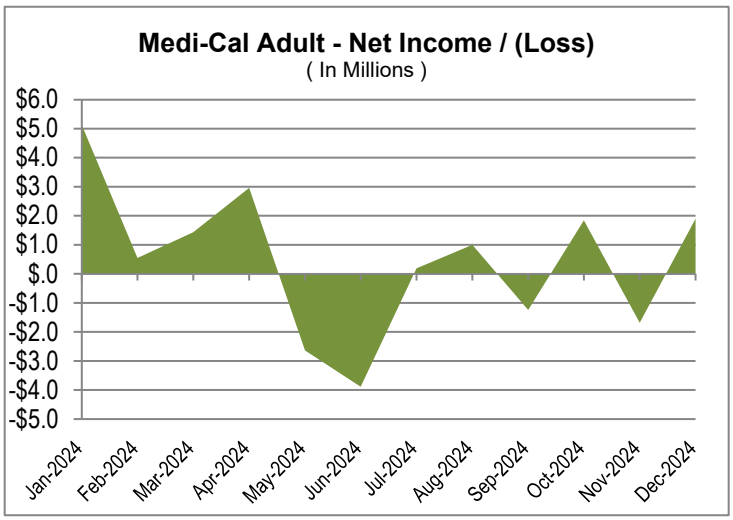
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
62,905	62,704	201	0.3%	Adult	375,884	375,822	62	0.0%
110,506	109,882	624	0.6%	Child	659,195	658,782	413	0.1%
36,127	35,458	669	1.9%	SPD	212,632	211,783	849	0.4%
40,798	40,144	654	1.6%	Duals	241,339	240,472	867	0.4%
154,560	151,400	3,160	2.1%	ACA OE	908,505	905,035	3,470	0.4%
254	254	0	0.0%	LTC	1,446	1,442	4	0.3%
1,286	1,267	19	1.5%	LTC Duals	7,562	7,540	22	0.3%
406,436	**401,109**	**5,327**	**1.3%**	**Medi-Cal Total**	**2,406,563**	**2,400,876**	**5,687**	**0.2%**
5,790	5,769	21	0.4%	Group Care	34,402	34,378	24	0.1%
412,226	**406,878**	**5,348**	**1.3%**	**Total**	**2,440,965**	**2,435,254**	**5,711**	**0.2%**

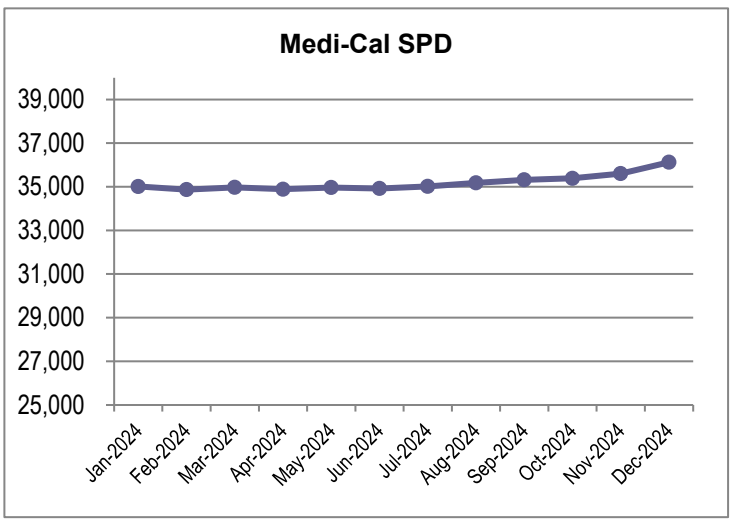
Enrollment and Profitability by Program and Category of Aid

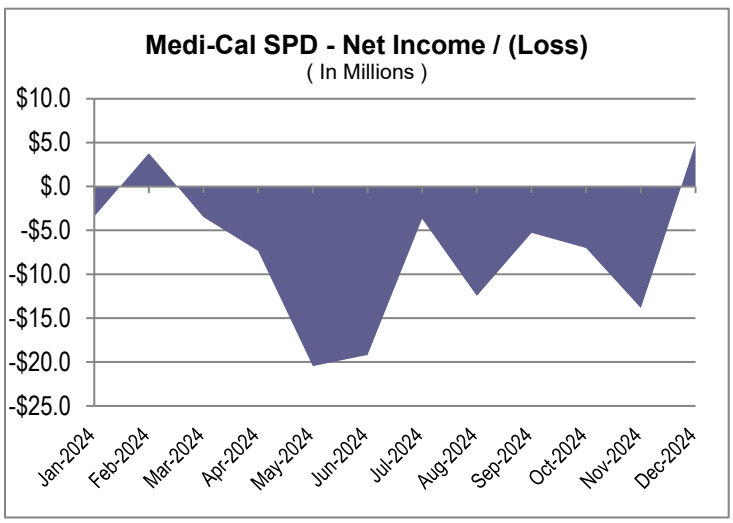




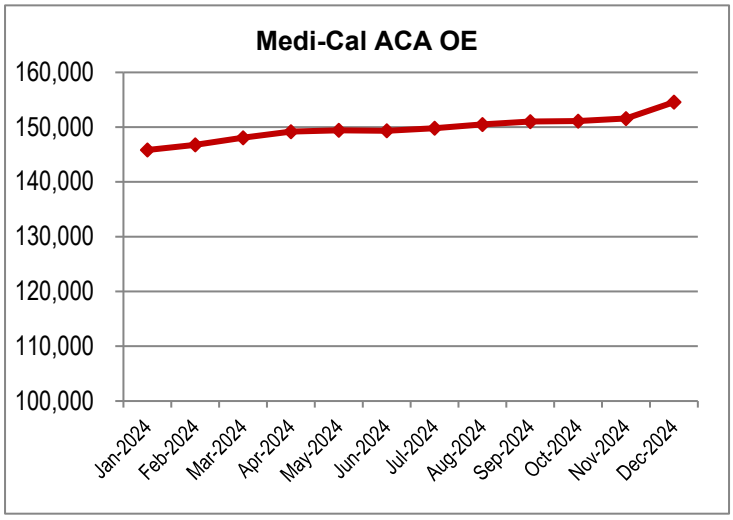


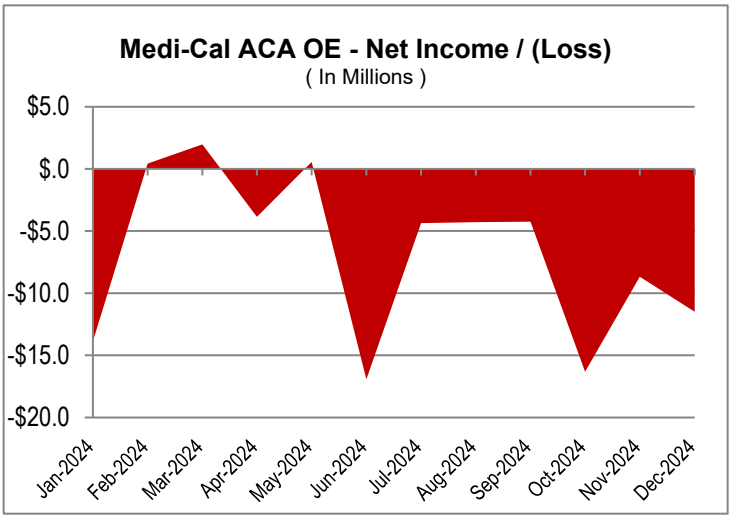


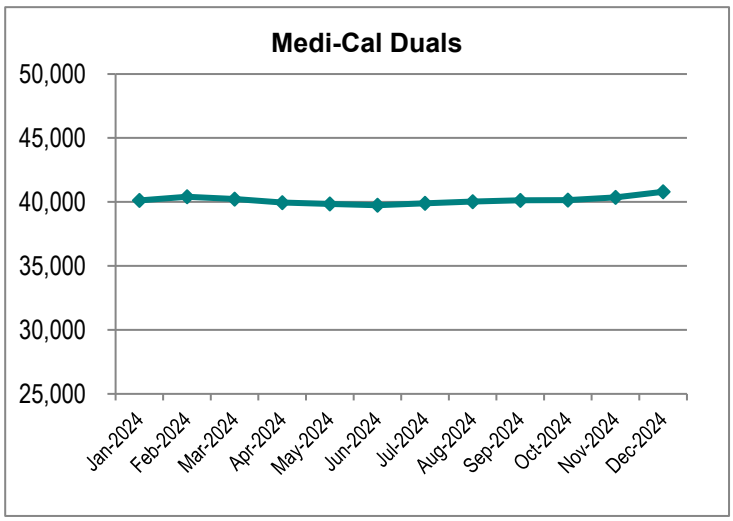


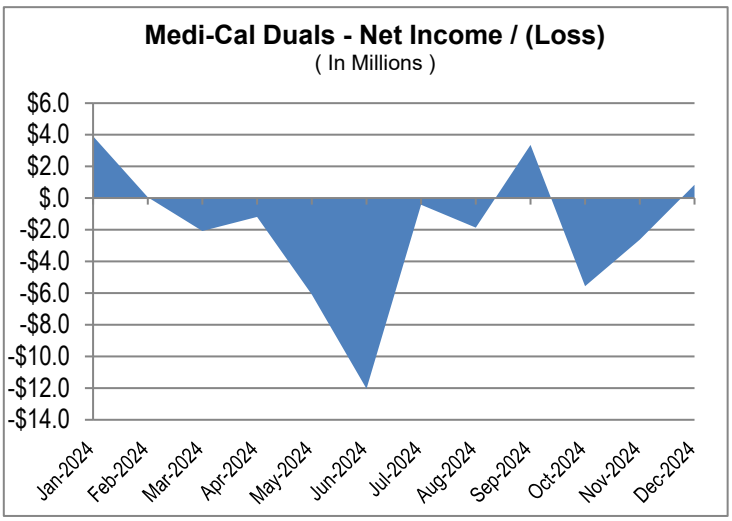


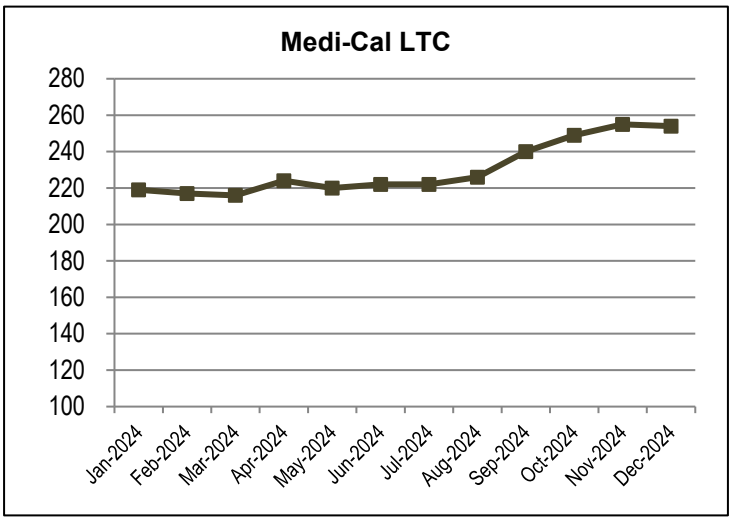
Enrollment and Profitability by Program and Category of Aid

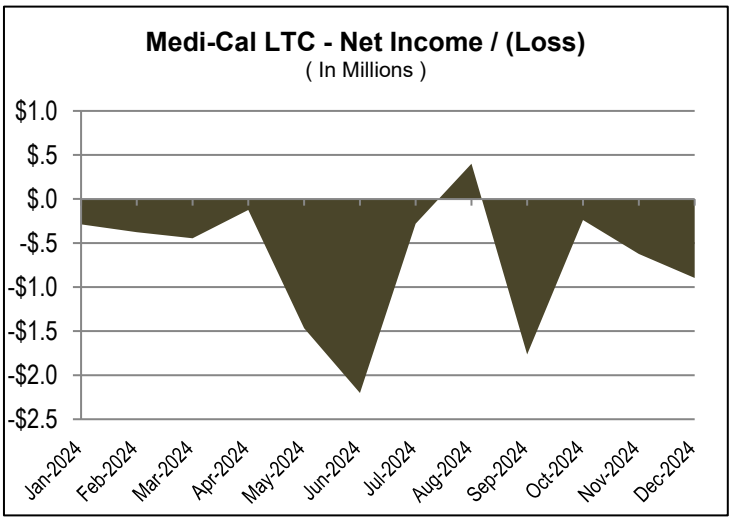




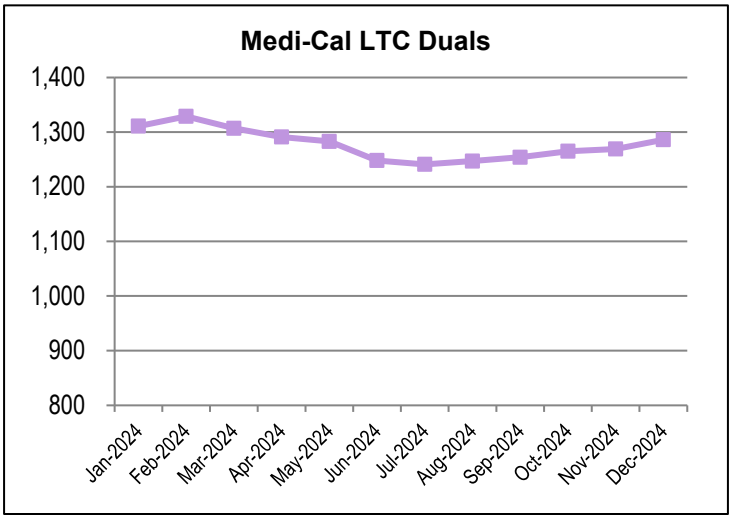


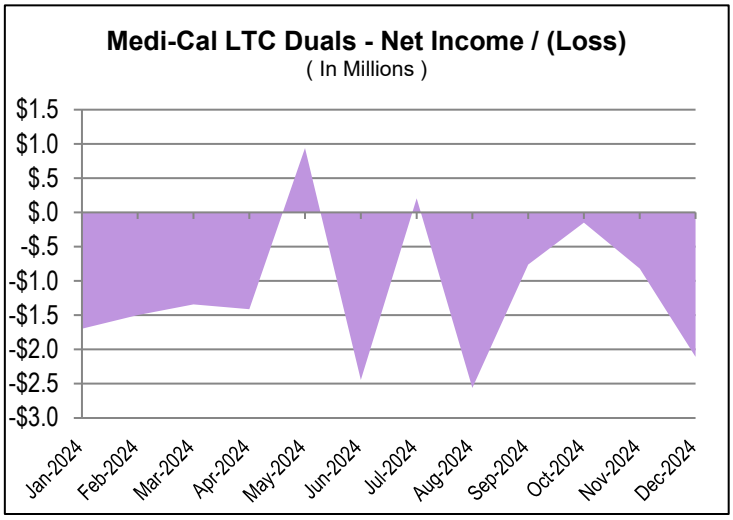


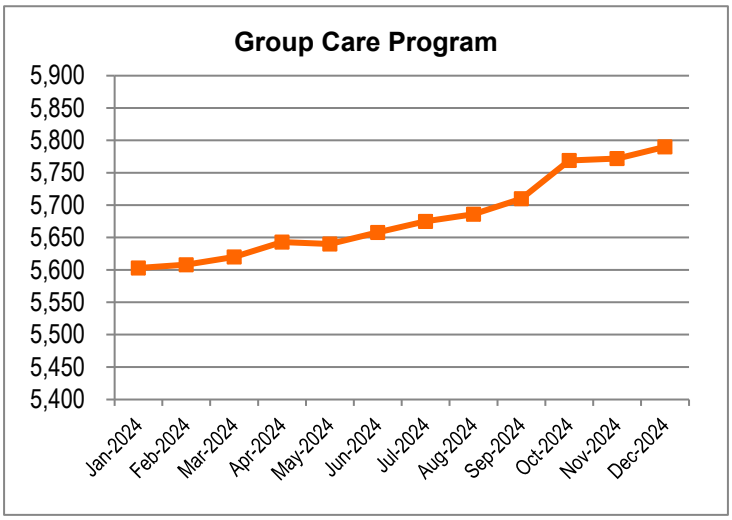


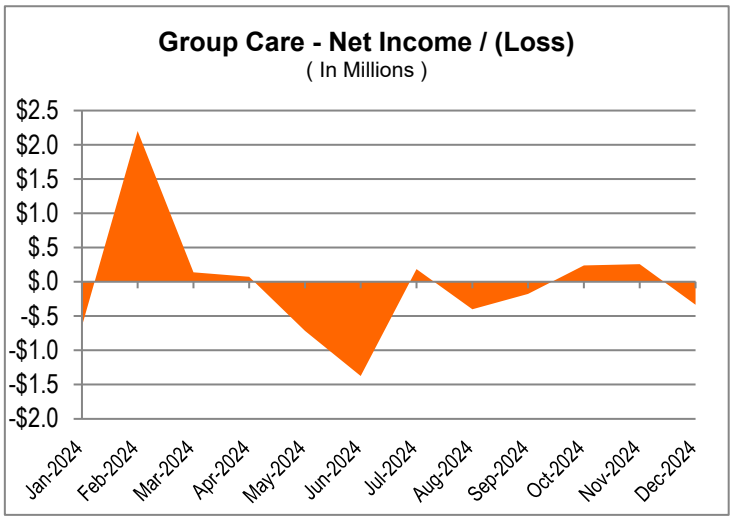


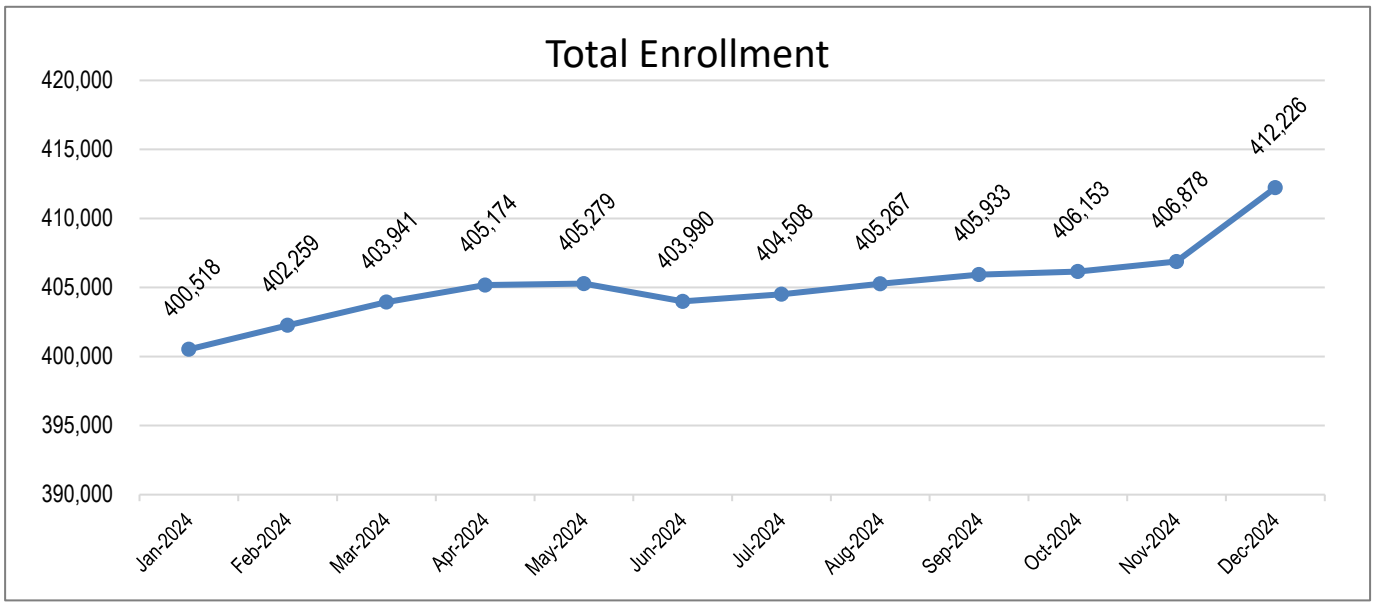
Enrollment and Profitability by Program and Category of Aid

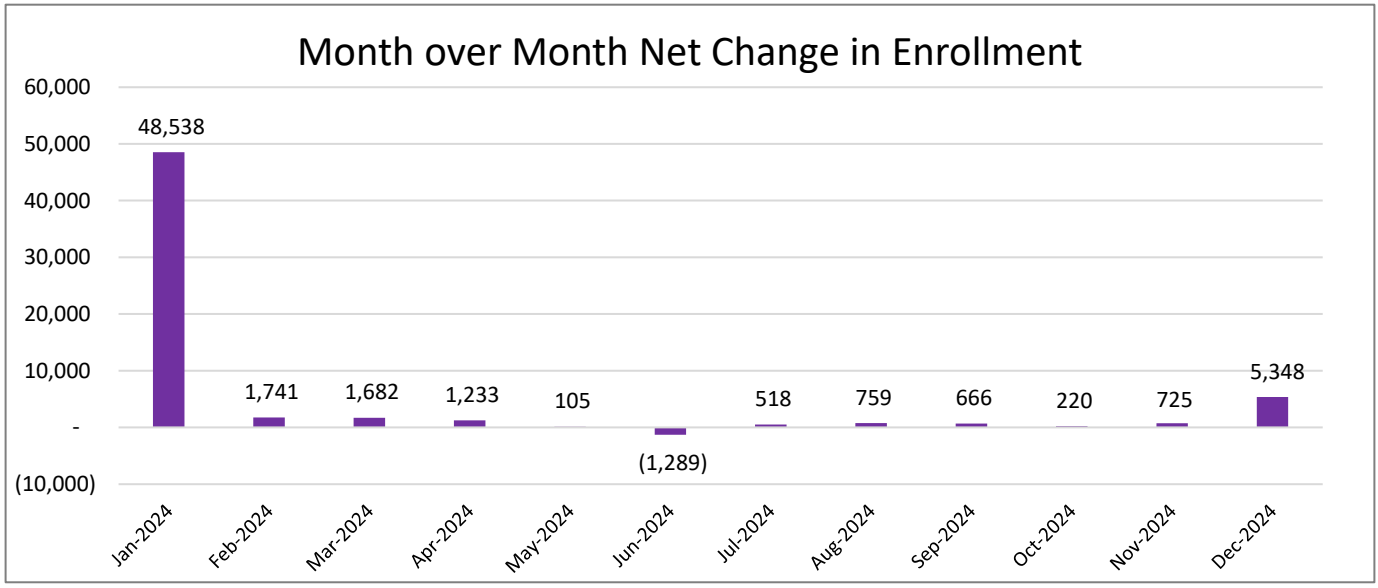








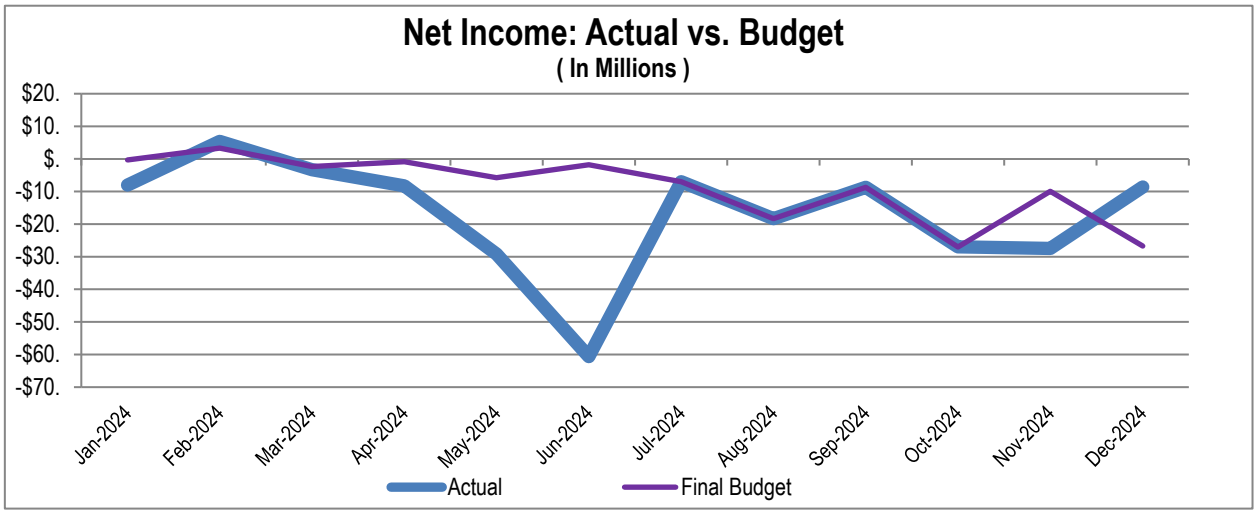




- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and ended May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the Alliance.
- In January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

Net Income

- For the month ended December 31st, 2024:
  - Actual Net Loss $8.6 million.
  - Budgeted Net Loss $26.8 million.
- For the fiscal YTD ended December 31st, 2024:
  - Actual Net Loss $97.2 million.
  - Budgeted Net Loss $97.8 million.

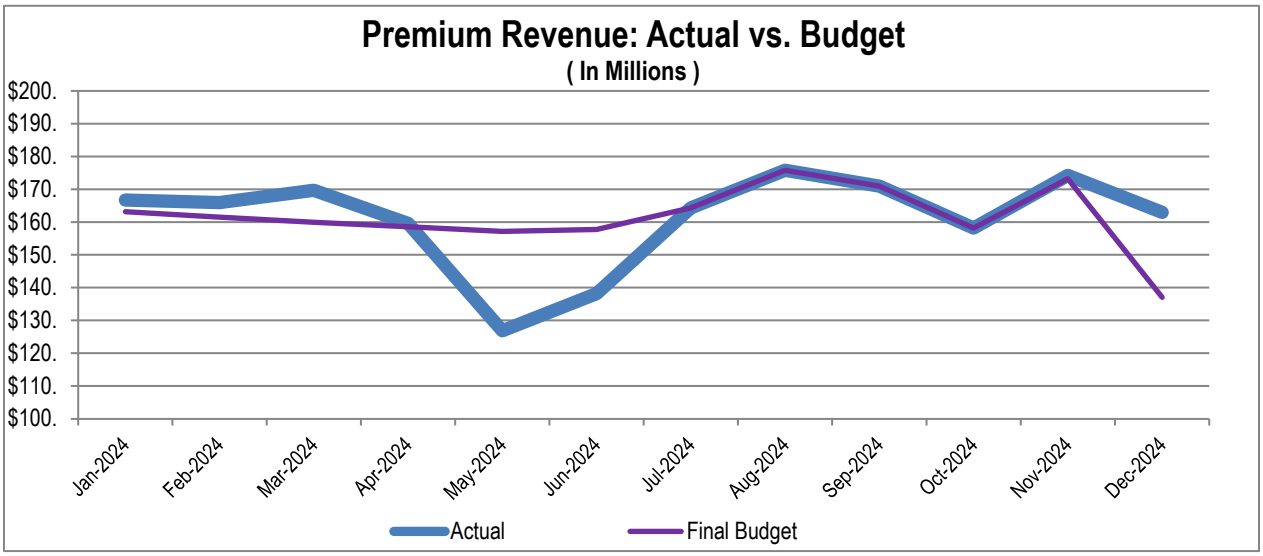


- The favorable variance of $18.1 million in the current month is primarily due to:
  - Favorable $25.9 million higher than anticipated Premium Revenue.
  - Favorable $1.9 million lower than anticipated Administrative Expense.
  - Unfavorable $10.1 million higher than anticipated Medical Expense.

Premium Revenue

- For the month ended December 31st, 2024:
  - Actual Revenue: $163.0 million.
  - Budgeted Revenue: $137.1 million.

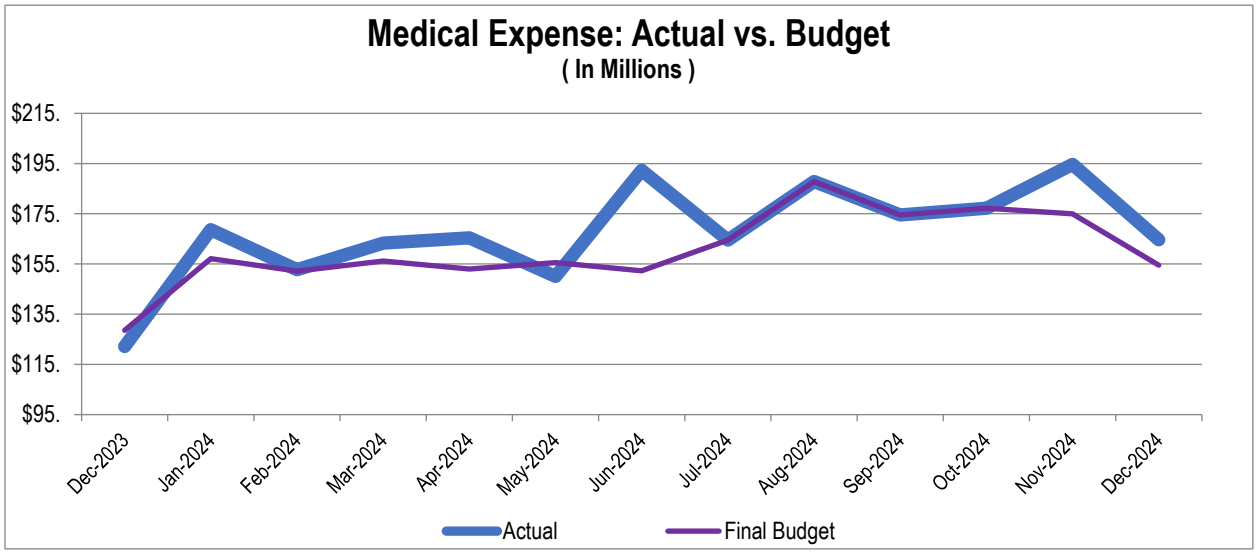
- For the fiscal YTD ended December 31st, 2024:
  - Actual Revenue: $1.0 billion
  - Budgeted Revenue: $979.5 million.



- For the month ended December 31st, 2024, the favorable Premium Revenue variance of $25.9 million is primarily due to the following:
  - Favorable CY2024 rate increase impact recorded.
  - Favorable volume variance for the current month.
  - Partially offset by a CY2022 to CY2024 Risk Corridor Adjustment recorded for MOT and ECM.

Medical Expense

- For the month ended December 31st, 2024:
  - Actual Medical Expense: $164.6 million.
  - Budgeted Medical Expense: $154.5 million.
- For the fiscal YTD ended December 31st, 2024:
  - Actual Medical Expense: $1.1 billion.
  - Budgeted Medical Expense: $1.0 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 our actuarial consultants.

- For December, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $523,000. Year to date, the estimate for prior years increased by $5.6 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 vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$101,867,753	$0	$101,867,753	$97,730,622	($4,137,131)	(4.2%)
Primary Care FFS	$21,177,085	$103,553	$21,280,638	$17,796,203	($3,380,883)	(19.0%)
Specialty Care FFS	$50,231,958	$225,513	$50,457,472	$49,467,511	($764,447)	(1.5%)
Outpatient FFS	$75,229,233	$372,476	$75,601,708	$72,449,386	($2,779,846)	(3.8%)
Ancillary FFS	$101,266,006	($392,708)	$100,873,298	$99,641,566	($1,624,440)	(1.6%)
Pharmacy FFS	$80,557,982	$236,838	$80,794,820	$81,015,415	$457,433	0.6%
ER Services FFS	$62,576,458	$139,638	$62,716,096	$62,536,828	($39,629)	(0.1%)
Inpatient Hospital FFS	$330,938,402	$3,251,176	$334,189,578	$320,106,876	($10,831,526)	(3.4%)
Long Term Care FFS Other	$204,581,218	$1,682,327	$206,263,545	$199,863,070	($4,718,148)	(2.4%)
Benefits & Services Net	$28,421,691	$0	$28,421,691	$31,797,343	$3,375,652	10.6%
Reinsurance	$997,634	$0	$997,634	$1,164,666	$167,032	14.3%
	$1,057,845,420	**$5,618,812**	**$1,063,464,232**	**$1,033,569,486**	**($24,275,934)**	**(2.3%)**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

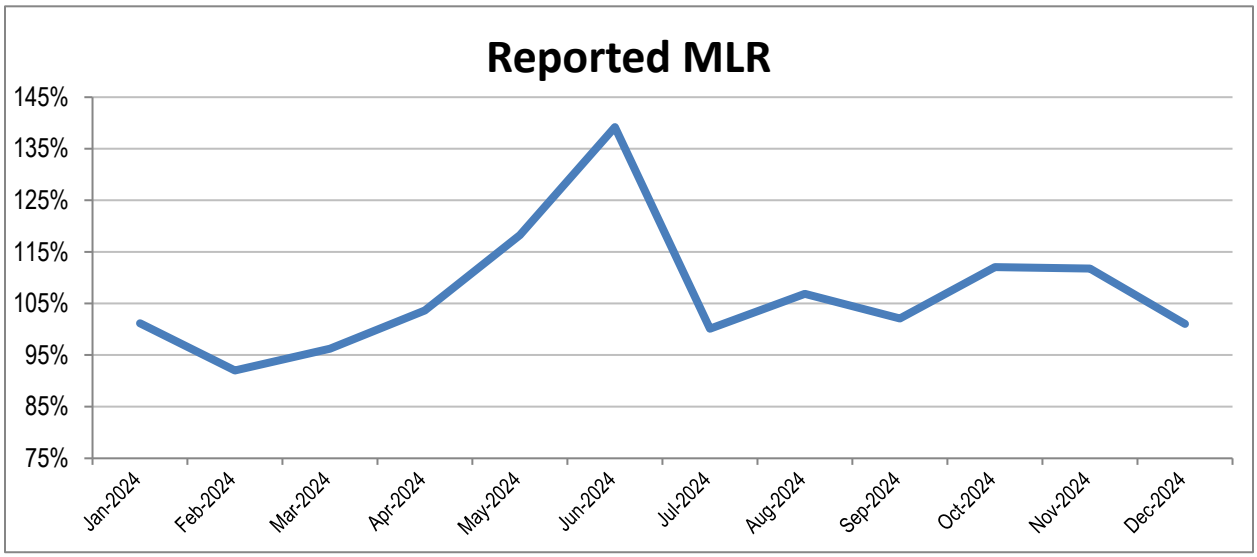
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$41.73	$0.00	$41.73	$40.13	($1.60)	(4.0%)
Primary Care FFS	$8.68	$0.04	$8.72	$7.31	($1.37)	(18.7%)
Specialty Care FFS	$20.58	$0.09	$20.67	$20.31	($0.27)	(1.3%)
Outpatient FFS	$30.82	$0.15	$30.97	$29.75	($1.07)	(3.6%)
Ancillary FFS	$41.49	($0.16)	$41.33	$40.92	($0.57)	(1.4%)
Pharmacy FFS	$33.00	$0.10	$33.10	$33.27	$0.27	0.8%
ER Services FFS	$25.64	$0.06	$25.69	$25.68	$0.04	0.2%
Inpatient Hospital FFS	$135.58	$1.33	$136.91	$131.45	($4.13)	(3.1%)
Long Term Care FFS Other	$83.81	$0.69	$84.50	$82.07	($1.74)	(2.1%)
Benefits & Services Net	$11.64	$0.00	$11.64	$13.06	$1.41	10.8%
Reinsurance	$0.41	$0.00	$0.41	$0.48	$0.07	14.5%
	$433.37	**$2.30**	**$435.67**	**$424.42**	**($8.95)**	**(2.1%)**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $24.3 million unfavorable to budget. On a PMPM basis, medical expense is 2.1% unfavorable to budget. For per-member-per-month expense:
    - Capitated Expense is over budget due to inclusion of Targeted Rate Increase (TRI) in capitation payments.
    - Primary Care Expense is over budget due to higher utilization and unit cost in the ACA OE and Child aid code categories.

- Specialty Care Expense is slightly above budget, driven by higher than expected SPD and ACA OE utilization.
- Outpatient Expense is over budget mostly driven by lab and radiology unit cost in the SPD, ACA OE and Adult aid code categories.
- Ancillary Expense is over budget due to higher Non-Emergency Transportation, lab and radiology, Behavioral Health, Home Health, DME, Medical Supplies and CBAS expense in the Child aid code category.
- Pharmacy Expense is under budget due to Non-PBM expense driven by lower utilization in the ACA OE aid code category.
- Emergency Room Expense is under budget driven by lower Child aid code category utilization and lower Dual member unit cost.
- Inpatient Expense is over budget driven by higher utilization in the SPD and ACA OE aid code categories.
- Long Term Care Expense is over budget due to higher unit cost in the SPD and ACA OE aid code categories.
- Other Benefits & Services is under budget, due to lower than expected purchased and professional services, community relations, licenses and insurance expense.
- Net Reinsurance is under budget because more recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported medical expense divided by Premium revenue) was 101.0% for the month and 105.7% for the fiscal year-to-date.



Administrative Expense

- For the month ended December 31st, 2024:
  - Actual Administrative Expense: $9.4 million.
  - Budgeted Administrative Expense: $11.3 million.

- For the fiscal YTD ended December 31st, 2024:
  - Actual Administrative Expense: $57.7 million.
  - Budgeted Administrative Expense: $60.7 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 %**
$5,708,733	$5,951,534	$242,801	4.1%	Employee Expense	$33,809,934	$34,406,434	$596,500	1.7%
82,891	74,912	(7,979)	(10.7%)	Medical Benefits Admin Expense	465,196	454,633	(10,564)	(2.3%)
2,160,244	2,997,118	836,874	27.9%	Purchased & Professional Services	13,480,907	14,783,029	1,302,123	8.8%
1,486,030	2,281,317	795,287	34.9%	Other Admin Expense	9,898,416	11,063,341	1,164,924	10.5%
$9,437,898	$11,304,880	$1,866,983	16.5%	Total Administrative Expense	$57,654,453	$60,707,437	$3,052,983	5.0%

The year-to-date variances include:

- Favorable Employee and Temporary Services and delayed training, travel, and other employee-related expenses.
- Favorable in Purchased & Professional Services, primarily for the timing for Consulting Services and Other Purchased Services.
- Favorable Printing/Postage/Promotion and Supplies & Other Expenses.
- Favorable in Licenses, Insurance & Fees for IT-related Licenses and Subscriptions as well as reduction in Insurance Premiums.
- Favorable in Provider Interest, Supplies & Other Expenses
- Unfavorable Medical Benefit Admin Fees as well as Building Occupancy costs.

The Administrative Loss Ratio (ALR) is 5.8% of net revenue for the month and 5.7% of net revenue year-to-date. Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $775,000.

Other Income / (Expense)

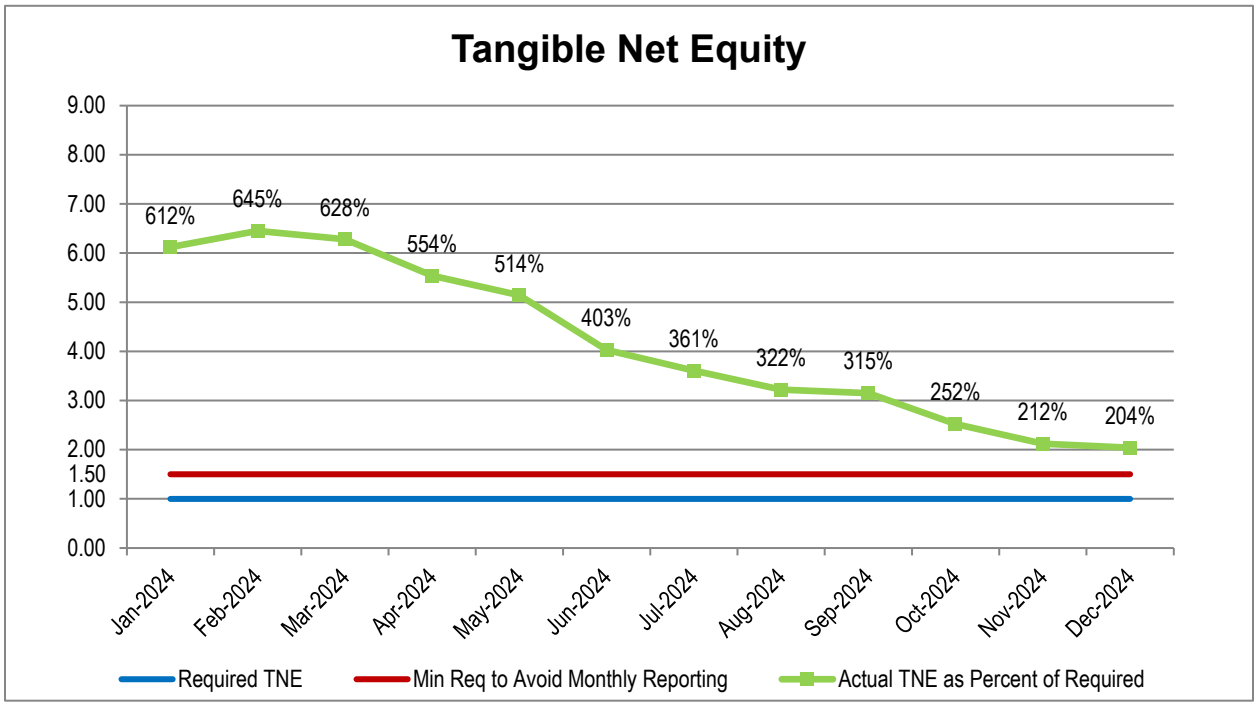
Other Income & Expense is comprised of investment income and claims interest. Fiscal year-to-date net investments show a gain of $17.5 million.

Managed Care Organization (MCO) Provider Tax

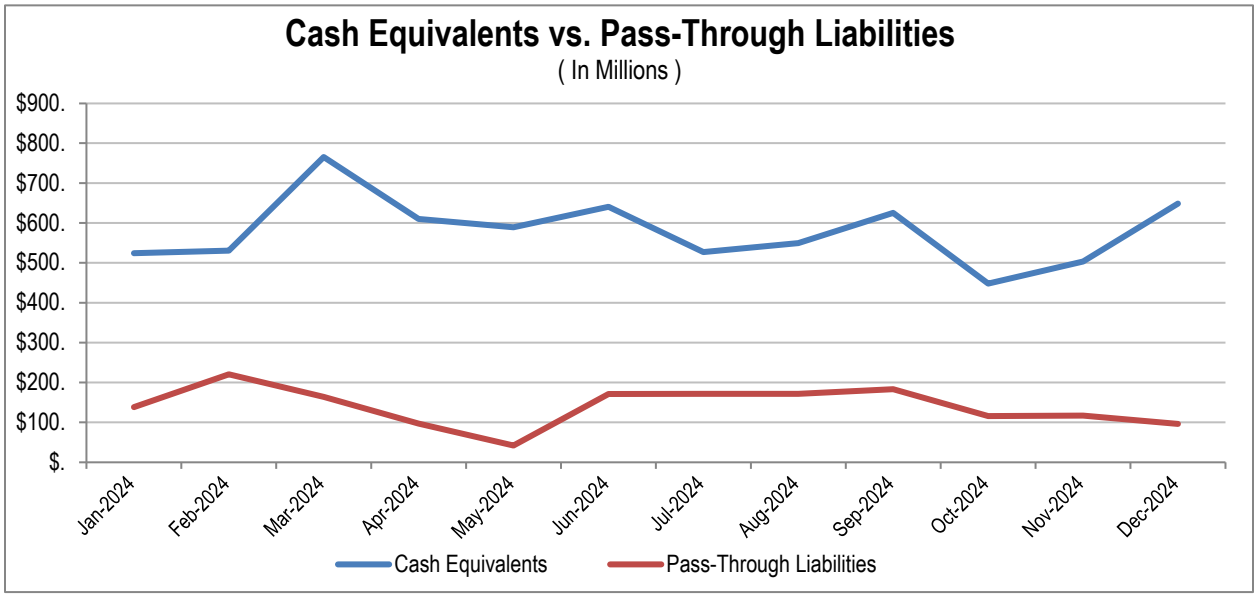
- Revenue:
  - For the month ended December 31st, 2024:
    - Actual: $64.5 million.
    - Budgeted: $63.7 million.
  - For the fiscal YTD ended December 31st, 2024:
    - Actual: $479.9 million.
    - Budgeted: $479.0 million.
- Expense:
  - For the month ended December 31st, 2024:
    - Actual: $64.5 million.
    - Budgeted: $63.7 million.
  - For the fiscal YTD ended December 31st, 2024:
    - Actual: $479.9 million.
    - Budgeted: $479.0 million.

Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
  - Required TNE $77.6 million
  - Actual TNE $158.2 million
  - Excess TNE $80.6 million
  - TNE % of Required TNE 204%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $648.6 million
    - Pass-Through Liabilities $96.2 million
    - Uncommitted Cash $552.4 million
    - Working Capital $99.3 million
    - Current Ratio 1.10 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $530,000.
- Annual capital budget: $2.0 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 DECEMBER 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
406,436	401,109	5,327	1.3%	1. Medi-Cal	2,406,563	2,400,876	5,687	0.2%
5,790	5,769	21	0.4%	2. GroupCare	34,402	34,378	24	0.1%
412,226	**406,878**	**5,348**	**1.3%**	**3. TOTAL MEMBER MONTHS**	**2,440,965**	**2,435,254**	**5,711**	**0.2%**
				REVENUE				
$162,960,491	$137,079,292	$25,881,199	18.9%	4. Premium Revenue	$1,006,435,650	$979,541,837	$26,893,812	2.7%
$64,497,329	$63,651,987	$845,342	1.3%	5. MCO Tax Revenue AB119	$479,901,248	$478,998,778	$902,470	0.2%
$227,457,820	**$200,731,280**	**$26,726,540**	**13.3%**	**6. TOTAL REVENUE**	**$1,486,336,898**	**$1,458,540,615**	**$27,796,282**	**1.9%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$10,453,108	$8,383,852	($2,069,256)	(24.7%)	7. Capitated Medical Expense	$101,867,753	$97,730,622	($4,137,131)	(4.2%)
				Fee for Service Medical Expenses				
$55,495,011	$52,329,810	($3,165,200)	(6.0%)	8. Inpatient Hospital Expense	$334,189,578	$320,106,876	($14,082,702)	(4.4%)
$7,576,142	$4,639,765	($2,936,377)	(63.3%)	9. Primary Care Physician Expense	$21,280,638	$17,796,203	($3,484,435)	(19.6%)
$9,172,103	$8,225,668	($946,434)	(11.5%)	10. Specialty Care Physician Expense	$50,457,472	$49,467,511	($989,960)	(2.0%)
$5,066,160	$6,740,978	$1,674,818	24.8%	11. Ancillary Medical Expense	$100,873,298	$99,641,566	($1,231,732)	(1.2%)
$13,141,836	$11,684,491	($1,457,345)	(12.5%)	12. Outpatient Medical Expense	$75,601,708	$72,449,386	($3,152,322)	(4.4%)
$10,816,202	$10,423,842	($392,361)	(3.8%)	13. Emergency Expense	$62,716,096	$62,536,828	($179,268)	(0.3%)
$11,145,374	$12,274,518	$1,129,144	9.2%	14. Pharmacy Expense	$80,794,820	$81,015,415	$220,595	0.3%
$37,589,778	$33,132,376	($4,457,402)	(13.5%)	15. Long Term Care Expense	$206,263,545	$199,863,070	($6,400,475)	(3.2%)
$150,002,605	$139,451,449	($10,551,157)	(7.6%)	16. Total Fee for Service Expense	$932,177,155	$902,876,856	($29,300,299)	(3.2%)
$3,832,426	$6,251,734	$2,419,308	38.7%	17. Other Benefits & Services	$28,421,691	$31,797,343	$3,375,652	10.6%
$359,151	$439,727	$80,576	18.3%	18. Reinsurance Expense	$997,634	$1,164,666	$167,032	14.3%
$164,647,291	**$154,526,761**	**($10,120,530)**	**(6.5%)**	**20. TOTAL MEDICAL EXPENSES**	**$1,063,464,232**	**$1,033,569,486**	**($29,894,746)**	**(2.9%)**
$62,810,529	**$46,204,518**	**$16,606,011**	**35.9%**	**21. GROSS MARGIN**	**$422,872,666**	**$424,971,129**	**($2,098,464)**	**(0.5%)**
				ADMINISTRATIVE EXPENSES				
$5,708,733	$5,951,534	$242,801	4.1%	22. Personnel Expense	$33,809,934	$34,406,434	$596,500	1.7%
$82,891	$74,912	($7,979)	(10.7%)	23. Benefits Administration Expense	$465,196	$454,633	($10,564)	(2.3%)
$2,160,244	$2,997,118	$836,874	27.9%	24. Purchased & Professional Services	$13,480,907	$14,783,029	$1,302,123	8.8%
$1,486,030	$2,281,317	$795,287	34.9%	25. Other Administrative Expense	$9,898,416	$11,063,340	$1,164,924	10.5%
$9,437,898	**$11,304,880**	**$1,866,983**	**16.5%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$57,654,453**	**$60,707,437**	**$3,052,983**	**5.0%**
$64,497,329	**$63,651,987**	**($845,342)**	**(1.3%)**	**27. MCO TAX EXPENSES**	**$479,901,248**	**$478,998,778**	**($902,470)**	**(0.2%)**
($11,124,698)	**($28,752,350)**	**$17,627,652**	**61.3%**	**28. NET OPERATING INCOME / (LOSS)**	**($114,683,036)**	**($114,735,085)**	**$52,050**	**0.0%**
				OTHER INCOME / EXPENSES				
$2,481,472	**$2,000,000**	**$481,472**	**24.1%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$17,521,795**	**$16,981,002**	**$540,793**	**3.2%**
($8,643,226)	**($26,752,350)**	**$18,109,124**	**67.7%**	**30. NET SURPLUS (DEFICIT)**	**($97,161,241)**	**($97,754,083)**	**$592,842**	**0.6%**
101.0%	112.7%	11.7%	10.4%	31. Medical Loss Ratio	105.7%	105.5%	(0.2%)	(0.2%)
5.8%	8.2%	2.4%	29.3%	32. Administrative Expense Ratio	5.7%	6.2%	0.5%	8.1%
(3.8%)	(13.3%)	9.5%	71.4%	33. Net Surplus (Deficit) Ratio	(6.5%)	(6.7%)	0.2%	3.0%

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

	12/31/2024	11/30/2024	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$114,463,648	$21,075,966	$93,387,682	443.1%
CNB Short-Term Investment	534,091,532	482,278,187	51,813,345	10.7%
Interest Receivable	5,317,151	4,717,269	599,882	12.7%
Premium Receivables	444,009,126	496,737,349	(52,728,223)	(10.6%)
Reinsurance Recovery Receivable	7,287,219	7,263,899	23,320	0.3%
Other Receivables	1,450,111	1,171,706	278,406	23.8%
Prepaid Expenses	724,913	749,760	(24,847)	(3.3%)
TOTAL CURRENT ASSETS	**1,107,343,699**	**1,013,994,135**	**93,349,564**	**9.2%**
OTHER ASSETS				
CNB Long-Term Investment	44,130,301	44,162,073	(31,773)	(0.1%)
CalPERS Net Pension Asset	(6,144,132)	(6,144,132)	0	0.0%
Deferred Outflow	14,319,532	14,319,532	0	0.0%
Restricted Asset-Bank Note	350,000	350,000	0	0.0%
GASB 87-Lease Assets (Net)	411,442	477,356	(65,913)	(13.8%)
GASB 96-SBITA Assets (Net)	3,829,974	3,886,019	(56,044)	(1.4%)
TOTAL OTHER ASSETS	**56,897,118**	**57,050,848**	**(153,730)**	**(0.3%)**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.0%
Furniture And Equipment	13,071,003	13,071,003	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	38,640,099	38,640,099	0	0.0%
Less: Accumulated Depreciation	(33,019,378)	(32,960,005)	(59,373)	0.2%
PROPERTY AND EQUIPMENT (NET)	**5,620,721**	**5,680,094**	**(59,373)**	**(1.0%)**
TOTAL ASSETS	**1,169,861,537**	**1,076,725,077**	**93,136,461**	**8.6%**
CURRENT LIABILITIES				
Trade Accounts Payable	9,791,559	8,805,061	986,499	11.2%
Incurred But Not Reported Claims	368,254,069	329,821,855	38,432,214	11.7%
Other Medical Liabilities	135,136,830	116,406,026	18,730,804	16.1%
Pass-Through Liabilities	96,151,184	116,963,192	(20,812,008)	(17.8%)
MCO Tax Liabilities	388,747,080	324,249,751	64,497,329	19.9%
GASB 87 and 96 ST Liabilities	1,248,045	2,923,836	(1,675,790)	(57.3%)
Payroll Liabilities	8,702,863	6,996,340	1,706,524	24.4%
TOTAL CURRENT LIABILITIES	**1,008,031,632**	**906,166,061**	**101,865,571**	**11.2%**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	288,473	374,358	(85,885)	(22.9%)
Deferred Inflow	3,327,530	3,327,530	0	0.0%
TOTAL LONG TERM LIABILITIES	**3,616,003**	**3,701,888**	**(85,885)**	**(2.3%)**
TOTAL LIABILITIES	**1,011,647,635**	**909,867,948**	**101,779,686**	**11.2%**
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	254,534,911	254,534,911	0	0.0%
Year-To-Date Net Surplus (Deficit)	(97,161,241)	(88,518,015)	(8,643,226)	9.8%
TOTAL NET WORTH	**158,213,903**	**166,857,128**	**(8,643,226)**	**(5.2%)**
TOTAL LIABILITIES AND NET WORTH	**1,169,861,538**	**1,076,725,077**	**93,136,461**	**8.6%**
Cash Equivalents	648,555,180	503,354,153	145,201,027	28.8%
Pass-Through	96,151,184	116,963,192	(20,812,008)	(17.8%)
Uncommitted Cash	552,403,995	386,390,961	166,013,034	43.0%
Working Capital	99,312,067	107,828,074	(8,516,007)	(7.9%)
Current Ratio	109.9%	111.9%	(2.0%)	(1.8%)

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,168,126	$9,477,045	$18,816,609	$18,816,608
GroupCare Receivable	6,207,132	3,099,839	(9,453)	(9,453)
Total	9,375,258	12,576,884	18,807,156	18,807,155
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	224,289,692	677,551,411	1,467,520,289	1,467,520,287
Premium Receivable	46,521,091	17,255,907	(77,056,152)	(77,056,152)
Total	270,810,783	694,807,318	1,390,464,137	1,390,464,135
Investment & Other Income Cash Flows				
Other Revenues	523,512	77,403	2,616,485	2,616,485
Interest Income	1,981,933	6,567,049	14,990,268	14,990,268
Interest Receivable	(599,882)	(209,497)	(3,401,087)	(3,401,087)
Total	1,905,563	6,434,955	14,205,666	14,205,666
Medical & Hospital Cash Flows				
Total Medical Expenses	(164,647,290)	(536,574,274)	(1,063,464,232)	(1,063,464,237)
Other Health Care Receivables	(293,463)	3,415,656	2,231,637	2,231,637
Capitation Payable	-	-	-	-
IBNP Payable	38,432,214	52,821,323	71,949,810	71,949,810
Other Medical Payable	(2,081,202)	(60,679,631)	(104,552,742)	(104,552,742)
Risk Share Payable	-	(1,000)	(2,680,192)	(2,680,192)
New Health Program Payable	-	-	-	-
Total	(128,589,741)	(541,017,926)	(1,096,515,719)	(1,096,515,724)
Administrative Cash Flows				
Total Administrative Expenses	(9,461,873)	(28,510,684)	(57,739,412)	(57,739,414)
Prepaid Expenses	24,848	72,103	(486,296)	(486,296)
Other Receivables	(8,263)	(7,317)	25,574	25,574
CalPERS Pension	-	-	-	-
Trade Accounts Payable	986,498	4,534,128	3,301,264	3,301,264
Payroll Liabilities	1,706,524	(1,797,170)	603,638	603,638
GASB Assets and Liabilities	(1,639,719)	(1,700,712)	(2,203,413)	(2,203,413)
Depreciation Expense	59,373	183,004	356,706	356,706
Total	(8,332,612)	(27,226,648)	(56,141,939)	(56,141,941)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(64,497,329)	(191,685,777)	(479,901,248)	(479,901,248)
MCO Tax Liabilities	64,497,329	66,217,027	228,963,566	228,963,566
Total	0	(125,468,750)	(250,937,682)	(250,937,682)
Net Cash Flows from Operating Activities	**145,169,251**	**20,105,833**	**19,881,619**	**19,881,609**

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	31,773	3,028,983	(11,138,055)	(11,138,052)
Total	31,773	3,028,983	(11,138,055)	(11,138,052)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	-	(529,610)	(529,610)
Purchases of Property and Equipment	-	-	(529,610)	(529,610)
Net Cash Flows from Investing Activities	**31,773**	**3,028,983**	**(11,667,665)**	**(11,667,662)**
Net Change in Cash	**145,201,024**	**23,134,816**	**8,213,954**	**8,213,947**
Rounding	4.00	-	-	7.00
Cash @ Beginning of Period	503,354,152	625,420,364	640,341,226	640,341,226
Cash @ End of Period	**$648,555,180**	**$648,555,180**	**$648,555,180**	**$648,555,180**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($8,643,229)	($63,097,827)	($97,161,241)	($97,161,251)
Add back: Depreciation & Amortization	59,373	183,004	356,706	356,706
Receivables				
Premiums Receivable	46,521,091	17,255,907	(77,056,152)	(77,056,152)
Interest Receivable	(599,882)	(209,497)	(3,401,087)	(3,401,087)
Other Health Care Receivables	(293,463)	3,415,656	2,231,637	2,231,637
Other Receivables	(8,263)	(7,317)	25,574	25,574
GroupCare Receivable	6,207,132	3,099,839	(9,453)	(9,453)
Total	51,826,615	23,554,588	(78,209,481)	(78,209,481)
Prepaid Expenses	24,848	72,103	(486,296)	(486,296)
Trade Payables	986,498	4,534,128	3,301,264	3,301,264
Claims Payable and Shared Risk Pool				
IBNP Payable	38,432,214	52,821,323	71,949,810	71,949,810
Capitation Payable & Other Medical Payable	(2,081,202)	(60,679,631)	(104,552,742)	(104,552,742)
Risk Share Payable	-	(1,000.00)	(2,680,192)	(2,680,192)
Claims Payable				
Total	36,351,012	(7,859,308)	(35,283,124)	(35,283,124)
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	1,706,524	(1,797,170)	603,639	603,638
GASB Assets and Liabilities	(1,639,719)	(1,700,712)	(2,203,413)	(2,203,413)
New Health Program	-	-	-	-
MCO Tax Liabilities	64,497,329	66,217,027	228,963,566	228,963,566
Total	64,564,134	62,719,145	227,363,792	227,363,791
Rounding	-	-	(1.00)	-
Cash Flows from Operating Activities	**145,169,251**	**20,105,833**	**19,881,619**	**19,881,609**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$270,810,783	$694,807,318	$1,390,464,137	$1,390,464,135
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	9,375,258	12,576,884	18,807,156	18,807,155
Other Income	523,512	77,403	2,616,485	2,616,485
Interest Income	1,382,051	6,357,552	11,589,181	11,589,181
Less Cash Paid				
Medical Expenses	(128,589,741)	(541,017,926)	(1,096,515,719)	(1,096,515,724)
Vendor & Employee Expenses	(8,332,612)	(27,226,648)	(56,141,939)	(56,141,941)
MCO Tax Expense AB119	0	(125,468,750)	(250,937,682)	(250,937,682)
Net Cash Flows from Operating Activities	**145,169,251**	**20,105,833**	**19,881,619**	**19,881,609**
Cash Flows from Investing Activities:				
Long Term Investments	31,773	3,028,983	(11,138,055)	(11,138,052)
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	0	0	(529,610)	(529,610)
Net Cash Flows from Investing Activities	**31,773**	**3,028,983**	**(11,667,665)**	**(11,667,662)**
Net Change in Cash	**145,201,024**	**23,134,816**	**8,213,954**	**8,213,947**
Rounding	4.00	-	-	7.00
Cash @ Beginning of Period	503,354,152	625,420,364	640,341,226	640,341,226
Cash @ End of Period	**$648,555,180**	**$648,555,180**	**$648,555,180**	**$648,555,180**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($8,643,229)	($63,097,826)	($97,161,242)	($97,161,251)
Add Back: Depreciation	59,373	183,004	356,706	356,706
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	51,826,615	23,554,588	(78,209,481)	(78,209,481)
Prepaid Expenses	24,848	72,102	(486,295)	(486,296)
Trade Payables	986,498	4,534,128	3,301,264	3,301,264
Claims Payable, IBNP and Risk Sharing	36,351,012	(7,859,308)	(35,283,124)	(35,283,124)
Deferred Revenue	0	0	0	0
Other Liabilities	64,564,134	62,719,145	227,363,792	227,363,791
Total	145,169,251	20,105,833	19,881,620	19,881,609
Rounding	-	-	(1)	-
Cash Flows from Operating Activities	**$145,169,251**	**$20,105,833**	**$19,881,619**	**$19,881,609**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF DECEMBER 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	110,506	62,905	36,127	154,560	40,798	254	1,286	406,436	5,790	-	412,226
Revenue	$32,113,435	$31,568,085	$52,641,938	$75,388,591	$18,808,695	$2,544,021	$11,224,927	$224,289,693	$3,168,127	$0	$227,457,820
Medical Expense	$13,875,439	$19,051,471	$40,620,076	$60,587,461	$11,032,081	$3,302,767	$12,682,293	$161,151,588	$3,412,019	$83,684	$164,647,291
Gross Margin	$18,237,996	$12,516,614	$12,021,862	$14,801,130	$7,776,614	($758,746)	($1,457,366)	$63,138,105	($243,892)	($83,684)	$62,810,529
Administrative Expense	$399,192	$950,285	$2,029,051	$2,614,179	$695,663	$145,770	$668,352	$7,502,493	$125,597	$1,809,808	$9,437,898
MCO Tax Expense	$17,536,197	$9,982,394	$5,732,994	$24,527,126	$6,474,235	$40,307	$204,075	$64,497,329	$0	$0	$64,497,329
Operating Income / (Expense)	$302,607	$1,583,935	$4,259,817	($12,340,176)	$606,716	($944,823)	($2,329,793)	($8,861,717)	($369,489)	($1,893,492)	($11,124,698)
Other Income / (Expense)	$125,447	$311,506	$666,804	$848,166	$227,924	$47,976	$220,507	$2,448,330	$33,142	$0	$2,481,472
Net Income / (Loss)	$428,054	$1,895,441	$4,926,621	($11,492,010)	$834,640	($896,847)	($2,109,286)	($6,413,386)	($336,348)	($1,893,492)	($8,643,226)
PMPM Metrics:											
Revenue PMPM	$290.60	$501.84	$1,457.14	$487.76	$461.02	$10,015.83	$8,728.56	$551.85	$547.17	$0.00	$551.78
Medical Expense PMPM	$125.56	$302.86	$1,124.37	$392.00	$270.41	$13,003.02	$9,861.81	$396.50	$589.30	$0.00	$399.41
Gross Margin PMPM	$165.04	$198.98	$332.77	$95.76	$190.61	($2,987.19)	($1,133.25)	$155.35	($42.12)	$0.00	$152.37
Administrative Expense PMPM	$3.61	$15.11	$56.16	$16.91	$17.05	$573.90	$519.71	$18.46	$21.69	$0.00	$22.89
MCO Tax Expense PMPM	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$0.00	$0.00	$156.46
Operating Income / (Expense) PMPM	$2.74	$25.18	$117.91	($79.84)	$14.87	($3,719.78)	($1,811.66)	($21.80)	($63.82)	$0.00	($26.99)
Other Income / (Expense) PMPM	$1.14	$4.95	$18.46	$5.49	$5.59	$188.88	$171.47	$6.02	$5.72	$0.00	$6.02
Net Income / (Loss) PMPM	$3.87	$30.13	$136.37	($74.35)	$20.46	($3,530.89)	($1,640.19)	($15.78)	($58.09)	$0.00	($20.97)
Ratio:											
Medical Loss Ratio	95.2%	88.3%	86.6%	119.1%	89.4%	131.9%	115.1%	100.9%	107.7%	0.0%	101.0%
Administrative Expense Ratio	2.7%	4.4%	4.3%	5.1%	5.6%	5.8%	6.1%	4.7%	4.0%	0.0%	5.8%
Net Income Ratio	1.3%	6.0%	9.4%	-15.2%	4.4%	-35.3%	-18.8%	-2.9%	-10.6%	0.0%	-3.8%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE DECEMBER 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	659,195	375,884	212,632	908,505	241,339	1,446	7,562	2,406,563	34,402	-	2,440,965
Revenue	$221,461,531	$205,833,985	$304,541,493	$518,659,689	$135,937,249	$15,514,724	$65,571,617	$1,467,520,289	$18,816,609	$0	$1,486,336,898
Medical Expense	$79,433,437	$124,163,002	$290,066,595	$375,374,562	$90,763,289	$17,964,302	$67,122,328	$1,044,887,515	$18,424,107	$152,610	$1,063,464,232
Gross Margin	$142,028,094	$81,670,983	$14,474,898	$143,285,127	$45,173,960	($2,449,577)	($1,550,711)	$422,632,774	$392,501	($152,610)	$422,872,666
Administrative Expense	$2,791,080	$6,642,236	$14,199,799	$18,052,122	$4,919,831	$1,010,378	$4,684,171	$52,299,618	$864,041	$4,490,794	$57,654,453
MCO Tax Expense	$131,740,753	$75,226,030	$42,342,501	$180,622,572	$48,165,226	$283,625	$1,520,540	$479,901,248	$0	$0	$479,901,248
Operating Income / (Expense)	$7,496,261	($197,283)	($42,067,402)	($55,389,567)	($7,911,097)	($3,743,581)	($7,755,422)	($109,568,092)	($471,540)	($4,643,404)	($114,683,036)
Other Income / (Expense)	$885,986	$2,196,179	$4,709,375	$5,990,262	$1,609,737	$338,837	$1,557,352	$17,287,728	$234,067	$0	$17,521,795
Net Income / (Loss)	$8,382,247	$1,998,896	($37,358,028)	($49,399,306)	($6,301,360)	($3,404,744)	($6,198,070)	($92,280,364)	($237,473)	($4,643,404)	($97,161,241)
PMPM Metrics:											
Revenue PMPM	$335.96	$547.60	$1,432.25	$570.89	$563.26	$10,729.41	$8,671.20	$609.80	$546.96	$0.00	$608.91
Medical Expense PMPM	$120.50	$330.32	$1,364.17	$413.18	$376.08	$12,423.45	$8,876.27	$434.18	$535.55	$0.00	$435.67
Gross Margin PMPM	$215.46	$217.28	$68.07	$157.72	$187.18	($1,694.04)	($205.07)	$175.62	$11.41	$0.00	$173.24
Administrative Expense PMPM	$4.23	$17.67	$66.78	$19.87	$20.39	$698.74	$619.44	$21.73	$25.12	$0.00	$23.62
MCO Tax Expense PMPM	$199.85	$200.13	$199.14	$198.81	$199.57	$196.14	$201.08	$199.41	$0.00	$0.00	$196.60
Operating Income / (Expense) PMPM	$11.37	($0.52)	($197.84)	($60.97)	($32.78)	($2,588.92)	($1,025.58)	($45.53)	($13.71)	$0.00	($46.98)
Other Income / (Expense) PMPM	$1.34	$5.84	$22.15	$6.59	$6.67	$234.33	$205.94	$7.18	$6.80	$0.00	$7.18
Net Income / (Loss) PMPM	$12.72	$5.32	($175.69)	($54.37)	($26.11)	($2,354.59)	($819.63)	($38.35)	($6.90)	$0.00	($39.80)
Ratio:											
Medical Loss Ratio	88.5%	95.1%	110.6%	111.0%	103.4%	117.9%	104.8%	105.8%	97.9%	0.0%	105.7%
Administrative Expense Ratio	3.1%	5.1%	5.4%	5.3%	5.6%	6.6%	7.3%	5.3%	4.6%	0.0%	5.7%
Net Income Ratio	3.8%	1.0%	-12.3%	-9.5%	-4.6%	-21.9%	-9.5%	-6.3%	-1.3%	0.0%	-6.5%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSES SUMMARY (ADMIN. DEPT. ONLY)				
$5,708,733	$5,951,534	$242,801	4.1%	Personnel Expenses	$33,809,934	$34,406,434	$596,500	1.7%
$82,891	$74,912	($7,979)	(10.7%)	Benefits Administration Expense	$465,196	$454,633	($10,564)	(2.3%)
$2,160,244	$2,997,118	$836,874	27.9%	Purchased & Professional Services	$13,480,907	$14,783,029	$1,302,123	8.8%
$549,854	$587,515	$37,662	6.4%	Occupancy	$3,194,006	$3,170,170	($23,837)	(0.8%)
$4,388	$553,936	$549,548	99.2%	Printing Postage & Promotion	$1,971,751	$2,931,368	$959,617	32.7%
$796,143	$939,307	$143,163	15.2%	Licenses Insurance & Fees	$3,658,334	$3,808,323	$149,989	3.9%
$135,645	$200,559	$64,914	32.4%	Other Administrative Expense	$1,074,325	$1,153,480	$79,155	6.9%
$3,729,165	$5,353,347	$1,624,182	30.3%	Total Other Administrative Expenses (excludes Personnel Expenses)	$23,844,519	$26,301,002	$2,456,483	9.3%
$9,437,898	$11,304,880	$1,866,983	16.5%	Total Administrative Expenses	$57,654,453	$60,707,437	$3,052,983	5.0%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,827,008	4,173,013	346,005	8.3%	Salaries & Wages	22,658,371	22,325,279	(333,092)	(1.5%)
338,573	360,093	21,519	6.0%	Paid Time Off	1,991,451	2,240,793	249,342	11.1%
8,118	8,755	637	7.3%	Compensated Incentives	19,856	22,299	2,442	11.0%
0	0	0	0.0%	Severence	0	400,000	400,000	100.0%
62,341	63,982	1,641	2.6%	Payroll Taxes	369,541	397,324	27,783	7.0%
62,318	25,460	(36,858)	(144.8%)	Overtime	419,448	365,539	(53,910)	(14.7%)
284,106	287,826	3,721	1.3%	CalPERS ER Match	1,854,133	1,995,432	141,299	7.1%
937,034	606,154	(330,880)	(54.6%)	Employee Benefits	5,783,530	5,132,979	(650,551)	(12.7%)
3,450	0	(3,450)	0.0%	Personal Floating Holiday	5,963	3,894	(2,070)	(53.2%)
20,069	28,000	7,931	28.3%	Language Pay	123,901	170,259	46,359	27.2%
5,950	0	(5,950)	0.0%	Med Ins Opted Out Stipend	20,700	16,010	(4,690)	(29.3%)
0	0	0	0.0%	Holiday Bonus	(400,000)	0	400,000	1,333,333,4…
95,989	0	(95,989)	0.0%	Sick Leave	488,645	270,728	(217,917)	(80.5%)
2,791	46,733	43,942	94.0%	Compensated Employee Relations	6,410	103,589	97,179	93.8%
20,480	25,450	4,970	19.5%	Work from Home Stipend	119,730	129,570	9,840	7.6%
2,536	8,498	5,962	70.2%	Mileage, Parking & LocalTravel	8,286	25,223	16,937	67.1%
647	21,242	20,595	97.0%	Travel & Lodging	15,491	72,517	57,026	78.6%
27,401	113,365	85,964	75.8%	Temporary Help Services	188,981	327,374	138,393	42.3%
3,196	120,564	117,368	97.3%	Staff Development/Training	62,413	264,559	202,146	76.4%
6,726	62,398	55,672	89.2%	Staff Recruitment/Advertisement	73,082	143,067	69,985	48.9%
5,708,733	**5,951,534**	**242,801**	**4.1%**	**Personnel Expense**	**33,809,934**	**34,406,434**	**596,500**	**1.7%**
29,601	22,018	(7,583)	(34.4%)	Pharmacy Administrative Fees	149,576	139,168	(10,408)	(7.5%)
53,291	52,894	(396)	(0.7%)	Telemedicine Admin. Fees	315,620	315,464	(156)	0.0%
82,891	**74,912**	**(7,979)**	**(10.7%)**	**Benefits Administration Expense**	**465,196**	**454,633**	**(10,564)**	**(2.3%)**
627,145	850,019	222,875	26.2%	Consultant Fees - Non Medical	3,604,826	4,193,457	588,631	14.0%
184,139	693,299	509,160	73.4%	Computer Support Services	3,096,666	3,314,111	217,445	6.6%
65,500	15,000	(50,500)	(336.7%)	Audit Fees	146,158	98,158	(48,000)	(48.9%)
0	17	17	100.0%	Consultant Fees - Medical	995	(15,322)	(16,317)	106.5%
193,254	324,107	130,853	40.4%	Other Purchased Services	1,446,423	1,621,717	175,293	10.8%
0	1,688	1,688	100.0%	Maint.&Repair-Office Equipment	0	3,376	3,376	100.0%
159,257	70,067	(89,190)	(127.3%)	Legal Fees	602,343	471,419	(130,924)	(27.8%)
0	0	0	0.0%	Member Health Education	320	320	0	0.0%
41,204	26,000	(15,204)	(58.5%)	Translation Services	155,447	139,064	(16,383)	(11.8%)
395,191	177,300	(217,891)	(122.9%)	Medical Refund Recovery Fees	1,704,189	1,469,971	(234,218)	(15.9%)
438,525	684,684	246,159	36.0%	Software - IT Licenses & Subsc	2,252,798	2,756,349	503,551	18.3%
17,963	106,237	88,274	83.1%	Hardware (Non-Capital)	197,334	444,896	247,563	55.6%
38,067	48,700	10,633	21.8%	Provider Credentialing	273,409	285,513	12,105	4.2%
2,160,244	**2,997,118**	**836,874**	**27.9%**	**Purchased & Professional Services**	**13,480,907**	**14,783,029**	**1,302,123**	**8.8%**
59,373	91,579	32,205	35.2%	Depreciation	356,706	421,117	64,411	15.3%
62,638	76,371	13,733	18.0%	Lease Building	448,825	402,143	(46,681)	(11.6%)
4,464	10,570	6,106	57.8%	Lease Rented Office Equipment	27,288	39,105	11,817	30.2%
(8,182)	20,023	28,205	140.9%	Utilities	84,744	102,284	17,539	17.1%
79,345	91,065	11,720	12.9%	Telephone	520,404	529,795	9,391	1.8%
26,578	48,772	22,194	45.5%	Building Maintenance	194,299	253,674	59,375	23.4%
325,636	249,136	(76,501)	(30.7%)	GASB96 SBITA Amort. Expense	1,561,740	1,422,052	(139,689)	(9.8%)
549,854	**587,515**	**37,662**	**6.4%**	**Occupancy**	**3,194,006**	**3,170,170**	**(23,837)**	**(0.8%)**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(104,250)	130,213	234,463	180.1%	Postage	244,019	515,752	271,733	52.7%
5,517	5,300	(217)	(4.1%)	Design & Layout	37,214	36,780	(434)	(1.2%)
(94,940)	219,790	314,730	143.2%	Printing Services	435,152	720,780	285,629	39.6%
5,500	6,910	1,410	20.4%	Mailing Services	48,882	48,203	(678)	(1.4%)
4,410	12,735	8,325	65.4%	Courier/Delivery Service	31,734	48,193	16,458	34.2%
0	520	520	100.0%	Pre-Printed Materials & Public	29	549	520	94.7%
0	0	0	0.0%	Promotional Products	43,118	43,118	0	0.0%
0	300	300	100.0%	Promotional Services	0	600	600	100.0%
188,151	178,167	(9,984)	(5.6%)	Community Relations	1,131,604	1,517,394	385,790	25.4%
4,388	**553,936**	**549,548**	**99.2%**	**Printing Postage & Promotion**	**1,971,751**	**2,931,368**	**959,617**	**32.7%**
10,000	50,000	40,000	80.0%	Regulatory Penalties	295,000	335,000	40,000	11.9%
78,187	31,600	(46,587)	(147.4%)	Bank Fees	235,366	196,181	(39,185)	(20.0%)
65	0	(65)	0.0%	Insurance Premium	976,728	982,916	6,188	0.6%
684,529	782,810	98,281	12.6%	License,Permits, & Fee - NonIT	1,693,211	1,802,506	109,295	6.1%
23,363	74,896	51,534	68.8%	Subscriptions and Dues - NonIT	458,029	491,720	33,691	6.9%
796,143	**939,307**	**143,163**	**15.2%**	**License Insurance & Fees**	**3,658,334**	**3,808,323**	**149,989**	**3.9%**
1,441	13,042	11,601	89.0%	Office and Other Supplies	48,453	59,200	10,747	18.2%
0	2,000	2,000	100.0%	Furniture & Equipment	0	4,000	4,000	100.0%
10,137	30,192	20,055	66.4%	Ergonomic Supplies	168,881	184,348	15,467	8.4%
18,196	30,475	12,279	40.3%	Meals and Entertainment	76,753	97,724	20,971	21.5%
0	0	0	0.0%	Miscellaneous	5,300	5,300	0	0.0%
0	4,850	4,850	100.0%	Member Incentive	0	9,700	9,700	100.0%
105,871	120,000	14,129	11.8%	Provider Interest (All Depts)	774,938	793,208	18,270	2.3%
135,645	**200,559**	**64,914**	**32.4%**	**Other Administrative Expense**	**1,074,325**	**1,153,480**	**79,155**	**6.9%**
3,729,165	**5,353,347**	**1,624,182**	**30.3%**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**23,844,519**	**26,301,002**	**2,456,483**	**9.3%**
9,437,898	**11,304,880**	**1,866,983**	**16.5%**	**TOTAL ADMINISTRATIVE EXPENSES**	**57,654,453**	**60,707,437**	**3,052,983**	**5.0%**

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

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 265,100	$ -	**$ 265,100**	$ 265,100	$ 0
	Cisco Routers	IT-FY25-01	$ -	$ -	**$ -**	$ 120,000	$ 120,000
	Cisco UCS Blades	IT-FY25-04	$ 264,510	$ -	**$ 264,510**	$ 873,000	$ 608,490
	PURE Storage	IT-FY25-06	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Exagrid Immutable Storage	IT-FY25-07	$ -	$ -	**$ -**	$ 500,000	$ 500,000
	Network Cabling	IT-FY25-09	$ -	$ -	**$ -**	$ 40,000	$ 40,000
Hardware Subtotal			**$ 529,610**	**$ -**	**$ 529,610**	**$ 1,948,100**	**$ 1,418,490**
2. Software:							
	Zerto renewal and Tier 2 add		$ -	$ -	**$ -**	$ -	$ -
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
3. Building Improvement:							
	1240 Exterior lighting update	FA-FY25-03	**$ -**	$ -	**$ -**	$ 30,000	$ 30,000
Building Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ 30,000**	**$ 30,000**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)		$ -	$ -	**$ -**	$ -	$ -
	Replace, reconfigure, re-design workstations		$ -	$ -	**$ -**	$ -	$ -
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
5. Leasehold Improvement:							
	ExacqVision NVR Upgrade, Cameras/Video System upgrade		$ -		**$ -**	$ -	$ -
Leasehold Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
6. Contingency:							
			$ -		**$ -**	$ -	$ -
Contingency Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
GRAND TOTAL			**$ 529,610**	**$ -**	**$ 529,610**	**$ 1,978,100**	**$ 1,448,490**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 12/31/24	**$ 38,640,099**
Fixed Assets @ Cost - 6/30/24	**$ 38,110,489**
Fixed Assets Acquired YTD	**$ 529,610**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2024

TANGIBLE NET EQUITY (TNE)	**QRT. END Jun-24**	**Jul-24**	**Aug-24**	**QRT. END Sep-24**	**Oct-24**	**Nov-24**	**QRT. END Dec-24**
Current Month Net Income / (Loss)	$(60,614,034)	$ (6,989,301)	$(18,354,880)	$ (8,719,238)	$(26,984,341)	$ (27,470,264)	$ (8,643,229)
YTD Net Income / (Loss)	$(68,581,898)	$ (6,989,303)	$(25,344,182)	$(34,063,414)	$(61,047,753)	$ (88,518,015)	$ (97,161,241)
Net Assets	$255,375,143	$248,385,840	$230,030,961	$221,311,729	$194,327,390	$ 166,857,128	$ 158,213,902
Subordinated Debt & Interest	-	-	-	-	-	-	-
Total Actual TNE	**$255,375,143**	**$248,385,840**	**$230,030,961**	**$221,311,729**	**$194,327,390**	**$ 166,857,128**	**$ 158,213,902**
Increase/(Decrease) in Actual TNE	$(60,614,034)	$ (6,989,301)	$(18,354,880)	$ (8,719,238)	$(26,984,341)	$ (27,470,264)	$ (8,643,229)
Required TNE (1)	**$ 63,328,179**	**$ 68,750,939**	**$ 71,470,183**	**$ 70,224,330**	**$ 77,225,116**	**$ 78,852,430**	**$ 77,630,344**
Min. Req'd to Avoid Monthly Reporting at 150% of Required TNE	$ 94,992,268	$103,126,409	$107,205,275	$105,336,495	$115,837,673	$ 118,278,645	$ 116,445,516
TNE Excess / (Deficiency)	$192,046,964	$179,634,901	$158,560,778	$151,087,399	$117,102,274	$ 88,004,698	$ 80,583,558
Actual TNE as a Multiple of Required	**4.03**	**3.61**	**3.22**	**3.15**	**2.52**	**2.12**	**2.04**
LIQUID TANGIBLE NET EQUITY							
Net Assets	$255,375,143	$248,385,840	$230,030,961	$221,311,729	$194,327,390	$ 166,857,128	$ 158,213,902
Less: Fixed Assets at Net Book Value	(5,447,816)	(5,662,370)	(5,863,098)	(5,803,725)	(5,739,467)	(5,680,094)	(5,620,720)
Net Lease Assets	(501,485)	(319,957)	(496,877)	(1,004,186)	(1,303,630)	(1,065,182)	(2,704,902)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$249,075,842**	**$242,053,513**	**$223,320,986**	**$214,153,818**	**$186,934,293**	**$ 159,761,852**	**$ 149,538,280**
Liquid TNE as Multiple of Required	**3.93**	**3.52**	**3.12**	**3.05**	**2.42**	**2.03**	**1.93**

Note (1): Required TNE reflects monthly and quarterly DMHC TNE calculations. Quarterly and Monthly Required TNE calculations differ slightly in calculation methodology.

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,951	109,784	109,731	109,662	109,561	110,506							659,195
Adult	62,708	62,641	62,550	62,578	62,502	62,905							375,884
SPD (retired Dec-24)	35,018	35,177	35,319	35,388	35,603	36,127							212,632
Duals (retired Dec-24)	39,892	40,024	40,124	40,144	40,357	40,798							241,339
ACA OE	149,801	150,482	151,005	151,098	151,559	154,560							908,505
MCAL LTC (retired Dec-24)	222	226	240	249	255	254							1,446
MCAL LTC Duals (retired Dec-24)	1,241	1,247	1,254	1,265	1,269	1,286							7,562
SPD with LTC (new Jan-25)	0	0	0	0	0	0							0
Duals with LTC (new Jan-25)	0	0	0	0	0	0							0
Medi-Cal Program	398,833	399,581	400,223	400,384	401,106	406,436							2,406,563
Group Care Program	5,675	5,686	5,710	5,769	5,772	5,790							34,402
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**							**2,440,965**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(173)	(167)	(53)	(69)	(101)	945							382
Adult	(38)	(67)	(91)	28	(76)	403							159
SPD (retired Dec-24)	98	159	142	69	215	524							1,207
Duals (retired Dec-24)	144	132	100	20	213	441							1,050
ACA OE	477	681	523	93	461	3,001							5,236
MCAL LTC (retired Dec-24)	0	4	14	9	6	(1)							32
MCAL LTC Duals (retired Dec-24)	(7)	6	7	11	4	17							38
SPD with LTC (new Jan-25)	0	0	0	0	0	0							0
Duals with LTC (new Jan-25)	0	0	0	0	0	0							0
Medi-Cal Program	501	748	642	161	722	5,330							8,104
Group Care Program	17	11	24	59	3	18							132
Total	**518**	**759**	**666**	**220**	**725**	**5,348**							**8,236**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%	27.4%	27.4%	27.3%	27.2%							27.4%
Adult % of Medi-Cal	15.7%	15.7%	15.6%	15.6%	15.6%	15.5%							15.6%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%	8.9%	8.9%							8.8%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%	10.1%	10.0%							10.0%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%	37.8%	38.0%							37.8%
MCAL LTC % of Medi-Cal	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%							0.1%
MCAL LTC Duals % of Medi-Cal	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%							0.3%
SPD with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%							0.0%
Duals with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%							0.0%
Medi-Cal Program % of Total	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%							98.6%
Group Care Program % of Total	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%							1.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**							**100.0%**

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

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	87,980	88,518	89,634	89,724	90,655	96,247							542,758
Alameda Health System	91,091	91,170	91,024	90,756	90,451	90,222							544,714
Directly-Contracted Subtotal	179,071	179,688	180,658	180,480	181,106	186,469							1,087,472
Delegated:													
CFMG	44,087	43,956	43,837	43,910	44,029	44,099							263,918
CHCN	181,350	181,623	181,438	181,763	181,743	181,658							1,089,575
Delegated Subtotal	225,437	225,579	225,275	225,673	225,772	225,757							1,353,493
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**							**2,440,965**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617	970	(178)	626	5,363							7,565
Delegated:													
CFMG	96	(131)	(119)	73	119	70							108
CHCN	255	273	(185)	325	(20)	(85)							563
Delegated Subtotal	351	142	(304)	398	99	(15)							671
Total	**518**	**759**	**666**	**220**	**725**	**5,348**							**8,236**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%	44.5%	44.4%	44.5%	45.2%							44.6%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%	10.7%							10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.7%	44.1%							44.6%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.5%	54.8%							55.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**							**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2025	FINAL BUDGET												
	Budget Jul-24	Budget Aug-24	Budget Sep-24	Budget Oct-24	Budget Nov-24	Budget Dec-24	Budget Jan-25	Budget Feb-25	Budget Mar-25	Budget Apr-25	Budget May-25	Budget Jun-25	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,951	109,784	109,731	109,662	109,772	109,882	110,102	110,212	110,322	110,432	110,542	110,653	1,321,045
Adult	62,708	62,641	62,550	62,578	62,641	62,704	62,767	62,830	62,893	62,956	63,019	63,082	753,369
SPD (retired Dec-24)	35,018	35,177	35,319	35,388	35,423	35,458	0	0	0	0	0	0	211,783
Duals (retired Dec-24)	39,892	40,024	40,124	40,144	40,144	40,144	0	0	0	0	0	0	240,472
ACA OE	149,801	150,482	151,005	151,098	151,249	151,400	151,551	151,703	151,855	152,007	152,159	152,311	1,816,621
MCAL LTC (retired Dec-24)	222	226	240	249	251	254	0	0	0	0	0	0	1,442
MCAL LTC Duals (retired Dec-24)	1,241	1,247	1,254	1,265	1,266	1,267	0	0	0	0	0	0	7,540
SPD with LTC (new Jan-25)	0	0	0	0	0	0	34,750	33,788	32,825	31,861	30,896	29,930	194,050
Duals with LTC (new Jan-25)	0	0	0	0	0	0	42,412	43,413	44,414	45,415	46,416	47,417	269,487
Medi-Cal Program	398,833	399,581	400,223	400,384	400,746	401,109	401,582	401,946	402,309	402,671	403,032	403,393	4,815,809
Group Care Program	5,675	5,686	5,710	5,769	5,769	5,769	5,769	5,769	5,769	5,769	5,769	5,769	68,992
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,515**	**406,878**	**407,351**	**407,715**	**408,078**	**408,440**	**408,801**	**409,162**	**4,884,801**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	13,386	(167)	(53)	(69)	110	110	220	110	110	110	110	111	14,088
Adult	8,596	(67)	(91)	28	63	63	63	63	63	63	63	63	8,970
SPD (retired Dec-24)	(5,783)	159	142	69	35	35	(35,458)	0	0	0	0	0	(40,801)
Duals (retired Dec-24)	(5,426)	132	100	20	0	0	(40,144)	0	0	0	0	0	(45,318)
ACA OE	8,631	681	523	93	151	151	151	152	152	152	152	152	11,141
MCAL LTC (retired Dec-24)	45	4	14	9	2	3	(254)	0	0	0	0	0	(177)
MCAL LTC Duals (retired Dec-24)	133	6	7	11	1	1	(1,267)	0	0	0	0	0	(1,108)
SPD with LTC (new Jan-25)	0	0	0	0	0	0	34,750	(962)	(963)	(964)	(965)	(966)	29,930
Duals with LTC (new Jan-25)	0	0	0	0	0	0	42,412	1,001	1,001	1,001	1,001	1,001	47,417
Medi-Cal Program	19,582	748	642	161	362	363	473	364	363	362	361	361	24,142
Group Care Program	182	11	24	59	0	0	0	0	0	0	0	0	276
Total	**19,764**	**759**	**666**	**220**	**362**	**363**	**473**	**364**	**363**	**362**	**361**	**361**	**24,418**
													0
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%
Adult % of Medi-Cal	15.7%	15.7%	15.6%	15.6%	15.6%	15.6%	15.6%	15.6%	15.6%	15.6%	15.6%	15.6%	15.6%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.4%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.0%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%	37.7%	37.7%	37.7%	37.7%	37.7%	37.7%	37.8%	37.8%	37.7%
MCAL LTC % of Medi-Cal	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MCAL LTC Duals % of Medi-Cal	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
SPD with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.7%	8.4%	8.2%	7.9%	7.7%	7.4%	4.0%
Duals with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.6%	10.8%	11.0%	11.3%	11.5%	11.8%	5.6%
Medi-Cal Program % of Total	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	100.0%
Group Care Program % of Total	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**101.4%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2025	FINAL BUDGET												
	Budget Jul-24	Budget Aug-24	Budget Sep-24	Budget Oct-24	Budget Nov-24	Budget Dec-24	Budget Jan-25	Budget Feb-25	Budget Mar-25	Budget Apr-25	Budget May-25	Budget Jun-25	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	87,980	88,518	89,634	89,724	89,786	89,849	90,244	90,630	91,016	91,401	91,786	92,171	1,082,739
Alameda Health System	91,091	91,170	91,024	90,756	90,843	90,930	90,951	90,960	90,968	90,976	90,984	90,992	1,091,645
Directly-Contracted Subtotal	179,071	179,688	180,658	180,480	180,629	180,779	181,195	181,590	181,984	182,377	182,770	183,163	2,174,384
Delegated:													
CFMG	44,087	43,956	43,837	43,910	43,953	43,996	44,035	44,033	44,030	44,027	44,024	44,021	527,909
CHCN	181,350	181,623	181,438	181,763	181,933	182,103	182,121	182,092	182,064	182,036	182,007	181,978	2,182,508
Delegated Subtotal	225,437	225,579	225,275	225,673	225,886	226,099	226,156	226,125	226,094	226,063	226,031	225,999	2,710,417
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,515**	**406,878**	**407,351**	**407,715**	**408,078**	**408,440**	**408,801**	**409,162**	**4,884,801**
													0
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	(11,969)	538	1,116	90	62	63	395	386	386	385	385	385	(7,778)
Alameda Health System	8,720	79	(146)	(268)	87	87	21	9	8	8	8	8	8,621
Directly-Contracted Subtotal	(3,249)	617	970	(178)	149	150	416	395	394	393	393	393	843
Delegated:													
CFMG	3,320	(131)	(119)	73	43	43	39	(2)	(3)	(3)	(3)	(3)	3,254
CHCN	19,693	273	(185)	325	170	170	18	(29)	(28)	(28)	(29)	(29)	20,321
Delegated Subtotal	23,013	142	(304)	398	213	213	57	(31)	(31)	(31)	(32)	(32)	23,575
Total	**19,764**	**759**	**666**	**220**	**362**	**363**	**473**	**364**	**363**	**362**	**361**	**361**	**24,418**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	21.7%	21.8%	22.1%	22.1%	22.1%	22.1%	22.2%	22.2%	22.3%	22.4%	22.5%	22.5%	22.2%
Alameda Health System	22.5%	22.5%	22.4%	22.3%	22.3%	22.3%	22.3%	22.3%	22.3%	22.3%	22.3%	22.2%	22.3%
Directly-Contracted Subtotal	44.3%	44.3%	44.5%	44.4%	44.4%	44.4%	44.5%	44.5%	44.6%	44.7%	44.7%	44.8%	44.5%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.8%	44.8%	44.7%	44.7%	44.6%	44.6%	44.5%	44.5%	44.7%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.6%	55.6%	55.5%	55.5%	55.4%	55.3%	55.3%	55.2%	55.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

	Variance Jul-24	Variance Aug-24	Variance Sep-24	Variance Oct-24	Variance Nov-24	Variance Dec-24	Variance Jan-25	Variance Feb-25	Variance Mar-25	Variance Apr-25	Variance May-25	Variance Jun-25	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	(211)	624							413
Adult	0	0	0	0	(139)	201							62
SPD (retired Dec-24)	0	0	0	0	180	669							849
Duals (retired Dec-24)	0	0	0	0	213	654							867
ACA OE	0	0	0	0	310	3,160							3,470
MCAL LTC (retired Dec-24)	0	0	0	0	4	0							4
MCAL LTC Duals (retired Dec-24)	0	0	0	0	3	19							22
SPD with LTC (new Jan-25)	0	0	0	0	0	0							0
Duals with LTC (new Jan-25)	0	0	0	0	0	0							0
Medi-Cal Program	0	0	0	0	360	5,327							5,687
Group Care Program	0	0	0	0	3	21							24
Total	**0**	**0**	**0**	**0**	**363**	**5,348**							**5,711**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	869	6,398							7,267
Alameda Health System	0	0	0	0	(392)	(708)							(1,100)
Directly-Contracted Subtotal	0	0	0	0	477	5,690							6,167
Delegated:													
CFMG	0	0	0	0	76	103							179
CHCN	0	0	0	0	(190)	(445)							(635)
Delegated Subtotal	0	0	0	0	(114)	(342)							(456)
Total	**0**	**0**	**0**	**0**	**363**	**5,348**							**5,711**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
$4,642,995	$1,715,115	($2,927,880)	(170.7%)	PCP Capitation	$23,936,384	$18,104,202	($5,832,182)	(32.2%)
6,129,483	6,535,937	406,454	6.2%	PCP Capitation FQHC	36,906,187	37,683,893	777,706	2.1%
381,239	447,488	66,249	14.8%	Specialty Capitation	2,274,832	2,401,105	126,272	5.3%
5,415,179	5,963,761	548,582	9.2%	Specialty Capitation FQHC	32,427,174	33,525,268	1,098,094	3.3%
767,862	713,010	(54,851)	(7.7%)	Laboratory Capitation	4,519,573	4,423,684	(95,889)	(2.2%)
344,449	340,265	(4,184)	(1.2%)	Vision Capitation	2,041,406	2,037,100	(4,306)	(0.2%)
110,915	130,192	19,278	14.8%	CFMG Capitation	661,970	698,703	36,733	5.3%
266,670	289,854	23,184	8.0%	ANC IPA Admin Capitation FQHC	1,598,694	1,644,961	46,268	2.8%
(8,638,183)	(8,638,182)	1	0.0%	Kaiser Capitation	(8,639,178)	(8,639,177)	1	0.0%
0	0	0	0.0%	Maternity Supplemental Expense	37,270	27,953	(9,318)	(33.3%)
1,032,499	886,412	(146,087)	(16.5%)	DME Capitation	6,103,440	5,822,931	(280,509)	(4.8%)
10,453,108	**8,383,852**	**(2,069,256)**	**(24.7%)**	**7. TOTAL CAPITATED EXPENSES**	**101,867,753**	**97,730,622**	**(4,137,131)**	**(4.2%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
12,747,300	0	(12,747,300)	0.0%	IBNR Inpatient Services	20,565,700	(3,303,163)	(23,868,863)	722.6%
382,419	0	(382,419)	0.0%	IBNR Settlement (IP)	616,972	(99,094)	(716,066)	722.6%
1,019,783	0	(1,019,783)	0.0%	IBNR Claims Fluctuation (IP)	1,645,254	(264,254)	(1,909,508)	722.6%
35,434,270	52,329,810	16,895,540	32.3%	Inpatient Hospitalization FFS	282,346,399	304,392,180	22,045,780	7.2%
3,144,456	0	(3,144,456)	0.0%	IP OB - Mom & NB	18,232,207	12,540,164	(5,692,043)	(45.4%)
1,520,717	0	(1,520,717)	0.0%	IP Behavioral Health	2,650,375	1,070,307	(1,580,068)	(147.6%)
1,246,066	0	(1,246,066)	0.0%	Inpatient Facility Rehab FFS	8,132,671	5,770,736	(2,361,935)	(40.9%)
55,495,011	**52,329,810**	**(3,165,200)**	**(6.0%)**	**8. Inpatient Hospital Expense**	**334,189,578**	**320,106,876**	**(14,082,702)**	**(4.4%)**
331,293	0	(331,293)	0.0%	IBNR PCP	495,951	(293,439)	(789,390)	269.0%
9,938	0	(9,938)	0.0%	IBNR Settlement (PCP)	14,881	(8,801)	(23,682)	269.1%
26,503	0	(26,503)	0.0%	IBNR Claims Fluctuation (PCP)	107,941	44,791	(63,150)	(141.0%)
4,085,203	2,907,858	(1,177,345)	(40.5%)	PCP FFS	22,974,408	20,826,871	(2,147,537)	(10.3%)
354,733	816,198	461,465	56.5%	PCP FQHC FFS	2,323,303	3,257,336	934,033	28.7%
0	0	0	0.0%	Physician Extended Hrs. Incent	12,000	12,000	0	0.0%
1,655,989	915,709	(740,280)	(80.8%)	Prop 56 Physician Pmt	(3,467,142)	(2,827,243)	639,899	(22.6%)
16,492	0	(16,492)	0.0%	Prop 56 Hyde	148,232	64,923	(83,309)	(128.3%)
67,185	0	(67,185)	0.0%	Prop 56 Trauma Screening	250,939	110,133	(140,807)	(127.9%)
71,308	0	(71,308)	0.0%	Prop 56 Developmentl Screening	247,471	96,040	(151,431)	(157.7%)
644,849	0	(644,849)	0.0%	Prop 56 Family Planning	578,748	(767,666)	(1,346,414)	175.4%
312,647	0	(312,647)	0.0%	Prop 56 VBP	(2,406,095)	(2,718,741)	(312,647)	11.5%
7,576,142	**4,639,765**	**(2,936,377)**	**(63.3%)**	**9. Primary Care Physician Expense**	**21,280,638**	**17,796,203**	**(3,484,435)**	**(19.6%)**
1,819,484	0	(1,819,484)	0.0%	IBNR Specialist	1,802,517	(747,176)	(2,549,693)	341.2%
54,585	0	(54,585)	0.0%	IBNR Settlement (SCP)	54,078	(22,414)	(76,492)	341.3%
145,558	0	(145,558)	0.0%	IBNR Claims Fluctuation (SCP)	144,200	(59,775)	(203,975)	341.2%
396,347	0	(396,347)	0.0%	Psychiatrist FFS	2,335,814	1,559,071	(776,743)	(49.8%)
2,980,795	8,098,287	5,117,492	63.2%	Specialty Care FFS	21,578,430	31,292,654	9,714,225	31.0%
256,427	0	(256,427)	0.0%	Specialty Anesthesiology	1,529,098	1,061,004	(468,094)	(44.1%)
1,575,522	0	(1,575,522)	0.0%	Specialty Imaging FFS	9,796,671	6,843,037	(2,953,634)	(43.2%)
23,956	0	(23,956)	0.0%	Obstetrics FFS	238,219	181,208	(57,012)	(31.5%)
302,253	0	(302,253)	0.0%	Specialty IP Surgery FFS	2,363,059	1,679,499	(683,560)	(40.7%)
893,567	0	(893,567)	0.0%	Specialty OP Surgery FFS	6,101,165	4,353,452	(1,747,712)	(40.1%)
603,120	0	(603,120)	0.0%	Speciality IP Physician	3,744,872	2,543,833	(1,201,039)	(47.2%)
120,488	127,381	6,893	5.4%	Specialist FQHC FFS	769,349	783,118	13,769	1.8%
9,172,103	**8,225,668**	**(946,434)**	**(11.5%)**	**10. Specialty Care Physician Expense**	**50,457,472**	**49,467,511**	**(989,960)**	**(2.0%)**
1,341,272	0	(1,341,272)	0.0%	IBNR Ancillary (ANC)	3,846,017	904,191	(2,941,826)	(325.4%)
40,238	0	(40,238)	0.0%	IBNR Settlement (ANC)	202,443	114,188	(88,255)	(77.3%)

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
107,301	0	(107,301)	0.0%	IBNR Claims Fluctuation (ANC)	471,591	236,248	(235,343)	(99.6%)
329,244	0	(329,244)	0.0%	IBNR Transportation FFS	647,956	207,856	(440,100)	(211.7%)
2,349,434	0	(2,349,434)	0.0%	Behavioral Health Therapy FFS	12,800,467	8,190,565	(4,609,901)	(56.3%)
1,764,142	0	(1,764,142)	0.0%	Psychologist & Other MH Prof	10,729,793	7,234,250	(3,495,542)	(48.3%)
386,534	0	(386,534)	0.0%	Other Medical Professional	2,682,753	1,865,835	(816,918)	(43.8%)
87,847	0	(87,847)	0.0%	Hearing Devices	830,277	674,558	(155,719)	(23.1%)
18,060	0	(18,060)	0.0%	ANC Imaging	264,666	228,147	(36,518)	(16.0%)
103,666	0	(103,666)	0.0%	Vision FFS	455,257	280,298	(174,959)	(62.4%)
10	0	(10)	0.0%	Family Planning	26	10	(16)	(164.6%)
5,507	0	(5,507)	0.0%	Laboratory FFS	8,151,435	6,593,456	(1,557,979)	(23.6%)
139,067	0	(139,067)	0.0%	ANC Therapist	907,928	644,262	(263,665)	(40.9%)
1,442,827	0	(1,442,827)	0.0%	Transp/Ambulance FFS	8,459,769	5,962,027	(2,497,742)	(41.9%)
1,517,441	0	(1,517,441)	0.0%	Non-ER Transportation FFS	13,501,990	8,526,483	(4,975,507)	(58.4%)
1,960,017	0	(1,960,017)	0.0%	Hospice FFS	13,619,645	9,250,960	(4,368,685)	(47.2%)
1,765,012	0	(1,765,012)	0.0%	Home Health Services	10,440,253	7,088,754	(3,351,500)	(47.3%)
0	14,071,194	14,071,194	100.0%	Other Medical FFS	128	27,835,409	27,835,281	100.0%
0	0	0	0.0%	Medical Refunds through HMS	558,501	290,192	(268,308)	(92.5%)
26,315	0	(26,315)	0.0%	DME & Medical Supplies FFS	249,389	187,833	(61,555)	(32.8%)
(10,480,681)	(10,147,528)	333,153	(3.3%)	ECM Base/Outreach FFS ANC	(5,471,692)	(5,128,954)	342,737	(6.7%)
69,351	97,030	27,678	28.5%	CS Housing Deposits FFS ANC	659,777	681,979	22,202	3.3%
433,654	787,285	353,630	44.9%	CS Housing Tenancy FFS ANC	4,191,008	4,766,721	575,713	12.1%
180,248	440,728	260,479	59.1%	CS Housing Navi Servic FFS ANC	2,619,444	2,779,445	160,002	5.8%
437,941	702,773	264,833	37.7%	CS Medical Respite FFS ANC	3,688,217	3,914,565	226,348	5.8%
203,082	162,994	(40,088)	(24.6%)	CS Med. Tailored Meals FFS ANC	1,219,860	1,200,203	(19,657)	(1.6%)
8,043	20,377	12,334	60.5%	CS Asthma Remediation FFS ANC	45,385	68,030	22,645	33.3%
0	10,067	10,067	100.0%	MOT Wrap Around (Non Med MOT)	0	19,931	19,931	100.0%
0	10,014	10,014	100.0%	CS Home Modifications FFS ANC	24,053	44,042	19,989	45.4%
267,685	533,503	265,819	49.8%	CS P.Care & Hmker Svcs FFS ANC	1,875,115	2,561,610	686,495	26.8%
0	20,024	20,024	100.0%	CS Cgiver Respite Svcs FFS ANC	42,347	82,335	39,988	48.6%
540,921	0	(540,921)	0.0%	CommunityBased Adult Svc(CBAS)	3,052,350	2,203,374	(848,977)	(38.5%)
21,981	25,000	3,019	12.1%	CS LTC Diversion FFS ANC	107,153	117,778	10,625	9.0%
0	7,517	7,517	100.0%	CS LTC Transition FFS ANC	0	14,986	14,986	100.0%
5,066,160	**6,740,978**	**1,674,818**	**24.8%**	**11. Ancillary Medical Expense**	**100,873,298**	**99,641,566**	**(1,231,732)**	**(1.2%)**
591,362	0	(591,362)	0.0%	IBNR Outpatient	1,862,373	231,629	(1,630,744)	(704.0%)
17,743	0	(17,743)	0.0%	IBNR Settlement (OP)	55,874	6,949	(48,925)	(704.1%)
47,308	0	(47,308)	0.0%	IBNR Claims Fluctuation (OP)	148,985	18,527	(130,458)	(704.1%)
2,336,578	11,684,491	9,347,914	80.0%	Outpatient FFS	14,935,328	33,614,737	18,679,409	55.6%
2,789,704	0	(2,789,704)	0.0%	OP Ambul Surgery FFS	16,725,019	11,593,959	(5,131,060)	(44.3%)
2,270,679	0	(2,270,679)	0.0%	Imaging Services FFS	15,078,399	10,130,403	(4,947,996)	(48.8%)
1,025,581	0	(1,025,581)	0.0%	Behavioral Health FFS	2,143,741	97,460	(2,046,280)	(2,099.6%)
701,464	0	(701,464)	0.0%	Outpatient Facility Lab FFS	4,242,040	2,863,424	(1,378,616)	(48.1%)
213,151	0	(213,151)	0.0%	Outpatient Facility Cardio FFS	1,253,942	844,453	(409,489)	(48.5%)
99,099	0	(99,099)	0.0%	OP Facility PT/OT/ST FFS	604,390	400,408	(203,982)	(50.9%)
3,049,167	0	(3,049,167)	0.0%	OP Facility Dialysis Ctr FFS	18,551,618	12,647,437	(5,904,181)	(46.7%)
13,141,836	**11,684,491**	**(1,457,345)**	**(12.5%)**	**12. Outpatient Medical Expense**	**75,601,708**	**72,449,386**	**(3,152,322)**	**(4.4%)**
1,364,855	0	(1,364,855)	0.0%	IBNR Emergency	2,699,371	(165,803)	(2,865,174)	1,728.1%
40,944	0	(40,944)	0.0%	IBNR Settlement (ER)	80,979	(4,974)	(85,953)	1,727.9%
109,188	0	(109,188)	0.0%	IBNR Claims Fluctuation (ER)	215,949	(13,266)	(229,215)	1,727.8%
8,127,296	10,423,842	2,296,545	22.0%	ER Facility	52,609,093	57,840,480	5,231,386	9.0%
1,173,919	0	(1,173,919)	0.0%	Specialty ER Physician FFS	7,110,704	4,880,392	(2,230,312)	(45.7%)
10,816,202	**10,423,842**	**(392,361)**	**(3.8%)**	**13. Emergency Expense**	**62,716,096**	**62,536,828**	**(179,268)**	**(0.3%)**
1,264,091	0	(1,264,091)	0.0%	IBNR Pharmacy (OP)	4,691,582	1,991,773	(2,699,809)	(135.5%)
37,922	0	(37,922)	0.0%	IBNR Settlement Rx (OP)	140,749	59,755	(80,994)	(135.5%)
101,127	0	(101,127)	0.0%	IBNR Claims Fluctuation Rx(OP)	375,328	159,342	(215,986)	(135.5%)

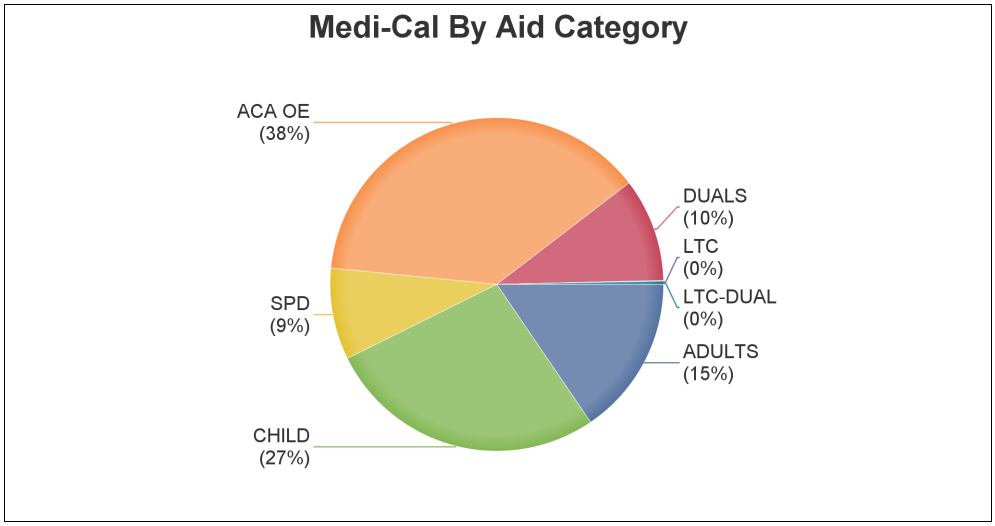
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED DECEMBER 31, 2024

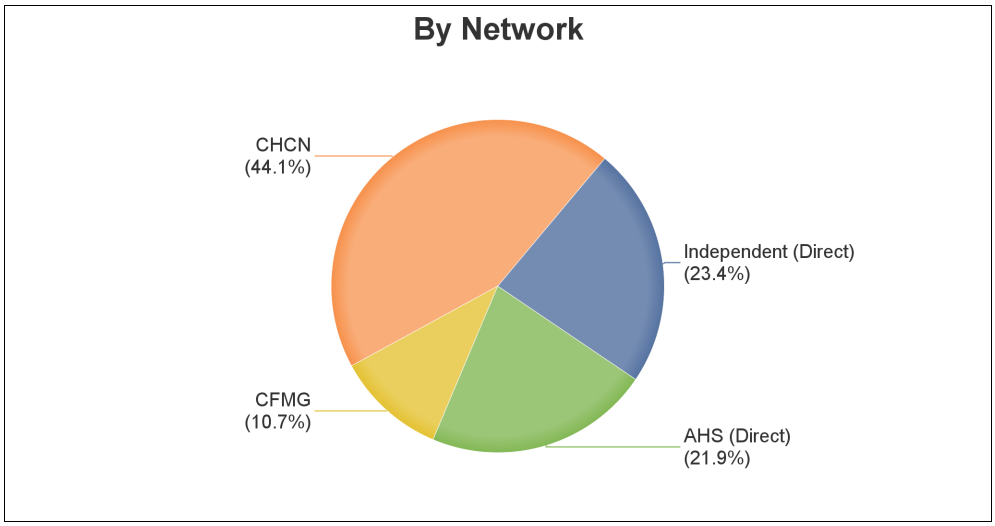
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
679,026	462,419	(216,607)	(46.8%)	Pharmacy FFS (OP)	4,428,236	3,956,726	(471,510)	(11.9%)
92,290	11,760,238	11,667,948	99.2%	Pharmacy Non PBM FFS Other-ANC	746,517	23,857,250	23,110,733	96.9%
6,470,486	0	(6,470,486)	0.0%	Pharmacy Non PBM FFS OP-FAC	54,362,619	39,326,556	(15,036,063)	(38.2%)
212,978	0	(212,978)	0.0%	Pharmacy Non PBM FFS PCP	1,380,101	985,563	(394,538)	(40.0%)
1,996,413	0	(1,996,413)	0.0%	Pharmacy Non PBM FFS SCP	14,442,925	10,617,727	(3,825,198)	(36.0%)
21,964	0	(21,964)	0.0%	Pharmacy Non PBM FFS FQHC	125,730	82,575	(43,155)	(52.3%)
17,635	0	(17,635)	0.0%	Pharmacy Non PBM FFS HH	119,898	91,629	(28,269)	(30.9%)
0	0	0	0.0%	RX Refunds HMS	(306)	(306)	0	0.0%
251,443	51,861	(199,582)	(384.8%)	Medical Expenses Pharm Rebate	(18,557)	(113,173)	(94,616)	83.6%
11,145,374	**12,274,518**	**1,129,144**	**9.2%**	**14. Pharmacy Expense**	**80,794,820**	**81,015,415**	**220,595**	**0.3%**
12,927,529	0	(12,927,529)	0.0%	IBNR LTC	15,581,793	(3,756,936)	(19,338,729)	514.7%
387,825	0	(387,825)	0.0%	IBNR Settlement (LTC)	467,453	(112,709)	(580,162)	514.7%
1,034,202	0	(1,034,202)	0.0%	IBNR Claims Fluctuation (LTC)	1,246,543	(300,555)	(1,547,098)	514.7%
1,204,718	0	(1,204,718)	0.0%	LTC - ICF/DD	9,211,157	6,755,726	(2,455,431)	(36.3%)
15,458,053	0	(15,458,053)	0.0%	LTC Custodial Care	134,938,572	99,683,289	(35,255,283)	(35.4%)
6,577,452	33,132,376	26,554,925	80.1%	LTC SNF	44,818,027	97,594,256	52,776,229	54.1%
37,589,778	**33,132,376**	**(4,457,402)**	**(13.5%)**	**15. Long Term Care Expense**	**206,263,545**	**199,863,070**	**(6,400,475)**	**(3.2%)**
150,002,605	**139,451,449**	**(10,551,157)**	**(7.6%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**932,177,155**	**902,876,856**	**(29,300,299)**	**(3.2%)**
0	203,323	203,323	100.0%	Clinical Vacancy #102	0	(1,186,111)	(1,186,111)	100.0%
175,237	361,258	186,021	51.5%	Quality Analytics #123	850,568	1,365,073	514,505	37.7%
321,184	306,063	(15,121)	(4.9%)	LongTerm Services and Support #139	1,457,786	1,553,066	95,280	6.1%
909,382	837,337	(72,045)	(8.6%)	Utilization Management #140	5,850,119	6,034,092	183,973	3.0%
746,074	650,615	(95,459)	(14.7%)	Case & Disease Management #185	4,137,592	4,290,669	153,077	3.6%
484,847	977,790	492,943	50.4%	Medical Management #230	7,107,685	7,890,686	783,001	9.9%
662,586	2,189,469	1,526,883	69.7%	Quality Improvement #235	5,995,042	8,144,005	2,148,963	26.4%
321,458	331,471	10,014	3.0%	HCS Behavioral Health #238	1,907,167	2,073,951	166,784	8.0%
155,410	332,288	176,878	53.2%	Pharmacy Services #245	730,561	1,197,383	466,822	39.0%
56,249	62,119	5,870	9.5%	Regulatory Readiness #268	385,171	434,528	49,357	11.4%
3,832,426	**6,251,734**	**2,419,308**	**38.7%**	**17. Other Benefits & Services**	**28,421,691**	**31,797,343**	**3,375,652**	**10.6%**
(1,431,000)	(1,319,182)	111,818	(8.5%)	Reinsurance Recoveries	(9,551,986)	(9,349,068)	202,919	(2.2%)
1,790,151	1,758,909	(31,242)	(1.8%)	Reinsurance Premium	10,549,620	10,513,733	(35,887)	(0.3%)
359,151	**439,727**	**80,576**	**18.3%**	**18. Reinsurance Expense**	**997,634**	**1,164,666**	**167,032**	**14.3%**
164,647,291	**154,526,761**	**(10,120,530)**	**(6.5%)**	**20. TOTAL MEDICAL EXPENSES**	**1,063,464,232**	**1,033,569,486**	**(29,894,746)**	**(2.9%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

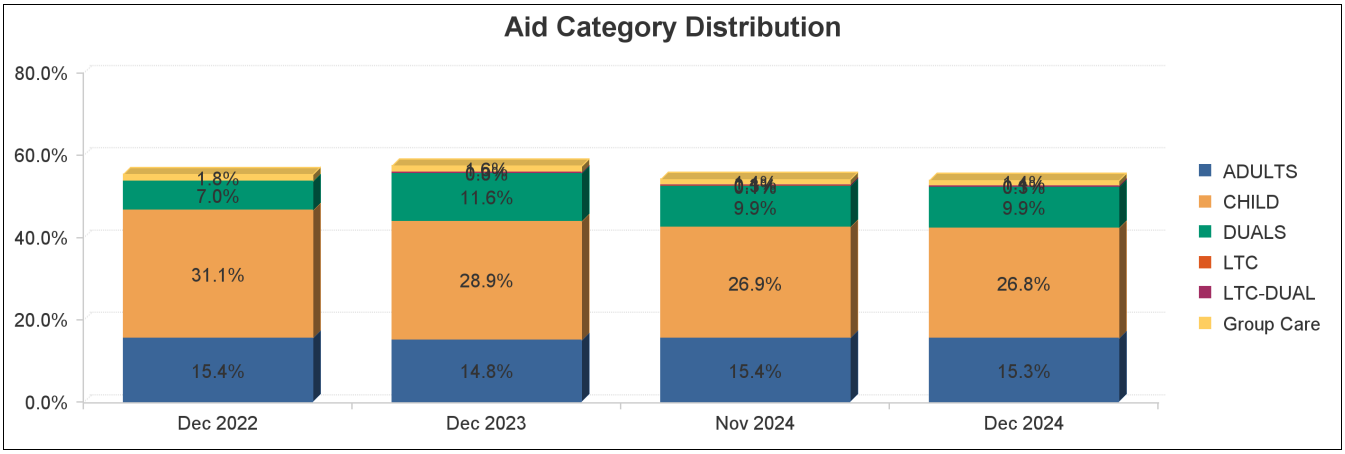
Category of Aid	Dec 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,957	15%	13,651	14,118	6	35,182
CHILD	110,547	27%	10,501	13,443	41,092	45,511
SPD	36,127	9%	12,122	5,685	1,433	16,887
ACA OE	154,565	38%	29,490	53,129	1,574	70,372
DUALS	40,812	10%	26,881	2,910	6	11,015
LTC	255	0%	240	7	0	8
LTC-DUAL	1,285	0%	1,284	0	0	1
Medi-Cal	406,548		94,169	89,292	44,111	178,976
Group Care	5,790		2,144	946	0	2,700
Total	**412,338**	**100%**	**96,313**	**90,238**	**44,111**	**181,676**
Medi-Cal %	98.6%		97.8%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.2%	1.0%	0.0%	1.5%
	Network Distribution		**23.4%**	**21.9%**	**10.7%**	**44.1%**
			% Direct:	**45%**	**% Delegated:**	**55%**





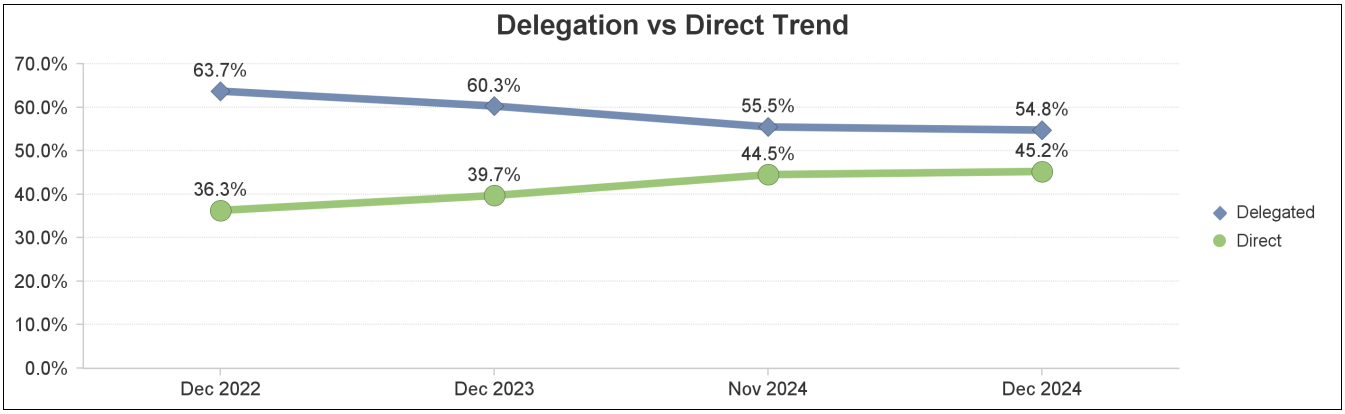
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
ADULTS	50,351	52,174	62,533	**62,957**	15.4%	14.8%	15.4%	15.3%	3.6%	20.7%	0.7%
CHILD	101,791	101,634	109,574	**110,547**	31.1%	28.9%	26.9%	26.8%	-0.2%	8.8%	0.9%
SPD	28,452	30,848	35,603	**36,127**	8.7%	8.8%	8.7%	8.8%	8.4%	17.1%	1.5%
ACA OE	118,397	119,669	151,559	**154,565**	36.1%	34.0%	37.2%	37.5%	1.1%	29.2%	2.0%
DUALS	23,028	40,976	40,360	**40,812**	7.0%	11.6%	9.9%	9.9%	77.9%	-0.4%	1.1%
LTC	0	135	255	**255**	0.0%	0.0%	0.1%	0.1%	0.0%	88.9%	0.0%
LTC-DUAL	0	951	1,269	**1,285**	0.0%	0.3%	0.3%	0.3%	0.0%	35.1%	1.3%
Medi-Cal	322,019	346,387	401,153	**406,548**	98.2%	98.4%	98.6%	98.6%	7.6%	17.4%	1.3%
Group Care	5,776	5,622	5,772	**5,790**	1.8%	1.6%	1.4%	1.4%	-2.7%	3.0%	0.3%
Total	**327,795**	**352,009**	**406,925**	412,338	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**7.4%**	**17.1%**	**1.3%**



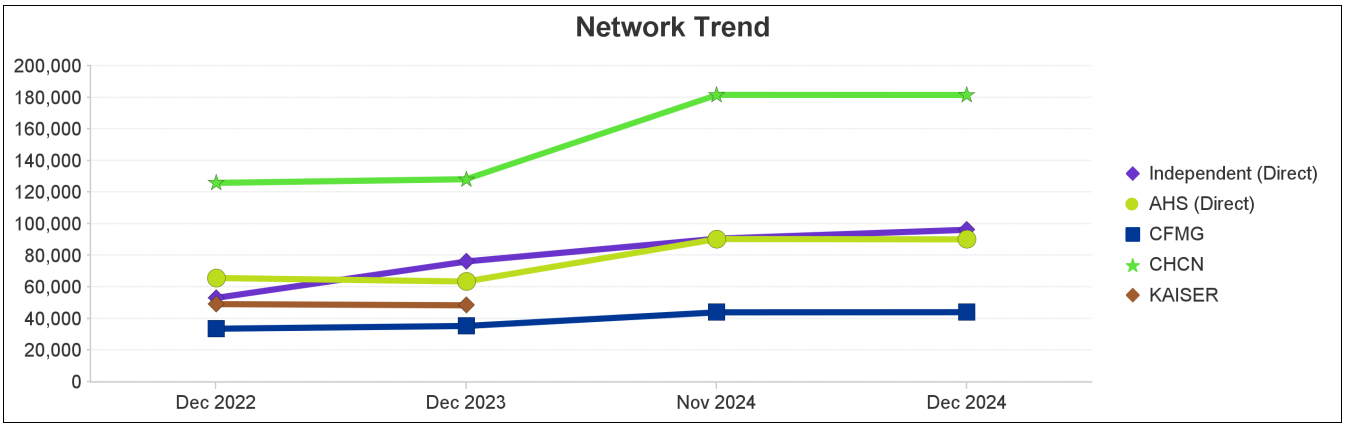
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
Delegated	208,881	212,220	225,785	**225,787**	63.7%	60.3%	55.5%	54.8%	1.6%	6.4%	0.0%
Direct	118,914	139,789	181,140	**186,551**	36.3%	39.7%	44.5%	45.2%	17.6%	33.5%	3.0%
Total	**327,795**	**352,009**	**406,925**	412,338	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**7.4%**	**17.1%**	**1.3%**



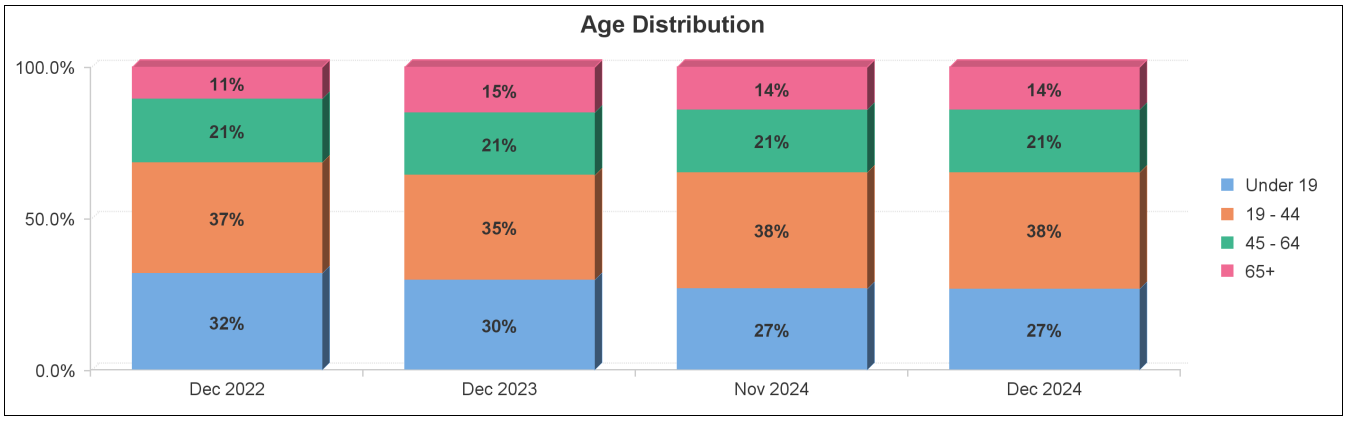
Network Trend

Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
Independent (Direct)	53,143	76,241	90,681	**96,313**	16.2%	21.7%	22.3%	23.4%	43.5%	26.3%	6.2%
AHS (Direct)	65,771	63,548	90,459	**90,238**	20.1%	18.1%	22.2%	21.9%	-3.4%	42.0%	-0.2%
CFMG	33,648	35,401	44,031	**44,111**	10.3%	10.1%	10.8%	10.7%	5.2%	24.6%	0.2%
CHCN	126,009	128,342	181,754	**181,676**	38.4%	36.5%	44.7%	44.1%	1.9%	41.6%	0.0%
KAISER	49,224	48,477	0	**0**	15.0%	13.8%	0.0%	0.0%	-1.5%	-100.0%	0.0%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**7.4%**	**17.1%**	**1.3%**



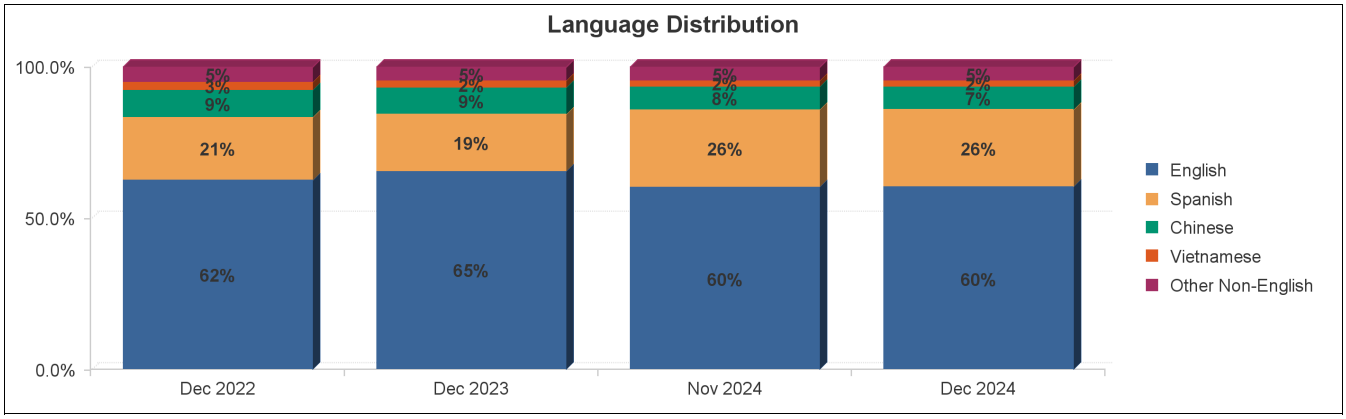
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
Under 19	104,022	104,062	108,407	**109,506**	32%	30%	27%	27%	0%	5%	1%
19 - 44	119,997	121,694	155,955	**158,707**	37%	35%	38%	38%	1%	30%	2%
45 - 64	68,606	72,612	84,411	**85,272**	21%	21%	21%	21%	6%	17%	1%
65+	35,170	53,641	58,152	**58,853**	11%	15%	14%	14%	53%	10%	1%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100%**	**100%**	**100%**	**100%**	**7%**	**17%**	**1%**



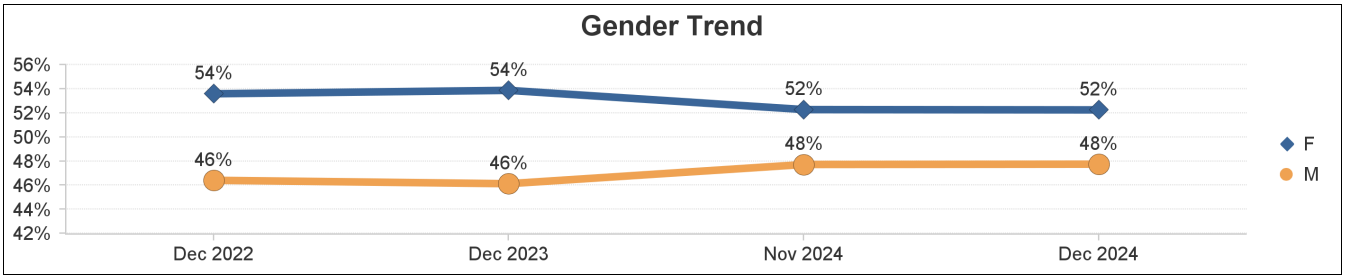
Language Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Dec 2022	Dec 2023	Nov 2024	Dec 2024	ec 2022	ec 2023	Nov 2024	ec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
English	204,635	229,835	244,547	**248,451**	62%	65%	60%	60%	12%	8%	2%
Spanish	68,179	66,602	104,072	**105,234**	21%	19%	26%	26%	-2%	58%	1%
Chinese	29,182	30,505	30,682	**30,806**	9%	9%	8%	7%	5%	1%	0%
Vietnamese	8,904	8,507	8,223	**8,294**	3%	2%	2%	2%	-4%	-3%	1%
Other Non-English	16,895	16,560	19,401	**19,553**	5%	5%	5%	5%	-2%	18%	1%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100%**	**100%**	**100%**	**100%**	**7%**	**17%**	**1%**



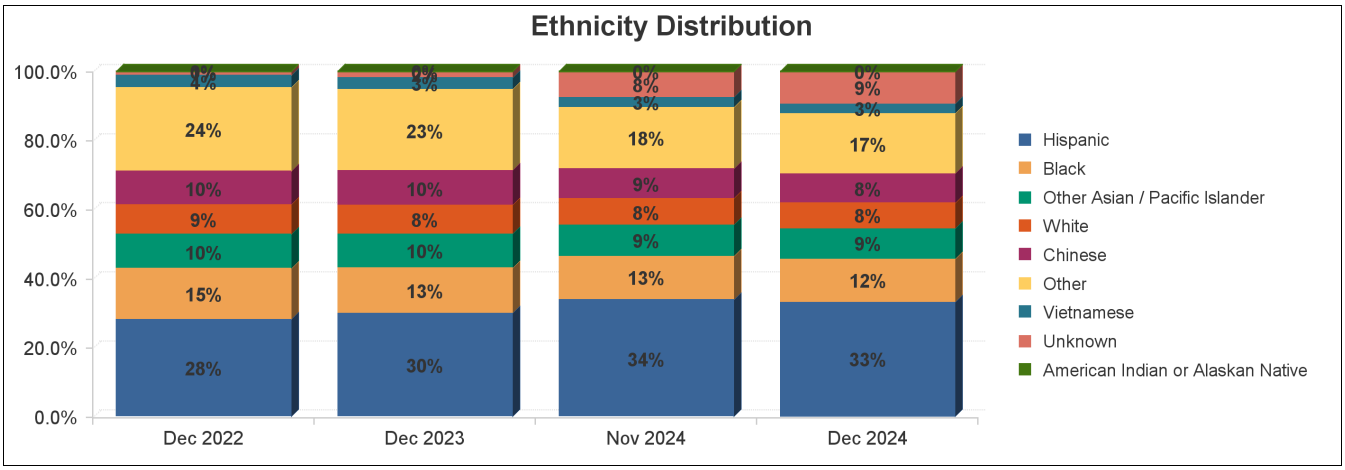
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
F	175,661	189,639	212,721	**215,451**	54%	54%	52%	52%	8%	14%	1%
M	152,134	162,370	194,204	**196,887**	46%	46%	48%	48%	7%	21%	1%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100%**	**100%**	**100%**	**100%**	**7%**	**17%**	**1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
Hispanic	92,030	104,945	137,424	**136,294**	28%	30%	34%	33%	14%	30%	-1%
Black	48,301	46,303	51,258	**51,323**	15%	13%	13%	12%	-4%	11%	0%
Other Asian / Pacific Islander	32,466	34,537	36,733	**36,322**	10%	10%	9%	9%	6%	5%	-1%
White	28,063	29,449	31,272	**30,931**	9%	8%	8%	8%	5%	5%	-1%
Chinese	31,839	35,470	34,944	**34,683**	10%	10%	9%	8%	11%	-2%	-1%
Other	79,375	82,447	72,555	**71,988**	24%	23%	18%	17%	4%	-13%	-1%
Vietnamese	11,505	11,943	11,441	**11,366**	4%	3%	3%	3%	4%	-5%	-1%
Unknown	3,531	6,228	30,524	**38,664**	1%	2%	8%	9%	76%	521%	27%
American Indian or Alaskan Native	685	687	774	**767**	0%	0%	0%	0%	0%	12%	-1%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100%**	**100%**	**100%**	**100%**	**7%**	**17%**	**1%**



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

Medi-Cal By City

City	Dec 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,231	40%	25,873	41,915	17,311	77,132
HAYWARD	65,187	16%	14,300	17,525	7,494	25,868
FREMONT	38,188	9%	16,105	6,638	2,252	13,193
SAN LEANDRO	33,420	8%	8,659	5,622	4,229	14,910
UNION CITY	14,789	4%	5,814	2,601	845	5,529
ALAMEDA	13,764	3%	3,382	2,444	2,038	5,900
BERKELEY	15,451	4%	4,479	2,274	1,760	6,938
LIVERMORE	13,237	3%	2,075	587	2,233	8,342
NEWARK	9,519	2%	2,855	4,099	553	2,012
CASTRO VALLEY	9,549	2%	2,754	1,555	1,422	3,818
SAN LORENZO	7,425	2%	1,541	1,662	860	3,362
PLEASANTON	7,807	2%	1,881	405	831	4,690
DUBLIN	7,641	2%	2,085	401	900	4,255
EMERYVILLE	2,887	1%	709	622	453	1,103
ALBANY	2,563	1%	698	302	570	993
PIEDMONT	482	0%	111	185	74	112
SUNOL	83	0%	24	14	6	39
ANTIOCH	63	0%	23	11	9	20
Other	2,262	1%	801	430	271	760
Total	406,548	100%	**94,169**	**89,292**	**44,111**	**178,976**

Group Care By City

City	Dec 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,825	32%	339	356	0	1,130
HAYWARD	664	11%	310	162	0	192
FREMONT	665	11%	442	80	0	143
SAN LEANDRO	609	11%	245	93	0	271
UNION CITY	289	5%	183	43	0	63
ALAMEDA	307	5%	88	27	0	192
BERKELEY	147	3%	48	10	0	89
LIVERMORE	100	2%	31	4	0	65
NEWARK	136	2%	80	31	0	25
CASTRO VALLEY	198	3%	86	31	0	81
SAN LORENZO	139	2%	45	28	0	66
PLEASANTON	71	1%	24	2	0	45
DUBLIN	119	2%	40	4	0	75
EMERYVILLE	35	1%	13	6	0	16
ALBANY	20	0%	10	1	0	9
PIEDMONT	8	0%	2	0	0	6
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	6	4	0	14
Other	433	7%	151	64	0	218
Total	**5,790**	**100%**	**2,144**	**946**	**0**	**2,700**

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

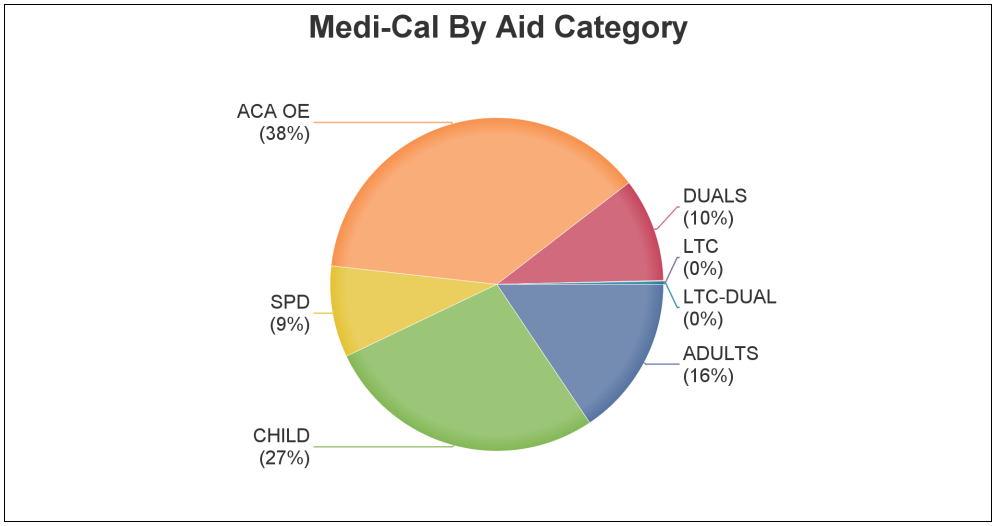
Total By City

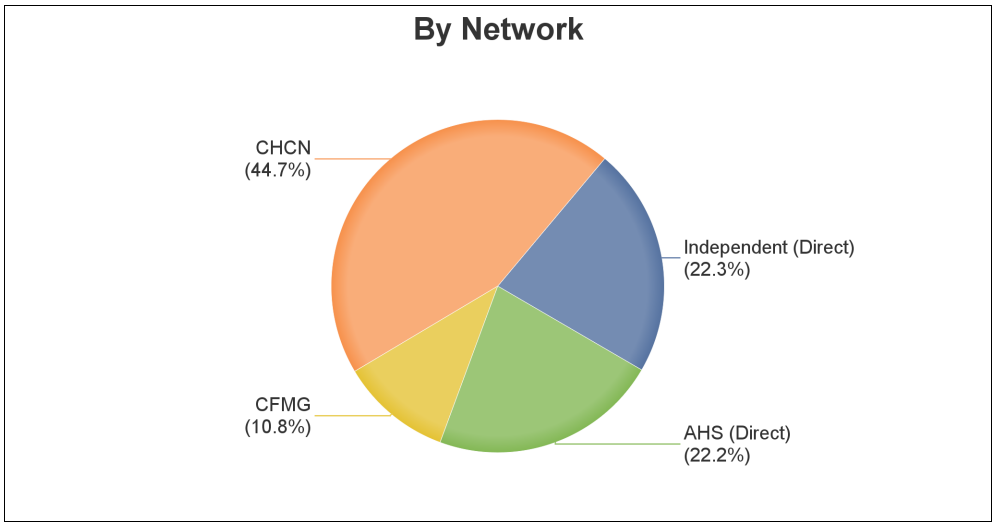
City	Dec 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	164,056	40%	26,212	42,271	17,311	78,262
HAYWARD	65,851	16%	14,610	17,687	7,494	26,060
FREMONT	38,853	9%	16,547	6,718	2,252	13,336
SAN LEANDRO	34,029	8%	8,904	5,715	4,229	15,181
UNION CITY	15,078	4%	5,997	2,644	845	5,592
ALAMEDA	14,071	3%	3,470	2,471	2,038	6,092
BERKELEY	15,598	4%	4,527	2,284	1,760	7,027
LIVERMORE	13,337	3%	2,106	591	2,233	8,407
NEWARK	9,655	2%	2,935	4,130	553	2,037
CASTRO VALLEY	9,747	2%	2,840	1,586	1,422	3,899
SAN LORENZO	7,564	2%	1,586	1,690	860	3,428
PLEASANTON	7,878	2%	1,905	407	831	4,735
DUBLIN	7,760	2%	2,125	405	900	4,330
EMERYVILLE	2,922	1%	722	628	453	1,119
ALBANY	2,583	1%	708	303	570	1,002
PIEDMONT	490	0%	113	185	74	118
SUNOL	84	0%	25	14	6	39
ANTIOCH	87	0%	29	15	9	34
Other	2,695	1%	952	494	271	978
Total	412,338	100%	**96,313**	**90,238**	**44,111**	**181,676**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

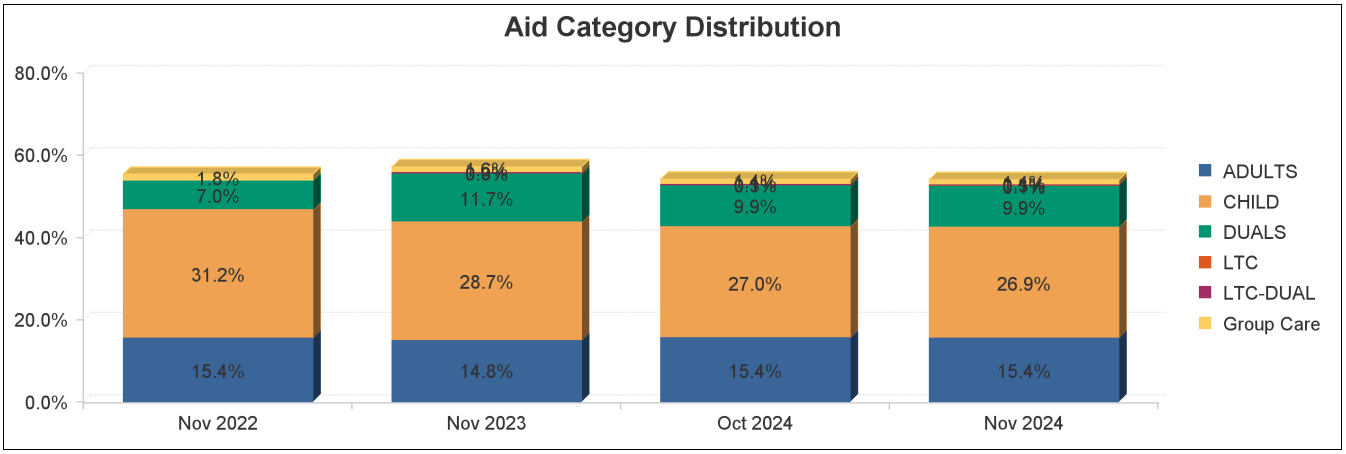
Category of Aid	Nov 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,533	16%	12,921	14,237	5	35,370
CHILD	109,574	27%	9,240	13,553	41,054	45,727
SPD	35,603	9%	11,685	5,651	1,430	16,837
ACA OE	151,559	38%	26,736	53,192	1,537	70,094
DUALS	40,360	10%	26,446	2,881	5	11,028
LTC	255	0%	239	7	0	9
LTC-DUAL	1,269	0%	1,268	0	0	1
Medi-Cal	401,153		88,535	89,521	44,031	179,066
Group Care	5,772		2,146	938	0	2,688
Total	**406,925**	**100%**	**90,681**	**90,459**	**44,031**	**181,754**
Medi-Cal %	98.6%		97.6%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.4%	1.0%	0.0%	1.5%
	Network Distribution		**22.3%**	**22.2%**	**10.8%**	**44.7%**
			% Direct:	**45%**	**% Delegated:**	**55%**





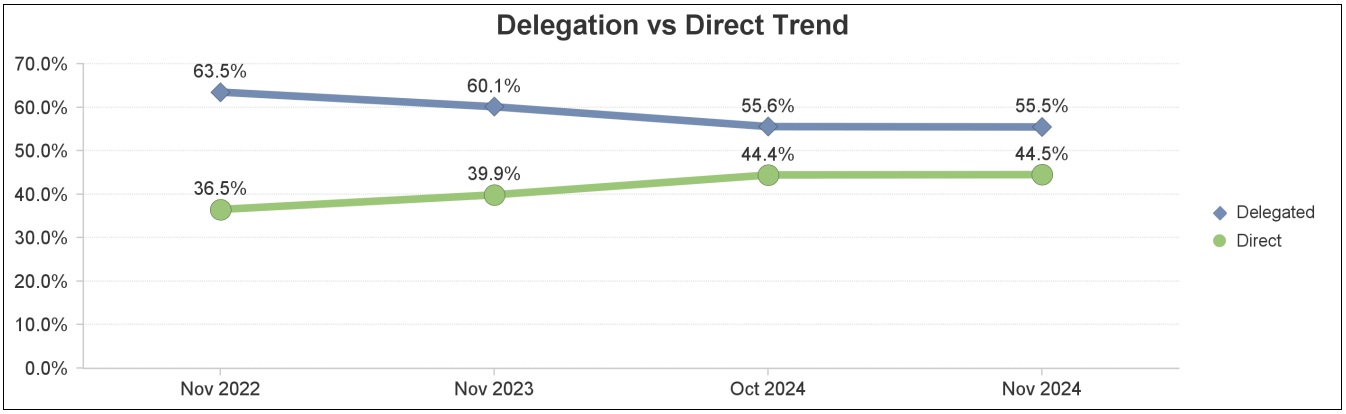
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
ADULTS	50,069	52,222	62,608	**62,533**	15.4%	14.8%	15.4%	15.4%	4.3%	19.7%	-0.1%
CHILD	101,653	101,557	109,680	**109,574**	31.2%	28.7%	27.0%	26.9%	-0.1%	7.9%	-0.1%
SPD	28,365	30,887	35,389	**35,603**	8.7%	8.7%	8.7%	8.7%	8.9%	15.3%	0.6%
ACA OE	117,328	120,666	151,098	**151,559**	36.0%	34.2%	37.2%	37.2%	2.8%	25.6%	0.3%
DUALS	22,719	41,217	40,144	**40,360**	7.0%	11.7%	9.9%	9.9%	81.4%	-2.1%	0.5%
LTC	0	139	249	**255**	0.0%	0.0%	0.1%	0.1%	0.0%	83.5%	2.4%
LTC-DUAL	0	980	1,265	**1,269**	0.0%	0.3%	0.3%	0.3%	0.0%	29.5%	0.3%
Medi-Cal	320,134	347,668	400,433	**401,153**	98.2%	98.4%	98.6%	98.6%	8.6%	15.4%	0.2%
Group Care	5,791	5,586	5,769	**5,772**	1.8%	1.6%	1.4%	1.4%	-3.5%	3.3%	0.1%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.4%**	**15.2%**	**0.2%**



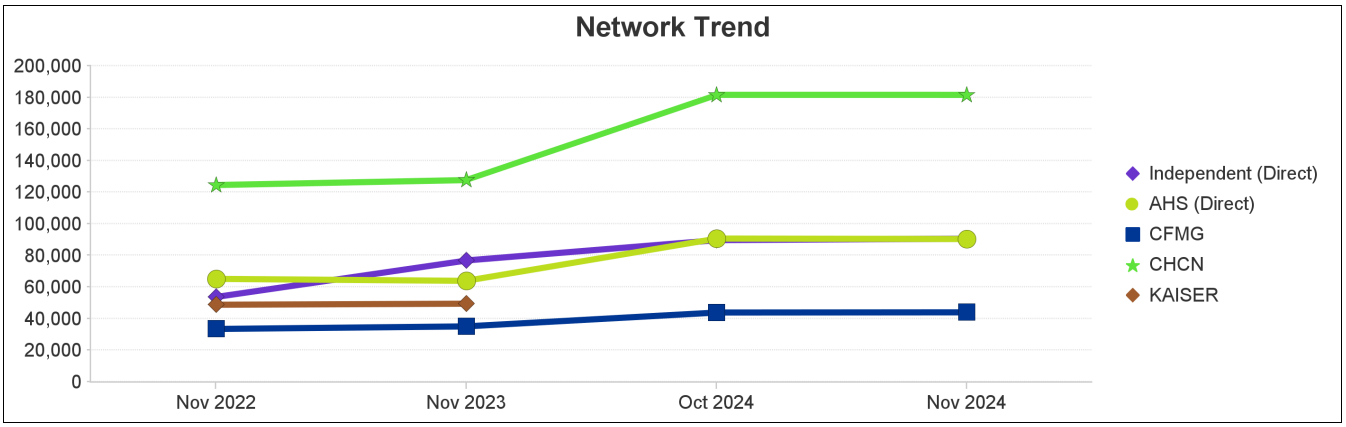
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Delegated	206,973	212,412	225,684	**225,785**	63.5%	60.1%	55.6%	55.5%	2.6%	6.3%	0.0%
Direct	118,952	140,842	180,518	**181,140**	36.5%	39.9%	44.4%	44.5%	18.4%	28.6%	0.3%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.4%**	**15.2%**	**0.2%**



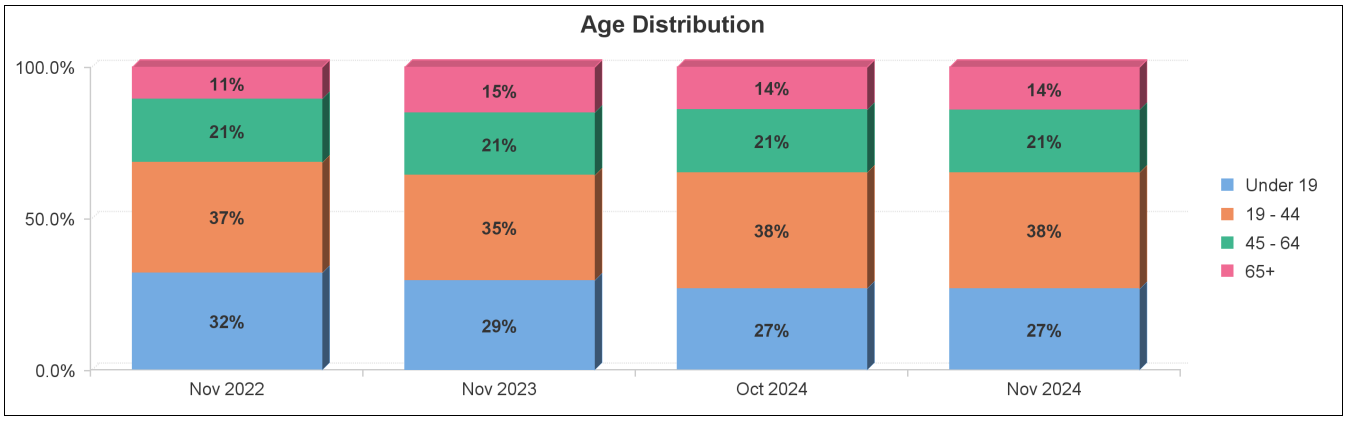
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Independent (Direct)	53,736	76,872	89,756	**90,681**	16.5%	21.8%	22.1%	22.3%	43.1%	18.0%	1.0%
AHS (Direct)	65,216	63,970	90,762	**90,459**	20.0%	18.1%	22.3%	22.2%	-1.9%	41.4%	-0.3%
CFMG	33,498	35,124	43,913	**44,031**	10.3%	9.9%	10.8%	10.8%	4.9%	25.4%	0.3%
CHCN	124,637	127,787	181,771	**181,754**	38.2%	36.2%	44.7%	44.7%	2.5%	42.2%	0.0%
KAISER	48,838	49,501	0	**0**	15.0%	14.0%	0.0%	0.0%	1.4%	-100.0%	0.0%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.4%**	**15.2%**	**0.2%**



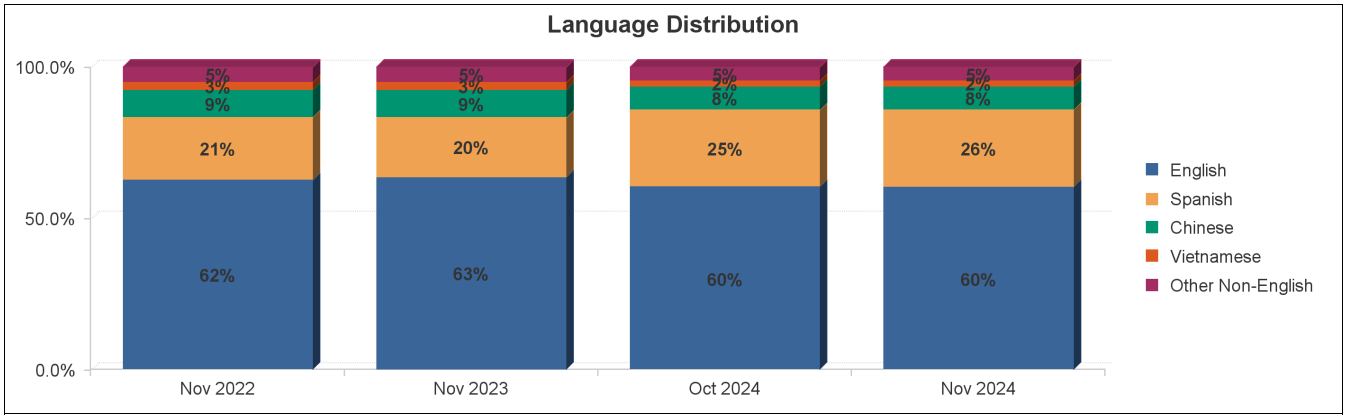
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Under 19	103,882	103,970	108,379	**108,407**	32%	29%	27%	27%	0%	4%	0%
19 - 44	119,055	122,671	155,783	**155,955**	37%	35%	38%	38%	3%	27%	0%
45 - 64	68,281	72,867	84,315	**84,411**	21%	21%	21%	21%	7%	16%	0%
65+	34,707	53,746	57,725	**58,152**	11%	15%	14%	14%	55%	8%	1%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100%**	**100%**	**100%**	**100%**	**8%**	**15%**	**0%**



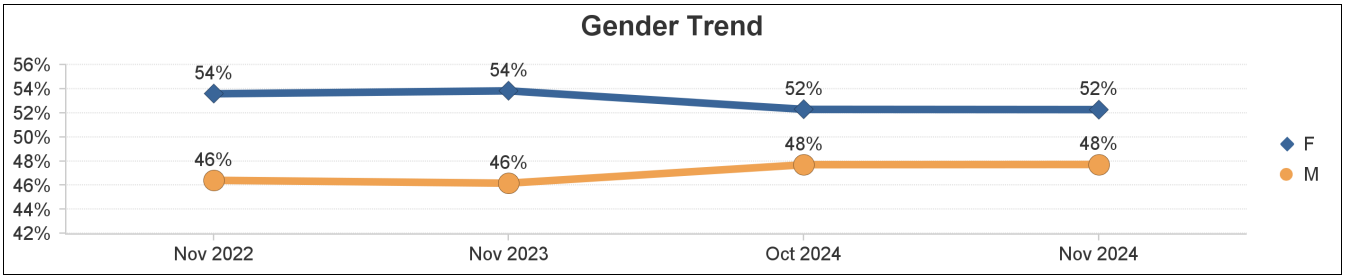
Language Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Nov 2022	Nov 2023	Oct 2024	Nov 2024	ov 2022	ov 2023	Oct 2024	ov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
English	203,441	223,617	244,693	**244,547**	62%	63%	60%	60%	10%	9%	0%
Spanish	67,653	69,914	103,228	**104,072**	21%	20%	25%	26%	3%	49%	1%
Chinese	29,111	32,047	30,669	**30,682**	9%	9%	8%	8%	10%	-4%	0%
Vietnamese	8,906	9,168	8,243	**8,223**	3%	3%	2%	2%	3%	-10%	0%
Other Non-English	16,814	18,508	19,369	**19,401**	5%	5%	5%	5%	10%	5%	0%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100%**	**100%**	**100%**	**100%**	**8%**	**15%**	**0%**



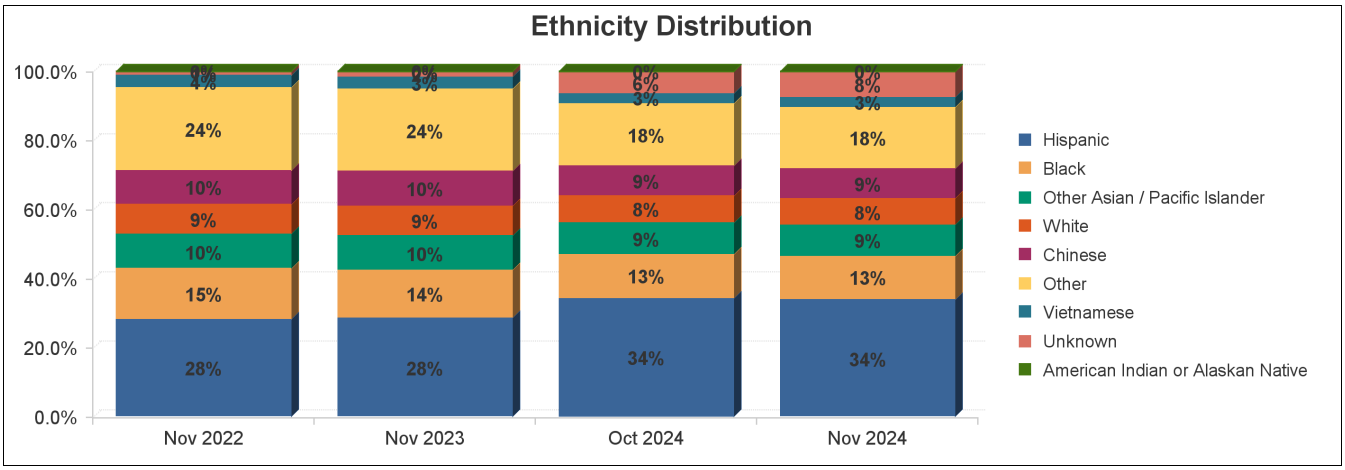
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
F	174,661	190,163	212,415	**212,721**	54%	54%	52%	52%	9%	12%	0%
M	151,264	163,091	193,787	**194,204**	46%	46%	48%	48%	8%	19%	0%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100%**	**100%**	**100%**	**100%**	**8%**	**15%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Hispanic	91,418	100,583	138,637	**137,424**	28%	28%	34%	34%	10%	37%	-1%
Black	48,247	48,956	51,748	**51,258**	15%	14%	13%	13%	1%	5%	-1%
Other Asian / Pacific Islander	32,346	35,233	37,202	**36,733**	10%	10%	9%	9%	9%	4%	-1%
White	28,029	30,370	31,678	**31,272**	9%	9%	8%	8%	8%	3%	-1%
Chinese	31,699	35,686	35,243	**34,944**	10%	10%	9%	9%	13%	-2%	-1%
Other	78,525	84,093	73,399	**72,555**	24%	24%	18%	18%	7%	-14%	-1%
Vietnamese	11,442	12,048	11,527	**11,441**	4%	3%	3%	3%	5%	-5%	-1%
Unknown	3,526	5,553	25,982	**30,524**	1%	2%	6%	8%	57%	450%	17%
American Indian or Alaskan Native	693	732	786	**774**	0%	0%	0%	0%	6%	6%	-2%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100%**	**100%**	**100%**	**100%**	**8%**	**15%**	**0%**



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

Medi-Cal By City

City	Nov 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	160,468	40%	23,965	42,182	17,289	77,032
HAYWARD	64,606	16%	13,417	17,513	7,538	26,138
FREMONT	37,685	9%	15,533	6,660	2,264	13,228
SAN LEANDRO	33,226	8%	8,333	5,646	4,218	15,029
UNION CITY	14,719	4%	5,668	2,602	853	5,596
ALAMEDA	13,794	3%	3,313	2,473	2,068	5,940
BERKELEY	14,902	4%	4,018	2,253	1,765	6,866
LIVERMORE	13,069	3%	1,864	604	2,251	8,350
NEWARK	9,417	2%	2,748	4,113	544	2,012
CASTRO VALLEY	9,533	2%	2,616	1,616	1,420	3,881
SAN LORENZO	7,390	2%	1,478	1,660	864	3,388
PLEASANTON	7,646	2%	1,765	401	829	4,651
DUBLIN	7,549	2%	1,973	432	901	4,243
EMERYVILLE	2,832	1%	649	602	458	1,123
ALBANY	2,542	1%	658	301	581	1,002
PIEDMONT	479	0%	117	184	64	114
SUNOL	87	0%	26	14	7	40
ANTIOCH	20	0%	8	7	0	5
Other	1,189	0%	386	258	117	428
Total	401,153	100%	**88,535**	**89,521**	**44,031**	**179,066**

Group Care By City

City	Nov 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,815	31%	349	349	0	1,117
HAYWARD	664	12%	318	156	0	190
FREMONT	658	11%	432	80	0	146
SAN LEANDRO	612	11%	241	95	0	276
UNION CITY	298	5%	186	49	0	63
ALAMEDA	303	5%	87	26	0	190
BERKELEY	146	3%	47	11	0	88
LIVERMORE	102	2%	32	4	0	66
NEWARK	133	2%	79	29	0	25
CASTRO VALLEY	194	3%	82	32	0	80
SAN LORENZO	142	2%	45	28	0	69
PLEASANTON	71	1%	26	2	0	43
DUBLIN	116	2%	41	4	0	71
EMERYVILLE	35	1%	14	5	0	16
ALBANY	20	0%	10	1	0	9
PIEDMONT	8	0%	2	0	0	6
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	6	4	0	14
Other	430	7%	148	63	0	219
Total	**5,772**	**100%**	**2,146**	**938**	**0**	**2,688**

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

Total By City

City	Nov 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,283	40%	24,314	42,531	17,289	78,149
HAYWARD	65,270	16%	13,735	17,669	7,538	26,328
FREMONT	38,343	9%	15,965	6,740	2,264	13,374
SAN LEANDRO	33,838	8%	8,574	5,741	4,218	15,305
UNION CITY	15,017	4%	5,854	2,651	853	5,659
ALAMEDA	14,097	3%	3,400	2,499	2,068	6,130
BERKELEY	15,048	4%	4,065	2,264	1,765	6,954
LIVERMORE	13,171	3%	1,896	608	2,251	8,416
NEWARK	9,550	2%	2,827	4,142	544	2,037
CASTRO VALLEY	9,727	2%	2,698	1,648	1,420	3,961
SAN LORENZO	7,532	2%	1,523	1,688	864	3,457
PLEASANTON	7,717	2%	1,791	403	829	4,694
DUBLIN	7,665	2%	2,014	436	901	4,314
EMERYVILLE	2,867	1%	663	607	458	1,139
ALBANY	2,562	1%	668	302	581	1,011
PIEDMONT	487	0%	119	184	64	120
SUNOL	88	0%	27	14	7	40
ANTIOCH	44	0%	14	11	0	19
Other	1,619	0%	534	321	117	647
Total	406,925	100%	**90,681**	**90,459**	**44,031**	**181,754**

ALAMEDA Alliance FOR HEALTH

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

Operations

Ruth Watson

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

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

Date: **February 14th, 2025**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:

    - The Member Services Department received a 26% decrease in calls in January 2025, totaling 21,834 compared to 29,606 in January 2024.
    - The abandonment rate for January 2025 was 5%, compared to 11% in January 2024.
    - The Department's service level was 93% in January 2025, compared to 71% in January 2024. The average speed to answer (ASA) was sixteen seconds (00:16) compared to one minute twenty-six seconds (01:26) in January 2024. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
    - The average talk time (ATT) was seven minutes and thirty-four seconds (07:34) for January 2025 compared to six minutes and fifty-eight seconds (06:58) for January 2024.
    - 100% of calls were answered within 10 minutes for January 2025 and 97% of calls were answered within 10 minutes for January 2024.
    - Outbound calls totaled 9,584 in January 2025 compared to 9,568 in January 2024.
    - The top five call reasons for January 2025 were: 1). Eligibility/Enrollment; 2). Change of PCP; 3). Benefits; 4). Grievances/Appeals; 5). Provider Network. The top five call reasons for January 2024 were: 1). Eligibility/Enrollment; 2). Change of PCP; 3). ID Card Requests; 4). Benefits; 5). Provider Network.
    - January utilization for the member automated eligibility IVR system totaled 1,599 in January 2025 compared to 3,082 in January 2024.
    - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests and in-person) while honoring the organization's policies. The Department responded to 1,530 web-based requests in January 2025 compared to 2,839 in January 2024. The top three web reason requests for January 2025 were: 1). Change of PCP; 2). ID Card Requests; 3). Update Contact Information. 64 members were assisted in-person in January 2025 compared to 119 in 2024.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health Unit received a total of 1,490 calls in January 2025 compared to 1,605 in January 2024.
    - The abandonment rate was nine percent (9%) in January 2025 compared to sixteen percent (16%) in 2024.
    - The service level was sixty-eight percent (68%) in January 2025 and seventy-one percent (71%) in January 2024.
    - The average speed to answer (ASA) was one minute and twenty-four seconds (01:24) compared to one minute and forty-eight seconds (01:48) in January 2024.
    - Calls answered in 10 minutes were ninety-nine percent (99%) in January 2025 compared to ninety-five percent (95%) in January 2024.
    - The Average Talk Time (ATT) in January 2025 was eight minutes and seven seconds (08:07) compared to nine minutes and forty-five seconds (9:45) in January 2024. MS BH Team utilizes the DHCS age-appropriate screening tools for Medi-Cal Mental Health Services to determine the appropriate delivery system for members who are not currently receiving mental health services when they contact the plan.
    - 1,337 outbound calls were completed in January 2025 compared to 1,164 in January 2024.
    - 150 screenings were completed in January 2025 compared to 217 in January 2024.
    - 90 outreach campaigns were completed in January 2025 compared to 213 in January 2024.
    - 50 referrals were made to the County (ACCESS) in January 2025 compared to 48 in January 2024.
    - 19 members were referred to Center Point for SUD services in January 2025 compared to 21 in January 2024.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 339,760 claims in January 2025 compared to 298,465 in January 2024.
    - The Auto Adjudication rate was 86.2% in January 2025 compared to 81.7% in January 2024.
    - Claims compliance for the 30-day turn-around time was 90.1% in January 2025 compared to 88.0% in January 2024. The 45-day turn-around time was 98.9% in January 2025 compared to 99.9% in January 2024.

- Monthly Analysis:

    - In the month of January, we received a total of 339,760 claims in the HEALTHsuite system. This represents an increase of 2.30% from December

and is higher, by 41,295 claims, than the number of claims received in January 2024.
  - Drivers of the higher volume of claims received includes:
    - Increased membership since January 2025 (Anthem member transition; Unsatisfactory Immigration Status member transition).
    - Certain provider types that bill more frequently, e.g., LTC facilities that bill weekly or bi-weekly.
    - Providers with dual eligible members who are submitting paper claims even though we receive the same claim in our COBA file.
  - We received 89% of claims via EDI and 11% of claims via paper.
  - During the month of January, 98.9% of our claims were processed within 45 working days.
  - The Auto Adjudication rate was 86.2% for the month of January.

Provider Services

- 12-Month Trend Summary:

  - The Provider Services department's call volume in January 2025 was 10,977 calls compared to 10,695 calls in January 2024.
  - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
  - The Provider Services department completed 286 calls/visits during January 2025.
  - The Provider Services department answered 7,377 calls for January 2025 and made 868 outbound calls.

Credentialing

- 12-Month Trend Summary:

  - At the Peer Review and Credentialing (PRCC) meeting held on January 21st, 2024, there were 141 initial network providers approved; 4 primary care providers, 8 specialists, 13 ancillary providers, 10 midlevel providers, and 106 behavioral health providers. Additionally, 30 providers were re-credentialed at this meeting; 11 primary care providers, 10 specialists, 2 ancillary providers, and 7 midlevel providers.

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

Provider Dispute Resolution

- 12-Month Trend Summary:

    - In January 2025, the Provider Dispute Resolution (PDR) team received 2,843 PDRs versus 2,172 in January 2024.
    - The PDR team resolved 2,635 cases in January 2025 compared to 1,461 cases in January 2024.
    - In January 2025, the PDR team upheld 64% of cases versus 62% in January 2024.
    - The PDR team resolved 99.9% of cases in January 2025 within 45 working days compared to 99.5% in January 2024; the regulatory requirement is 95% within 45 working days.

- Monthly Analysis:

    - AAH received 2,843 PDRs in January 2025.
    - In the month of January, 2,635 PDRs were resolved. Out of the 2,635 PDRs, 1,678 were upheld and 957 were overturned.
    - 2,635 out of 2,632 cases were resolved within 45 working days resulting in a 99.9% compliance rate.
    - The average turnaround time for resolving PDRs in January was 38 days.
    - There were 3,377 PDRs pending resolution as of January 31st, with no cases older than 45 working days.
    - The overturn rate for PDRs was 36%, which did not meet our internal goal of 25% or less.
- The primary reason which caused the Department to miss their goal of 25% or less was:
        - Incorrect Contract rate – 399 cases that were paid incorrectly
        - 311 cases adjusted per California Emergency Physicians (CEP) contract amendment.
    - The full breakdown of all 957 overturned PDRs is:

Category	# of Cases	% of Cases	Comments
System Related Issues	**48**	**5%**	
General configuration issues	17	2%	Non-covered code, modifier, etc.
Financial responsibility	18	2%	Mental Health denied to delegate
Claims Editing System (CES)	13	1%	
OHC Issues	**66**	**6%**	OHC Member TPL data, incorrect primary EOB not matching, incorrect manual entry-HMS
Eligibility	**24**	**3%**	Eligibility is updated after the claim processed
Authorization Issues	**176**	**18%**	
Processor error	111	11%	Claim denied in error; authorization was on file
UM/retro auth review	65	7%	Auth updated after claim was processed and sent for medical review
Provider duplicate claim	**15**	**2%**	The documentation received confirmed claim was not a duplicate
Timely filing	**6**	**1%**	The documentation received confirmed claim was submitted on time
Incorrect Rates	**536**	**56%**	
Contract	399	42%	Incorrect rates in the system 311 CEP - Contract change
Letter of Agreement (LOA)	8	1%	Underpaid; LOA on file
COB calculation	129	13%	Incorrectly calculated
Processor Errors	**71**	**7%**	
Duplicate claim	30	3%	The claim was a duplicate; the processor paid it in error
Incorrect Manual Denial	25	4%	Claim manually denied incorrectly
Incorrect Manual Pricing	16		Claim manually priced incorrectly
Provider billing	**7**	**1%**	Corrected claim due to provider error
Overpayment	**8**	**1%**	Provider request recoupment due to overpayment
PDR Overturn Totals	**957**	**100%**	

Community Relations and Outreach

- 12-Month Trend Summary:

    - In January 2025, the Alliance completed 830 member orientation outreach calls and 83 member orientations by phone.
    - The C&O Department reached 1,368 people (78% identified as Alliance members) during outreach activities, compared to 1,682 individuals (83% self-identified as Alliance members) in January 2024.
    - The C&O Department spent a total of $650.00 on donations, fees, and/or sponsorships, compared to $600.00 in January 2024.
    - The C&O Department reached members in 14 cities/unincorporated areas throughout Alameda County, and the Bay Area, compared to 13 cities in January 2024.

- Monthly Analysis:

    - In January 2025, the C&O Department completed 830 member orientation outreach calls and 83 member orientations by phone, and 63 Alliance website inquiries.
    - Among the 1,368 people reached, 78% identified as Alliance members.
    - In January 2025, the C&O Department reached members in 14 locations throughout Alameda County, and the Bay Area.
    - Please see attached **Addendum A**.

Housing and Community Services Program Report – January Activities

Overview

Services Program (HCSP) leads, develops, and implements a comprehensive housing and homelessness strategy for Alameda Alliance for Health (Alliance). HCSP will evaluate the current processes for members' access to the healthcare system, identify the barriers to achieving housing outcomes for members, and create a strategic plan to establish partnerships with various community stakeholders.

Project Status Updates:

- Denial Process Workflow in TruCare – in progress
- Developing Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis for the housing bundle – ongoing
- Development of Standard Operating Procedures (SOPs) for housing-related CS – completed
- Housing Community Supports (CS) automation planning for referrals – in progress
- ROI project for housing-related CS – ongoing
- Developed operating definitions for reasonable and necessary criteria
- Operationalizing new HCPCS code for Outreach billing – in progress
- Updating Housing Job Descriptions – in progress

Staffing:

- Housing Coordinator – Two positions; recruitment to begin in February

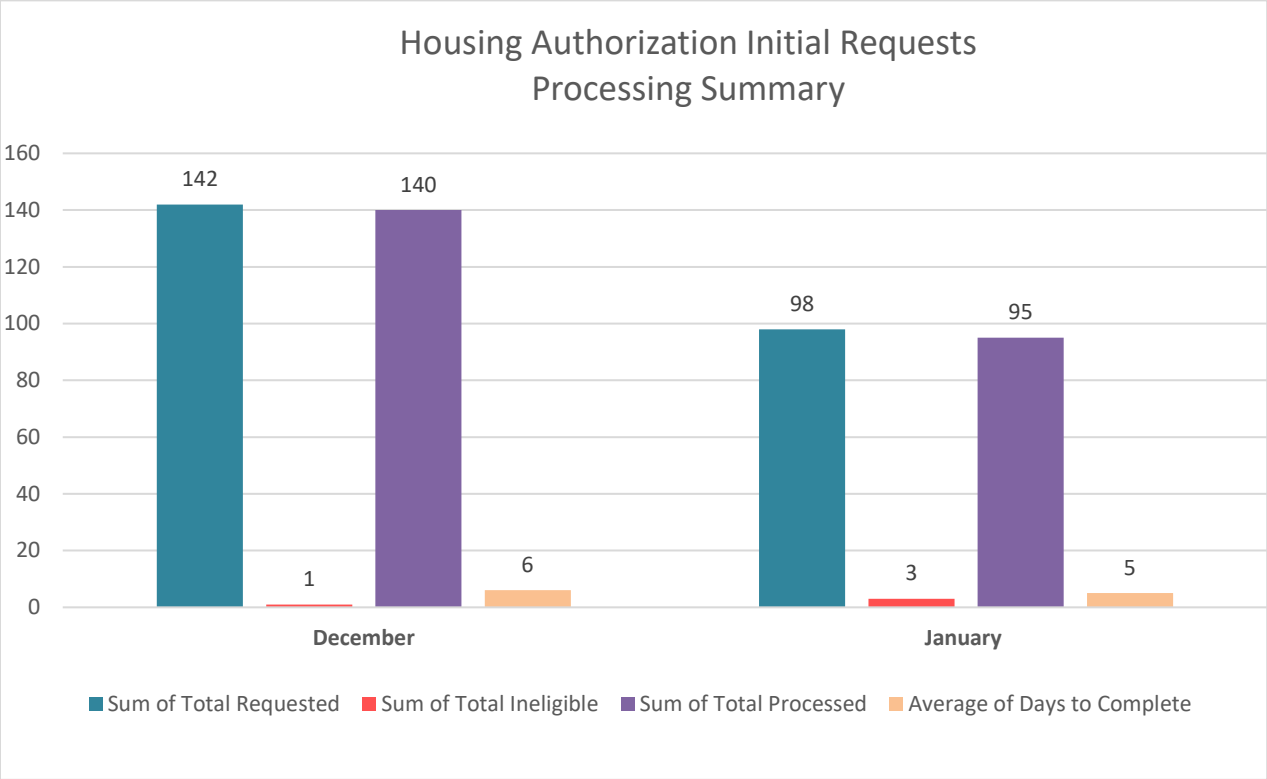
Interdepartmental Collaborations:

- Health Care Services and Housing Operations
    - ECM/CS Operational Efficiency Workgroup – ongoing
- TruCare Steering Committee Workgroup – ongoing
- CalAIM CS Hot Topics Workgroup – ongoing
- Alameda CalAIM Path Collaborative - ongoing

Community Networks and Partnership Development:

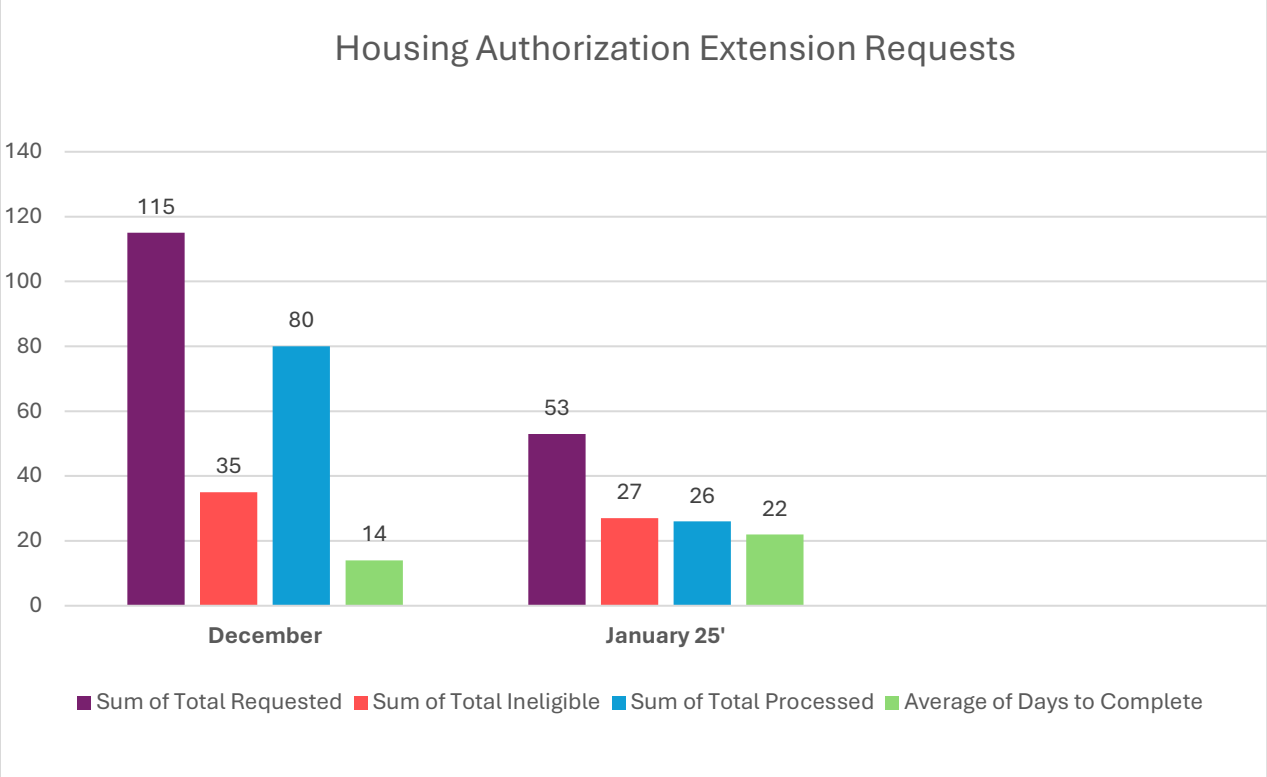
- Continued participation with various stakeholders throughout Alameda County, including the Continuum of Care (CoC), Racial Equity Committee, Outreach Access and Coordination Committee, Healthcare for the Homeless Oakland Regional Housing Meeting, Homeless Management Information System (HMIS) Committee, and Corporation for Supportive Housing Advisory Council.
    - Corporation for Supportive Housing Advisory Council – Transitional Rent Discussion
    - DHCS Transitional Rent Workgroup; next meeting scheduled for 02/05/2025
    - National Association of Housing and Redevelopment Officials Regional Conference – AAH presented on CalAIM Housing Community Supports – January 27th – 28th
    - Housing Community Supports Implementation Learning Collaborative
    - Corporation for Supportive Housing, Medicaid, and Housing Related Services Workgroup – 01/23/2025

Housing Authorization Efficiency Project Report:



The Initial Housing Authorization Request Report is a point-in-time report focusing on Initial Authorization completion for the Housing & Community Supports Department. The following provides an overview of Initial Authorization requests for December 2024 and January 2025:

- December 2024:
  - HCSD received 4 batches of initial housing authorizations requests which included 142 individual requests
    - 1 authorization was determined to be ineligible due to the member not meeting the criteria for the service
  - The team completed 140 authorizations, with an improved average completion time of 6 days per batch
- January 2025:
  - HCSD received 6 batches of initial housing authorizations requests which included 136 individual requests
    - 3 authorizations were determined to be ineligible due to members not meeting the criteria for the service
  - The team completed 98 authorizations, with an average completion time of 5 days per batch
  - Please note that the January data for “total ineligible”, “total processed”, and “average days to complete” excludes 38 initials that were submitted on 1/31/2025 . HCSD will report on the completion of January initials during the next board report.



- December 2024:
  - HCSD received a total of 4 batches of extension authorization requests which included 115 individual requests
    - 35 requests were determined to be ineligible due to members not meeting the criteria for the service
    - The team completed 80 authorization extensions, with an average completion time of 14 days per batch; this exceeded the 30-day completion requirement by 16 days

- January 2025:
  - HCSD received 1 batch of extension authorization requests which included 53 individual requests
    - 27 requests were determined to be ineligible due to members not meeting the criteria for the service
    - The team completed 26 authorization extensions, with an average completion time of 22 days per batch; this exceeded the 30-day completion requirement by 8 days

Community Health Worker Program – The Community Health Worker (CHW) Benefit aims to mitigate health disparities and improve health outcomes of Alliance members by bridging the gap between health and housing systems of care to support members' overall health and wellness through the deployment of preventative services that create positive outcomes on a member's social determinants of health.

Project Status Updates:

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

Staffing Updates:

- CHW Program Manager – anticipate recruiting to resume in February

CHW Provider Updates:

- **First 5 of Alameda County:** Alameda Alliance has partnered with First 5 since 2020 and is now expanding the relationship to become a contracted CHW provider, focusing on pediatric members (ages 0-5), to conduct well-child visits, outreach screenings and assessments – contracting activities in progress
- **Journey Health:** Medical Group and CHW provider specializing in eliminating health disparities through population health approach to member wellness and enhancing members' access to care for the most vulnerable patients and communities.
    - Areas of focus with the Alliance
        - Member follow-up for Mental Health (FUM) Measures in Emergency Department (ED) – active project
        - Solving for care gaps and improving A1C and primary care follow-up for AAH members – go-live extended to Q2
        - Working with AAH on CHW organization recruitment in Hayward to assist in closing care gaps – in progress
    - Provider recruitment: Journey Health has been instrumental in supporting expansion of the provider network for AAH recruited CBOs who were not ready to contract with the health plan directly. The following updates highlight newly subcontracted provider organizations through Journey:
        - **Glad Tiding Community Development Corporation:** Specializing in spiritual health and wellness in Hayward California. Supporting community health education, housing and workforce development. – Active Program will support AAH health education gaps in Hayward- Go live April 2025
        - **Good Life Path:** Specializing in health education courses such as healthy aging, cooking and nutrition, mindfulness meditation and open food panty and group exercise location. – Area of focus is on A1C
        - **Inspiring Communities:** Recognized by the CDC National Diabetes Prevention Program and American Diabetes Association for self-management education and support program, Inspiring Communities supports improving health literacy and reducing populations-based health education disparities to increase members ability to make informed health decisions.
        - **Youth Alive:** Specializing in breaking the cycle of violence through trauma informed practice focusing on saving lives and violence prevention and intervention. – Go Live to serve members is March 2025

- **Pair Team Medical Group:** Specializing in community health education helping patients manage health condition and navigate the healthcare delivery systems and addressing social determinants of health.
- **Our Roots Organization**: Specializing in perinatal depression and mental wellness for under-resourced BIPOC women and other birthing communities impacted by poverty. Currently in pre-contract phase.
    - Area of focus with the Alliance:
        - Outreach and health education services to approximately 600 high risk perinatal members – go live expected for March 2025.
- **Roots Community Health Center**: Specializing in uplifting communities through medical, behavioral health care, health navigation, workforce enterprises, justice-involved specialties, housing, outreach, advocacy and Community Health work. Roots also has two (2) new CHW providers, certified in asthma remediation, which brings on additional specialty services.
    - Areas of focus with the Alliance:
        - Actively providing health education, health navigation, screening and assessment for Alameda Alliance members with Asthma.
- **Zocalo Health**: Primary care group aimed to better patient experiences and access to behavioral health, health related social needs, and care. Zocalo Health also provides CHW services including health education, navigation, advocacy, screening and assessments. Zocalo Health specializes in serving the Latin(x)(o)(e) population with deep roots in cultural and linguistic competency. Currently in the pre-contract phase with Alameda Alliance.

Incentives & Reporting Board Report – January 2025 Activities

Current Incentive and Grant Programs

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

- The Alliance worked with Local Education Agencies (LEAs) and program partners on the Project Outcome Report (POR), which was submitted to DHCS on December 19th
    - The POR was the final SBHIP report for the entire program measurement period of January 1st, 2022, to December 31st, 2024; the Alliance is awaiting approval from DHCS, and payment is anticipated by April 2025
- To date, $8.9M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $7.9M has been paid to LEA and SBHIP partners

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

- Total eligible dollars available to the Alliance under this program was $44M
- The Alliance earned a total of $38M based on submission of deliverables and achievement of DHCS-defined metrics
    - $19.9M has been awarded to our HHIP partners to date

- A HHIP funding opportunity was released in June 2024 to SBHIP LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
    - The Alliance received applications from 10 LEAs totaling $1.3M in requests; all submitted applications were approved and work on the funded programs continues
- In a separate HHIP-funded initiative, the Alliance awarded $11.2M in funding to 10 community partners through a program that supports the HHIP goals of reducing and preventing homelessness
    - MOUs are in place or underway for projects related to capacity building, innovation, diversity and health equity, and housing stability

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

- Program highlights:
    - Launched on June 1st, 2024
    - 15 applications received totaling $6M in funding requests
    - $2M in funding awarded to 13 provider partners, pending finalization of MOUs and related program deliverables for the following:
        - Nineteen providers in total, 6 of which are bilingual, including:
            - 6 Mid-Level Providers
            - 5 Behavioral Health Clinicians
            - 5 MD/DOs
            - 3 OB/GYNs
    - Grants were provided to 5 practices to support Community Health Worker (CHW) training certificate costs for 33 CHWs

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

- The original funding was $700 million over 5 years; however, due to state budget constraints, the funding was reduced to $140 million over 3 years
- Alameda Health System was the only Alliance-associated applicant selected by DHCS to participate
- The Alliance submitted EPT MCP Practice numerators, denominators, and rates for Alameda Health System, the contracted EPT practices, for the Healthcare Effectiveness Data and Information Set (HEDIS) like key performance indicators (28 measures total) for MY 2023.

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

- Scholarships are intended to offset costs related to the following:
    - Medi-Cal Provider Application and Validation for Enrollment (PAVE)
    - Contracting and credentialing with the Alliance

    - Continued education, training, and administrative and operational support required to be a Doula
- Scholarships of up to $1,000 per person are available for Doulas both intending to contract with the Alliance and Doulas already contracted with the Alliance
- Program materials were developed and shared with community partners in December; to date, 23 applications have been received
    - In January 2025, 20 scholarships were awarded totaling $20K to support:
        - 7 awardees who are currently contracted with the Alliance
        - 13 awardees that intend to contract with the Alliance

Grant Program Updates

- The Incentives and Reporting team selected a grant management software system, Submittable, to support the various grant and incentive programs the Alliance participates in; the team is in month 4 of implementing the system
    - Submittable creates an online application process for community partners, an electronic evaluation process, reporting for fund management, and awardee deliverable tracking
    - The Doula Scholarship Program application was piloted within Submittable in December and continues to be used for partner communications and deliverable tracking
- The Alliance submitted an application on January 14th to participate in an opportunity through the California Improvement Network (CIN), a learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading good ideas, and implementing improvements
    - The CIN opportunity is a two-year program which, if selected, would involve the Alliance participating in an equity focused learning network
    - There is no funding available for the initial CIN opportunity; however, it is an opportunity to partner and connect with other organizations that are also working to improve health equity
        - Those selected to participate in the above activities will be eligible to apply for a $40k action project award to support implementation efforts for partners
- A meeting with The California Wellness Foundation was held on January 23rd to discuss funding opportunities and eligibility criteria
- An inquiry was submitted to the California Endowment on January 31st to be considered for their grant opportunities
- Meetings with internal teams took place with Health Equity, Health Care Services and Behavioral Health (clinical and operational) leads to further development grant seeking strategies
- A grant opportunity through Healthy Tomorrows Partnership for Children Program was presented to Health Care Services with team leads on January 22nd to support underserved communities with behavioral health screenings and referrals, children's immunizations, and adolescent well visits
    - Team Leads in Health Care Services made the decision not pursue this opportunity internally; however, it was shared with a community partner

Recruiting and Staffing

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

Incentive and Grant Program Descriptions

Student Behavioral Health Incentive Program (SBHIP) – program launched in January 2022 to support new investments in behavioral health services, infrastructure, information technology and data exchange, and workforce capacity for school-based and school-affiliated behavioral health providers. Incentive payments will be paid to Medi-Cal managed care plans (MCPs) to build infrastructure, partnerships, and capacity, statewide, for school behavioral health services. The program ended December 31st, 2024.

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

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

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

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

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

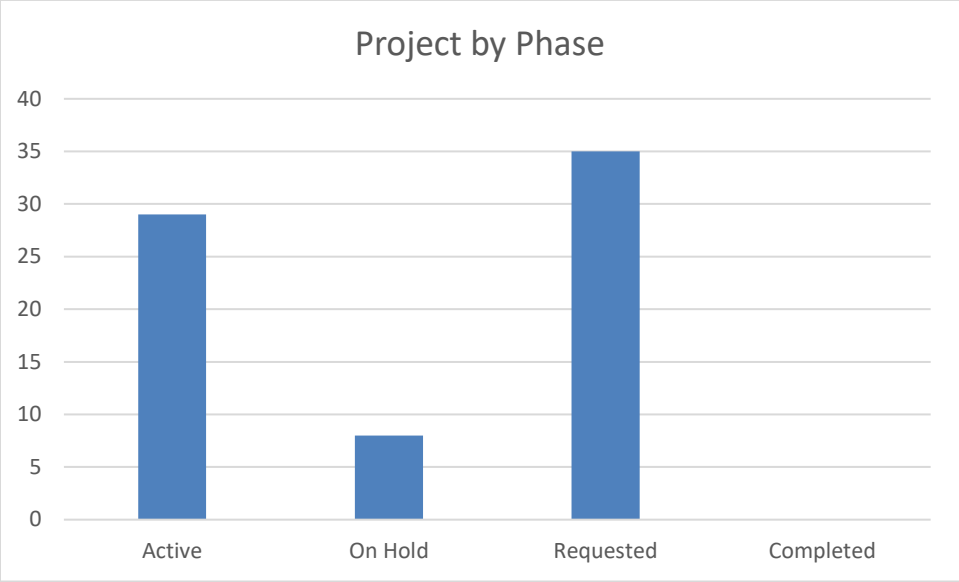
Doula Scholarship Program – program launched in December 2024 to grow the Doula provider network to increase access to these services for members.

Integrated Planning

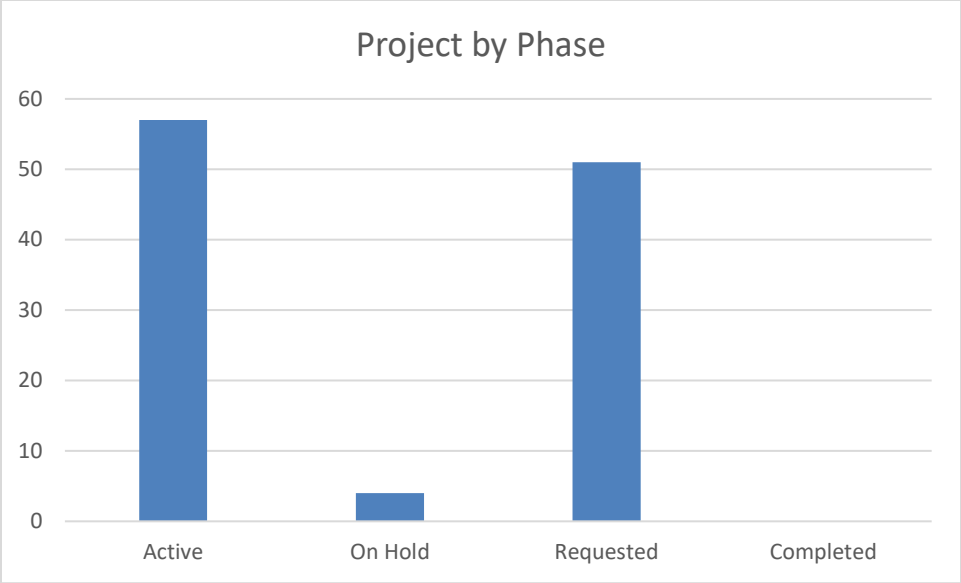
Ruth Watson

INTEGRATED PLANNING DIVISION BOARD REPORT – JANUARY 2025 ACTIVITIES

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



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



- D-SNP Key Initiatives and Dates
  - DMHC Material Modification Submission – MA Service Area Expansion – March 2024
  - DMHC Material Modification Submission – DSNP Product – August 2024
  - CMS Notice of Intent to Apply – November 2024
  - CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025
  - CMS Formulary & Bid Submission (Benefit Determination) – June 2025
  - CMS SMAC Submission – July 7th, 2025
  - Rebate Allocation with CMS and Health Plan – July / August 2025
  - Annual Enrollment Period (AEP) – October thru December 2025
  - IT System Readiness – December 15th, 2025
  - Open Enrollment Period (OEP) Begins – January 1st, 2026
- D-SNP Activities – January 2025
  - Provider Services & Contracting
    - In preparation for CMS Application submission on February 12th, 2025, Provider Services & Contracting focus was to meet network adequacy requirements. Current contracting status is as follows:
      - 107 Letters of Intent (LOIs) pending AAH execution
        - 55 meet CMS Network Adequacy
        - 52 do not meet CMS Network Adequacy
      - 154 Provider Contract Amendments
        - 112 meet CMS Network Adequacy
        - 42 do not meet CMS Network Adequacy
    - Rates and Reimbursement
      - Work is in process with Milliman on the development of Capitation Rates and Rates Analysis
  - Product
    - Began CMS Application Submission planning efforts
      - Downloaded Part C, Part D, and SNP Attestations and Supporting document templates

        - Developed process and timeline for the review and submission of the attestations and supporting documents.
    - Received approval on the D-SNP Product Name “Alameda Alliance Wellness”
    - Began benefit structure design discussion with Milliman
    - Initiated integrated member materials requirements to support Evidence of Coverage (EOC), Summary of Benefits (SOB), and Member Letters.
- Sales
    - Project Kick off with Nations CRM to support the implementation of the Sales System and Hearing and FlexCard Supplemental Benefits.
- Vendor Management
    - Continued engagement with the following vendors to support Supplemental Benefit Offering(s)
        - Dental – in Pre-Del / Contracting
        - Vision – in Pre-Del / Contracting
        - Hearing – in Pre-Del / Contracting / Project Kickoff
        - Flex Card – in Pre-Del / Contracting / Project Kickoff
        - MTM – in Pre-Del / Contracting
        - HRA – scoring in process
- Quality
    - Model of Care
        - MOC completed and compiled for submission on February 12th, 2025, with application.
        - MOC matrixes for CMS and DHCS have been completed and are in final review.
    - Quality Program
        - Quality Committee Charters are under review for edits to include DSNP in existing committees and to establish new committees where needed.
        - Quality Policies revisions have started
- Future state PQI workflow draft has been completed, and requirements gathering is in final stages with minimal impacts to QualitySuite. Health Care Services (HCS) and Behavioral Health (BH)
    - Redlining UM and CM Program Descriptions for DSNP elements
    - DSNP Prior Authorization Forms drafts are complete and in final stages of review
    - The HRA draft was approved by AAH leaders and submitted for formatting to meet CMS requirements Future State (DSNP) Inpatient and OP UM Business BRD – System Requirements Documentation started in collaboration with vendor.
    - Future State DSNP CM Global Workflow in draft – Outlining process flows for new DSNP components to include Face-to-Face visit, Palliative Care Program, and Dementia Care Program

- Continuing to define structure for California Integrated Care Management (CICM) to include new requirements outlined in the CY2026 Program Guide
- Completing inventory of existing CM and UM artifacts including assessments and notes to identify needs
- BH UM Future State (DSNP) Business Process Documentation in progress – Defining program model and IT needs as this will be a new process for DSNP
- BH CM – Continuing to document proposed DSNP CM program structure. Beginning initial discussion of CBO integrations for BH CM Programs
- Creating inventory of DNSP Member and Provider letters needed

- Finance
  - All draft Finance policies were uploaded into PolicyTech for review and approval
  - Confirmed final policy approval at the AOC meeting on April 16th, 2025
  - Confirmed the Finance training schedule for the following sessions:
    - Bid 101
    - Revenue and Medical Expense
    - Admin Expense / Regulatory / Budgeting and Forecasting
- Compliance
  - DMHC Material Modification – D-SNP Product (Filing #20244060)
    - Initial AAH responses submitted to DMHC on 9/9/24
    - DMHC Comment Table received 1/7/25; responses due 2/6/25
  - Submitted responses to DCHS Checklist #2 questions on 1/10/25
  - HPMS Priority Access confirmed for the following AAH employees
    - Tome Meyers, Executive Director, Medicare
    - Ruth Watson, COO
    - Richard Golfin, III, CCO & CPO
    - Stephen Smythe, Director, Compliance & Special Investigations
    - Marie Broadnax, Manager, Regulatory Affairs & Compliance
    - Jill Drake, Supervisor, Regulatory Affairs & Compliance
    - Sam Gustas - Director, Data Exchange and Interoperability
  - Continued development on the process to manage enterprise wide requests for HPMS access
  - Continued Compliance policy review
  - Confirmed Compliance policy approval at AOC on April 16th, 2025
- Enrollment and Eligibility
  - Initial discussion and development of member enrollment and disenrollment letters to support HEALTHsuite configuration

- Pharmacy
    - Pre-delegation audit for MTM is nearing completion, targeting to be completed by January 31st, 2025.
    - PBM and MTM contracting negotiations are on track to be completed by February 7, 2025.
    - 24 P&Ps in development with Rebellis: 13 in review, 11 approved by P&T committee in December 2024. 36 Additional P&Ps identified but not started.
    - Members who enroll in Part C D-SNP Plan will automatically be enrolled in Part D
    - AAH will delegate Part D appeals to PerformRx (PBM) and AAH will own Part D grievances
    - Pre-delegation audit for MTM is nearing completion, targeting to be completed by January 31st, 2025.
    - PBM and MTM contracting negotiations are on track to be completed by February 7, 2025.
    - 24 P&Ps in development with Rebellis: 13 in review, 11 approved by P&T committee in December 2024. 36 Additional P&Ps identified but not started.
    - Members who enroll in Part C D-SNP Plan will automatically be enrolled in Part D
    - AAH will delegate Part D appeals to PerformRx (PBM) and AAH will own Part D grievances
- Operations (Claims / Member Services / Mailroom / IVR)
    - Continue development of Claims, Member Services, Mailroom, and IVR business process and requirements
- IT
    - TruCare: Developing DSNP system workflows for UM, CM and Behavioral Health, securing business approvals, and configuring in TruCare HEALTHsuite: Workstream Leads identified and working sessions are in progress. Staging Region upgrade complete. RAM provided with 4 options for Plan Structure. Leadership engaged to decide on the best option for AAH. Project Chater review complete and with Executive Sponsor (Ruth) for approval. High priority Enrollment model letters review in progress
    - QualitySuite: Upgrade planned during weekend of March 22nd. Grievances and Appeals (G&A) – requirements complete. Appeals requirements will be sent out for approval. Appeals reporting requirements in progress.
- Policies / SOPs / KPIs
    - Continued policy review within all workstreams
    - Continued development of KPI strategy and tracking documents for all workstreams
- Stars
    - Phase 1 of Star strategy underway

        - Phase 1 defined as HEDIS measures already supported under the Medi-Cal line of business and Operational measures that will impact Star ratings on day 1.
        - Discovery and documentation of existing AAH initiatives that impact Star measures
        - Focus on implementing D-SNP members in existing initiatives as appropriate
    - Reviewing concurrent development of 4 foundational initiatives (as discovery allows)
        - TruCare Star gap integration
        - Pay-for-Performance and Pay-for-Reporting program
        - EMR Data feeds
        - Prospective Chart Review
- D-S NP Program Decisions Reviewed
    - Grievance & Appeals
        - AAH will delegate Part D appeals to PerformRx (PBM) and AAH will own Part D grievances
    - Health Care Services
        - Model of Care (MOC) Training will be provided to all of the AAH organization.
        - OCR (internal solution) will be used to create D-SNP Prior Authorization forms.
    - Pharmacy
        - Members who enroll in Part C D-SNP Plan will automatically be enrolled in Part D
        - AAH will delegate Part D appeals to PerformRx (PBM) and AAH will own Part D grievances
        - AAH will delegate D-SNP Part D Pharmacy Appeals to PBM in 2026
        - AAH Pharmacy will not participate in the M3P program
    - Product
        - Confirmed two D-SNP phone lines will be available to members; one for Member Services and the second one for Sales.
    - Provider Services & Contracting
        - Confirmed In Person Townhall location will be at the Alameda Alliance for Health offices
    - Vendor Management
        - Confirmed selection of Nations Hearing as the D-SNP Hearing provider.
        - Confirmed selection of VSP as the D-SNP Vision provider

- **CalAIM Initiatives:**
  - Community Supports (CS):
    - Due to Budget Constraints, all CS enhancement and expansion are on hold.
  - Justice-Involved (JI) Initiative:
    - CalAIM Re-entry
      - Correctional facilities go-live date for pre-release services is determined based on DHCS readiness assessment and will go-live with pre-release services within a 24-month phase in period. (10/1/2024 – 9/30/2026)
        - Santa Rita Jail is targeting to go-live on 7/1/2026 with pre-release services; Juvenile Justice Center's go-live is TBD.
        - Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of October 1st, 2024, even if facilities in their county will go-live later.
        - JI project team is developing a contact list for the counties going live with pre-release to support coordination of referrals for any AAH members being released from these counties.
      - DHCS has indicated they intend to release a revised JI Policy Guide; impacts to project scope and schedule will be assessed once this is released.
      - DHCS JI Learning Collaboratives initiated in August and continues through January 2025. These collaborative sessions include correctional facilities, county behavioral health agencies, probation, managed care plans, and ECM providers.
      - On 10/28/24, AAH SLT approved to place CalAIM JI Re-Entry project on hold until July 2025 to await final policy guide from DHCS and give Alameda County partners time to develop their internal processes and readiness.
  - AAH/Roots JI Pilot Project:
    - Project closeout processes are in progress and expected to close the project on 12/6.

  - CYBHI Fee Schedule – Effective January 1st, 2024, the Alliance is partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule.
    - Cohort 1 is intended to be a "learning" cohort
    - DHCS continues holding a series of meetings with Cohort participants; these include Onboarding Sessions for the LEAs as well as Technical Office Hours each Thursday of the month
      - The meetings held have been heavily focused on the LEA process
    - The Alliance will utilize Carelon as the Third-Party Administrator (TPA)
    - The Claims submission date has been extended from April 1st, 2024, to July 1st, 2024
      - It may not be true that all MCPs or LEAs have systems set up, however, LEAs may submit claims for up to 180 days from the date of service.

        - Claims may be submitted retroactively back to July 1st, 2024, as long as they are submitted by end of the year
    - DHCS Health Plan Work Group (HPWG were to meet every week, Fridays between August and September 10-11am, however, most meetings were cancelled Q4 2024 but have since restarted)
        - High Level Timeline provided by Carelon for Claims Processing without solid Go Live Date
        - 2 Options for the Interim ASO Model proposed
            - Option 1: Proceed with MCP system ingestion of claims
            - Option 2: Proceed without MCP system ingestion of claims
            - Risk to Health Plan (Carelon) Potential for errors due to manual claim report reviews, which can lead to future recoupment risks.
            - Manual Review Risks: eligibility check, correct fee schedule rate payment (minimal risk), duplicate payments to providers (minimal risk)
        - 2 MOUs between Plans and Carelon not yet finalized.
- Target date for draft MOUs is Friday 2/14
        - Program Design and Documentation not yet finalized
        - Invoice Template introduced

Recruiting and Staffing

- Integrated Planning Open position(s):
    - Business Analyst – Integrated Planning – Position pending
    - Backfill Business Analyst – Integrated Planning – Position pending
    - Backfill Business Analyst – Integrated Planning – Position targeted to start March 3, 2025

Integrated Planning

Supporting Documents Project Descriptions

Key projects currently in-flight:

- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs.
  - Enhanced Care Management (ECM) – ECM will target eight (8) specific populations of vulnerable and high-risk children and adults
    - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022
    - Two (2) additional PoF became effective on January 1st, 2023
    - One (1) PoF became effective on July 1st, 2023
    - Two (2) PoF became effective on January 1st, 2024
  - *Restarting in July 2025* - Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
    - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
      - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024
      - MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by October 1st, 2024
      - Correctional facilities will have two years from 10/1/2024-9/30/2026 to go live based on readiness
  - Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary.

- CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed and a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site. CYBHI requires commercial health plans and the Medi-Cal delivery system, as applicable, to reimburse, at or above the published rates, these school-linked providers, regardless of network provider status, for services furnished to students pursuant to the fee schedule. Effective January 1st, 2024, the Alliance is partnering with the Alameda County Office of Education (ACOE) and several Local Education Agencies (LEAs) who were selected to participate in the CYBHI Fee Schedule Cohort 1.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	January 2025
Incoming Calls (R/V)	21,834
Abandoned Rate (R/V)	5%
Answered Calls (R/V)	20,764
Average Speed to Answer (ASA)	00:16
Calls Answered in 30 Seconds (R/V)	93%
Average Talk Time (ATT)	07:34
Calls Answered in 10 minutes	100%
Outbound Calls	9,584

Top 5 Call Reasons (Medi-Cal and Group Care) January 2025
Eligibility/Enrollment
Change of PCP
Benefits
Grievances/Appeals
Provider Network Info

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) January 2025
Change PCP
ID Card Requests
Update Contact Info

MSBH	January 2025
Incoming Calls (R/V)	1490
Abandoned Rate (R/V)	9%
Answered Calls (R/V)	1354
Average Speed to Answer (ASA)	01:24
Calls Answered in 30 Seconds (R/V)	68%
Average Talk Time (ATT)	08:07
Calls Answered in 10 minutes	99%
Outbound Calls	1337
Screenings Completed	150
ACBH Referrals	50
SUD referrals to Center Point	19

Claims Department
December 2024 Final and January 2025 Final

METRICS

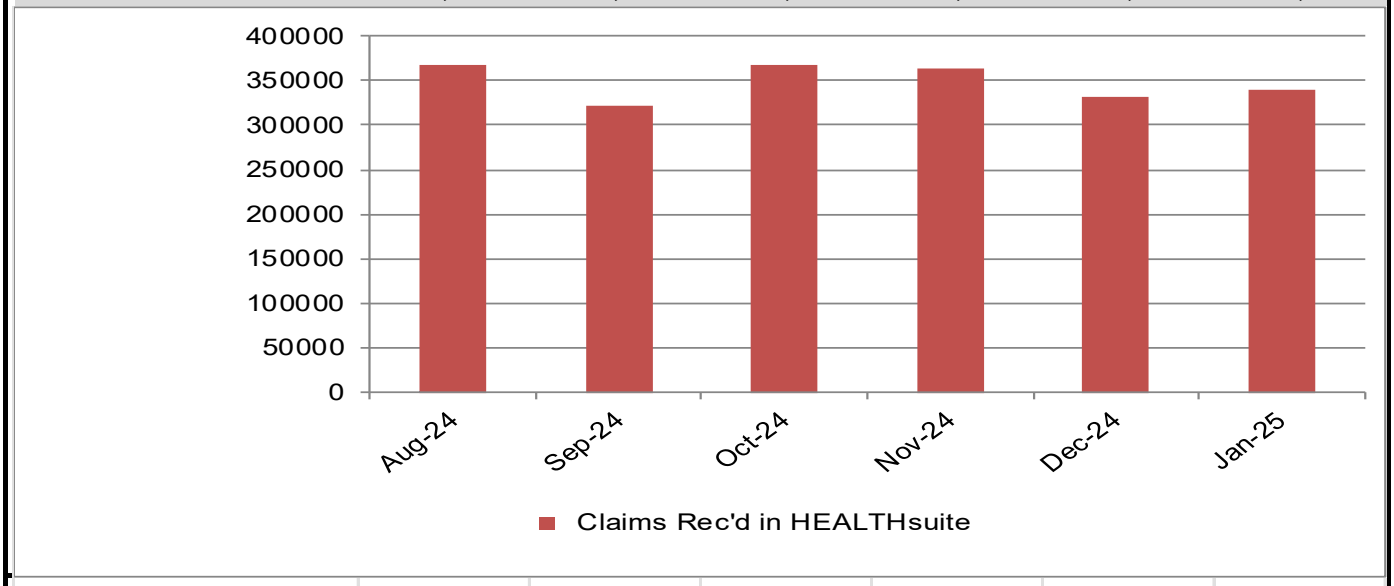
Claims Compliance	Dec-24	Jan-25
90% of clean claims processed within 30 calendar days	90.2%	90.1%
95% of all claims processed within 45 working days	99.3%	98.9%
Claims Volume (Received)	**Dec-24**	**Jan-25**
Paper claims	34,446	37,398
EDI claims	297,662	302,362
Claim Volume Total	**332,108**	**339,760**
Percentage of Claims Volume by Submission Method	**Dec-24**	**Jan-25**
% Paper	10.37%	11.01%
% EDI	89.63%	88.99%
Claims Processed	**Dec-24**	**Jan-25**
HEALTHsuite Paid (original claims)	224,568	261,048
HEALTHsuite Denied (original claims)	38,592	84,279
HEALTHsuite Original Claims Sub-Total	**263,160**	**345,327**
HEALTHsuite Adjustments	56,589	31,665
HEALTHsuite Total	**319,749**	**376,992**
Claims Expense	**Dec-24**	**Jan-25**
Medical Claims Paid	$119,016,631	$166,817,056
Interest Paid	$105,882	$98,259
Auto Adjudication	**Dec-24**	**Jan-25**
Claims Auto Adjudicated	260,398	297,645
% Auto Adjudicated	88.7%	86.2%
Average Days from Receipt to Payment	**Dec-24**	**Jan-25**
HEALTHsuite	14	16
Pended Claim Age	**Dec-24**	**Jan-25**
0-30 calendar days	64,568	56,182
HEALTHsuite		
31-61 calendar days	29,816	37,974
HEALTHsuite		
Over 62 calendar days	778	15,275
HEALTHsuite		
*Pended claims over 31 days are high due to investigation of 3 providers for FWA		
Overall Denial Rate	**Dec-24**	**Jan-25**
Claims denied in HEALTHsuite	38,592	84,279
% Denied	12.1%	22.4%

Claims Department
December 2024 Final and January 2025 Final

Top 5 HEALTHsuite Denial Reasons	Jan-25 % of all denials
Responsibility of Provider	25%
No Benefits Found For Dates of Service	14%
Non-Covered Benefit For This Plan	11%
Duplicate Claims	11%
Must Submit Paper Claim With Copy of Primary Payor EOB	8%
% Total of all denials	**69%**

Claims Received By Month

Run Date	9/1/2024	10/1/2024	11/1/2024	12/1/2024	1/1/2025	2/1/2025
Claims Received Through	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**
Claims Rec'd in HEALTHsuite	368,235	322,196	367,989	364,130	332,108	339,760



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing January 2025 to January 2024 as follows: 30 Days - 90.1% (2025) vs 88.0% (2024) 45 Days - 98.9% (2025) vs 99.9% (2024) 90 Days - 99.9% (2025) vs 99.9% (2024)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 339,760 claims in January 2025 vs 298,465 in January 2024	N/A	N/A
EDI - the volume of EDI submissions was 88.99% which exceeded our normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 345,327 in January 2025 (21 working days) vs 276,682 in January 2024 (21 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in January 2025 was $166,817,056 (5 check runs) vs $112,276.627 in January 2024 (5 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in January 2025 was $98,259 vs $84,602 in January 2024	N/A	< $496,000 per fiscal year or $30,000 per month
Auto Adjudication - the AAH rate in January 2025 was 86.2% vs 81.7% in January 2024	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in January 2025 was 16 days vs 15 days in January 2024	N/A	<= 25 days
Pended Claim Age - comparing January 2025 to January 2024 as follows: 0-30 calendar days - 56,182 (2025) vs 32,848 (2024) 31-61 calendar days - 37,974 (2025) vs 7,036 (2024) Over 62 calendar days - 15,275 (2025) vs 4 (2024) *Pended claims over 31 days are high due to investigation of 3 providers for FWA	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 January 2025 to January 2024	N/A	N/A

Provider Relations Dashboard January 2025

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10977											
Abandoned Calls	3600											
Answered Calls (PR)	7377											
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	2910											
Abandoned Calls (R/V)												
Answered Calls (R/V)	2910											
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	868											
N/A												
Outbound Calls	868											
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	14755											
Abandoned Calls	3600											
Total Answered Incoming, R/V, Outbound Calls	11155											

Provider Relations Dashboard January 2025

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.1%											
Benefits	5.1%											
Claims Inquiry	39.4%											
Change of PCP	2.5%											
Check Tracer	0.7%											
Complaint/Grievance (includes PDR's)	5.8%											
Contracts/Credentialing	0.8%											
Demographic Change	0.0%											
Eligibility - Call from Provider	21.0%											
Exempt Grievance/ G&A	0.0%											
General Inquiry/Non member	0.0%											
Health Education	0.0%											
Intrepreter Services Request	0.5%											
Provider Portal Assistance	3.4%											
Pharmacy	0.1%											
Prop 56	0.1%											
Provider Network Info	0.0%											
Transportation Services	0.0%											
Transferred Call	0.0%											
All Other Calls	15.5%											
TOTAL	100.0%											

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	28											
Contracting/Credentialing	29											
Drop-ins	127											
JOM's	2											
New Provider Orientation	100											
Quarterly Visits	0											
UM Issues	0											
Total Field Visits	286	0	0	0	0	0	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS - JANUARY 2025						
Practitioners		BH/ABA 2,607	AHP 647	PCP 391	SPEC 762	PCP/SPEC 13
AAH/AHS/CHCN Breakdown			AAH 3,180	AHS 303	CHCN 601	COMBINATION OF GROUPS 336
Facilities	432					

VENDOR SUMMARY **Credentialing Verification Organization, Symplyr CVO**					
	Number	**Average Calendar Days in Process**	**Goal - 25 Business Days***	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	109	6	Y	Y	Y
Recred Files in Process	5	0	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**114**				
		*** 25 business days = 35 calendar days**			

January 2025 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	4
SPEC	8
ANCILLARY	13
MIDLEVEL/AHP	10
BH/ABA	106
Sub-total	**141**
Recredentialing	
PCP	11
SPEC	10
ANCILLARY	2
MIDLEVEL/AHP	7
Sub-total	**30**
TOTAL	**171**

January 2025 Facility Approvals	
Initial Credentialing	**2**
Recredentialing	**17**
Sub-total	**19**
Facility Files in Process	**42**

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

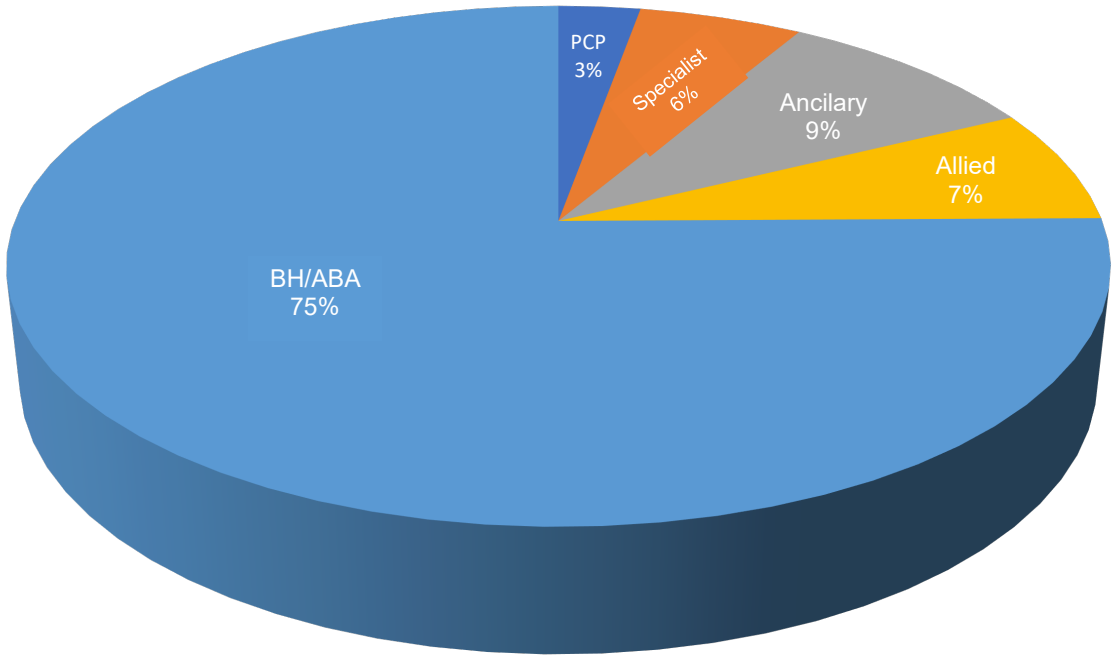
LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Adams	Emily	BH	INITIAL	1/21/2025
Alexander	Magin	Primary Care Physician	INITIAL	1/21/2025
Alvarado Olmedo	Cynthia	BH	INITIAL	1/21/2025
Alvarez	Arissa	BH-Telehealth	INITIAL	1/21/2025
Anchondo	Alina	Ancillary	INITIAL	1/21/2025
Arras	Nichole	ABA-Telehealth	INITIAL	1/21/2025
Arun	Aparna	Primary Care Physician	INITIAL	1/21/2025
Atherton	Nichole	Specialist	INITIAL	1/21/2025
Ballard	Ryan	ABA-Telehealth	INITIAL	1/21/2025
Barreto	Nerissa	Allied Health	INITIAL	1/21/2025
Brosgart	Lucia	Allied Health	INITIAL	1/21/2025
Brownlee	Cynthia	BH-Telehealth	INITIAL	1/21/2025
Buseck	Susan	BH	INITIAL	1/21/2025
Cameron	Frances	BH-Telehealth	INITIAL	1/21/2025
Campbell	Meghan	ABA	INITIAL	1/21/2025
Cangiamilla	Ashley	ABA-Telehealth	INITIAL	1/21/2025
Cantu	Humberto	BH	INITIAL	1/21/2025
Carr	Brandon	BH	INITIAL	1/21/2025
Casey	John	BH	INITIAL	1/21/2025
Cavaness	Hilary	ABA-Telehealth	INITIAL	1/21/2025
Cavnar	Clancy	BH	INITIAL	1/21/2025
Chen	Kevin	ABA	INITIAL	1/21/2025
Church	Jason	ABA-Telehealth	INITIAL	1/21/2025
Cobar	Daniel	BH	INITIAL	1/21/2025
Coker	Deanna	ABA-Telehealth	INITIAL	1/21/2025
Cox	Denee	BH	INITIAL	1/21/2025
Crawford	Jackie	ABA	INITIAL	1/21/2025
Cummings	Ronald	BH	INITIAL	1/21/2025
Damasco	Genevive	Ancillary	INITIAL	1/21/2025
Damroth	Monique	BH	INITIAL	1/21/2025
Daqiq	Sanna	Allied Health	INITIAL	1/21/2025
David	Shane	BH	INITIAL	1/21/2025
De Oliveira Campos	Juliana	BH	INITIAL	1/21/2025
Desai	Vijeta	ABA	INITIAL	1/21/2025
Eifler	Amber	ABA-Telehealth	INITIAL	1/21/2025
Escasena	Diavonti	BH	INITIAL	1/21/2025
Estrada	Natalia	BH	INITIAL	1/21/2025
Ethridge	Lisa	ABA-Telehealth	INITIAL	1/21/2025
Fahouri	Gina	BH	INITIAL	1/21/2025
Fields Brewer	Asha	Ancillary	INITIAL	1/21/2025
Flanigan	Kathleen	BH	INITIAL	1/21/2025
Freeman	Jasmine	ABA-Telehealth	INITIAL	1/21/2025
Freeman	Miranda	Ancillary	INITIAL	1/21/2025
Garcia Ortiz	Aymie-Lee	BH	INITIAL	1/21/2025
Garcia Ramirez	Carlos	ABA-Telehealth	INITIAL	1/21/2025
Gergis	Amy	ABA-Telehealth	INITIAL	1/21/2025
Ginsburg	Zoe	Primary Care Physician	INITIAL	1/21/2025
Gonzalez	Sandy	ABA-Telehealth	INITIAL	1/21/2025
Greenan	Keara	Ancillary	INITIAL	1/21/2025
Heidarzadeh	Taban	ABA-Telehealth	INITIAL	1/21/2025
Hein	Jeremiah	BH	INITIAL	1/21/2025
Hernandez	Kacey	ABA-Telehealth	INITIAL	1/21/2025
Hilke	Kevin	BH	INITIAL	1/21/2025
Hyde	Lauren	ABA-Telehealth	INITIAL	1/21/2025
Inloes	Allison	Ancillary	INITIAL	1/21/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Irizarry	Dre	BH	INITIAL	1/21/2025
Islas	America	BH-Telehealth	INITIAL	1/21/2025
Javier	Elena	Ancillary	INITIAL	1/21/2025
Johnson	Jodilynn	ABA-Telehealth	INITIAL	1/21/2025
Kamiya	Deana	Ancillary	INITIAL	1/21/2025
Karki	Rekha	Allied Health	INITIAL	1/21/2025
Keith	Courtney	BH-Telehealth	INITIAL	1/21/2025
Kilgore	Nadia	ABA	INITIAL	1/21/2025
Kim	Christine	BH	INITIAL	1/21/2025
Kim	Sunjoo	ABA	INITIAL	1/21/2025
Kulkarni	Renu	Primary Care Physician	INITIAL	1/21/2025
Kwock	Jaremy	Allied Health	INITIAL	1/21/2025
Lestari	Irene	Ancillary	INITIAL	1/21/2025
Li	Fengmei	BH	INITIAL	1/21/2025
Licata	Christine	Specialist	INITIAL	1/21/2025
Long	Hunter	ABA-Telehealth	INITIAL	1/21/2025
Lopez	Pauline	Ancillary	INITIAL	1/21/2025
Lopez	Susan	BH-Telehealth	INITIAL	1/21/2025
Lozano	Christian	BH	INITIAL	1/21/2025
Lugtu	Leslie	ABA-Telehealth	INITIAL	1/21/2025
Luna	Courtney	ABA-Telehealth	INITIAL	1/21/2025
Macaspac	Amethyst	BH	INITIAL	1/21/2025
Maharaj	Ranika	Allied Health	INITIAL	1/21/2025
Mai	Daniel	ABA	INITIAL	1/21/2025
McCollins	Dennis	BH	INITIAL	1/21/2025
Meah	Audrey	BH-Telehealth	INITIAL	1/21/2025
Mefford	Shelby	ABA	INITIAL	1/21/2025
Mendonsa	Andrew	BH-Telehealth	INITIAL	1/21/2025
Mendoza	Virginia	BH-Telehealth	INITIAL	1/21/2025
Mezquita	Lily	ABA-Telehealth	INITIAL	1/21/2025
Mitchell	Kevin	Specialist	INITIAL	1/21/2025
Mody	Avani	BH-Telehealth	INITIAL	1/21/2025
Monroe	Eboni	ABA-Telehealth	INITIAL	1/21/2025
Montgomery	LeAnn	ABA-Telehealth	INITIAL	1/21/2025
Moore	Courtney	ABA-Telehealth	INITIAL	1/21/2025
Moriarty	John	BH	INITIAL	1/21/2025
Murphy	Marina	BH	INITIAL	1/21/2025
Negash	Tsigereda	BH-Telehealth	INITIAL	1/21/2025
Nguyen	Natalie	BH-Telehealth	INITIAL	1/21/2025
Noguchi	Huma Pekcan	BH	INITIAL	1/21/2025
Ochoa	Ronald	BH-Telehealth	INITIAL	1/21/2025
Orandi	Cyrus	Specialist	INITIAL	1/21/2025
Over	Margaret	Allied Health	INITIAL	1/21/2025
Park	Beachi	BH-Telehealth	INITIAL	1/21/2025
Perea	Adriana	ABA-Telehealth	INITIAL	1/21/2025
Pfeil	Sarah	Specialist	INITIAL	1/21/2025
Pham	Cynthia	ABA-Telehealth	INITIAL	1/21/2025
Pinney	Daniel	BH	INITIAL	1/21/2025
Prasai	Kalpana	Allied Health	INITIAL	1/21/2025
Quintana	Edward	BH-Telehealth	INITIAL	1/21/2025
Raimondo	Marcella	BH	INITIAL	1/21/2025
Ramirez	Teresa	BH-Telehealth	INITIAL	1/21/2025
Ramming	Brianna	BH-Telehealth	INITIAL	1/21/2025
Resendez	Cynthia	BH	INITIAL	1/21/2025
Rogers	Rodman	Specialist	INITIAL	1/21/2025
Romans	Dusti	BH-Telehealth	INITIAL	1/21/2025
Samuels	Deanne	BH-Telehealth	INITIAL	1/21/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Sanchez Martinez	Blanca	ABA-Telehealth	INITIAL	1/21/2025
Sandler	Janine	BH	INITIAL	1/21/2025
Sanftner	Serom	LCSW SP_CHW	INITIAL	1/21/2025
Sargsyan	Sona	BH-Telehealth	INITIAL	1/21/2025
Sarkisyan	Vadim	BH	INITIAL	1/21/2025
Schmid	Anamaria	BH-Telehealth	INITIAL	1/21/2025
Schuyler	Patricia	BH-Telehealth	INITIAL	1/21/2025
Shea	Timothy	Specialist	INITIAL	1/21/2025
Silliman	Rebecca	BH	INITIAL	1/21/2025
Smith	Helen	Allied Health	INITIAL	1/21/2025
Soltani	Angela	Allied Health	INITIAL	1/21/2025
Soorma	Mariyam	BH-Telehealth	INITIAL	1/21/2025
Steineckert	Ashley	BH-Telehealth	INITIAL	1/21/2025
Topete	Liliana	BH-Telehealth	INITIAL	1/21/2025
Torres	Trina	ABA-Telehealth	INITIAL	1/21/2025
Tuli	Ekta	ABA-Telehealth	INITIAL	1/21/2025
Valentine	Ingrid	BH	INITIAL	1/21/2025
Vang	Nancy	ABA	INITIAL	1/21/2025
Vargas	Megan	ABA-Telehealth	INITIAL	1/21/2025
Vaughan	Paige	Ancillary	INITIAL	1/21/2025
Warnesky	Colleen	BH-Telehealth	INITIAL	1/21/2025
Watson	LaRonna	BH-Telehealth	INITIAL	1/21/2025
Watson	Shantel	Doula	INITIAL	1/21/2025
Webber	Lindsey	ABA-Telehealth	INITIAL	1/21/2025
Williams	Kelly	BH-Telehealth	INITIAL	1/21/2025
Wong	Emily	ABA	INITIAL	1/21/2025
Woolery	Rebekah	BH	INITIAL	1/21/2025
Yee	Amanda	Specialist	INITIAL	1/21/2025
Zecca	Natalie	BH	INITIAL	1/21/2025
Benitez	Fredalyne	Ancillary	RE-CRED	1/21/2025
Bulman	Linda	Allied Health	RE-CRED	1/21/2025
Caler	Aliya	Allied Health	RE-CRED	1/21/2025
Chang	Yu-Ming	Specialist	RE-CRED	1/21/2025
Chen	Tammy	Primary Care Physician	RE-CRED	1/21/2025
Ciccone	Adam	Allied Health	RE-CRED	1/21/2025
Close	Liesl	Specialist	RE-CRED	1/21/2025
Diaz	Alejandro	Primary Care Physician	RE-CRED	1/21/2025
Finch	Mark	Primary Care Physician and Specialist	RE-CRED	1/21/2025
Flores	Lauren	Allied Health	RE-CRED	1/21/2025
Fredrickson	Matilde	Primary Care Physician	RE-CRED	1/21/2025
Gollapalle	Mythri	Primary Care Physician	RE-CRED	1/21/2025
Hays	Erin	Allied Health	RE-CRED	1/21/2025
Kong	Li	Specialist	RE-CRED	1/21/2025
Kumar	Pradeep	Primary Care Physician and Specialist	RE-CRED	1/21/2025
Litman	Vanessa	Primary Care Physician	RE-CRED	1/21/2025
Mack	Porshia	Primary Care Physician	RE-CRED	1/21/2025
Marsh	Mike	Ancillary	RE-CRED	1/21/2025
Pampalone	Ingrid	Allied Health	RE-CRED	1/21/2025
Rahman	Sarah	Primary Care Physician	RE-CRED	1/21/2025
Ricker	Denise	Specialist	RE-CRED	1/21/2025
Rofagha	Soraya	Specialist	RE-CRED	1/21/2025
Singh	Navdeep	Specialist	RE-CRED	1/21/2025
Stein	Andrew	Specialist	RE-CRED	1/21/2025
Stinghen	Donato	Specialist	RE-CRED	1/21/2025
Suri	Rajesh	Primary Care Physician	RE-CRED	1/21/2025
Taylor	Jennifer	Specialist	RE-CRED	1/21/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Tinkelenberg	Judith	Allied Health	RE-CRED	1/21/2025
Williams	Andrea	Primary Care Physician	RE-CRED	1/21/2025
Wright	Dale	Specialist	RE-CRED	1/21/2025

JANUARY PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	4
SPECIALIST	8
ANCILLARY	13
ALLIED	10
BH/ABA	106
TOTAL	141

Provider Dispute Resolution
December 2024 and January 2025

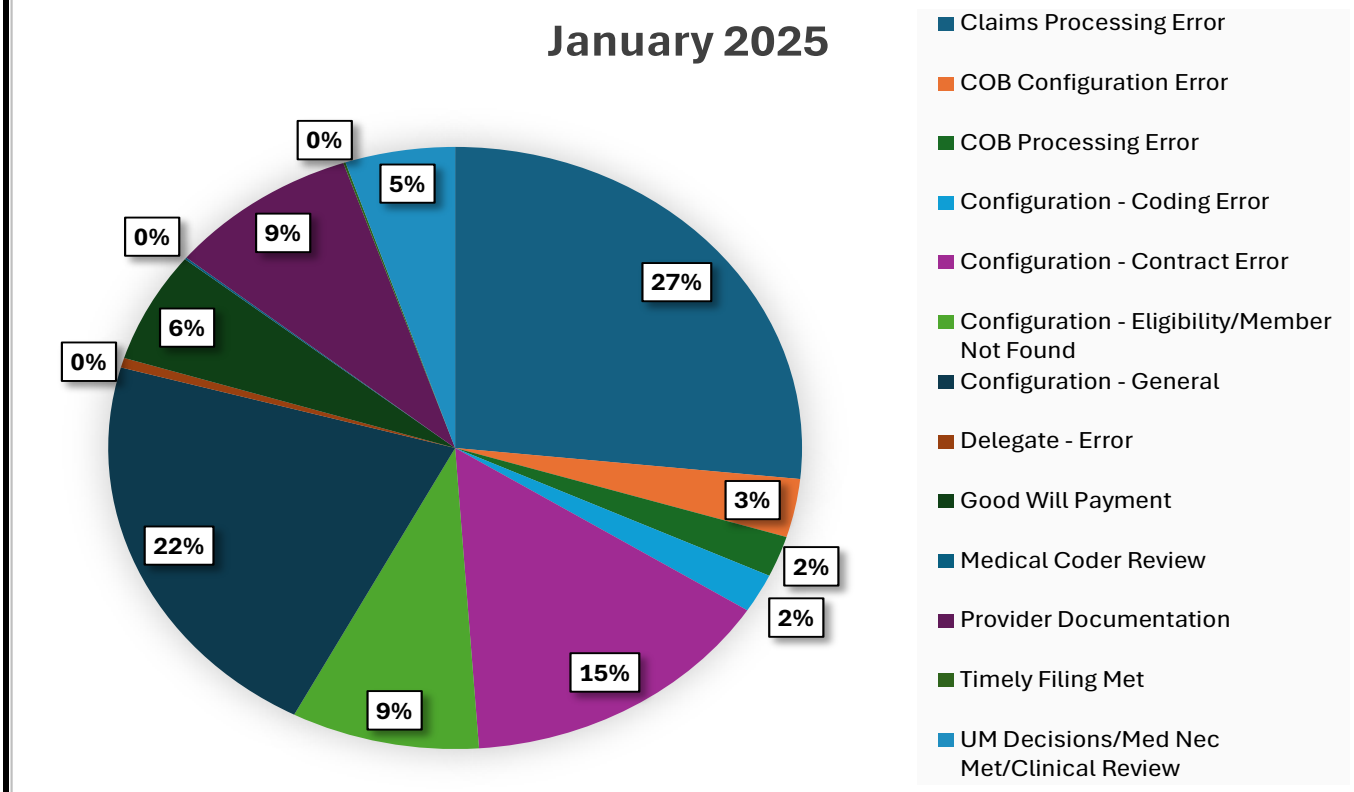
METRICS

PDR Compliance	Dec-24	Jan-25
# of PDRs Resolved	2,185	2,635
# Resolved Within 45 Working Days	2,182	2,632
% of PDRs Resolved Within 45 Working Days	99.9%	99.9%
PDRs Received	**Dec-24**	**Jan-25**
# of PDRs Received	3,173	2,843
PDR Volume Total	**3,173**	**2,843**
PDRs Resolved	**Dec-24**	**Jan-25**
# of PDRs Upheld	1,508	1,678
% of PDRs Upheld	69%	64%
# of PDRs Overturned	677	957
% of PDRs Overturned	31%	36%
Total # of PDRs Resolved	**2,185**	**2,635**
Average Turnaround Time	**Dec-24**	**Jan-25**
Average # of Days to Resolve PDRs	42	38
Oldest Resolved PDR in Days	167	242
Unresolved PDR Age	**Dec-24**	**Jan-25**
0-45 Working Days	3,961	3,377
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**3,961**	**3,377**

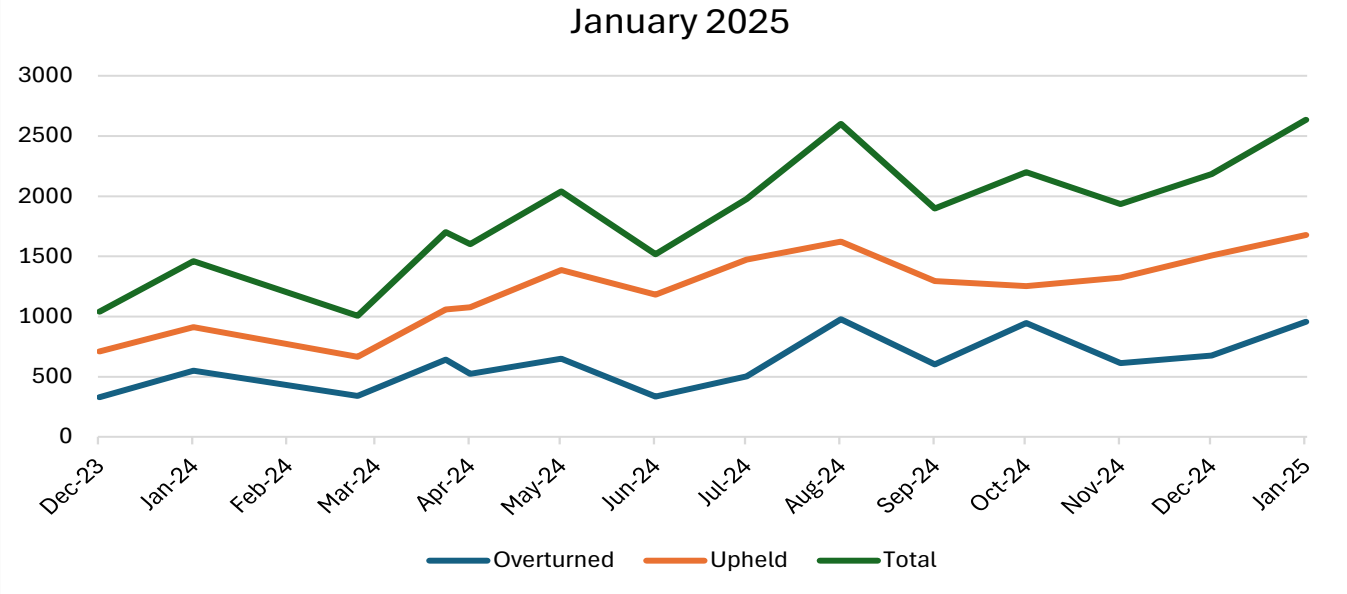
Provider Dispute Resolution
December 2024 and January 2025

Jan-25

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Resolved - 2,635 in January 2025 vs 1,461 in January 2024	N/A	N/A
# of PDRs Received - 2,843 in January 2025 vs 2,172 in January 2024	N/A	N/A
# of PDRs Resolved within 45 working days - 2,632 in January 2025 vs 1,455 in January 2024	N/A	N/A
% of PDRs Resolved within 45 working days - 99.9% in January 2025 vs 99.5% in January 2024	95%	95%
Average # of Days to Resolve PDRs - 38 days in January 2025 vs 42 days in January 2024	N/A	30
Oldest Resolved PDR in Days - 242 days in January 2025 vs 77 days January 2024	N/A	N/A
# of PDRs Upheld - 1,678 in January 2025 vs 912 in January 2024	N/A	N/A
% of PDRs Upheld - 64% in January 2025 vs 62% in January 2024	N/A	> 75%
# of PDRs Overturned - 957 in January 2025 vs 549 in January 2024	N/A	N/A
% of PDRs Overturned - 36% in January 2025 vs 38% in January 2024	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 27% (2025) vs 32% (2024) Configuration errors - 47% (2025) vs 34% (2024) COB - 5% (2025) vs 22% (2024) Clinical Review/UM Decisions/Medical Necessity Met - 5% (2025) vs 11% (2024)	N/A	N/A

ALLIANCE IN THE COMMUNITY
FY 2024-2025 | JANUARY 2025 OUTREACH REPORT

In January 2025, the Alliance completed **830** member orientation outreach calls among net new and non-utilizer members and conducted **83** member orientations (**10%** member participation rate). In addition, in January 2025, the Outreach team completed **63** Alliance website inquiries, seven (**7)** service requests, two (**2)** community events, and three (**3)** member education events. The Alliance reached a total of **1285** people and spent a total of $650 on donations, fees, and/or sponsorships at the 2025 Chinatown Lunar New Year Bazaar, Community Food Distribution, Laney's Welcome Back Week Resource Fair and Vietnamese American Community Center of the East Bay (VACCEB) 30th Anniversary & Lunar New Year Celebration events.*

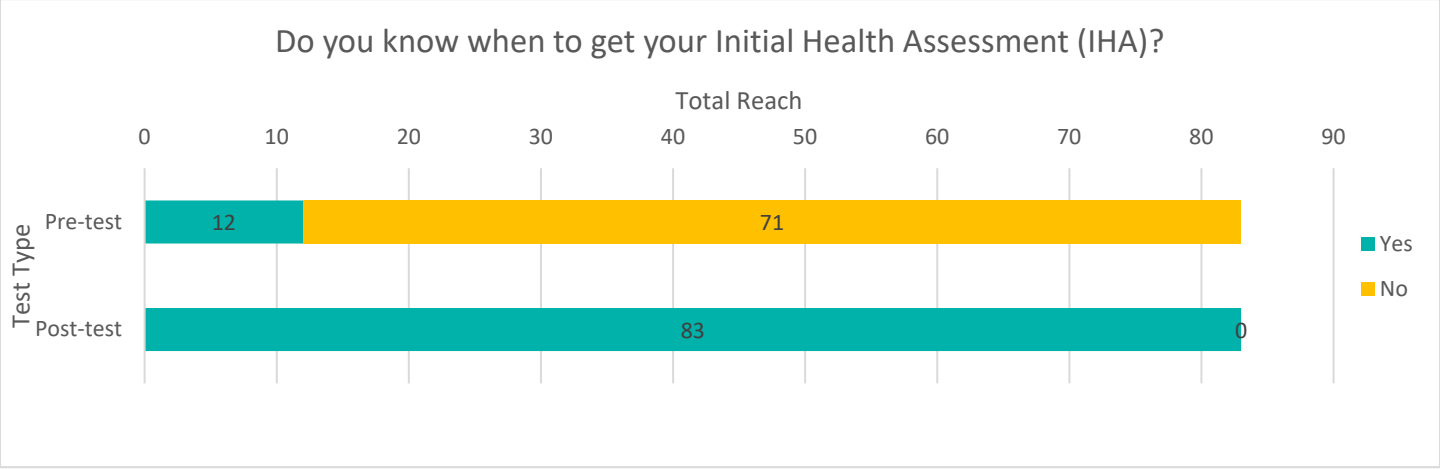
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **36,919** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of January 31, 2025, the Outreach Team completed **45,897** member orientation outreach calls and conducted **9,362** member orientations (**20.4%** member participation rate).

The Alliance Member Orientation (MO) program has existed since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment (IHA) by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between January 1, through January 31, 2025 (21 working days) – **83** members completed an MO by phone.

After completing the MO **100%** of members who completed the post-test survey in January 2025 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 24-25\Q3\1. January 2025**

FY 2023-2024 JANUARY 2024 TOTALS

2 COMMUNITY EVENTS
3 MEMBER EDUCATION EVENTS
132 MEMBER ORIENTATIONS
0 MEETINGS/ PRESENTATIONS/
0 COMMUNITY TRAINING
5 TOTAL INITIATED/ INVITED EVENTS
137 TOTAL COMPLETED **EVENTS**

13 CITIES

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

1153 TOTAL REACHED AT COMMUNITY EVENTS
397 TOTAL REACHED AT MEMBER EDUCATION EVENTS
132 TOTAL REACHED AT MEMBER ORIENTATIONS
0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
0 TOTAL REACHED AT COMMUNITY TRAINING
1402 MEMBERS REACHED AT ALL EVENTS
1682 **TOTAL REACHED AT ALL EVENTS**

$600.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2024-2025 JANUARY 2025 TOTALS

2 COMMUNITY EVENTS
3 MEMBER EDUCATION EVENTS
83 MEMBER ORIENTATIONS
1 MEETINGS/ PRESENTATIONS
0 COMMUNITY TRAINING
6 TOTAL INITIATED/ INVITED EVENTS
88 TOTAL COMPLETED **EVENTS**

14 CITIES**

Alameda
Belmont
Berkeley
Castro Valley
Dublin
Emeryville
Fremont
Hayward
Newark
Oakland
Pleasanton
San Leandro
San Lorenzo
Union City

808 TOTAL REACHED AT COMMUNITY EVENTS
477 TOTAL REACHED AT MEMBER EDUCATION EVENTS
83 TOTAL REACHED AT MEMBER ORIENTATIONS
0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
0 COMMUNITY TRAINING
1062 MEMBERS REACHED AT ALL EVENTS
1368 **TOTAL REACHED AT ALL EVENTS**

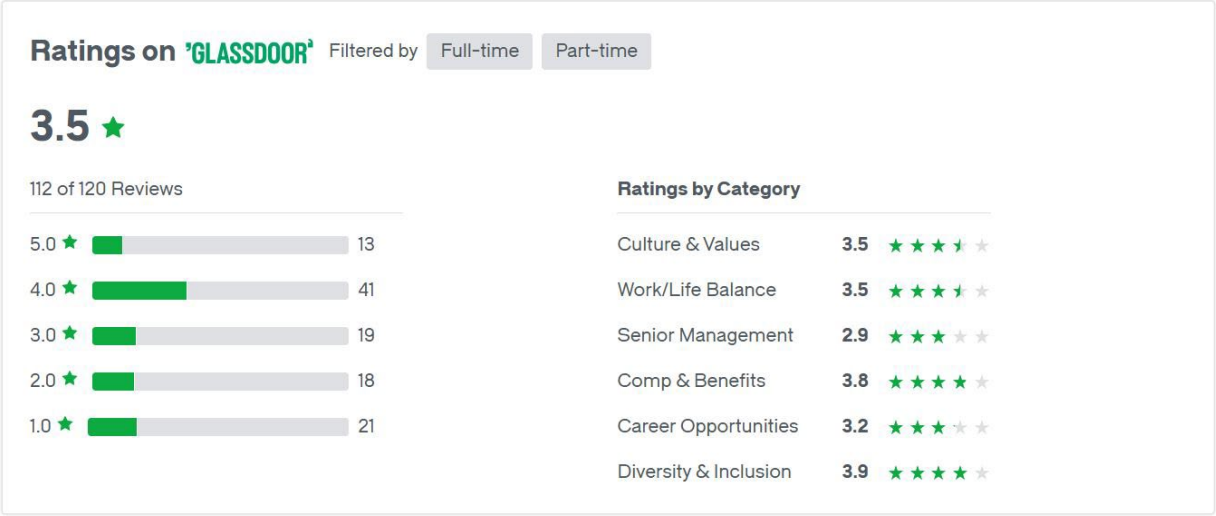
$650.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

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

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 **January 1, 2025**, and **January 31, 2025**:

1. Alliance Website:
    - Received **29,000** unique visits
    - Received **25,000** new user visits
    - The top **10** website page visits were:
        i. Homepage
        ii. Provider Page
        iii. Find a Doctor
        iv. Benefits and Covered Services
        v. Members Medi-Cal
        vi. Careers
        vii. Check in for Check-ups
        viii. Contact Us
        ix. Members
        x. Get a New ID Card
2. Facebook Page:
    - Increased Fans from **633** to **637**
    - Did not receive any reviews in **January 2025**
3. Glassdoor Page:
    - **3.5** out of a **5-star** overall rating
    - Did not receive any reviews in **January 2025**
4. Instagram Page:
    - Page debuted **June 10, 2021**
    - Increased in followers from **595** to **598**
5. X (previously Twitter) Page:
    - Maintained followers at **359**
6. LinkedIn Page:
    - Maintained followers at **6.1k**
    - Received **112-**page clicks
7. Yelp Page:
    - Page visits **91**
    - Appeared in Yelp searches **117** times
    - Did not receive any reviews in **January 2025**
8. Google Page:
    - **2,443** website clicks were made from the business profile
    - **1,856** calls made from the business profile
    - Did not receive any reviews in **January 2025**

GLASSDOOR OVERVIEW

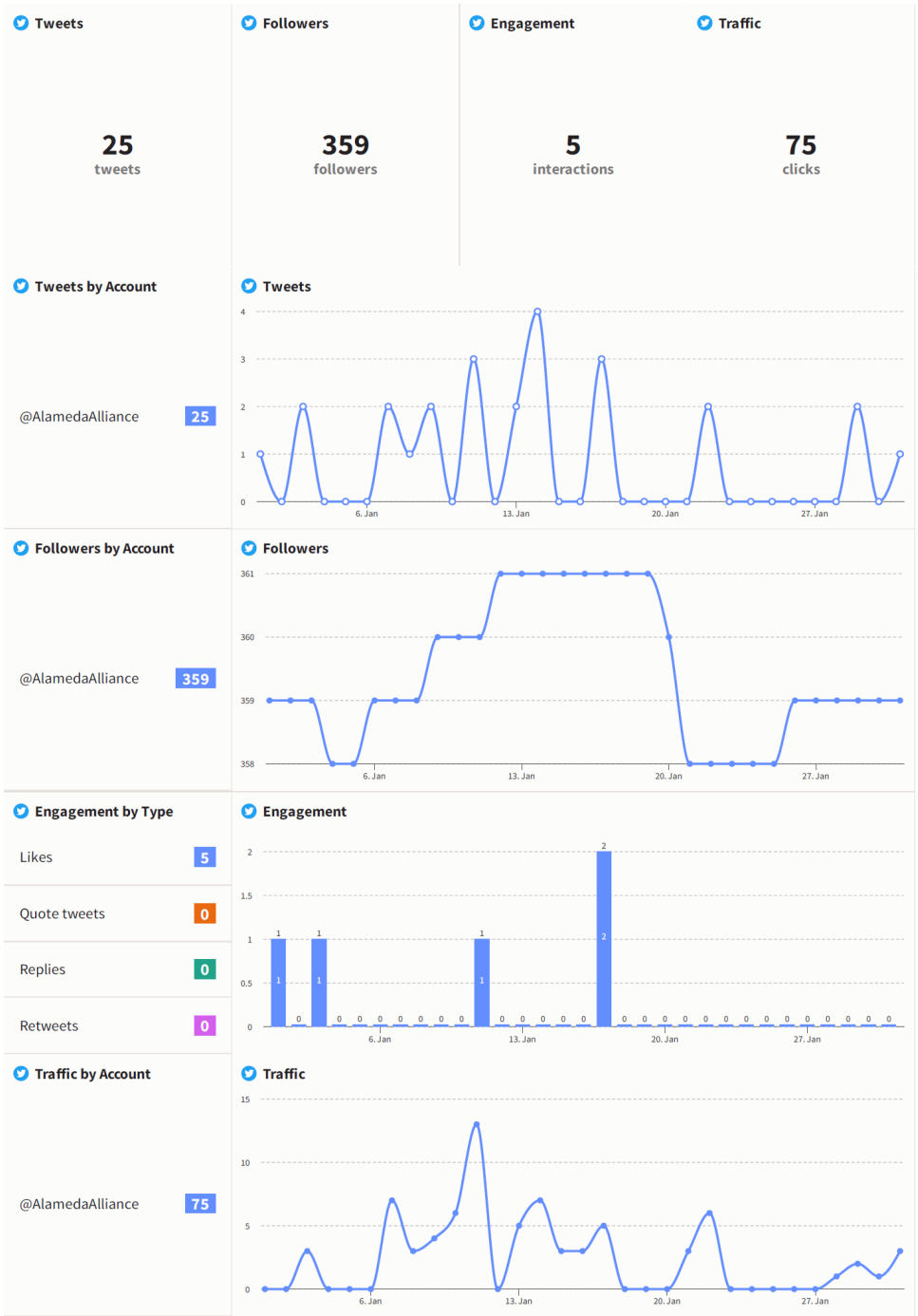


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q3\1. January 2025

FACEBOOK OVERVIEW

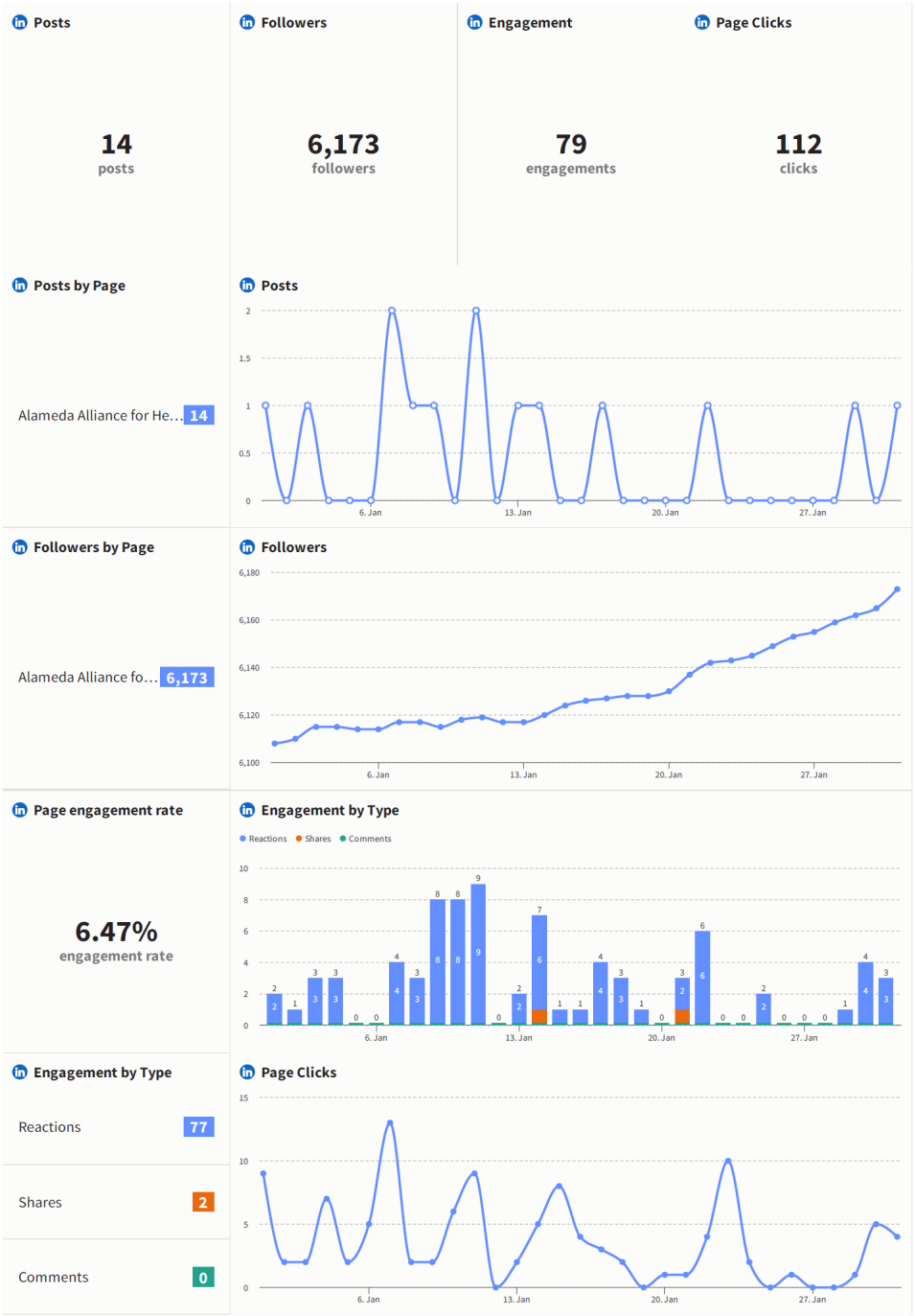
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q3\1. January 2025

X (previously TWITTER) OVERVIEW



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q3\1. January 2025

LINKEDIN OVERVIEW



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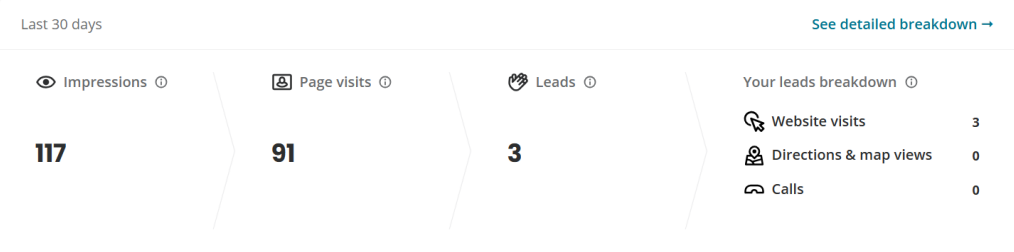
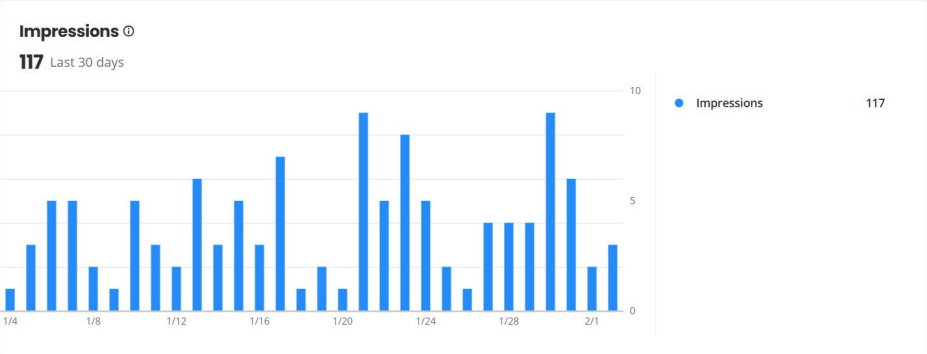
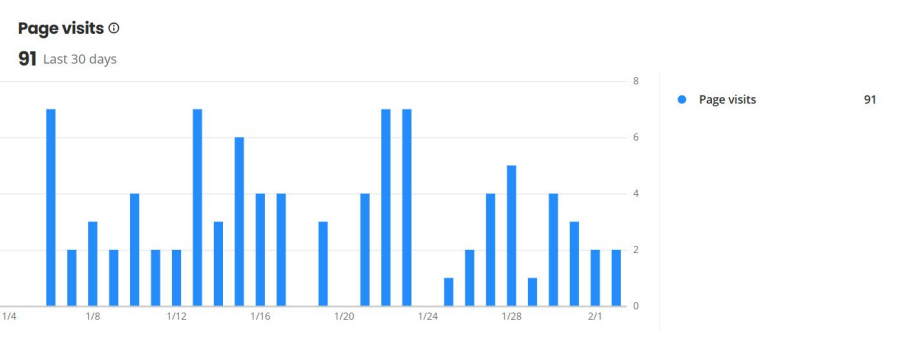
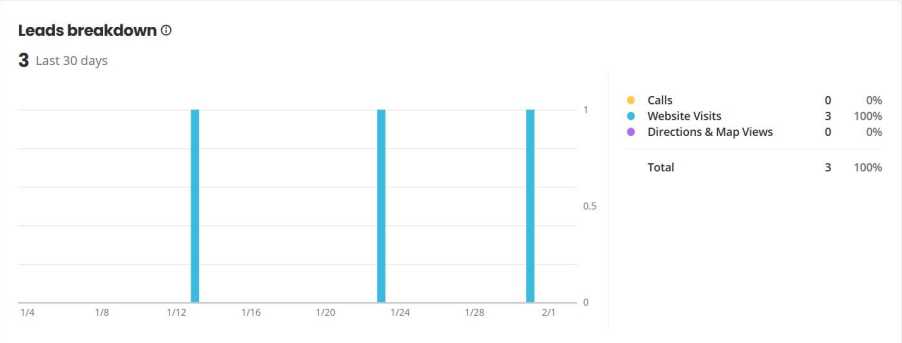
YELP OVERVIEW



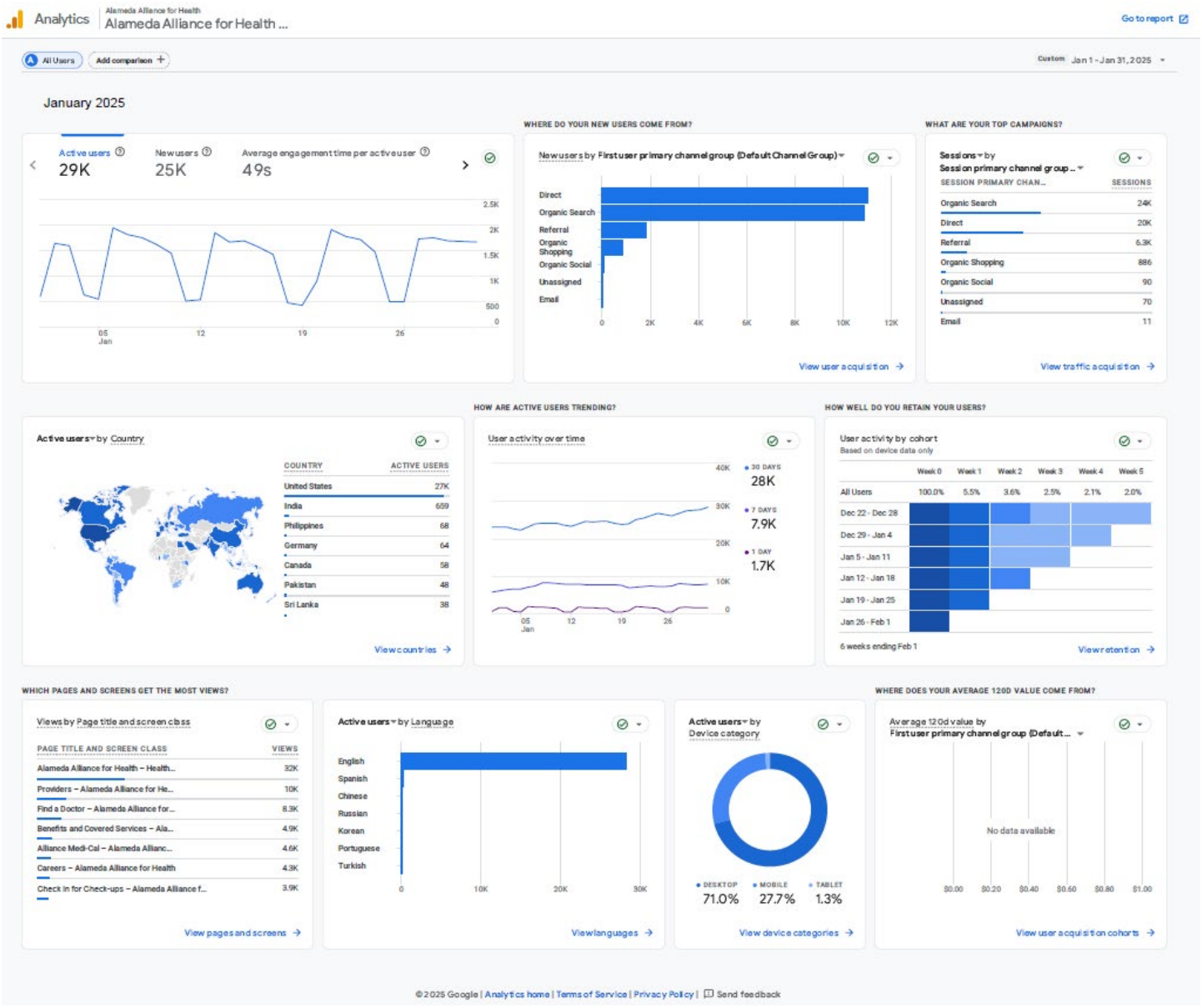






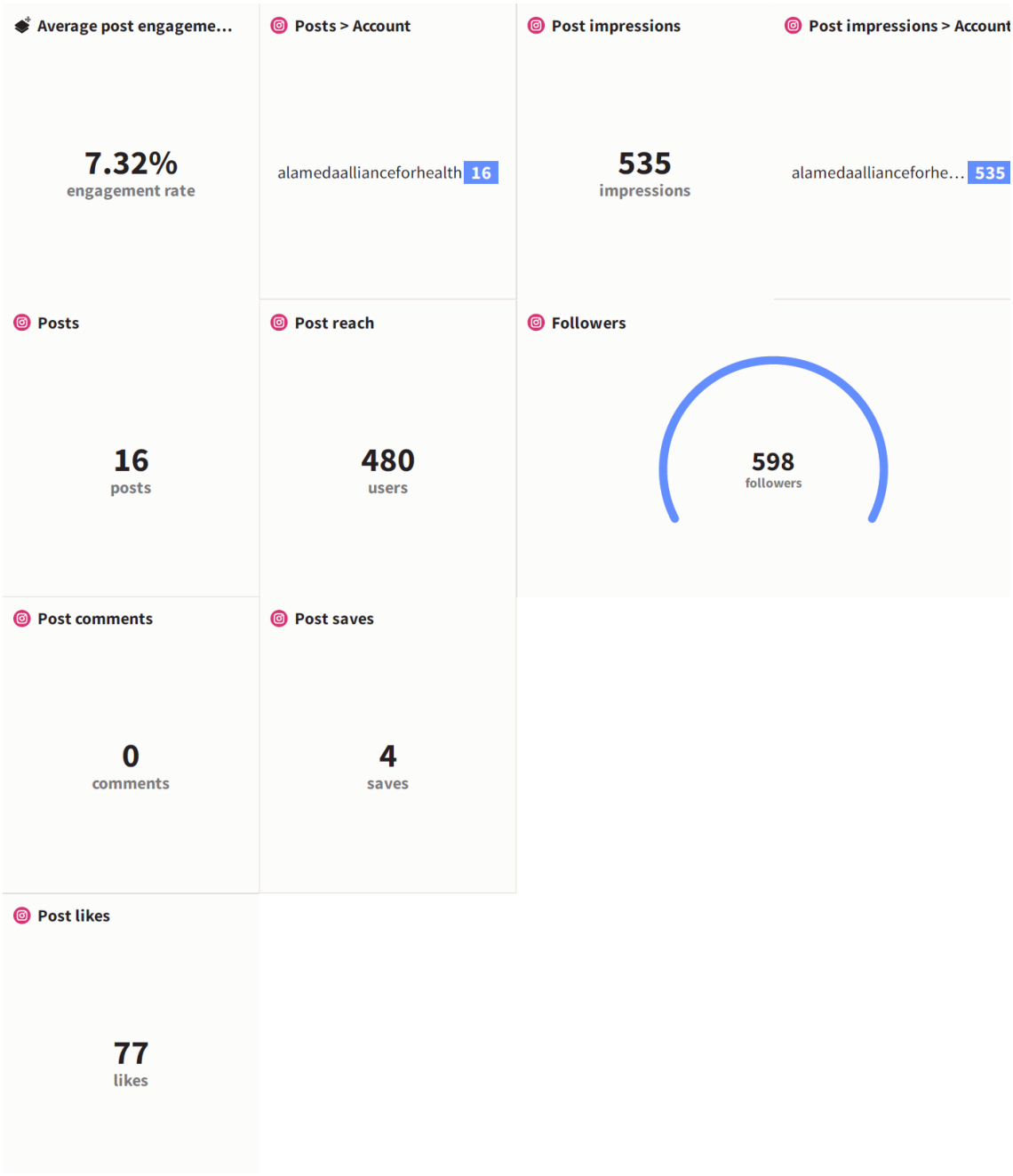
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q3\1. January 2025

ALLIANCE WEBSITE OVERVIEW:



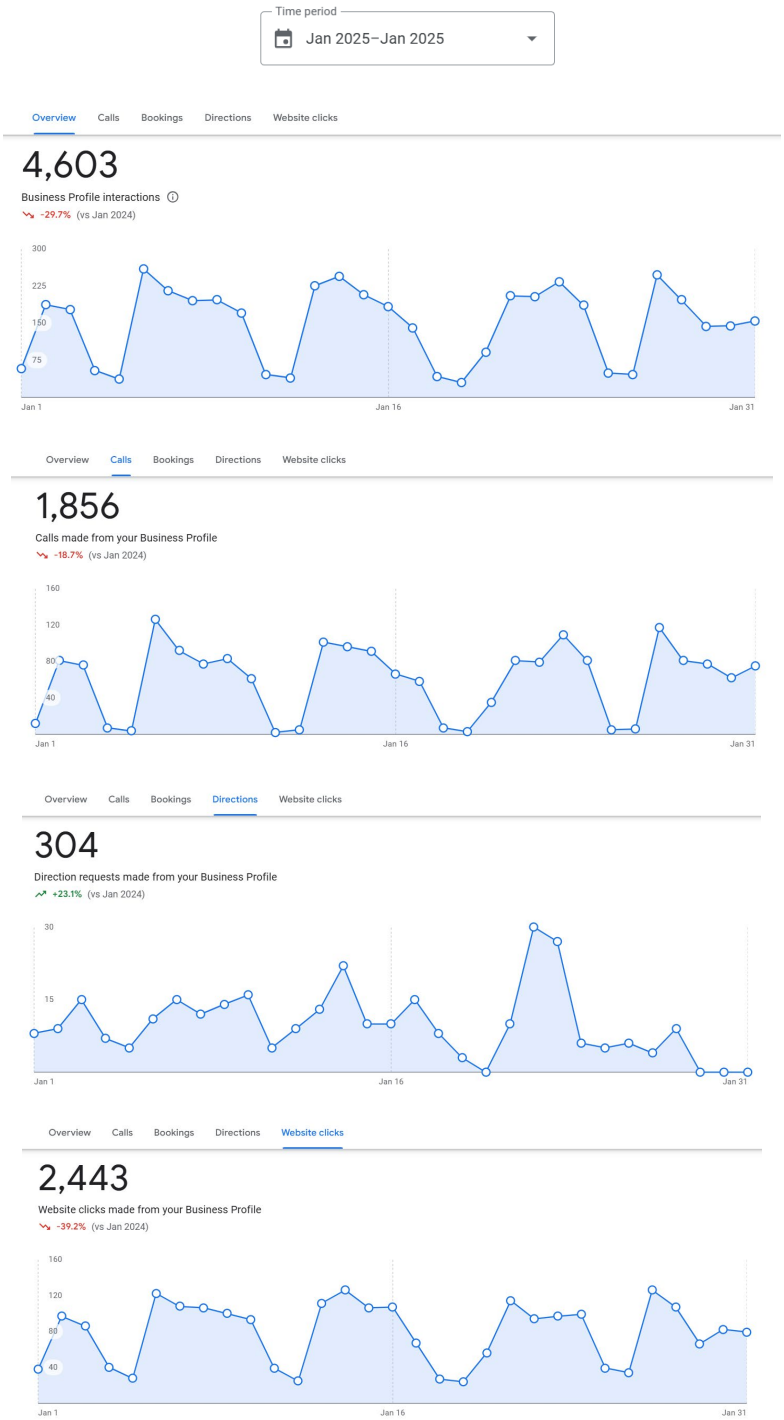
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q3\1. January 2025

INSTAGRAM OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q3\1. January 2025

GOOGLE OVERVIEW:



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Compliance

Richard Golfin III

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

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

Date: **February 14th, 2025**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2025 Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) Routine Full Medical Survey (Joint Audit)

    - On October 3rd, 2024, the Plan received notification from DMHC stating it will conduct a joint routine survey with the DHCS beginning March 3rd, 2025. The lookback period is from October 1st, 2022, through September 30th, 2024. On December 23rd, 2024, the Plan received DMHC case file selections. Seven hundred and seventy-three (773) cases were selected across the following areas:

        - Member Services,
        - Grievance & Appeals,
        - Utilization Management,
        - Pharmacy, Claims, and
        - Quality Improvement

      All Plan case files have been submitted as of January 17th, 2025.CHCN and CFMG case files have been submitted as of January 29th, 2025. Carelon's case files were submitted on February 4th, 2025. The audit will be held onsite March 3rd, 2025, through March 7th, 2025, with virtual follow-up meetings to continue through March 14th, 2025.

    - On December 16th, 2024, the Plan received notification from DHCS regarding the joint routine survey along with the Pre-Audit Request. The lookback period is from June 1st, 2024, through February 28th, 2025. The DHCS will be reviewing the following areas: Utilization Management, Case Management and Coordination of Care, and State Supported Services. The pre-audit materials have been submitted on January 19th, 2025. The department likewise requested supplemental information related to Access and Availability with a focus on transportation services. The materials were submitted timely on January 22nd, 2025.

- On January 28th, 2025, the Plan received an additional request from the DHCS for Post Stabilization Authorization information. The materials were submitted timely to the department on February 5th, 2025.

- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey

  - The DHCS conducted its 2024 Routine Full Medical Survey from June 17th, 2024, through June 28th, 2024. The Plan received its Final Audit Report on November 18th, 2024, citing twenty (20) final audit findings. CAP updates are provided to the DHCS on the 15th of each month. The DHCS extended the due date for January, the Plan submitted the update timely on January 24th, 2025.

- 2023 Department of Health Care Services (DHCS) Focused Medical Survey

  - On September 4th, 2024, the DHCS issued the Final Medical Survey Audit Report and CAP Request for the 2023 DHCS Focused Medical Survey. The DHCS identified findings related to Behavioral Health Services and Transportation Services. Nine (9) CAPs were identified, one (1) has been accepted and eight (8) have been partially accepted. The Plan submitted the update for January timely on January 17th, 2025. The next update is due February 10th, 2025.

- 2024 Department of Health Care Services (DHCS) Facility Site Review (FSR) and Medical Record Review (MRR)

  - All ten (10) PCP CAPs are closed and have been submitted to DHCS' Site Review Unit. Due to the file sizes, two (2) CAPs were submitted via SFTP on January 6th, 2025.

- 2024 Health Services Advisory Group, Inc. (HSAG) Network Adequacy Validation Audit (NAV)

  - On January 17th, 2025, the Plan received its NAV Validation Ratings from HSAG. The Plan received a perfect score of "High Confidence" in the validation ratings. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators.

Compliance Activity Updates

- Centers for Medicare & Medicaid Services (CMS) D-SNP Application and Model of Care

  - In advance of the February 12th, 2025, CMS Medicare Advantage Dual Eligible Special Needs Plan application due date, Compliance worked in partnership with various internal Alliance staff and delegates to gather all the materials needed to complete the application package. The materials have been

uploaded into CMS' Health Plan Management System (HPMS) and the application submitted the morning of Wednesday in time to meet the deadline.

- Department of Health Care Services (DHCS)
  - All Medi-Cal Managed Care Plans that are submitting an application to provide an EAE DSNP effective January 1st, 2026, must submit a State Specific Model of Care Matrix and Health Risk Assessment to DHCS by February 12th, 2025. The Plan's SMEs expect to finalize and submit prior to the DHCS deadline.
- Department of Managed Health Care (DMHC) Medicare Filings – CY26 Medicare, 2024 EAE D-SNP Material Modification Filing (E-Filing *No. 20244060*):
  - The Plan submitted its responses to the DMHC on January 7th, 2025, via comment table and anticipates that DMHC will approve and close out this filing within the next 30 days.
- New Legislation
  - DMHC's annual Newly Enacted Statutes (APL 24-023) includes a significantly higher number of bills than previous years. Seventeen of the 23 newly enacted statutes impact on the Plan's Medi-Cal and/or Group Care lines of business. Impactful bills include, but are not limited to:
    - AB 3275 requires health plans, effective January 1st, 2026, to reimburse claims within 30 *calendar* days after receipt of claims. The current requirement is 45 *business* days.
    - SB 729 requires large group health plans (excluding Medi-Cal), effective July 1st, 2025, to provide coverage for the diagnosis and treatment of infertility and fertility services.
  - Compliance has begun partnering with impacted areas to identify implementation steps and submit an e-Filing with DMHC by March 21st.
- 2024 Board of Governors Training
  - As outlined in the Compliance Plan, the Plan has assigned HIPAA and FWA training to all new and standing members of the Board. Of the eighteen Board members, eight (42%) have either completed their training or submitted sufficient proof of equivalent outside training. One member (6%) has training in progress and six (33%) have not started. The Plan continues coordination with the Board Clerk and the Board Chair to improve Board training rates of compliance.
- Confidentiality Agreements
  - As required by the Code of Conduct and Compliance Plan, all Board Members must sign Confidentiality Agreements. Of the eighteen Board Members, seventeen (94%) have signed.
- 2022 Behavioral Health Insourcing Material Modification:

Undertaking No. 6	
Undertaking	**Closeout**
"Submit an Amendment filing to demonstrate compliance with the Federal Mental Health Parity and Addiction Equity Act ("MHPAEA") (42 USC § 300 gg-26) and its regulations (45 CFR § 146.136) and Section 1374.76 of the Act."	On January 22, 2025, DMHC notified the Plan that it had completed its review of the Plan's Amendment Filing pertaining to MHPAEA compliance in nonquantitative treatment limitations (NQTL). The Filing was closed subject to four conditions: 1) The Plan utilizes the NQTLs that were reviewed by the DMHC. 2) The Plan utilizes the MHPAEA compliant policies and procedures, evidence of coverage and other documents reviewed by the DMHC. 3) The Plan binds any entity to which it delegates the application of NQTLs to use only those processes, strategies, evidentiary standards, or other factors as approved by the DMHC. 4) If any of the above has not been fully implemented, the Plan must operationalize within 30 days of the closing of the Filing.

Compliance

Supporting Documents

Q4 2024 - PRESENT APL IMPLEMENTATION TRACKING LIST						
#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
Q4 2024						
35	10/30/2024	DMHC	24-019	Amendments to Rule 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2025	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to inform health care service plans (health plans) of new amendments to 28 CCR § 1300.67.2.2 and the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for the reporting year (RY) 2025 Annual Network Report submission.
36	10/31/2024	DHCS	18-022	Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services (TECHNICAL CHANGE)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify the requirements for Medi-Cal managed care health plans (MCPs) regarding their responsibilities to provide members with access to freestanding birth centers (FBCs) as well as to services provided by Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs).
37	11/3/2024	DHCS	23-024	Doula Services (TECHNICAL CHANGE)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the qualifications for providing doula services, effective for dates of service on or after January 1, 2023.
38	11/13/2024	DMHC	24-020	RY 2026/MY 2025 Provider Availability Survey Manual and Report Form Amendments	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide notice to health care service plans (health plans) of amendments to Rule 1300.67.2.2 and the following reporting year (RY) 2026/measurement year (MY) 2025 Timely Access Compliance Report documents: Provider Appointment Availability Survey (PAAS) Manual, PAAS Report Forms and the Timely Access Submission Instruction Manual (TA Instruction Manual).
39	12/5/2024	DHCS	24-016	Diversity, Equity, and Inclusion Training Program Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the Diversity, Equity, and Inclusion (DEI) training program requirements.
40	12/5/2024	DHCS	24-017	Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the transgender, gender diverse, intersex (TGI) cultural competency training program and Provider Directory changes required by Senate Bill (SB) 923 (Chapter 822, Statutes of 2022) for the purpose of providing trans-inclusive health care to MCP Members.
41	12/12/2024	DMHC	24-021	Notice of Amendments to Rules 1300.67.2.1, 1300.67.2 and Incorporated Documents – Network Adequacy Standards and Methodology for RY 2025	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to notice amendments to 28 CCR § 1300.67.2.1, 28 CCR § 1300.67.2, and documents incorporated by reference. References to "Rule" refer to the California Code of Regulations (CCR), title 28. The amendments are noticed pursuant to Senate Bill (SB) 225 (Wiener, Chapter 601, Statutes of 2022).
42	12/13/2024	DHCS	24-018	Medical Loss Ratio Requirements For Subcontractors And Downstream Subcontractors	MEDI-CAL	The purpose of this All-Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on the Medical Loss Ratio (MLR) requirements set forth by the federal Centers for Medicare & Medicaid Services (CMS) in the California Advancing & Innovating Medi-Cal (CalAIM) Section 1915(b) waiver's Special Terms and Conditions (STCs) and pursuant to the MCPs' contractual requirements in Exhibit A, Attachment III, Provision 3.1.5(B)(31).
43	12/13/2024	DMHC	24-022	Children and Youth Behavioral Health Initiative, Certified Wellness Coaches	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC), together with the Department of Health Care Access and Information (HCAI), issues this All-Plan Letter (APL) 24-022 - Children and Youth Behavioral Health Initiative, Certified Wellness Coaches to provide health care service plans with information regarding the establishment of the state Wellness Coach certification program and encourage health plans to provide access to Wellness Coach services as a means of increasing behavioral health resources to health plan members.
44	12/20/2024	DMHC	24-023	Newly Enacted Statutes Impacting Health Plans (2024 Legislative Session)	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) 24-023, which outlines the newly enacted statutory requirements for health care service plans (plans) regulated by the Department of Managed Health Care (DMHC).
45	12/31/2024	DHCS	24-019	Minor Consent to Outpatient Mental Health Treatment or Counseling	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) regarding the provision of non-specialty mental health outpatient treatment or counseling services to minors as a result of Assembly Bill (AB) 665 (Chapter 338, Statutes of 2023)1 which amended Family Code (Fam. Code) section 6924.
Q1 2025						
1	1/9/2025	DMHC	25-001	Southern California Fires and Enrollees' Continued Access to Health Care Services	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) 25-001, which provides information regarding Health and Safety Code section 1368.7.
2	1/17/2025	DHCS	25-001	2024-2025 Medi-Cal Managed Care Health Plan Meds/834 Cutoff and Processing Scheduling	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with the 2024-2025 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.
3	1/13/2025	DHCS	25-002	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, 2026. 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.
4	1/15/2025	DHCS	25-003	Establishing D-SNPs by 2026	DSNP	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with information regarding the Department of Health Care Services' (DHCS) enforcement of California Welfare and Institutions Code (W&I) section 14184.208, related to the requirement for MCPs to operate or be affiliated with a Dual Eligible Special Needs Plan (D-SNP) by 2026, to provide integrated care through affiliated MCPs and D-SNPs for dually eligible Medicare and Medi-Cal Members.
5	1/28/2025	DMHC	25-002	Plan Year 2026 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 25-002 to assist in the preparation of Plan Year 2026 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules).

COMPLIANCE DASHBOARD SUMMARY											
	Resource	Type								TOTAL	% Completed
			2018	2019	2020	2021	2022	2023	2024		
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	24	20	165	
		Total Self-Identified Issues	12	0	0	2	0	2	7	23	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**27**	**188**	
		Total In Progress	0	0	0	0	0	8	27	35	
		Total Completed	50	28	7	35	15	18	0	153	**95%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**27**	**161**	
	DMHC	Total State Audit Findings			5	6	8	3		22	
		Total Self-Identified Issues			3	0	0	0		3	
		Total Findings			**8**	**6**	**8**	**3**		**25**	
		Total In Progress			0	0	1	3		4	
		Total Completed			8	6	7	0		21	**84%**
		Total Findings	**NA**	**NA**	**8**	**6**	**8**	**3**		**25**	
	DMHC Financial Services	Total State Audit Findings		5			4			9	
		Total Self-Identified Issues		0			0			0	
		Total Findings		**5**			**4**			**9**	
		Total In Progress		0			0			0	
		Total Completed		5			4			9	**100%**
		Total Findings	**NA**	**5**	**NA**	**NA**	**4**	**NA**		**9**	
STATE AUDIT FINDINGS		In Progress	0	0	0	0	1	11	20	32	
		Completed	38	33	12	39	26	16	0	164	**84%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**27**	**20**	**196**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	7	7	
		Completed	12	0	3	2	0	2	0	19	**73%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**7**	**26**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**29**	**27**	**222**	

COMPLIANCE DASHBOARD SUMMARY			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	196	88%
	Total Self-Identified Issues	26	12%
	Total Findings	**222**	
	Total In Progress	40	18%
	Total Completed	182	82%
	Total Findings	**222**	
STATE AUDIT FINDINGS	In Progress	32	16%
	Completed	164	84%
	Total Findings	**196**	
SELF-IDENTIFIED FINDINGS	In Progress	7	27%
	Completed	19	73%
	Total Findings	**26**	

2024 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	20	74%
	Total Self-Identified Issues	7	26%
	Total Findings	**27**	
	Total In Progress	27	100%
	Total Completed	0	0%
	Total Findings	**27**	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

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

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

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R = Repeat Findings

2024 DHCS Audit - *Audit Review Period* 6/1/2023 - 5/31/2024 *Audit Onsite Dates - June 17, 2024 - June 28, 2024*			
#	**Category**	**Deficiency**	**Department Responsible**
7	CM and CoC	(2.1.1) Provision of Blood Lead Screening The Plan did not ensure that blood lead screening tests were conducted for members up to six years of age.	QI
9	CM and CoC	(2.3.1) Provision of Behavioral Health Therapy (BHT) Services The Plan did not ensure the provision of BHT services in accordance with approved BHT treatment plans for members under the age of 21.	Behavioral Health
8	CM and CoC	(2.3.2) Timely Access to Behavioral Health Therapy (BHT) Services The Plan did not arrange and coordinate BHT services for members under the age of 21 within 60 calendar days.	Behavioral Health
10	CM and CoC	(2.4.1) Notice of Action (NOA) Letters for Continuity of Care (COC) Requests The Plan did not ensure that NOAs for COC requests that were sent to members contained a clear explanation of the reason for the denial decision.	UM
11	Access and Availability	(3.1.1) Appointment Waitlist Timeliness The Plan did not ensure members were able to obtain medically necessary appointments within established timely access standards. One of the Plan's medical groups placed members on an appointment waitlist and had members waiting up to six months to make an appointment.	QI
12	Access and Availability	(3.1.2) Monitoring In-Office Wait Times for Specialty and Behavioral Health Services The Plan did not monitor in-office wait time for specialists and behavioral health providers.	QI
13	Access and Availability	(3.1.3) Monitoring Telephone Calls for Specialty and Behavioral Health Services The Plan did not monitor wait times for specialty and behavioral health providers to answer and return telephone calls.	Behavioral Health

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

2024 DHCS Audit - *Audit Review Period* 6/1/2023 - 5/31/2024 *Audit Onsite Dates - June 17, 2024 - June 28, 2024*			
#	**Category**	**Deficiency**	**Department Responsible**
14	Member Rights	(4.1.1) Grievances Involving Clinical Issues The Plan did not ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues.	G&A
15	Member Rights	(4.1.2) Resolution of Grievances The Plan did not completely resolve the members' grievances.	G&A
16	Member Rights	(4.1.3) Clear and Concise Resolution Letters The Plan's written resolution did not contain a clear and concise explanation of the Plan's decision.	G&A
17	Member Rights	(4.1.4) Grievance Letters: Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT) The Plan did not include updated NDN and LAT information with grievance acknowledgement and resolution letters.	G&A
18	Member Rights	(4.2.1) Monitoring of Linguistic Performance The Plan did not assess the performance of its vendors' staff that provided linguistic services such as interpreter services.	Cultural and Linguistic Services
19	Member Rights	(4.3.1) Notification to DHCS The Plan did not notify DHCS within 24 hours upon discovery of any suspected breach or security incident, unauthorized access, use or disclosure of PHI or PI.	Compliance
20	Quality Management	(5.3.1) Notification of Provider Terminations The Plan did not meet DHCS reporting and member notification requirements for provider terminations.	Operations

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

2024 DHCS Audit - *Audit Review Period* 6/1/2023 - 5/31/2024 *Audit Onsite Dates - June 17, 2024 - June 28, 2024*			
#	**Category**	**Deficiency**	**Department Responsible**
21	Fraud, Waste, and Abuse	(6.2) Fraud, Waste, and Abuse The Plan does not have a regular method of reviewing services have been delivered by network providers or received by members	Compliance Claims UM
22	State Supported Services	(3.6) State Supported Services The Plan did not distribute minimum payments for State Supported Services claims as described in APL 23-015	Claims
23	CM and CoC	(2.1) California Childrens Services (CCS) The Plan did not monitor CCS referral program pathways to identify members who may be eligible for CCS	Case Management
24	CM and CoC	(2.1) Initial Health Assessment (IHA) The Plan did not ensure reasonable member outreach attempts for the IHA document	QI
25	CM and CoC	(2.1) Initial Health Assessment (IHA) The Plan did not ensure the provision of Initial Health Assessments for members	QI
26	CM and CoC	(2.1) Member Outreach Attempts for Initial Health Assessment (IHA) The Plan did not ensure that reasonable member outreach attempts for IHAs were conducted and documented for newly enrolled members.	QI
27	CM and CoC	(2.3) Behavioral Health Therapy (BHT) The Plan did not ensure care coordination for members needing BHT services	Behavioral Health

KEY
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Orange = Plan Observations (Not Included in the Preliminary Report)
R = Repeat Findings

2023 DMHC Follow-Up Review : *Audit Review Period 11/1/2022 - 05/31/2023* *Audit Onsite Dates* - 10/23/2023 - 10/27/2023			
#	**Category**	**Deficiency**	**Department Responsible**
1	Grievances & Appeals	When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform complainants of their right to contact the Department.	G&A
3	Grievances & Appeals	The Plan does not correctly display the statement required by Section 1368.02(b) in all required enrollee communications.	G&A Member Services UM Rx
6	Prescription (Rx) Drug Coverage	The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.	Rx

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2023 DHCS Focused Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*				
#	Category	Deficiency	Corrective Action Plan (CAP)	
1	BH	(2.1) Case Management and Care Coordination The Plan did not ensure the provision of coordination of care to deliver mental health care services to its members. Recommendation: Revise and implement policies and procedures to ensure the Plan coordinates care with the MHP.	1. On April 1, 2023 the Plan insourced behavioral health. The Plan met with the County to identify mechanisms for care coordination. A process was identified for data sharing for mental health, pending system implementation. To support care coordination, and MOU was executed on 4/2023. A manual process has been put in place to include by-weekly case discussions and TOC tools. 2. Policy BH-005 has been updated for written procedure for care coordinators role in care coordination and is going through the committee approval process. **Update 12/13/2024:** Policy BH-005 was approved at QIHEC on 11/15/2024, and will be presented for review and approval at the Administrative Oversight Committee on 12/18/2024.	
2	BH	(2.2) Information Exchange with the County Mental Health Plan (MHP) The Plan did not follow the written policies and procedures in its MOU for the timely sharing of medical information with the MHP. Recommendation: Implement policies and procedures to ensure the Plan follows agreed upon written policies and procedures in its MOU for the timely exchange of medical information with the MHP.	1. The Plan and the County collaborated to revise the agreed-upon MOU for multiple state and federal requirements, including information exchange between both systems for SMHS with implementation date of 04/04/2023. 2. The Plan and the County established a plan for data exchange to support coordination of care and closed-loop referrals, which is currently in the final stages. We have continued to monitor the county's progress with data issues caused by its new electronic health management system. **Update 12/13/2024:** The Plan and the County continue to work together on the data sharing and electronic health systems.	
3	BH	(2.3) Confirmation of Referred Treatments for Substance Use Disorder (SUD) The Plan did not make good faith efforts to confirm whether members received referred treatment for SUD and document when and where treatment was received, and any next steps following treatment. Recommendation: Revise and implement policies and procedures to ensure the Plan makes good faith efforts to confirm whether members received referred SUD treatment and document when and where treatment was received, and any next steps following treatment.	1. The Behavioral Health Department has developed and implemented a department-specific policy for the care of coordination for SUD on 3/19/2024. Update 11/10/2024: Care coordination policies for MH and SUD members have been combined into policy BH-005. **Update 12/13/2024:** Policy BH-005 has been approved by QIHEC, and is scheduled to go to AOC on 12/18/2024 for final review and approval. 2. The issue of 42 CFR posing a barrier to care coordination for individuals with SUD is a standing agenda item in leadership meetings with the Plan and the County. Issues with signed releases from members are preventing confirmation of SUD referrals, however a newly established MOU has a written policy to encourage Medi-Cal Managed Care beneficiaries for signed release for members starting or currently in treatment until this has been operationalized at the county. **Update 12/13/2024:** Discussions around universal release forms for SUD members are continuing. 3. Update MOU to include an agreement that Medi-Cal managed care beneficiaries will be encouraged to complete the form. 4. Establish and implement process for regular exchange of information between the Plan and the County to ensure compliance with 42 CFR.	
4	BH	(2.4) Follow Up for Referred Substance Use Disorder Treatments The Plan did not follow up with members who did not receive referred treatments to understand barriers and make subsequent adjustments to referrals. Recommendation: Revise and implement policies and procedures to ensure the Plan awareness of members who did not receive referred SUD treatments, to understand barriers and make subsequent adjustment to referrals, if warranted.	1. Develop form in coordination with county efforts for Enhanced Care Management for disclosure to support care coordination between the County, the MCP, and practitioners providing SUD and physical health services to the beneficiary. **Update 12/13/2024:** Discussion continues regarding universal release forms to accomplish care coordination for SUD members. 2. Information regarding the Plan's PCP legal process for coordination of care for SUD members was included in P&P BH-006. **Update 12/13/2024:** Policy BH-005 and BH-006 were combined, and BH-005 was approved at QIHEC on 11/15/2024, and will be presented for review and approval at the Administrative Oversight Committee on 12/18/2024. 3. When the BH department identifies a member who needs to be referred for SUD treatment, a referral is completed and the receipt of the referral is confirmed and communicated during routine coordination meetings with the Plan and the County, as well as front line staff. There are reporting challenges with SUD treatment due to 42 CFR and the County and the Plan are working to address this. **Update 12/14/2024:** Ongoing Bi-weekly case discussions, TOC tools with the County regarding SUD members.	
5	NMT & NEMT	(3.1) Door-to-Door Assistance The Plan did not have a process in place to ensure that door-to-door assistance was provided for all members receiving NEMT services. Recommendation: Revise and implement policies and procedures to ensure door-to-door assistance is being provided for all members receiving NEMT services.	1. Remediating this involves an Alliance policy update and additional training of our transportation vendor. The Transportation Vendor has training and oversight in place in the form of repeat random audits of their transportation providers. Since the 2023 audit, this process was updated by the transportation provider. Additionally, AAH will participate in at least five (5) transportation trips per quarter with the broker to ensure door-to-door assistance is being provided when applicable. **Update 12/13/2024:** The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips.	
6	NMT & NEMT	(3.2) Monitoring of Door-to-Door Assistance The Plan did not conduct monitoring activities to verify NEMT providers were providing door-to-door assistance for members receiving NEMT services, per APL 22-008 Recommendation: Revise and implement policies and procedures to ensure the Plan conducts monitoring activities, to ensure providers provide door-to-door assistance, for all members receiving NEMT services.	1. This is a policy and process update. To ensure that the broker is appropriately spot checking NEMT and NMT transportation providers for the correct level of service, AAH will participate in at least five (5) transportation trips per quarter with the broker. **Update 12/13/2024:** The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips.	

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2023 DHCS Focused Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*				
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	
7	NMT & NEMT	(3.3) Transportation Liaison The Plan did not have a direct line to the transportation liaison that it provided to providers and members, and the transportation liaison did not process authorizations after business hours. Recommendation: Revise and implement policies and procedures to ensure there is a direct line to the transportation liaison and authorizations are processed after business hours.	To improve member access to transportation services and ensure that after-hours authorizations are being properly handled, the Plan will implement the following measures: Inclusion of Transportation Liaison Contact Information: The Plan will include the transportation liaison's phone number in the member handbook and on the Health Plan's website. This will ensure that members have easy access to contact information for transportation-related inquiries and support. Reporting of After-Hours Trip Reservations: The Plan will require subcontractors to report any trip reservations that could not be completed or authorized during after-hours periods. This reporting requirement will help the Plan track issues and address them effectively. Follow-Up with Members: The Transportation Liaison and the Case Management Team will follow up with members regarding any issues related to trip reservations that were not completed or authorized after hours. This proactive approach will ensure that members receive the support they need and that any problems are resolved in a timely manner. **Update 12/13/2024:** On track and awaiting publication of the new edition of member handbook with liaison contact number.	
8	NMT & NEMT	(3.4) **R** Physician Certification Statement Forms The Plan did not ensure that members had the required PCS forms for NEMT services, nor did the Plan ensure that PCS forms contained all required components. Recommendation: Implement policies and procedures to ensure PCS forms are on file for all members receiving NEMT services and that the forms contain all the required components.	1. The PCS form intake was insourced beginning 3/1/2023, and AAH staff was hired to coordinate the PCS form effort and transportation.	
9	NMT & NEMT	(3.5) Ambulatory Door-to-Door The Plan did not ensure its delegate, provided the appropriate level of service for members requiring ambulatory door-to-door service. Recommendation: Revise and implement policies and procedures to ensure its delegate provides the appropriate level of service for members requiring ambulatory door-to-door service.	. Remediating this involves an Alliance policy update and additional training of our transportation vendor. The Transportation Vendor has training and oversight in place in the form of repeat random audits of their transportation providers. Since the 2023 audit, this process was updated by the transportation provider. Additionally, the Plan will participate in at least five (5) transportation trips per quarter with the broker to ensure door-to-door assistance is being provided when applicable. **Update 12/13/2024:** The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips.	

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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
1	UM	(1.5.1) Notice of Action (NOA) Letters The Plan did not ensure a delegate sent NOA letters to providers and members.	The Plan received the delegate's Root Cause Analysis (RCA) and CAP on 04/14/2023. After review and evaluation of the delegate's document the Plan issued a formal CAP on 05/31/2023 and received the delegate's CAP response on 06/27/2023. The initial corrective actions completed by the delegate includes updating their IT script and ensuring the identified missing NOA letters were sent out to the member and that outreach was completed to confirm that services approved or had denial modification authorizations were utilized by members. The delegate also developed workflows to detect and mitigate failures. The CAP includes the delegate's implementation of a remediation plan. The remediation plan includes updates in their workflow, training, and an internal monthly audit- with results submitted to The Alliance for review. The Plan reviewed and evaluated the delegate's CAP implementation and progress during the interim and provided guidance. The CAP was approved and closed on 09/25/2023. (Completed) The delegate is expected to continue its internal monthly audit for the NOA letters and fax confirmation. The Plan will continue to monitor the audit results for compliance. Please see document 1.5.1_AAH Response for full details. (On Track) Additionally, the Plan will review the UM delegates' P&P's to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation and these will be evaluated annually at minimum. (On Track) 1a. Monitoring of the delegate's monthly internal audit is ongoing. (On Track) 2. Review the UM delegates' policies and procedures to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation. (On Track) Update 3/8/2024 P&P review complete and P&P deemed adequate. Review of the delegate's P&P regarding NOAs is ongoing and The Alliance will continue to meet with the delegate to have P&P appropriately updated. **Update 4/5/2024** The delegates have submitted all requested policies for review. The policies have been reviewed and the delegates have made all necessary revisions.	**3/31/2024**	Completed	Compliance UM	State	DHCS	2023

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

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
4	Access and Availability	(3.1.1) First Prenatal Visit The Plan's policies and procedures for a first prenatal visit for a pregnant member is not compliant with the standard of two weeks upon request.	The Plan has edited Timely Access Standard table, policy QI-107 and QI-114 to reflect the first prenatal visit standard within 2 weeks of the request. (Completed)	Q4 2023	Completed	Quality	State	DHCS	2023
5	Family Planning and State Supported Services	(3.6.1) Non-contracted Provider Payments The Plan did not pay non-contracted providers at the appropriate Medi-Cal fee-for-service rate.	A Change Request was entered to change non-contract mid-level providers reimbursements to 100% of the Medi-Cal rate moving forward. (Completed)	11/16/2023	Completed	Claims	State	DHCS	2023
6	Family Planning and State Supported Services	(3.6.2) Proposition 56 Family Planning Payments The Plan did not distribute add-on payments for institutional family planning service claims as required by APL 22-011.	1. P&P has been revised to ensure that Family Planning services paid on institutiona claims are paid As part of Prop 56 payments. 1a. The Plan's Analytics Team is in the midst of preparing the payment details for the retro payment on the FP institutional data and looking to complete by 11/30/2023 timeline. (On Track) 2. The Analytics dept has calculated the retroactive payments due to facilities as a result of finding 3.6.2, APL 22-011 and APL 23-008. (On Track) 2a. Payments will be distributed to providers prior to or latest by Nov 30, 2023. (On Track) 2b. Facility providers with qualifying Family Planning services as per APL 23-008 will be included as part of our monthly Prop 56 payment processing going forward starting Dec 2023. (On Track)	1/15/2024	Completed	Claims	State	DHCS	2023
7	NMT & NEMT	(3.8.1) R Physician Certificate Statement (PCS) Forms The Plan did not ensure PCS forms were on file for members receiving NEMT services.	1.The Plan made the decision to no longer allow courtesy NEMT trips for members without a PCS form on file and the decision to insource PCS form acquisition to the Plan's Case Management Department beginning 3/1/23. Working alongside the Plan's transportation subcontractor, the Plan created new workflows to ensure the transportation subcontractor was not scheduling NEMT trips for members unless there was a confirmed valid PCS form on file, or the Plan provided a verbal authorization due to a trip being of an urgent nature. The Plan hired two transportation coordinators to focus on PCS acquisition leveraging the Plan's preexisting relationships with the provider network and access to EHR's. Through the end of 2022 and beginning of 2023, the Plan's transportation subcontractor trained its call center agents on the new workflow. On 2/14/23, the Plan trained its transportation coordinators on PCS acquisition. On 2/21/23, the Plan trained its entire case management team, that participates in phone shifts for the Plan's case management phone line, on the parameters for verbal authorizations for NEMT trips of an urgent nature. The Plan continues to report on the success of the new workflows at the Plan's UM Committee. (On Track) 1a.The Plan is working with its analytics team to create a report using PCS data elements to match up against subcontractor's report of all NEMT trips taken each month. This report will assist in finding any gaps in PCS compliance. The Plan estimates this report to go live 12/1/2023. (On Track)	12/15/2023	Completed	Case Management	State	DHCS	2023
8	NMT & NEMT	(3.8.2) Transportation Providers' Medi-Cal Enrollment Status The Plan did not ensure all transportation providers were enrolled in the Medi-Cal program.	The Plan has updated the P&P VMG-005 from reviewing the Transportation Providers (TP) on a quarterly review to a monthly review. Attached for reference is the updated P&P. The Plan began reviewing the TP monthly for the utilization from April 2023 to current. (Completed and Ongoing)	4/1/2023	Completed	Vendor Management	State	DHCS	2023

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

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

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2022 DMHC Behavioral Health Investigation - *Audit Review Period* 4/1/2020 - 4/30/2022 *Audit Onsite Dates - September 7, 2022 - September 8, 2022*							INTERNAL AUDITS	
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**Agency**
1	UM	The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855)	The Alliance reviews and/or updates all policy and procedures at least annually, to ensure our policy and procedures content is reflective of current regulatory requirements. All UM policy and procedures including any updates and the UM Program Description, are reviewed in the Utilization Management Committee (UMC), subsequently reviewed, and approved at our Board Delegated Quality Improvement Health Equity Committee (QIHEC) which reports directly to the Alliance Board of Governors. In response and in compliance with SB 855, The Alliance has updated UM-063 - Gender Affirmation Surgery and Transgender Services and the Alliance UM Program Description. Both bodies of work are aligned with current WPATH Standards of Care. The Alliance is contracted with WPATH to provide training on WPATH Standards of Care - all UM decision makers (including RNs and physicians) are required to complete WPATH training to ensure the most current WPATH standards required by SB 855 are used for medical necessity decision-making. 100% of current UM reviewers will complete WPATH Training by Q2 2024 & 100% of newly hired UM reviewers will complete WPATH Training within 90-days of their start date The Alliance also conducts annual Inter-Rater Reliability Studies (IRR) with all UM decision makers to ensure that documented criteria is being applied consistently and accurately by decision makers. Additional training and testing is conducted when a passing score is not met. Annual IRR: 100% of UM reviewers will complete the Annual IRR Studies by Q3 2024	In Progress	Closed 9/27/2022 Q2 2024 Q3 2024	UM Behavioral Health	State	DMHC
2	Quality Assurance	The Plan does not ensure its delegate consistently documents quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.	As of 4/1/2023, The Alliance has terminated its contract with the delegate. Since termination, The Alliance has insourced all mental and behavioral health services and processes all quality of care issues identified. The Alliance follows its internal policy and procedures and workflows to ensure that all quality of care problems are identified, reviewed and further, that effective action is taken to improve care whe deficiencies are identified, and that follow-up is planned where indicated.	4/1/2023	Completed	UM Quality Assurance Behavioral Health Compliance	State	DMHC
#	**Category**	**Barriers to Care**	**Plan Response**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**Agency**
1	Pharmacy Services	The Plan has limited ability to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy and lacks policies and procedures for these treatments.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	UM Behavioral Health Pharmacy Provider Contracting	State	DMHC
2	Cultural Competency and Health Equity	Neither the Plan nor its delegate conduct assessments pertaining to cultural competency and health equit specific to the Plan's enrollee population.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	Quality Assurance Behavioral Health	State	DMHC
3	Enrollee Experience	Enrollees experience difficulties obtaining appointments.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	Quality Assurance Behavioral Health	State	DMHC

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R = Repeat Findings

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

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Yellow = Plan Observations (included in final report)
R = Repeat Findings

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

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

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

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
4	QI	(2.1.1) The Plan did not document attempts to contact members and schedule the IHA.	1. The plan will continue to inform members of the IHA through the EOC, welcome letters to all new members, and videos. - In addition, all members are eligible for a new member orientation (including a financial incentive). - Information regarding the IHA will be included in the member newsletter. The Alliance will initiate a new phone campaign where all new members will receive a phone call encouraging the member to receive an IHA. This phone log will be appropriately documented. The Alliance will create a call script for new member phone calls. 2. The plan will create a report to identify new plan members Update 5/12/2023: Fulfillment Report created to track mailing of member Orientation reports that contain reminder to schedule IHA to new members. Member Orientation Service Request tracking report tracks outreach attempts to members to complete new member orientation, which includes communication about scheduling IHAs 3. The plan will create workflows for informing members of the IHA Update 5/12/2023: Clinical QI Program Coordinator will review IVR reports to determine all new members have received an outreach call. 4. The plan will update the IHA P&P to reflect the updated workflows Update 3/10/2023: Draft policy QI-124 completed, IVR outreach is pending DHCS approval of script. Upon DHCS approval we will continue to develop the process for IVR outreach and develop desktop procedures. Update 4/15/2023: The updated P&P was approved at Compliance Committee 3/21/2023 5. The plan will create a phone call campaign, create a script, and work with the state for approval Update 3/10/2023: Awaiting DHCS approval of script. Update 6/9/2023: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreach attempts via providers, by reviewing documentation as part of FSRs.	9/8/2023	Completed	QI		State	DHCS	2022
5	CM	**R** (2.5.1) The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.	1. The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with the MHP to review redline changes to the MOU. The MHP is currently under review of the redline changes and will notify the Alliance when they can move forward wit signing the MOU. The MHP MOU vetting process includes County Board of Supervisor (BOS) approval. Therefore, the Alliance is hoping to execute the MOU by the end of 2022.	12/31/2023	Completed	Provider Relations		State	DHCS	2022
6	Provider Relations	**R** (3.1.1) The Plan did not monitor the network providers' compliance with requirements for when appointments were extended.	1. The Provider Manual was edited to update the requirements, providers were advised in the Quarterly Provider Packet, and The Alliance Provider Representatives advised providers during PCP visits. Additionally, fax blasts were sent to providers regarding the updated requirements, and the Provider Education document was updated to reflect the requirements. 2. Edit P&P and Quality of Access Workflow to ensure all cases are reviewed by a QI Nurse. If a case is determined to be related to access, QI / A&A staff will review data for ED / Inpatient Stays as a result of delay in appointment. If the member does have an ED / IP Claim, the QI RN will then work the case up as a PQI / Quality of Care. This will be reviewed by the Medical Director and follow the PQI process. Finally, all QOA cases with available MRs will be reviewed to ensure the appropriate provider documentation. Update 03/10/2023: Policy QI-114 has been updated and is awaiting approval at committee Update 4/14/2023: P&P Q1-114 was approved at Compliance Committee 3/21/2023	3/21/2023	Completed	Provider Relations QI		State	DHCS	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
7	Claims	(3.6.1) The Plan improperly denied emergency services claims.	1. Case #7 – The claim was paid on 8/11/2021. The vendor was notified of the finding on 5/19/2022 and asked to review their internal process to ensure that codes on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. 2. Case #20 –The vender was notified of the issue on 5/19/2022 and asked to review their internal process to ensure that dates on clams are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. In addition, an edit was enhanced to ensure that the date range order is correct. 3. The claim was paid on 1/5/2022 correctly. The Claims Processor was shown the claim finding for review along with the correct workflow document that shows the correct process to help ensure moving forward this does not occur again. This workflow was also reviewed by the Claim Processor team and training occurred.	10/11/2022	Completed	Claims		State	DHCS	2022
8	Access and Availability	**R** (3.8.1) The Plan did not use PCS forms for NEMT services.	1. The Plan will educate providers on PCS requirements. Update 3/10/2023: Provider Alert PCS Form Reminder and Form was sent out to Providers in a fax blast on Tuesday, 12/27/22. 2. Refine PCS workflows to meet all regulatory requirements. Update 3/10/2023: Workflow updated. 3. The Plan will conduct staff trainings on process workflow changes.Update 4/15/2023: Training completed 1/31/2023. 4. The Plan will ensure that the transportation subcontractor trains their staff on the PCS process workflow changes. The transportation subcontractor will provide training materials and sign in sheetsUpdate 4/15/2023: Training completed 1/31/2023. 5. The Plan will develop reports on PCS form outcomes using both transportation subcontractor information and the Plan's process to obtain PCS forms.Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 6. The Plan will monitor process workflows from the transportation subcontractor and the Plan to obtain missing PCS forms Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 7. The Plan will analyze trends in provider practices and provide feedback to providers regarding PCS form requirements. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022, where trends analyzed. 8. The plan will evaluate whether to continue having the transportation subcontractor manage the PCS forms or take the direct management of PCS forms back into the Plan.Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. Will continue to analyze quarterly. 9. The Plan will provide a quarterly report to UM CommitteeUpdate 4/15/2023: Reports developed and presented at UM Committee Q4 2022.	4/1/2023	Completed	UM		State	DHCS	2022
9	Member Rights	**R** (4.1.1) The Plan did not send acknowledgement and resolution letters within the required timeframes.	1. The G & A Department Leadership and Quality Assurance Specialist will reference the daily reports to ensure the acknowledgment and resolution letters are sent timely 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement and resolution letters. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/20222	Completed	G&A		State	DHCS	2022

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

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

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Orange = Plan Observations (not included in the final report)
R = Repeat Findings

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

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

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

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

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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
18	Access	(3.4.1) The Plan did not ensure standing referral determinations and processing were made within the required timeframes.	1. The Plan will develop a standing referral workflow. 11/12/2021: Standing referral workflow has been developed 2. The Plan will update The Alliance system of record for UM and CM, TruCare (TC) to add user define field in order to identify standing referral status to ensure correct TAT, which would include a reportable field for monthly reporting. Update 12/10/2021: TruCare has been updated to add the user defined field. 3. The Plan will revise TruCare (TC) to capture timeframes for processing Standing Referrals. Update 12/10/2021: The reporting TAT has been scheduled to begin in December, with the first report, containing December data, due in January. 4. The Plan will revise Authorization Aging report for day to day management and to report on timeframes for Standing Referrals. Update 01/14/2022: Revision of aging report complete 5. The Plan will conduct staff training on standard work for Standing Referrals. Update 01/14/2022: Staff training on standing referrals completed 11/16/2021 6. The Plan will monitor Standing Referral timeframes with the daily Authorization Aging report. 7. The Plan will report results quarterly to UMC. Update 09/09/2022: Standing referrals are now being tracked and reported on during UM Committee quarterly	High	3/25/2022	Completed	UM Case Management	Completed	State	DHCS	2021
19	Access	(3.6.1) The Plan improperly denied emergency services claims and family planning claims.	1.The Plan updated its monitoring report criteria to include a denial code (code:0630) which would allow us to identify claims prior to finalizing adjudication.	Low	3/26/2021	Completed	Claims IT (Config)		State	DHCS	2021
20	Access	(3.6.2) The Plan did not pay interest for family planning claims not completely reimbursed within 45 working days of receipt.	1. The Plan reviewed the issue thru Claims Processor & Specialist training to ensure staff understands the issue that resulted in no interest. The trainings were completed in May 2021.	Low	5/1/2021	Completed	Claims		State	DHCS	2021
21	Access	(3.8.1) The Plan did not ensure its transportation broker's NEMT providers were enrolled in the Medi-Cal program.	1. The Plan notified its transportation broker that remaining unenrolled NEMT providers need to complete PAVE application by 12/01/2021. Update 12/10/2021: The notification letter was sent to the transportation broker on 12/1/2021, 2. The Plan will audit transportation broker providers to ensure drivers are enrolled in the Medi-Cal program. This was last completed August 27, 2021. Monitoring will be conducted on an annual basis.	Low	12/31/2022	Completed	Vendor Management		State	DHCS	2021
22	Access	(3.8.2) The Plan did not require PCS forms for NEMT services.	1. The Plan will require transportation broker to provide ongoing reports on rates of obtaining PCS forms from providers: Update 11/12/2021: UM Team working with Vendor Management and the transportation broker to obtain needed reports. Update 12/10/2021: The report was received from transportation broker on 10/28/2021. 2. The Plan will analyze trends in provider practices on a quarterly basis. Update 12/10/2021: The first report will be given at UMC in January 2022. Update 2/11/2022: Awaiting reports from the transportation broker 3. The Plan will educate providers on PCS requirements and provide data on their performance: Update 2/11/2022: Awaiting reports from the transportation broker 3.a. Provider newsletter. Update 2/11/2022: Awaiting reports from the transportation broker 3.b. Individual office contacts 4. The Plan will finalize process workflow to obtain missing PCS forms. Update 11/12/2021: UM Team working with Vendor Management and the transportation broker to obtain needed reports. Update 12/10/2021: The workflow has been finalized based on the reports received from the transportation broker 5. The Plan will conduct staff trainings on process workflow. Update 12/10/2021: Training was completed 11/8/2021. 6. The Plan will provide a quarterly report to UMC. Update 01/14/2021: Reporting will begin at UMC in Q1 2022. Update 2/11/2022: Awaiting reports from the transportation broker Update 09/09/2022: NEMT services are now being tracked and reported quarterly at the UM Committee.	Medium	12/31/2022	Completed	Vendor Management UM		State	DHCS	2021
23	Member Rights	(4.1.1) The Plan did not ensure that the medical director fully resolved QOC grievances prior to sending resolution letters.	1. The Plan updated G&A-003 Grievance and Appeals Receipt, Review and Resolution to include the process for the medical director's review and resolution of all levels of quality of care grievances prior to sending a resolution letter to members. The policy will be reviewed at the Health Care Quality Committee on November 18, 2021 and the Compliance Committee Meeting on November 23, 2021. Update 12/10/2021: G&A-003 was approved at the Compliance Committee meeting on 11/23/2021 2. The Plan will provide training to the medical directors to review G&A-003 Grievance and Appeals Receipt, Review and Resolution by November 30, 2021. Update 3/11/2022: Training was completed 1/12/2022	Medium	1/12/2022	Completed	G&A		State	DHCS	2021
24	Member Rights	(4.1.2) The Plan did not consistently implement its procedure for processing grievances. The Plan considered member's grievances resolved and classified as exempt without conducting investigation.	1. The Plan is updating its policy and procedures for processing Exempt Grievances to reflect its current process. The policy MBR-0024 will be reviewed at the Compliance Committee Meeting on November 23, 2021. Update 12/10/2021: MBR-024 was approved at Compliance Committee on 11/23/2021 2. The Plan will provide staff training by November 30, 2021. Update 1/14/2022: Training was completed 11/19/2021	Low	11/30/2021	Completed	Member Services		State	DHCS	2021

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
35	Fraud, Waste, and Abuse (FWA)	6.3.1 The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10-working days.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to ensure timely reporting of incidents to DHCS. Staff training on updated procedures was conducted on 7/17/2018. The Plan updated its monitoring tracking log to monitor the reporting timeframe requirement.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
36	Fraud, Waste, and Abuse (FWA)	6.3.2 The Plan did not conduct prompt and complete investigations of all suspected fraud and abuse incidents.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to investigate all suspected incidents and update DHCS until the case closure. Standardized investigation form for documentation was implemented as of 7/17/2018. Staff training on updated procedures was conducted on 7/17/2018.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
37	State Supportive Services	SSS.1 The Plan denied state supported services (SSS) claims containing procedures that normally require prior authorization outside of a SSS setting. These claims were denied based on edits in the Plan's claims system and review by claims analysts; the Plan's process did not include exceptions for FP or ER services.	The Plan updated its system configuration to ensure SSS claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
38	State Supportive Services	SSS.2 The Plan did not disclose the specific rationale used in determining why claims are rejected.	The Plan's Remittance Advice (RA) includes the specific rationale for claims denials. Denial codes can be applied at the Header level, line level or both. The Plan's claims processing system edits each claims and assigns all denial or informational codes that are applicable to the claim. Update as of 1/31/2019: The Plan will provide training to providers to ensure comprehension concerning the remittance advice set-up. Update as of 3/6/19: The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by 5/31/2019. Update 4/8/2019: The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
1	Prior Authorizations	Authorizations were auto-approved for hospital.	Effective 9/17/2018, the Plan started to review and impose standard UM authorization guidelines for hospital authorizations.	9/17/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
2	Appeal	The Plan's expedited appeals checklist does not include a reminder to call the member when the case is de-escalated from urgent to routine.	The expedited appeals checklist has been updated. Staff training will be conducted by 10/1/2018. Checklist includes requirements of De-expedited: Decision to de-expedite must be made within 24 hours. Send ack letter within 3 calendar days notifying of priority change and right to contact DMHC. Follow standard appeal process. If 24 hour TAT is not met, proceed with expedited appeal.	10/1/2018	Completed	Grievance & Appeals	✓	Self Identified	AAH	2018	Completed
3	Delegation Oversight	Some authorization cases included many errors with subcontractor's notices of actions. Plan oversight of authorizations and notices is in process.	Reestablished bi weekly meetings with subcontractors and conducted monthly focused file audit which included NOAs, conducted clinical case rounds for overturned appeals. The plan will continue to monitor during annual audit review process. The Plan will be terminating services subcontractor and consuming this function to review authorization effective 4/1/2019.	12/1/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
4	Care Coordination	The Plan did not annually review the County MOU for CCS services.	Update 9/27/2019: MOUs have transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including CCS. Update as of 12/2/2019: The MOUs have been transitioned to the Provider Services team. The MOU was executed with an effective date of 8/1/2019	8/1/2019	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
5	Care Coordination	The Plan did not annually review the County MOU for Early intervention/development disabilities.	Update 9/27/2019: MOUs have been transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including EI/DD services. Update as of 12/2/2019: The Plan is currently working on developing a full county MOU to include services for early intervention and development disabilities services Update 7/10/2020: The MOU was sent to the County for review on6/16/2020. Update 10/9/2020: The County has accepted the Alliance's edits and the MOU is currently under review for final approval with the County.Update 11/10/2020: The County has cancelled the November 3rd meeting. This agenda item will be carried over to the December 15th docket.**Update 5/14/2021**: The MOU was approved by the county board on 4/6/2021.	~~2/28/20~~ TBD	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
6	Initial Health Assessment (IHA)	The Plan did not have a process for validating the procedure codes used for IHA completion.	P&P will be updated to include the detail of the process for annual validation and codes. The validated for this year will occur prior to 11/1/2018. Update 11/6/2018: Codes were validated and updated by QM department.	11/1/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
7	Initial Health Assessment (IHA)	The Plan does not have a system in place for monitoring member's missed appointments.	Missed appointments are identified during the Medical Record Review that is part of a FSR. The criteria for missed primary care appointments and outreach efforts, which is part of DHCS's tool. The FSR review nurse evaluates this information and if a deficiency is identified the provider is educated on the importance of outreaching to the member and that documentation of the outreach attempts is required.	11/26/2019	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
8	Access & Availability	The Plan did not monitor appointment wait times.	Policy and procedure is in place for monitoring appointment wait time standards. Standardized process for monitoring and corrective action plan in place as of 9/20/2018.	9/20/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
9	Grievances	Some exempt grievance cases were not resolved within the next business day timeframe (applied to 1 3 cases).	Policies and procedures in place are compliant with the exempt grievance resolution timeframe requirements. Staff training refresher of resolving all exempt grievances by close of next business day was conducted on 10/12/2018.	10/12/2018	Completed	Member Services	✓	Self Identified	AAH	2018	Completed

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

ALAMEDA Alliance FOR HEALTH

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

Health Care Services

Donna Carey, MD

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

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

Date: **February 14th, 2025**

Subject: **Health Care Services Report**

Utilization Management (UM)

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

- Authorization Turn-Around Times (goal = 95%)
    - Inpatient/outpatient: overall 98%, above goal
    - LTC: overall 99%, above goal
    - BH: overall 82%, below goal

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

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

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

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

- There was not a significant change in total authorization volume from December 2024 to January 2025.

Total Authorization Volume (Medical Services)			
Authorization Type	**November 2024**	**December 2024**	**January 2025**
Inpatient	2,755	3,346	3,081
Outpatient	4,090	4,310	4,532
Long-Term Care	691	918	917
Total	**7,536**	**8,574**	**8,530**

***Source**: #02569_AuthTAT_Summary*

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

Utilization Management: Outpatient

- Anthem-transition authorization activity 1 yr. Post CoC is running between 7-10% of active authorizations daily.

- Foster care CoC cases are averaging 3-5/day. We are reviewing pended claims each week to identify CoC services and ensure there are no delays in the care for this population. With each case, we are reviewing for any potential care coordination or case management needs and referring to CM as needed.

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

- OP processed a total of 4,532 authorizations in the month of January.

- OP Turnaround times continue to exceed the benchmark of 95% with the average being 100% in the month of January.

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

Total Outpatient Authorization Volume			
Authorization Status	**November 2024**	**December 2024**	**January 2025**
Approvals	3,885	4,088	4,351
Partial Approvals	27	28	20
Denials	178	194	161
Total	**4,090**	**4,310**	**4,532**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**November 2024**	**December 2024**	**January 2025**
Overall Denial Rate	**3.9%**	**3.8%**	**3.5%**
Denial Rate Excluding Partial Denials	**3.6%**	**3.5%**	**3.1%**
Partial Denial Rate	**0.4%**	**0.3%**	**0.4%**

***Source**: #03690_Executive_Dashboard*

Outpatient Turn Around Time Compliance			
Line of Business	**November 2024**	**December 2024**	**January 2025**
Overall	100%	99%	100%
Medi-Cal	100%	99%	100%
IHSS	100%	100%	100%
Benchmark	*95%*	*95%*	*95%*

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- Total inpatient auth volume decreased from 3,346 authorizations processed in December to 3,081 in the month of January.

- Inpatient overall average LOS was 5.6 in October and November rising slightly to 5.7 in December. Admits per thousand 54.1 in October 53.0 in November, up to 56.7 in December. Days per thousand aligned with admits per 1,000 with a decrease from October 304.8 to to 297.3 in November and back up to 321.6 in December. The trend is consistent among Child, Adult, ACA and SPD categories.

- IP overall denial rate was 2.8% in October, 2.4% in November and 2.7% in December.

- IP Auth TAT compliance continues to surpass 95% benchmark, with overall TAT of 97% in November and 96% in December and January.

- IP UM continues weekly hospital rounds with tertiary care centers UCSF and Stanford, as well as contracted hospital providers; Alameda Health System, Sutter, Kindred LTACH, Kentfield LTACH, Washington, and Summit, to review members' current active admissions discuss UM issues, address discharge barriers, offer other opportunities for supporting throughput and appropriate discharge.

- Kaiser interdisciplinary rounds began in January, with the goal of supporting AAH members at Kaiser facilities who have complex discharge needs and high ER utilization.

Total Inpatient Authorization Volume			
Authorization Status	**November 2024**	**December 2024**	**January 2025**
Approvals	2,717	3,281	3,040
Partial Approvals	0	0	0
Denials	38	65	41
Total	**2,755**	**3,346**	**3,081**

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**October 2024**	**November 2024**	**December 2024***
Authorized LOS	**5.6**	**5.6**	**5.7**
Admits/1,000	**54.1**	**53.0**	**56.7**
Days/1,000	**304.8**	**297.3**	**321.6**

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

Inpatient Authorization Denial Rates			
Denial Rate Type	**November 2024**	**November 2024**	**December 2024**
Full Denials Rate	**1.2%**	**1.0%**	**0.9%**
Partial Denials	**1.5%**	**2.0%**	**1.4%**
All Types of Denials Rate	**2.7%**	**3.0%**	**2.3%**

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance			
Line of Business	**November 2024**	**December 2024**	**January 2025**
Overall	**97%**	**96%**	**96%**
Medi-Cal	**97%**	**95%**	**96%**
IHSS	**96%**	**97%**	**100%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during January 2024 was 2,275 members. This is a decrease of 5.44% from December 2024.

- Month to Month, the admissions, days and readmissions are decreasing. From October to December the admissions decreased by 51.09%, the days decreased by 64.64% and the readmissions also decreased by 34.62%. Some of this could be due to a lag in claims data being available, but we are seeing a decrease overall.

Totals	October 2024	November 2024	December 2024*
Admissions	137	109	67
Days	1,018	828	360
Readmissions	26	36	17

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

- LTC Staff continue to participate in SNF collaboratives around the county to ensure that our facility partners are updated with the processes and program enhancements.

- Having virtual rounds with AHS and Eden LTC facilities to coordinate on complex cases

- 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.

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

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

- Authorization volume increased in January, compared to October 2024 and about the same compared to December.

- Authorization processing turn-around time (TAT) increased to 99% in January 2025 and is now meeting the threshold of 95%. We currently have a temporary nurse working to assist with the volume and are interviewing for a regular LTC Nurse position.

Total LTC Authorization Volume			
Authorization Status	**November 2024**	**December 2024**	**January 2025**
Approvals	647	863	881
Partial Approvals	0	0	0
Denials	44	36	36
Total	**691**	**918**	**917**

Source: #02569_AuthTAT_Summary

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

LTC Turn Around Time Compliance			
Line of Business	**November 2024**	**December 2024**	**January 2025**
Medi-Cal	**92%**	**94%**	**99%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Behavioral Health

- In December, Behavioral Health processed 636 authorizations, 366 Care Coordination referrals, and 203 Mental Health Screenings.

- In January, The Behavioral Health Department processed 691 authorizations, 407 Care Coordination referrals, and 234 Mental Health Screenings.

Total BH Authorization Volume			
	24-Nov	**24-Dec**	**25-Jan**
Approvals	474	634	685
Partial Approval	0	0	0
Denials	1	2	6
Total	475	636	691

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
**Goal ≥95%*	**24-Nov**	**24-Dec**	**25-Jan**
Determination TAT%	95%	98%	75%
Notification TAT%	97%	97%	99%

Source: 14939_BH_AuthTAT

- January 2025 TAT does not meet goals. The department received 80 authorizations during the holiday week. These authorizations did not properly upload for review due to a systems issue. The issue has been identified, ameliorated, and updated training has been provided to staff.

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
**Goal ≥95%*	**24-Nov**	**24-Dec**	**25-Jan**
Determination TAT%	98%	100%	99%
Notification TAT%	100%	96%	100%

Source: 14939_BH_AuthTAT

Behavioral Health Denial Rates

**Goal ≤ 5%*	BH Denial Rates	
24-Nov	**24-Dec**	**25-Jan**
0.01%	0.01%	0.01%

Source: 14939_BH_AuthTAT

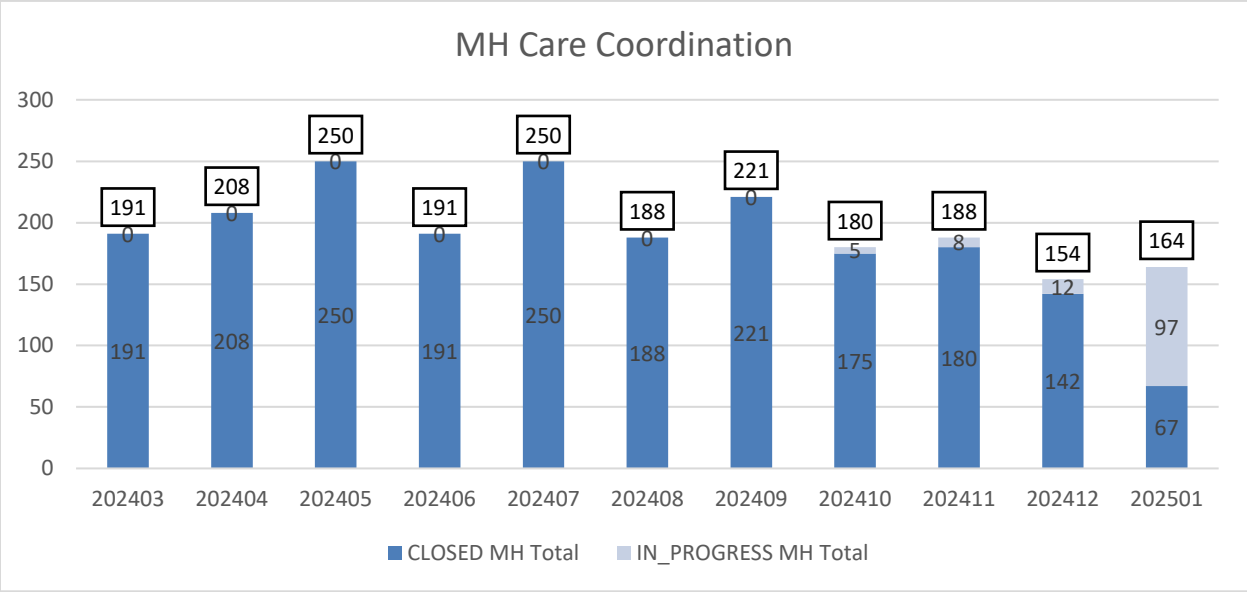
Mental Health Care Coordination

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

Total # Medi-Cal Screening Tools			
	24-Nov	24-Dec	25-Jan
Youth Screenings	60	69	77
Adults Screenings	124	134	157

Source: PBI_14460 – MLS BH TruCare Assessments

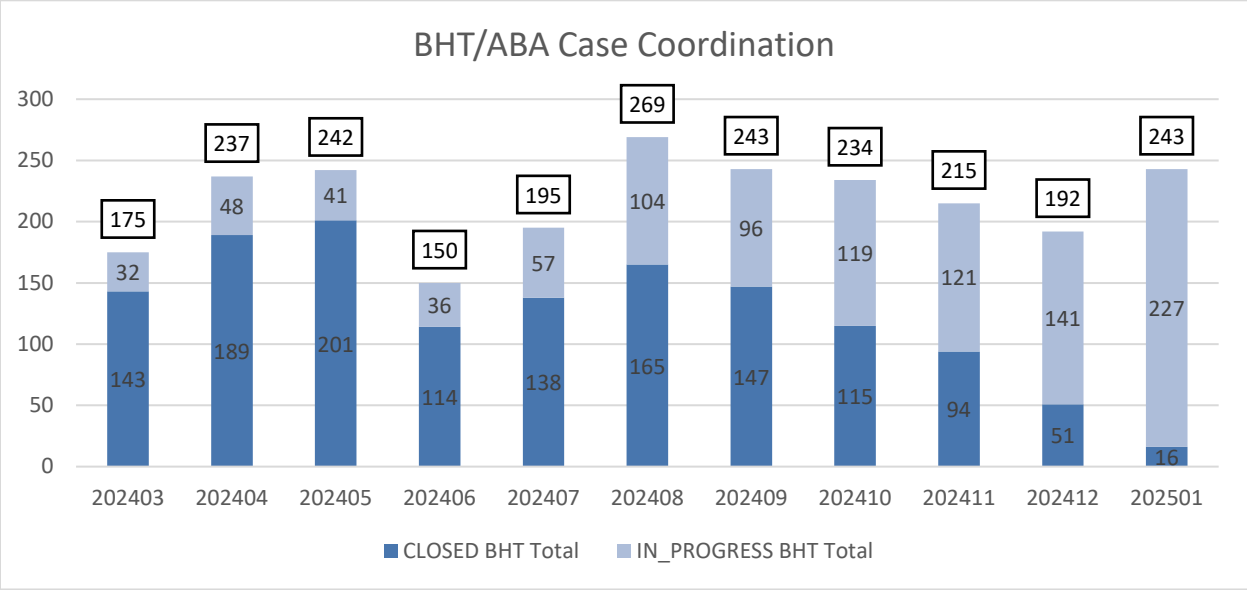
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA)

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

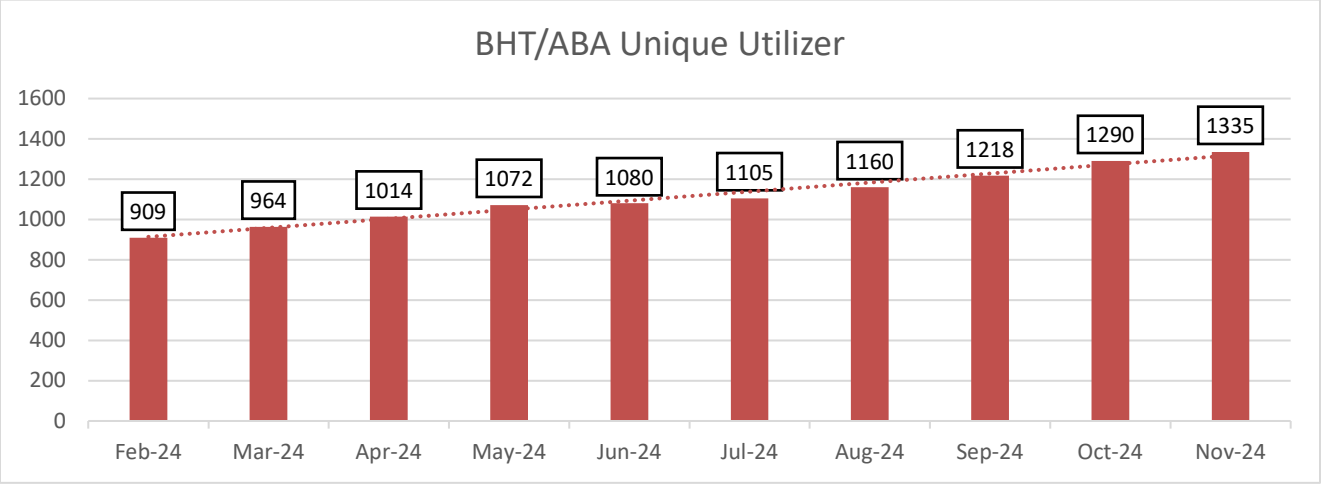


Source: 14665_BH_Cases

Behavioral Health Unique Utilizers

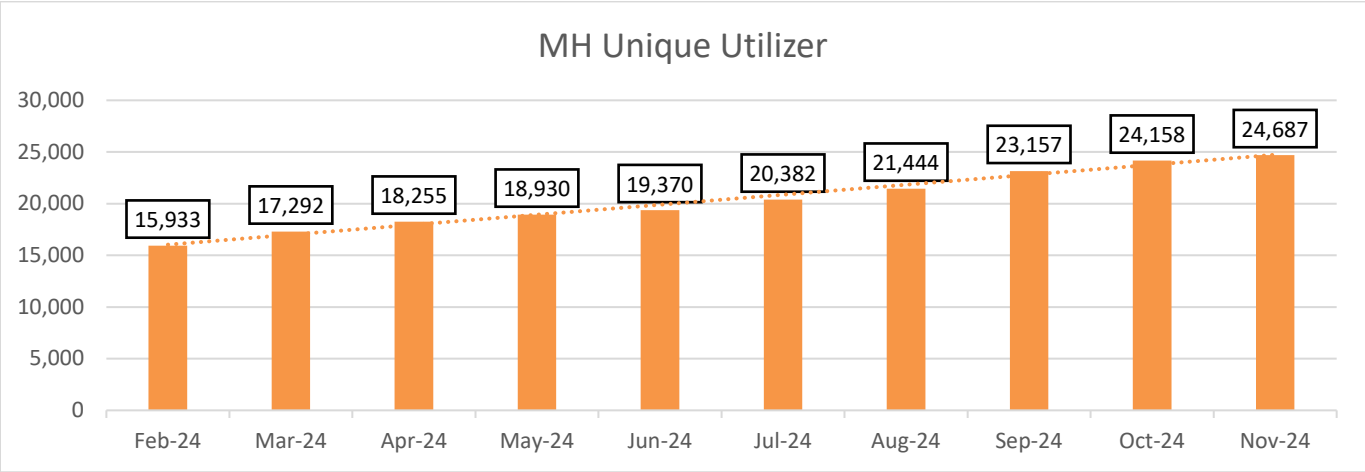
- Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.

- We observed a continuing rise in unique utilizers of BHT/ABA services, reflecting a 3% increase compared to the previous month.



Source: PBI 14621 BHT Utilization Report

- The number of unique utilizers of mental health services has increased by 2% compared to the previous month.



Source: PBI 14637 BH12M Report

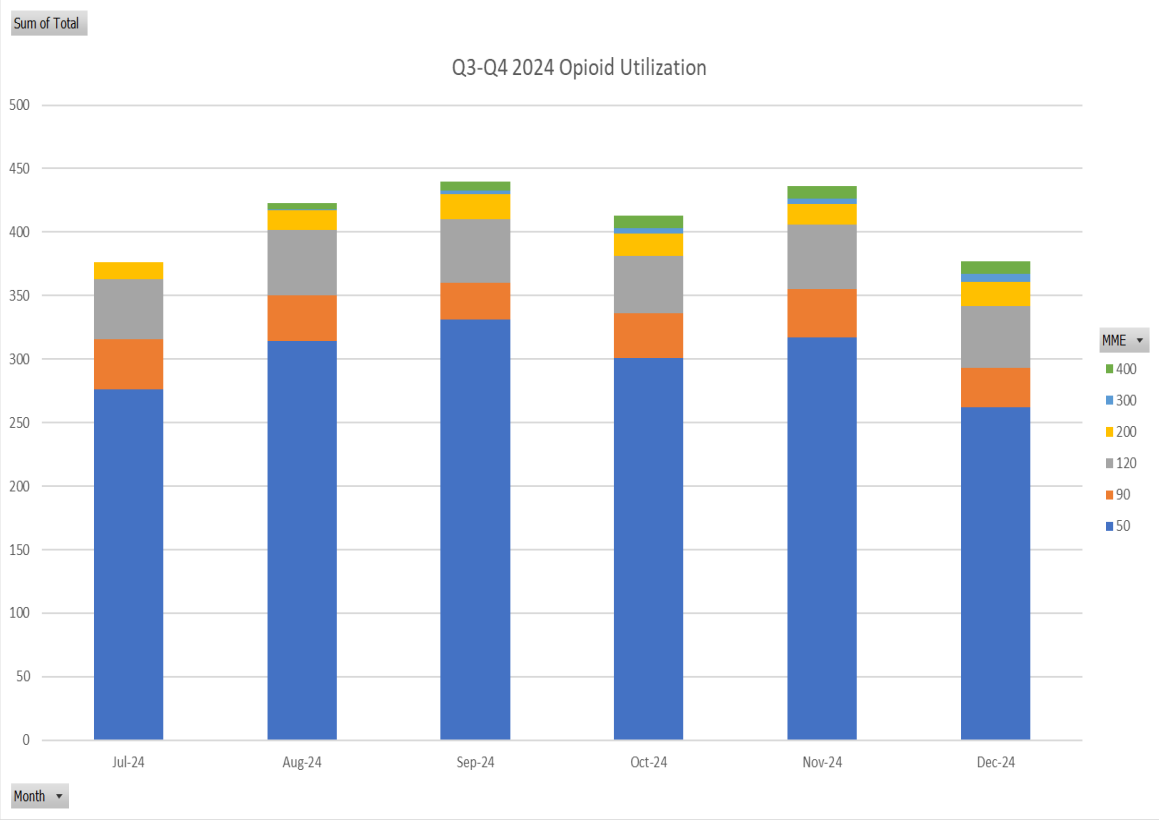
Pharmacy

- Pharmacy is collaborating with population health, QI, and disease management on creating clinical programs for HEDIS measures for high blood pressure, asthma, and diabetes.

- Pharmacy and QI did an educational webinar with PCPs at Roots Community Health Center on clinical information on hypertension, diabetes and asthma to help improve HEDIS measures. There were 11 PCPs who attended. The team worked with C&O to create educational handouts to send to providers. The clinic receives monthly reports with a list of identified members with potential gaps in care.

- 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 dependance, 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). Less than 200 MME has slightly decreased from October to December. At least 200 MME or higher remained around the same.



MME	IHSS	MCAL	Total
October			**413**
50	18	283	301
90	3	32	35
120	3	42	45
200	1	17	18
300	1	3	4
400	1	9	10
November			**436**
50	17	300	317
90	2	36	38
120	5	46	51
200	1	15	16
300		4	4
400		10	10
December			**377**
50	13	249	262
90	4	27	31
120	3	46	49
200	2	17	19
300	1	5	6
400		10	10

Case and Disease Management

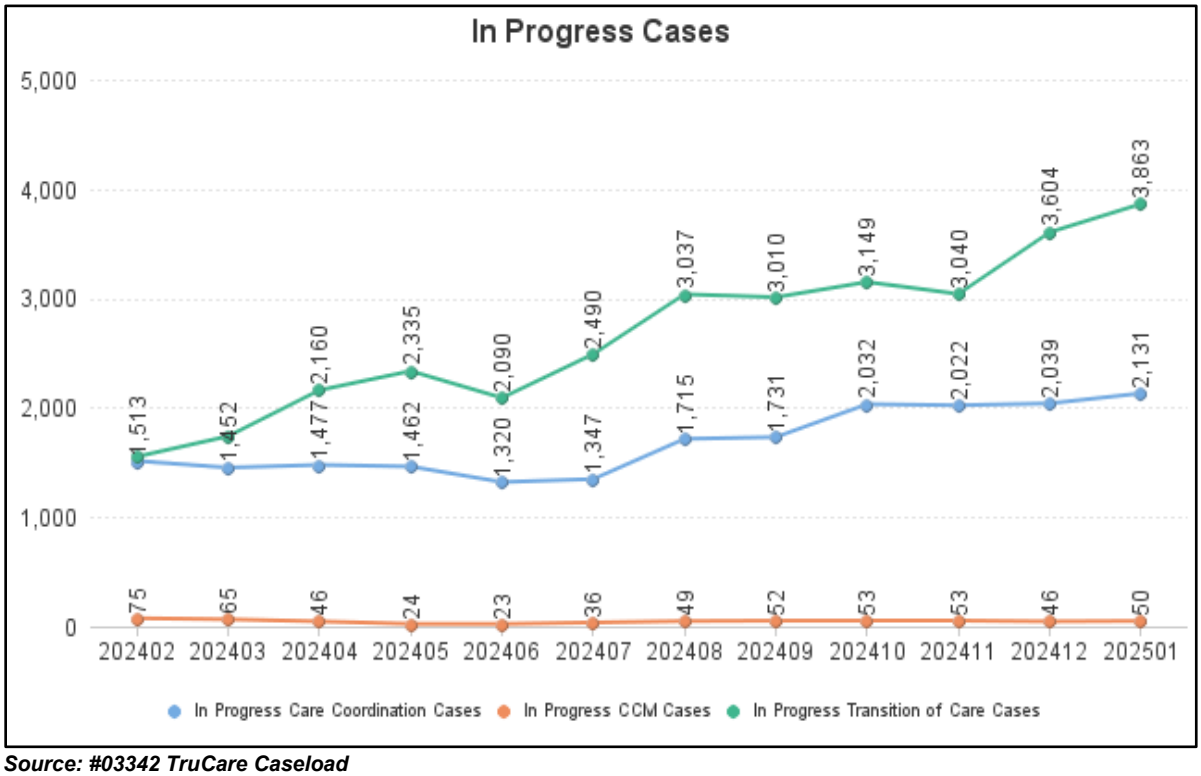
- The CM Team is assisting with coordination of continuity of care for the incoming foster youth population.

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

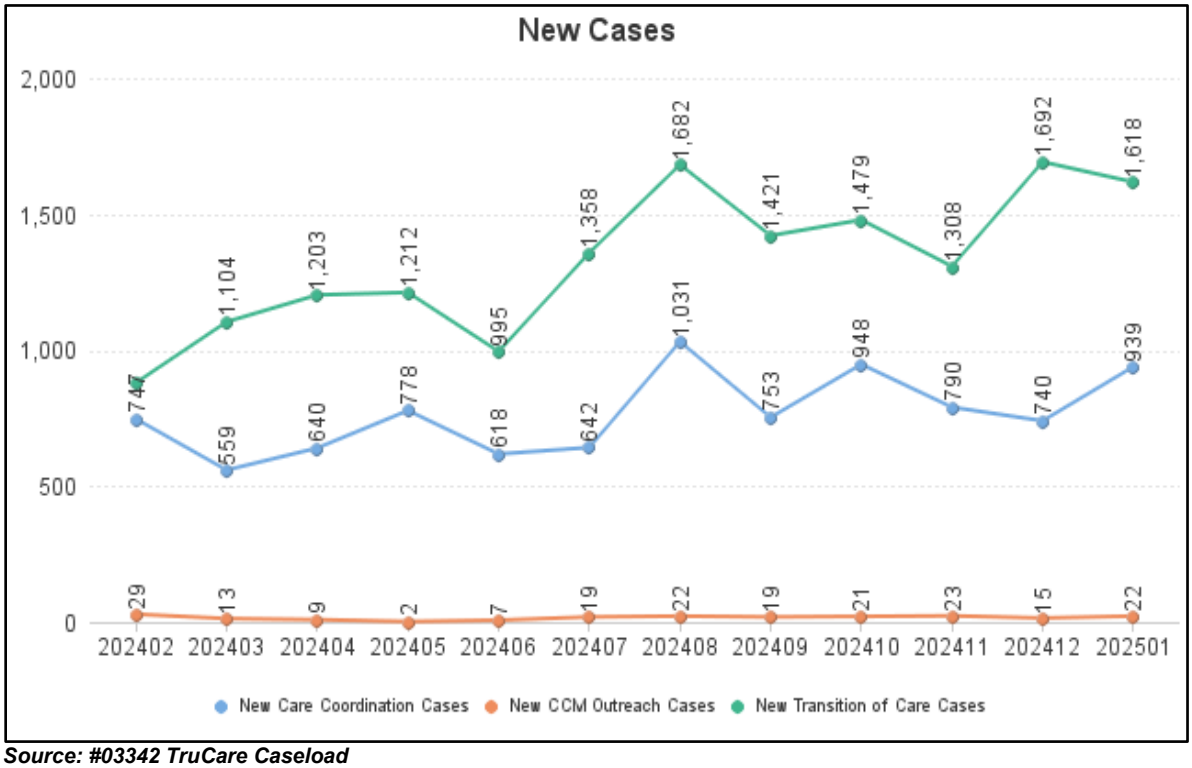
- The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including but not limited to scheduling and ensuring follow-up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners,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

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

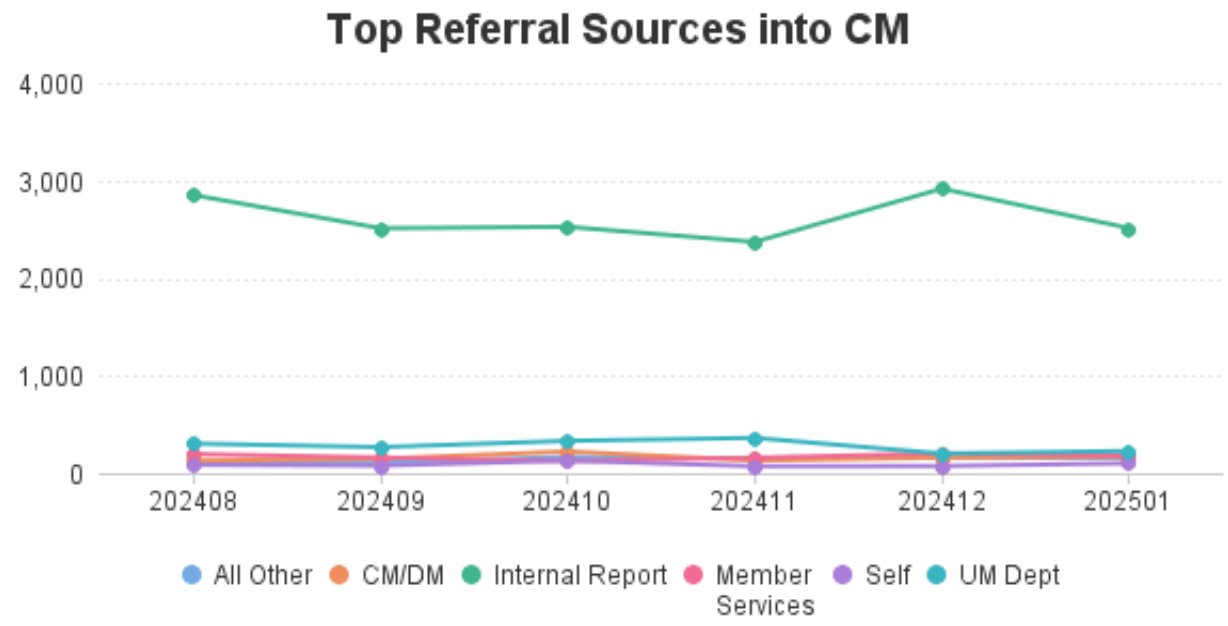
- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues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



Source: #03342 TruCare Caseload



Source: #03342 TruCare Caseload



Source: #03881 Case and Disease Management Dashboard - *data only available through September 2024

CalAIM

Enhanced Case Management

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

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

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

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

- As a result of this fall's audit of ECM providers, the ECM team has developed training for the ECM providers to re-educate the ECM provider network on the core services DHCS is requiring for ECM. The ECM team will conduct monthly training session for all ECM providers' frontline staff to reinforce ECM requirements and expectations. The first training session was held on Friday, 2/7/25. There was a great turnout with a very engaged audience.

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

- ECM staff, including the Foster Care/Child Welfare Liaison continue to participate in DHCS Foster Care Youth Transition Stakeholder meetings, work with county foster programs and staff as the mandatory transition of Foster Care Youth went live on 1/1/2025. In addition to collaborating with county entities and external child welfare partners, the ECM team is working with DHCS data to determine courses of action related to coordination of care for new members from the child welfare/foster care youth transition.

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

- ECM referral standards and ECM presumptive authorization process went live 1/1/2025. The ECM team educated providers/CBOs/public about these changes through the monthly ECM/CS Collaborative and additional educational webinars. During these educational meetings, providers were trained on the new ECM referral form and presumptive authorization process.

	October 2024		November 2024		December 2024	
ECM Providers	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**
ACBH	-	14	-	14	-	14
Alameda Health System (AHS)	16	191	13	197	-	186
Bay Area Community Services (BACS)	6	118	-	122	-	122
California Cardiovascular Consultants	-	170	-	170	-	168
California Children's Services (CCS)	16	21	11	23	-	18
CHCN	66	928	83	968	-	926
East Bay Innovations (EBI)	2	111	2	114	-	114
Full Circle	68	215	-	191	-	182
Institute on Aging	333	202	-	201	-	202
La Familia	36	33	-	32	-	31
MedZed	41	537	49	541	-	503
Roots Community Health Center	12	203	1	212	1=-	220
Seneca Family Services	56	45	41	55	-	55
Pair Team	372	554	456	616	-	590
Titanium Health Care	420	491	790	497	-	480
Tiburcio Vasquez Health Center (Street Medicine)	-	88	-	96	-	96
BACH (Street Medicine)	-	71	-	73	-	75
Lifelong (Street Medicine)	8	219	4	218	-	234
Roots Community Health Center (Street Medicine)	Combined with Roots 'traditional' ECM program					

***Source**: #13360 ECM Dashboard*

Community Supports (CS)

- The team implemented new authorization criteria and Utilization Management processes effective 12/1/2024. The changes were needed to ensure full compliance with regulatory and contractual expectations. We continue to meet with CS providers to address questions about the new processes and support this change.
- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance offers the following community supports:
    - Housing Navigation
    - Housing Deposits
    - Tenancy Sustaining Services
    - Medical Respite
    - Medically Tailored/Supportive Meals
    - Asthma Remediation
    - (Caregiver) Respite Services
    - Personal Care & Homemaker Services
    - Environmental Accessibility Adaptations (Home Modifications)
    - Nursing Facility Transition/Diversion to Assisted Living Facilities
    - Community Transition Services/Nursing Facility Transition to a Home
- Further CS service & network expansion is paused; potential providers have been notified.
- AAH CS staff continue to meet with CS providers to work through logistical issues as they arise, including referral management, claims payment and member throughput.
- DHCS outlined new closed loop referral requirements and moved the closed loop referral target date to 07/01/25. AAH is working on requirements to comply with the new DHCS requirements.
- Housing-related community support has transitioned to the Operations team effective 10/01/24. The Health Care Services and Operations teams coordinate to ensure communication and process alignment, where possible.

Community Supports	Services Authorized in October 2024	Services Authorized in November 2024	Services Authorized in December 2024
Housing Navigation	1,006	904	903
Housing Deposits	259	233	219
Housing Tenancy	1,066	1,008	1,002
Asthma Remediation	93	100	101
Meals	1,657	1,505	1,412
Medical Respite	127	111	87
Transition to Home	22	22	23
Nursing Facility	28	30	26
Home Modifications	1	0	0
Homemaker Services	113	96	79
Caregiver Respite	8	5	5
Total	**4,380**	**4,014**	**3,857**

***Source**: #13581 Community Support Auths Dashboard*

Grievances & Appeals

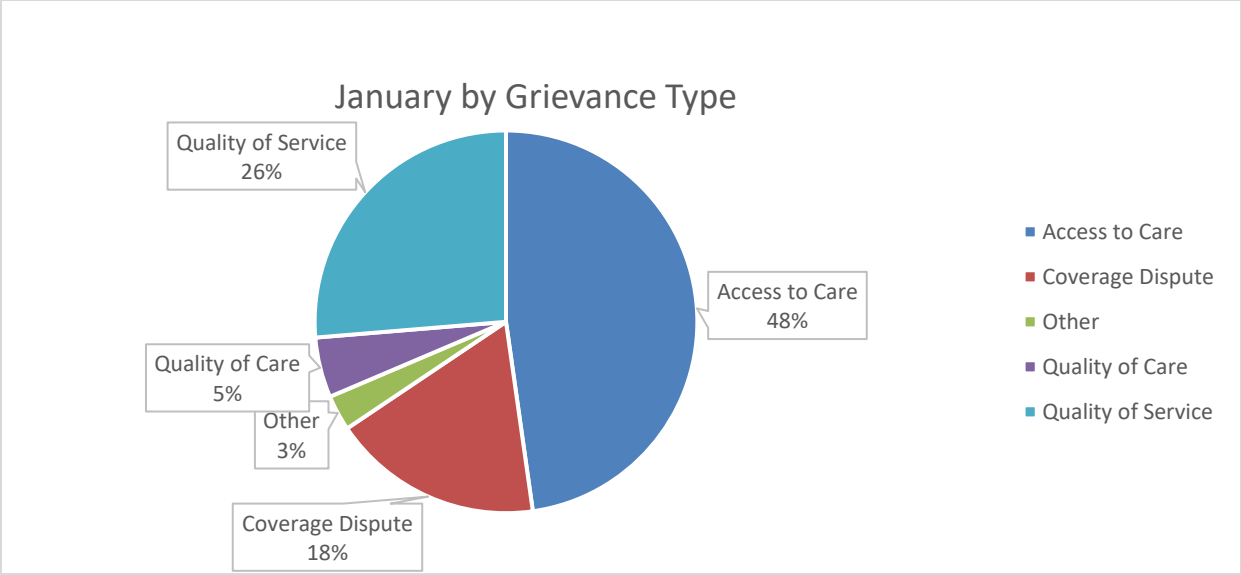
- All cases were resolved within the goal of 95% of regulatory timeframes.
- Grievances cases were resolved within the goal of 95% of regulatory timeframes.
- Appeal cases were not resolved within the 95% of regulatory timeframes.
- Total Unique grievances resolved in January were 7.13 complaints per 1,000 members.

January 2025 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,827	30 Calendar Days	95% compliance within standard	1,771	96.90%	3.52
Expedited Grievance	1	72 Hours	95% compliance within standard	1	100.00%	0.00
Exempt Grievance	1,715	Next Business Day	95% compliance within standard	1,715	100.00%	3.61
Standard Appeal	50	30 Calendar Days	95% compliance within standard	47	94.00%	0.12
Expedited Appeal	1	72 Hours	95% compliance within standard	1	100.00%	0.00
Total Cases:	3,594		95% compliance within standard	3,535	98.30%	7.13

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

Standard Grievances:

- There were 1,548 unique grievance cases resolved during the reporting period, with a total of 1,828 grievances including all 280 shadow cases.



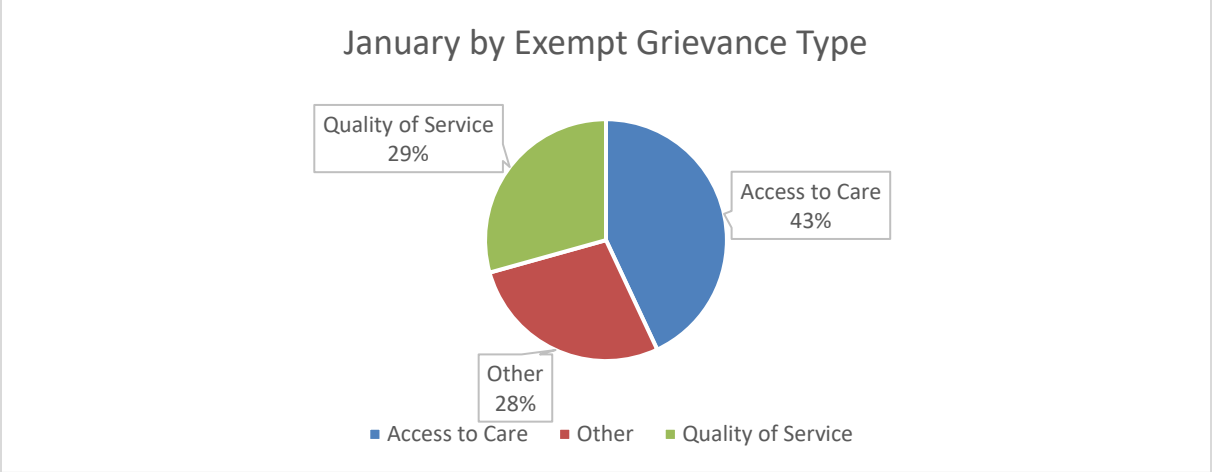
- **873** of 1,828 (48%) cases were related to Access to Care, the top 4 grievance categories are:
  - (319) Timely Access
  - (168) Technology/Telephone
  - (153) Authorization
  - (153) Provider Availability

- **481** of 1,828 (61%) cases were related to Quality of Service, the top 3 categories are:
  - (141) Plan Customer Service
  - (82) Provider/Staff Attitude
  - (74) Transportation

- **326** of 1,828 (18%) cases were related to Coverage Dispute, the top 3 grievance categories are:
  - (157) Provider Direct Member Billing
  - (94) Provider Balance Billing
  - (43) Reimbursement

Exempt Grievances:

- There were 1,492 unique exempt grievance cases resolved during the reporting period, with a total of 1,715 exempt grievances including all 233 shadow cases.



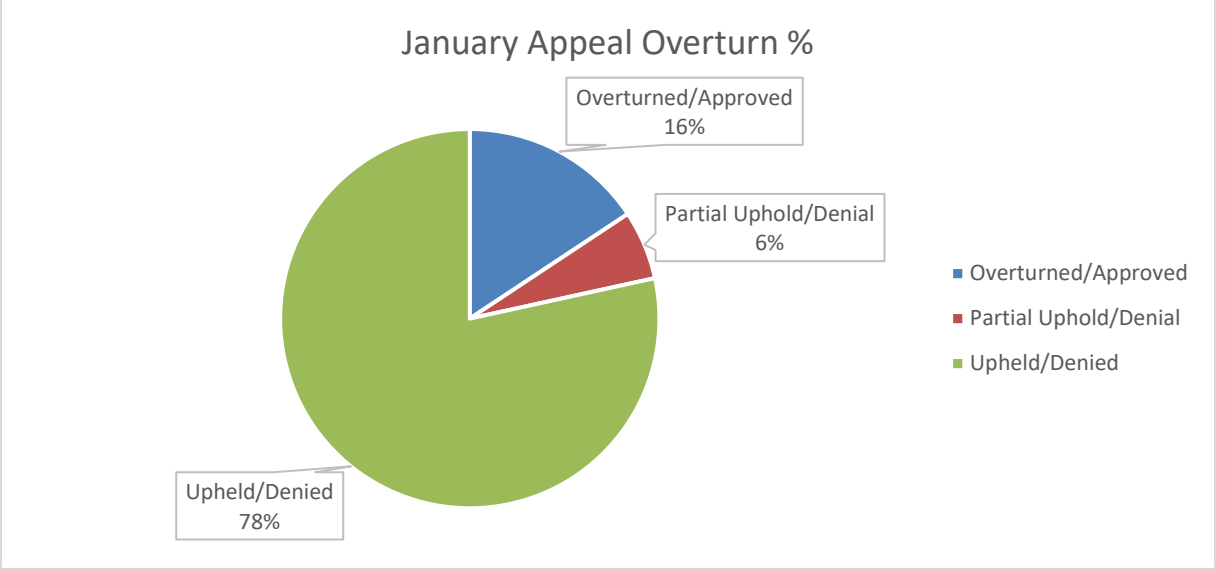
- 738 of 1,715 (43%) cases were related to Access to Care, the top 3 categories were:
  - (425) Telephone/Technology
  - (169) Provider Availability
  - (70) Geographic Access

- 503 of 1,715 (29%) cases were related to Quality of Service, the top 2 categories were:
  - (255) Plan Customer Service
  - (210) Provider/Staff Attitude

- 474 of 1,715 (28%) cases were related to Other, the 2 categories were:
  - (426) Enrollment
  - (48) Eligibility

Appeals:

- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of January 2025, we met our goal with a 16% overturn rate.



- **8** out of 51 (16%) cases were overturned for the month of January 2025:
  - (2) Out of Network (no INN)
  - (6) Disputes Involving Medical Necessity

Quality

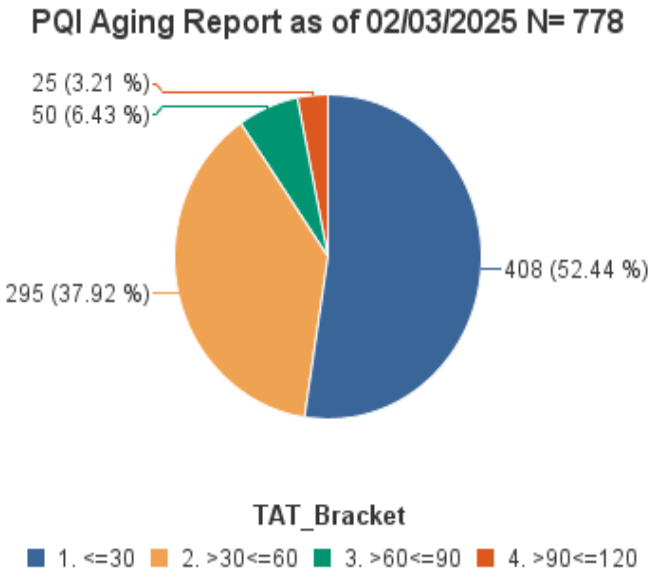
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQI cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

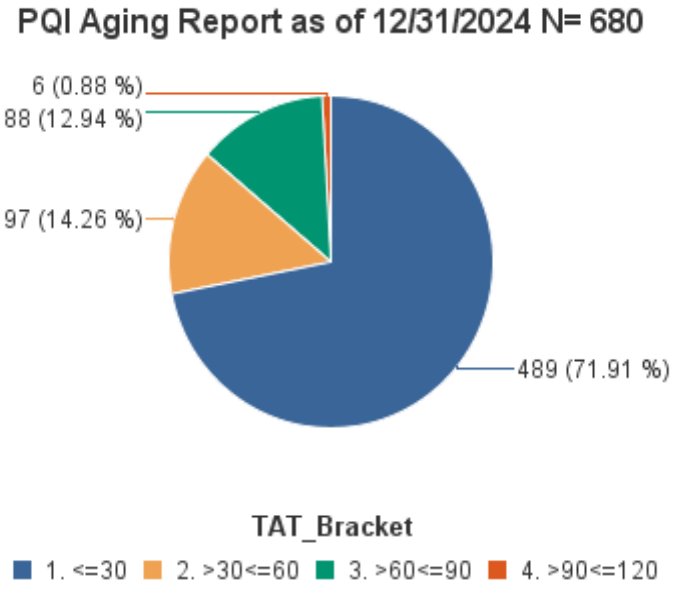
- Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics Services team after they are triaged by the QI Clinical team. Quality of Care and Service issues are reviewed by the QI RN Reviewers. Final leveling for Quality-of-Care cases is determined by the Sr Medical Director of Quality after RN review is completed. Weekly meetings are scheduled for the purpose of Quality-of-Care case review with the Sr Medical Director.

- All cases for this lookback of December 2024 and January 2025 were closed within the 120-day TAT. Therefore, turnaround times for case review and closure remain well within the benchmark of 95% per PQI P&P QI-104 for this lookback period.

- When cases are open for >120 days, the reason continues to be primarily due to delay in receipt of medical records and/or provider responses. As part of the escalation process of obtaining medical records and/or responses, efforts are made to identify barriers with specific providers to find ways to better collaborate to achieve resolution.

- The total number of PQIs including all categories increased by 98 referrals from December 2024 to January 2025. TATs are closely monitored on a weekly basis to ensure timely closure of cases within the standard 95%.

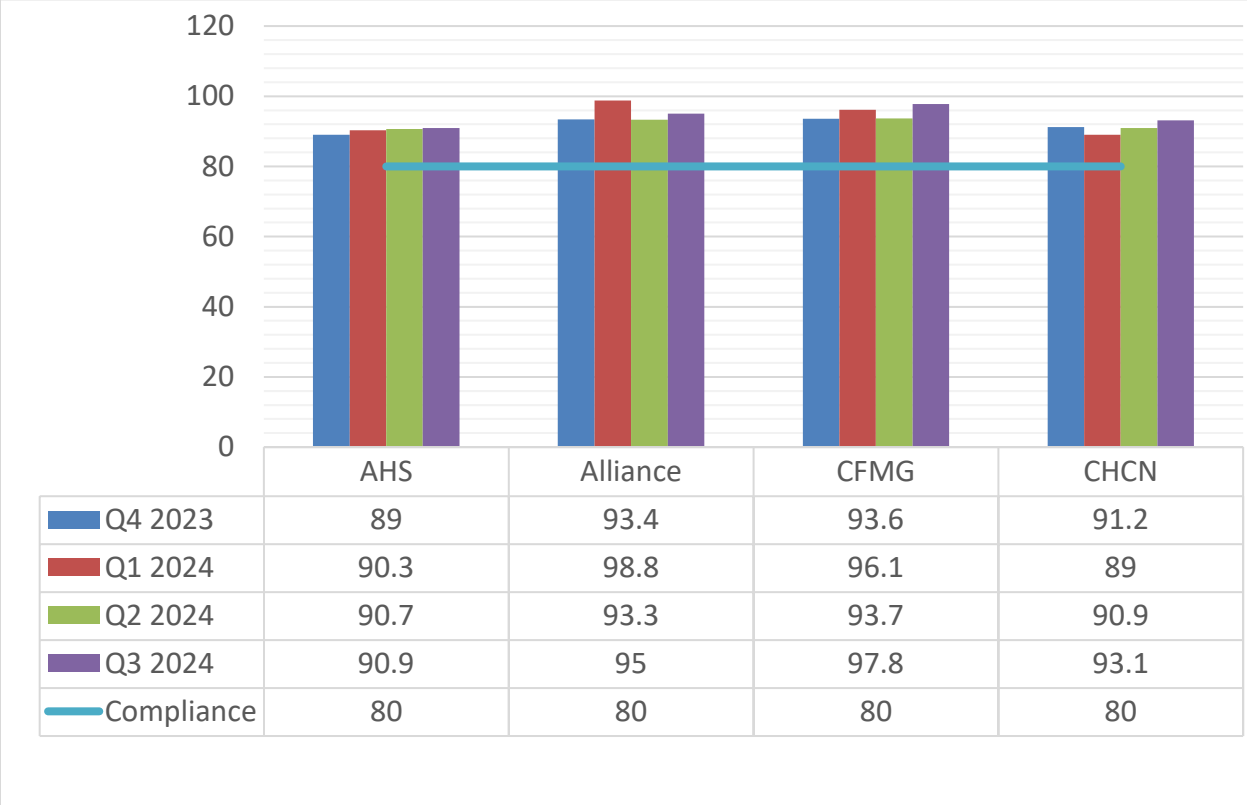




CG-CAHPS Survey

Survey Objective: The Clinician and Group Consumer Assessment Provider and Systems (CG-CAHPS) measures member experience with health care providers and staff, as well as with in-office wait time, provider time to answer calls during business hours, and provider call return time during business hours.

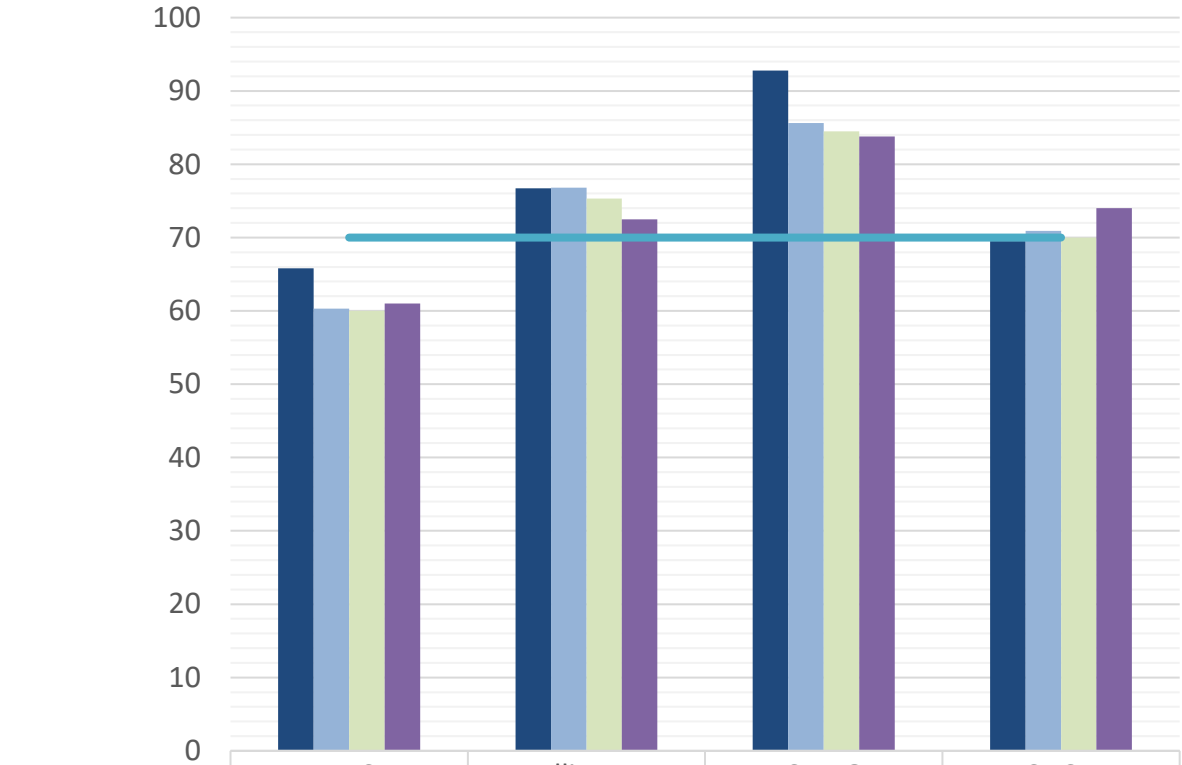
PCP In-Office Wait Time Compliance Rate by Network (%)



	AHS	Alliance	CFMG	CHCN
Q4 2023	89	93.4	93.6	91.2
Q1 2024	90.3	98.8	96.1	89
Q2 2024	90.7	93.3	93.7	90.9
Q3 2024	90.9	95	97.8	93.1
Compliance	80	80	80	80

- Office wait time includes both times spent in the waiting room and the exam room before seen by the doctor:
    - Compliance rate: Less than 60 minutes
- All delegate providers continue to score above the 80% compliance threshold from Q4 2023 to Q3 2024.

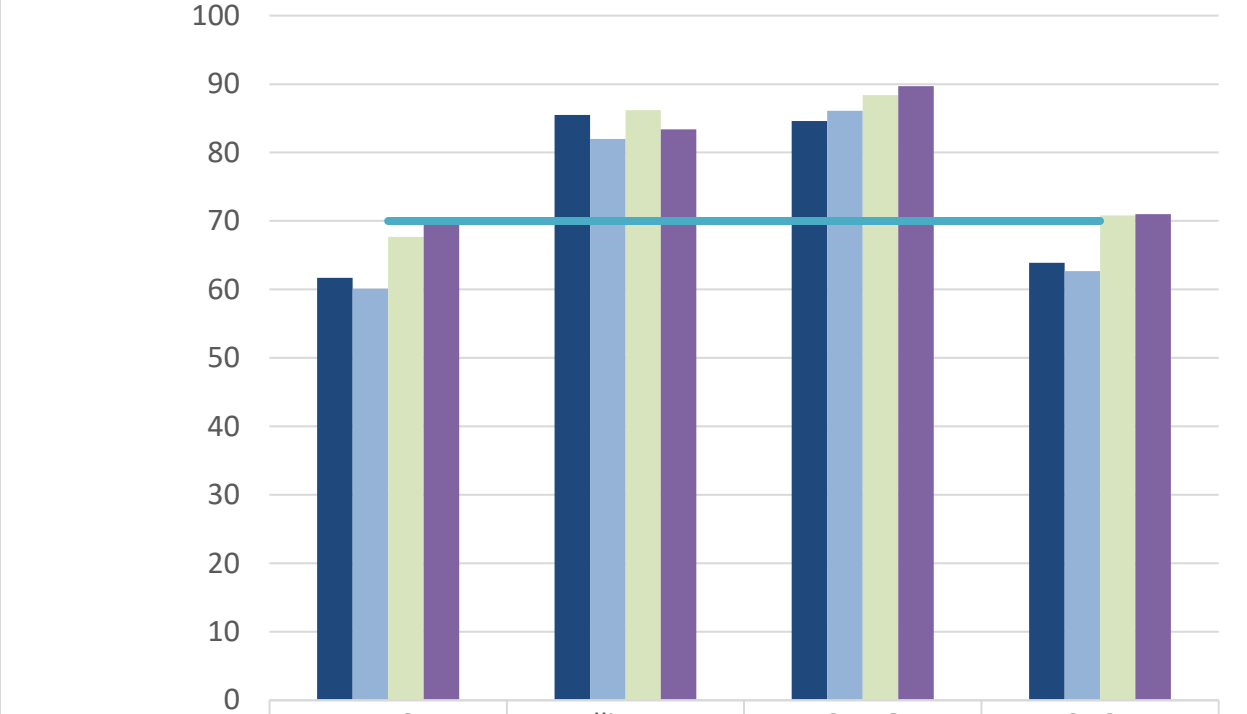
PCP Call Return Time Compliance Rate by Network (%)



	AHS	Alliance	CFMG	CHCN
Q4 2023	65.8	76.7	92.8	69.5
Q1 2024	60.3	76.8	85.6	70.9
Q2 2024	60	75.3	84.5	70
Q3 2024	61	72.5	83.8	74
Compliance	70	70	70	70

- Call return time – when a member called provider's office during regular office hour, when did a member get a call back:
    - Compliance rate: Within 1 business day
- Only AHS continues to not meet the threshold goal. All other network providers met the 70% threshold goal from Q4 2023 to Q3 2024.

PCP Time To Answer Call Compliance Rate by Network (%)



	AHS	Alliance	CFMG	CHCN
Q4 2023	61.7	85.5	84.6	63.9
Q1 2024	60.1	82	86.1	62.7
Q2 2024	67.7	86.2	88.4	70.8
Q3 2024	70.4	83.4	89.7	71
Compliance	70	70	70	70

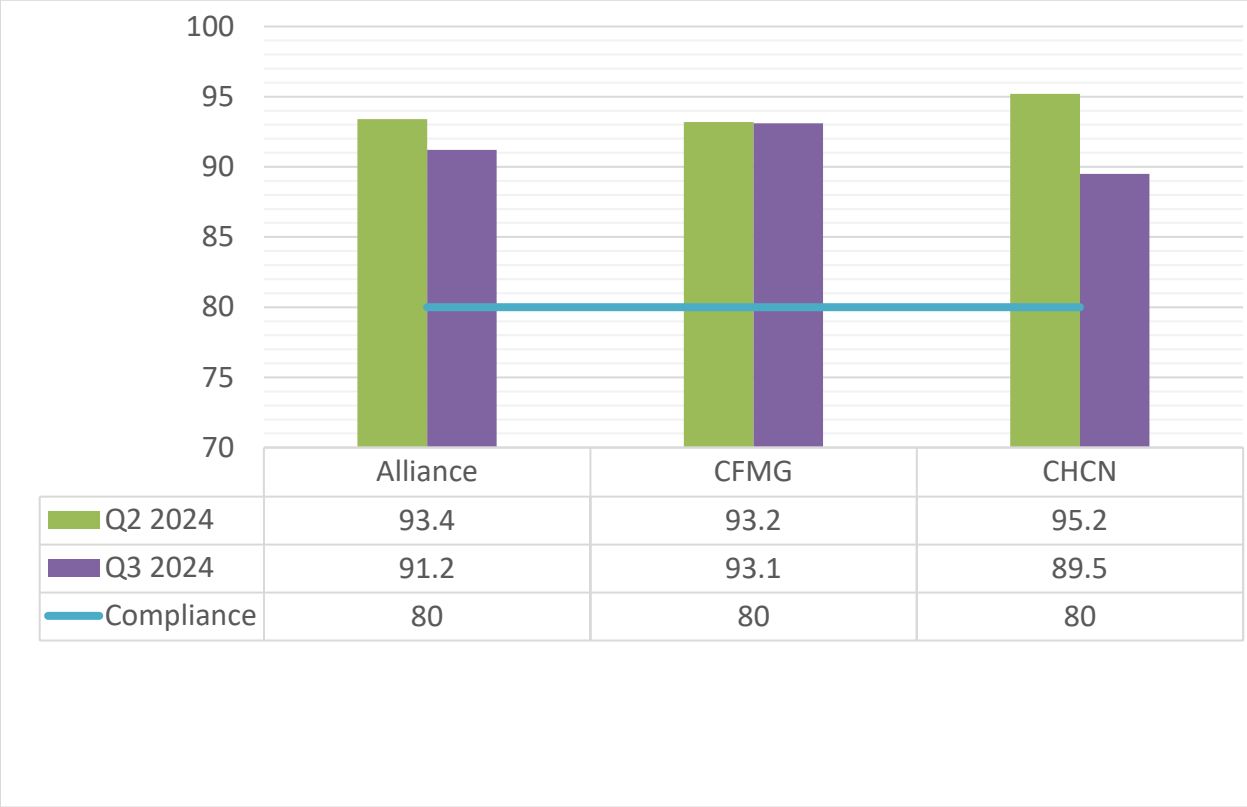
- Time to answer call – when a member called provider's office during regular office hours, how long did a member wait to speak to a staff member:
    - Compliance rate: 0 – 10 minutes

- AHS continues to score below the 70% threshold goal from Q4 2023 to Q2 2024. However, with a 2.7% increase in compliance rate in Q3 2023, AHS met the threshold goal in Q3 2024.

- CHCN didn't meet the threshold goal from Q4 2023 to Q1 2024. The increase in compliance rate was noted for CHCN. From Q2 2024 to Q3 2024, CHCN met the threshold goal for Time to Answer Call.

- The Alliance and CFMG providers continue to score above the 70% compliance threshold from Q4 2023 to Q3 2024.

BH In-Office Wait Time Compliance Rate by Network (%)

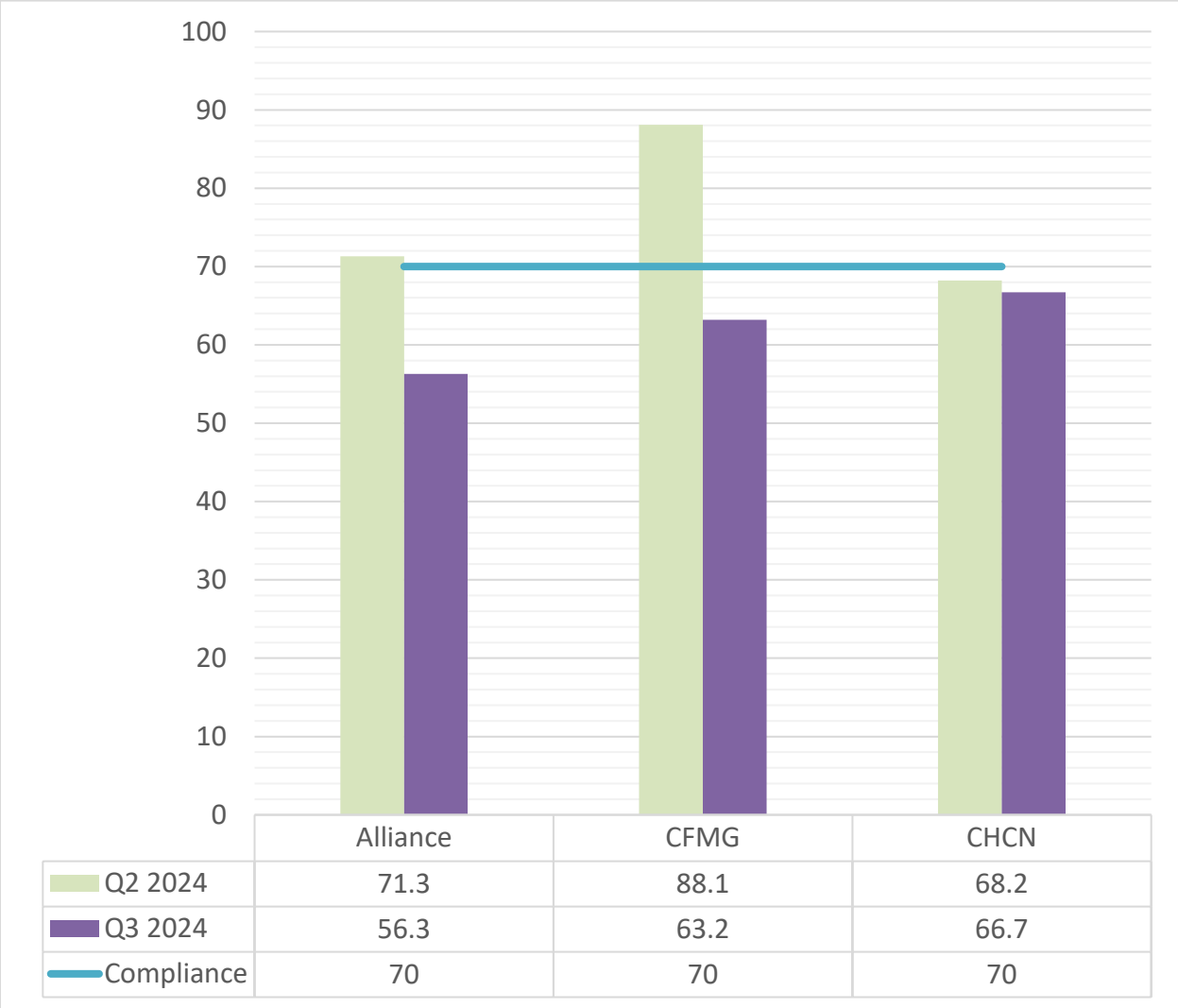


	Alliance	CFMG	CHCN
Q2 2024	93.4	93.2	95.2
Q3 2024	91.2	93.1	89.5
Compliance	80	80	80

- Office wait time includes both times spent in the waiting room and the exam room before seen by the doctor:
    - Compliance rate: Less than 60 minutes

- All delegate providers continue to score above the 80% compliance threshold from Q2 2024 to Q3 2024.

BH Call Return Time Compliance Rate by Network (%)

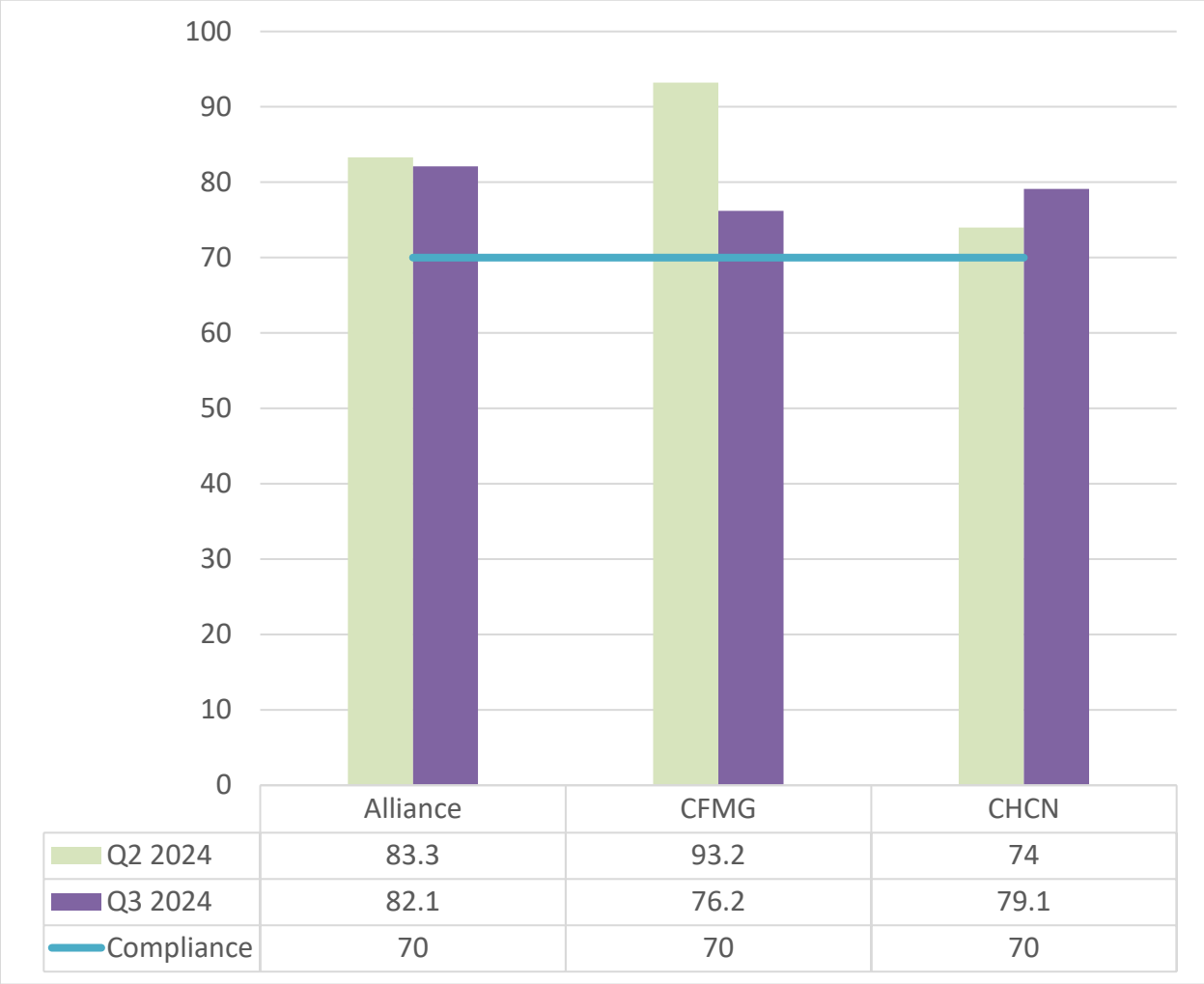


	Alliance	CFMG	CHCN
Q2 2024	71.3	88.1	68.2
Q3 2024	56.3	63.2	66.7
Compliance	70	70	70

- Call return time – when a member called provider's office during regular office hour, when did a member get a call back:
    - Compliance rate: Within 1 business day

- The decrease in compliance rate was noted from Q2 2024 to Q3 2024. The Alliance, CHCN, and CFMG providers didn't meet the compliance threshold for Q3 2024.

BH Time To Answer Call Compliance Rate by Network (%)



	Alliance	CFMG	CHCN
Q2 2024	83.3	93.2	74
Q3 2024	82.1	76.2	79.1
Compliance	70	70	70

- Time to answer call – when a member called provider's office during regular office hours, how long did a member wait to speak to a staff member:
    - Compliance rate: 0 – 10 minutes

- All delegates providers continue to score above the 70% compliance threshold from Q2 2024 to Q3 2024.

Next Action Steps:

- Track and Trend Compliance rates.
- Share results with Delegate and Direct entities.
- Share results with Provider Services and FSR staff to incorporate as part of provider and office education for identification of barriers and improvement opportunities.
- Onsite/Virtual office visits to provider not meeting compliance rate year over year.
- CAPs to be sent to non-compliant provider.

ALAMEDA Alliance FOR HEALTH

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

Health Equity

Lao Paul Vang

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

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

Date: **February 14th, 2025**

Subject: **Health Equity Report**

Internal Collaboration

- **Meetings and check-ins with Division Chiefs Update**
  - The CHEO meets with the Alliance division chiefs on a 1x1 basis monthly to update on Health Equity (HE) and Diversity, Equity, and Inclusion (DEI) activities.

- **Faith-Based Community Engagement Update**
  - As part of the broader strategic effort to fulfill milestone # 5 in our Health Equity Roadmap, we established a cross-functional stakeholder workgroup, FBCE, in Dec 2024
  - Meetings are scheduled to put in motion the effort of intentional collaboration that will lead to partnerships with faith-based organizations (FBOs). (Dec. 9th, Dec. 20th, Jan. 23rd, and Feb. 10th).
  - We established the three (3) critical factors to identify priority FBOs and guide our work: 1) members' relationships with the faith-based organization, 2) the health disparity gap, and 3) available funding and resources.
  - Subgroups have been formed to address specific aspects of the FBO's partnership. Specifically, we collaborate with PHM and QI teams to develop culturally appropriate education for specific ethnic minority FBOs.
  - We have identified three (3) high disparity areas that impact the BIPOC, which HE will lead a collaborative effort to address:
    - Women's health preventive screening Breast cancer and Cervical cancer screenings
    - Child well-visits
    - Doula Services

- **SOGI Data Workgroup**
  - We continue to participate in weekly meetings, which consist of inter-functional groups to plan for the implementation of SOGI data collection.

- **PHM Workgroup**
  - Health Equity continues to collaborate with PHM and participates in their weekly workgroup.

- **Over/Under Utilization Workgroup**
  - As of December, we joined the Healthcare Services Department in

their workgroup to discuss and share best practices for overcoming overutilization and underutilization.

- **Alliance Publication Workgroup**
  - As part of the Health Equity Roadmap milestone # 4 Communication, Health Equity joined the Alliance Publication workgroup organized by Communication & Outreach to help create content for social media postings and articles.
  - The aim is to position the Alliance as the champion for health equity for our members.

External Collaboration

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update**
  - Ongoing discussions regarding health equity-related issues and DEI training curriculum.

- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**
  - DHCS CHEO and MCPs CHEOs met to collaborate on Health Equity and DEI initiatives.
  - The meeting consisted of DHCS and CHEO Updates.

- **America Heart Association**
  - We initiated a discussion with AHA to explore potential collaboration to close health disparity gaps in cardiovascular disease incidences among the BIPOC (Black people, Indigenous, and Persons-of-Color).

Advancing Health Equity Initiative (AHEI) Update

- **DEI Training APL 23-025/ 24-016 Update**
  - We are waiting for DHCS approval of the DEI training curriculum.
  - Timeline:
    - November 2024: completed training curriculum submitted to DHCS.
    - Feb/March (Tentative) 2025: DEI Provider's Pilot launched. One of our providers, California Cardiovascular Consultants, has been selected to receive the pilot training.
    - April – June 2025: pilot training completed.
    - July to Dec 2025: training will be given to the downstream network, providers, and vendors.

- **APL 24-018: TGI-SB 923 Update**

    - HED continued to co-lead with IPD on the implementation of APL 24-018. Weekly meetings and subgroup meetings with a multitude of stakeholders are held to execute actions in fulfillment of all the requirements as per APL.

    - Timeline:
        - Dec 2024: confirmation of vendor
        - Jan-Feb 2025: implementation of training for all staff
        - Feb 14th, 2025: submission of all documents to State, which include Evidence-based TGI training curriculum, updated online Providers Directory for gender-confirming services, G&A, and Policy and Procedures.

- **Alliance Health Equity Strategic Roadmap**

    - A total of six milestones have been identified:

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

    - We initiated or participated in a number of strategies that are aimed at specific Health Equity milestones that have been initiated and implemented in phases, namely:

        1) Alliance Publication Workgroup: milestone # 4
        2) Faith-Based Community Engagement Workgroup: milestone #5
        3) Non-utilization study: milestone # 6

- **Application to the California Improvement Network (CIN) program**

    - The Health Equity Division submitted a membership application to California Improvement Network (CIN) - a learning and action community that advances equitable healthcare experiences and outcomes for Californians through cross-sector connections. As a member, Alliance would have an opportunity to apply for a grant to advance specific health equity among our Medicaid members.

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

- **DEIB Committee Update –**

    - The DEIB Committee met on January 3rd and discussed the HE

Roadmap and Community Engagement Strategy.

- **VIA Committee Update** –
    - At the January 24th VIA meeting, the Committee discussed the three 2025 Social Event dates. The dates are pending Matt Woodruff's approval.
    - Dr. Ang and Michelle Lewis introduced the AHA Walk Event to the Committee. The Committee will discuss this Event more at future meetings.

ALAMEDA Alliance FOR HEALTH

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

Information Technology

Sasikumar Karaiyan

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

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

Date: **February 14th, 2025**

Subject: **Information Technology Report**

Call Center System Availability

- In January 2024, AAH phone systems and call center applications maintained 100% availability even as they supported 97% of employees working remotely.

- Alliance continues to introduce new features to enhance efficiency. Our call center applications now support English speech-to-text functionality. Additionally, Alliance is working on extending this system to include Spanish language support. The project to enable the Spanish language pack for Calabrio is currently in progress, including the preparation of installation scripts. Selected Member Services staff will conduct translation reviews and phrase tuning, with this phase expected to commence by the end of March 2025.

Encounter Data

- In the month of January 2025, the Alliance submitted 180 encounter files to the Department of Health Care Services (DHCS) with a total of 368,504 encounters.

Enrollment

- The Medi-Cal Enrollment file for the month of January 2025 was received and loaded to HEALTHsuite.

HEALTHsuite

- The Alliance received 327,434 claims in the month of January 2025.

- A total of 345,327 claims were finalized during the month out of which 297,645 claims auto adjudicated. This sets the auto-adjudication rate for this period to 86.2%.

TruCare

- A total of 20,512 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.9%.

IT Security Program

- The IT Security 3.0 initiative ranks among the Alliance's foremost objectives for fiscal year 2025. Our aim is to consistently enhance and advance our security measures, secure our network perimeter against threats and vulnerabilities, and bolster our security policies and procedures.

- Alliance is conducting IT Security Risk Management and enterprise Security Penetration test.

- Implemented vulnerability scanning tool that helps find vulnerabilities in network, systems, and devices, is expected kickoff in February. The results will provide visibility and identification of IT security gaps.

- Draft of A policy is undergoing revision and review.

Microsoft InTune roll-out

- To enhance workstation security, Alliance is deploying Microsoft Intune on our workstations and mobile devices. This cloud-based service specializes in mobile device and application management, allowing the Alliance to secure and manage access to corporate data on mobile devices while protecting information. Intune enables device and app management, data protection, and policy compliance.

    - The engineering team has finished the core technical setups and is currently supporting the IT Service Desk on user migrations. Emails have been dispatched to all staff members as part of the campaign and rollout plan.

    - 541 migrations were completed, covering 8 departments, bringing project completion to 80.9%. Migrations are ramping up and remaining waves will be scheduled.

    - Manual pre-check tasks have been automated for efficiency.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrolment in the month of January 2025”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of January 2025”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal and Group Care Member enrollment in the month of January 2025

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
December	412,859	9,415	9,458	5,780	143	154

1. MC – Medi-Cal Member 2. GC – Group Care Member

Table 1-2 Summary of Primary Care Physician (PCP) Auto-Assignment for the Month of January 2025

Auto-Assignments	Member Count
Auto-assignments MC	4,790
Auto-assignments Expansion	4,586
Auto-assignments GC	61
PCP Changes (PCP Change Tool) Total	9,437

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of January 2025”.
- There were 20,512 authorizations processed within the TruCare application.
- TruCare Application Uptime – 99.9%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of January 2025*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,792
Provider Portal Requests (Zipari)	6,442
EDI (CHCN)	6,867
Provider Portal to AAH Online (Long Term Care)	19
ADT	1311
Behavioral Health COC Update - Online	319
Behavioral initial evaluation - Online	81
Manual Entry (all other not automated or faxed vs portal use)	2,681
Total	20,512

Key: EDI – Electronic Data Interchange

Web Portal Consumer Platform

- The following table 3-1 is a supporting document from the Web Portal summary section. (Portal reports are always one month behind current month)

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

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	7,902	5,605	508,970	649
MCAL	121,070	3,520	8,603	1,198
IHSS	3,899	83	353	18
Total	132,871	9,208	517,926	1,865

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

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1,680,203
Provider - Claims	Claim Status	253,991
Provider - authorizations	Auth Submit	16,028
Directory Config	Provider Directory	9,380
Provider - authorizations	Auth Search	8,174
Member My Care	Member Eligibility	4,604
Provider - Claims	Submit professional claims	4,341
Member Config	Provider Directory	4,327
Member Help Resources	Find a Doctor or Hospital	3,018
Provider - eligibility	Member Eligibility	2,656
Member Help Resources	ID Card	2,313
Provider - eligibility/claim	Member Roster	1,760
Member Help Resources	Select or Change Your PCP	1,758
Member My Care	My Claims Services	1,377
Member Home	MC ID Card	1,370
Member My Care	Authorization	1,068
Provider - Home	Behavior Health Forms SSO	1,032
Provider - reports	Reports	911
Provider - Provider Directory	Provider Directory 2019	827
Provider - Home	Forms	665
Member My Care	My Pharmacy Medication Benefits	443
Member Help Resources	FAQs	325
Member Help Resources	Forms Resources	308
Member My Care	Member Benefits Materials	300
Provider - Provider Directory	Instruction Guide	268

Call Center – Call Volume Overview:

Members - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
October	8437	7798	269
November	7427	6186	390
December	8438	6912	414
January	14078	10705	1483

Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
October	10863	8972	1751
November	8931	6786	2007
December	9598	7285	2152
January	13400	8682	3822

- Calls Presented: Total number of calls received.
- Calls Handled: Total number of calls answered.
- Calls Abandoned: Calls abandoned before being completely answered.

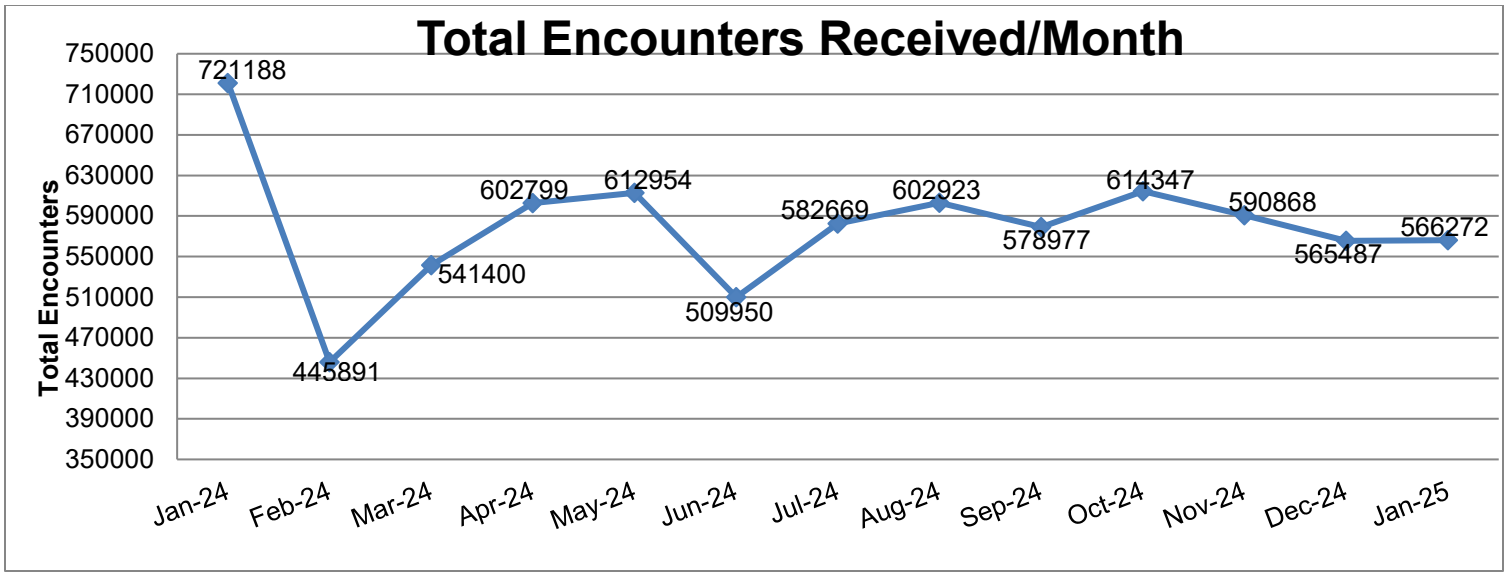
Note: It is important to note that there is a slight discrepancy between the number of calls presented, handled, and abandoned. This discrepancy is due to calls being rerouted to the XAQT vendor, which are not included in the calls handled or abandoned statistics. This rerouting can account for some of the differences observed in the totals.

Encounter Data from Trading Partners 2025

- **AHS**: January weekly files (9,709 records) were received on time.
- **BACH**: January monthly files (426 records) were received on time.
- **BACS**: January monthly files (93 records) were received on time.
- **CHCN**: January weekly files (117,483 records) were received on time.
- **CHME**: January monthly files (7,781 records) were received on time.
- **CFMG**: January monthly files (13,536 records) were received on time.
- **Docustream**: January monthly files (694 records) were received on time.
- **EBI**: January monthly files (1,440 records) were received on time.
- **FULLCIR**: January monthly files (806 records) were received on time.
- **HCSA**: January monthly files (2,432 records) were received on time.
- **IOA**: January monthly files (3,008 records) were received on time.
- **Kaiser**: January bi-weekly files (0 records) were received on time.
- **LAFAM**: January monthly files (112 records) were received on time.
- **LIFE**: January monthly files (228 records) were received on time
- **LogistiCare**: January weekly files (28,671 records) were received on time.
- **March Vision**: January monthly files (15,146 records) were received on time.
- **MED**: January monthly files (758 records) were received on time.
- **OMATOCHI**: January monthly files (0 records) were received on time.
- **PAIRTEAM**: January monthly files (3,436 records) were received on time.
- **Quest Diagnostics**: January weekly files (18,002 records) were received on time.
- **SENECA**: January monthly files (1 records) were received on time.
- **SERENE**: January monthly files (107 records) were received on time.
- **TITANIUM**: January monthly files (2,487 records) were received on time.
- **TVHC**: January monthly files (156 records) were received on time.
- **Magellan**: January monthly files (494,805 records) were received on time.

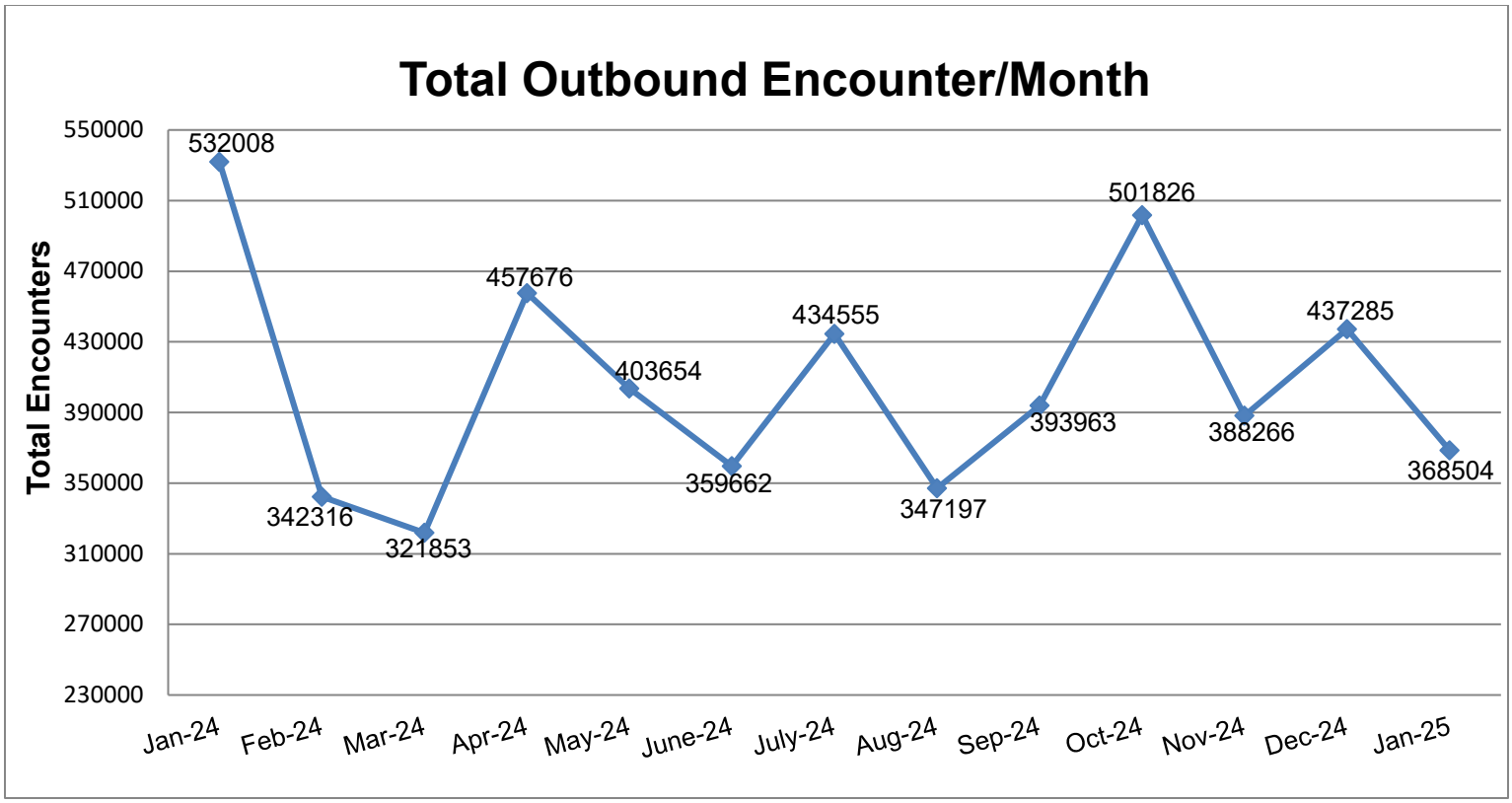
Trading Partner Encounter Inbound Submission History

Trading Partners	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Health Suite	298465	266339	308453	322786	375454	297267	332150	368235	322196	367989	364130	332108	339760
AHS	4570	7736	7005	6573	8412	13316	7296	8859	7498	8309	10535	7261	9709
BACH											795		426
BACS	59	57	55	64	70	77	88	86	85	76	98	104	93
CHCN	96124	103674	122217	170653	122445	110650	135444	122293	155825	125042	127223	127327	117483
CHME	5843	5560	6022	7969	7107	7449	7242	6902	7680	7102	7589	7458	7781
CFMG	12043	10557	12651	16394	15934	21143	10776	22335	16421	16045	21352	16696	13536
Docustream	930	814	698	302	1589	749	934	1102	1067	704	678	828	694
EBI	1047	2903	1625	1700	184	2043	1623	1825	3394	1640	1725	1476	1440
FULLCIR	828	1586	213	2261	8478	2842	1362	1798	3809	2523	2038	1085	806
HCSA	2223	2097	2822	7118	5535	3663	6841	3256	3386	2389	3423	2335	2432
IOA	1453	1233	1054	1925	1163	1280	847	752	4227	588	1064		3008
Kaiser	77407	3725	9966	2286	886	1079	2052	172	236	159			
LAFAM		60	39	105	116	86	70	88	63	89	76	83	112
LIFE						1694		614	168	119	335	997	228
LogistiCare	182822	20774	35600	32632	27531	16205	43038	29732	16139	49941	16183	34122	28671
March Vision	9693		6183	3633	8546	7092	6404	7719	5769	5143	6016	6285	15146
MED	535	742	683	633	722	744	615	608	610	645	656	619	758
OMATOCHI				29				2					
PAIRTEAM				5344	7582		5763		9359	1108	2204	5816	3436
Quest	27022	17658	22306	18000	18001	22500	18000	22502	18004	18002	22501	18003	18002
SENECA	124	222	112	159	113	71	109	129	101	105	117	131	1
SERENE												654	107
TITANIUM		154	3696	2233	3086		2015	3914	2815	6192	1537	2099	2487
TVHC									125	437	593		156
Total	721188	445891	541400	602799	612954	509950	582669	602923	578977	614347	590868	565487	566272



Outbound Encounter Submission

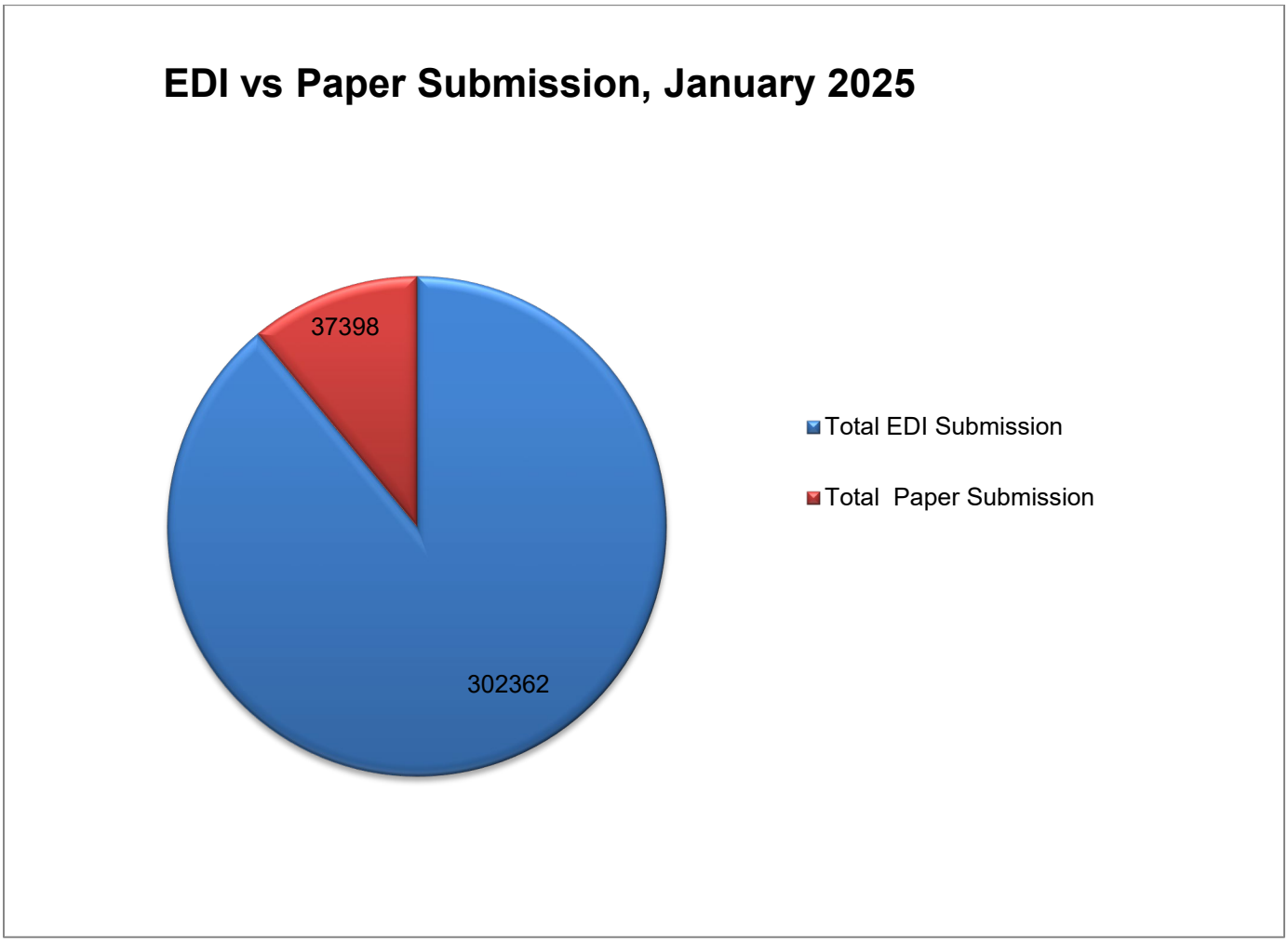
Trading Partners	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Health Suite	172386	177658	147776	250835	198595	204068	230706	183371	210971	276473	218194	263242	182192
AHS	5667	7497	6968	6524	7002	10684	6703	7101	8727	8201	10403	6850	7710
BACH											739	6	407
BACS	55	55	47	59	66	72	80	80	78	74	79	41	128
CHCN	67063	74336	80498	104625	107577	77200	94476	87485	87806	108806	88573	84649	85439
CHME	5703	5470	5889	7558	6749	7310	7095	6762	6994	6974	7474	7342	7426
CFMG	10145	7730	6757	13467	11561	11506	9994	4	24076	13152	13882	11342	9362
Docustream	387	600	377	267	839	570	725	806	715	545	482	239	634
EBI	987	1347	1002	1589	60	1835	1443	1727	3242	1559	1641	494	2208
FULLCIR	653	540	116	1636	5401	2410	1084	674	1515	1767	1470	79	1298
HCSA	2142	2013	2769	4710	5363	3493	6757	3171	3310	2376	3394	2255	2497
IOA	1378	1156	1000	1868	1029	1221	749	680	1374	549	949		2783
Kaiser	76335	3542	9650	1905	1292	812	1404	113	216	62		23	
LAFAM			16	92	103	58	66	81	58	86	62	3	178
LIFE						28		598	159	91	76	202	508
LogistiCare	157548	40529	34931	32247	27487	16221	43019	30006	16046	49705	15235	34035	28502
March Vision	2700	2616	3736	2407	5719	4553	3766	3482	4066	3543	3980	4156	9586
MED	446	624	528	518	579	654	552	540	514	579	568	55	546
OMATOCHI				56									
PAIRTEAM				4279	4422		3246		4617	782	1960	994	6334
Quest	28299	16589	16333	20983	16912	16898	20898	16854	16937	21144	16909	21044	16828
SENECA	114	14	199	140	109	69	108	127	94	91	100	6	112
SERENE													82
TITANIUM			3261	1911	2789		1684	3535	2332	5267	1278	228	3600
TVHC									116		818		144
Total	532008	342316	321853	457676	403654	359662	434555	347197	393963	501826	388266	437285	368504


Total Outbound Encounter/Month
Total Encounters
550000
510000
470000
430000
390000
350000
310000
270000
230000
532008
342316
321853
457676
403654
359662
434555
347197
393963
501826
388266
437285
368504
Jan-24
Feb-24
Mar-24
Apr-24
May-24
June-24
July-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25

HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
25-Jan	302362	37398	339760

Key: EDI – Electronic Data Interchange

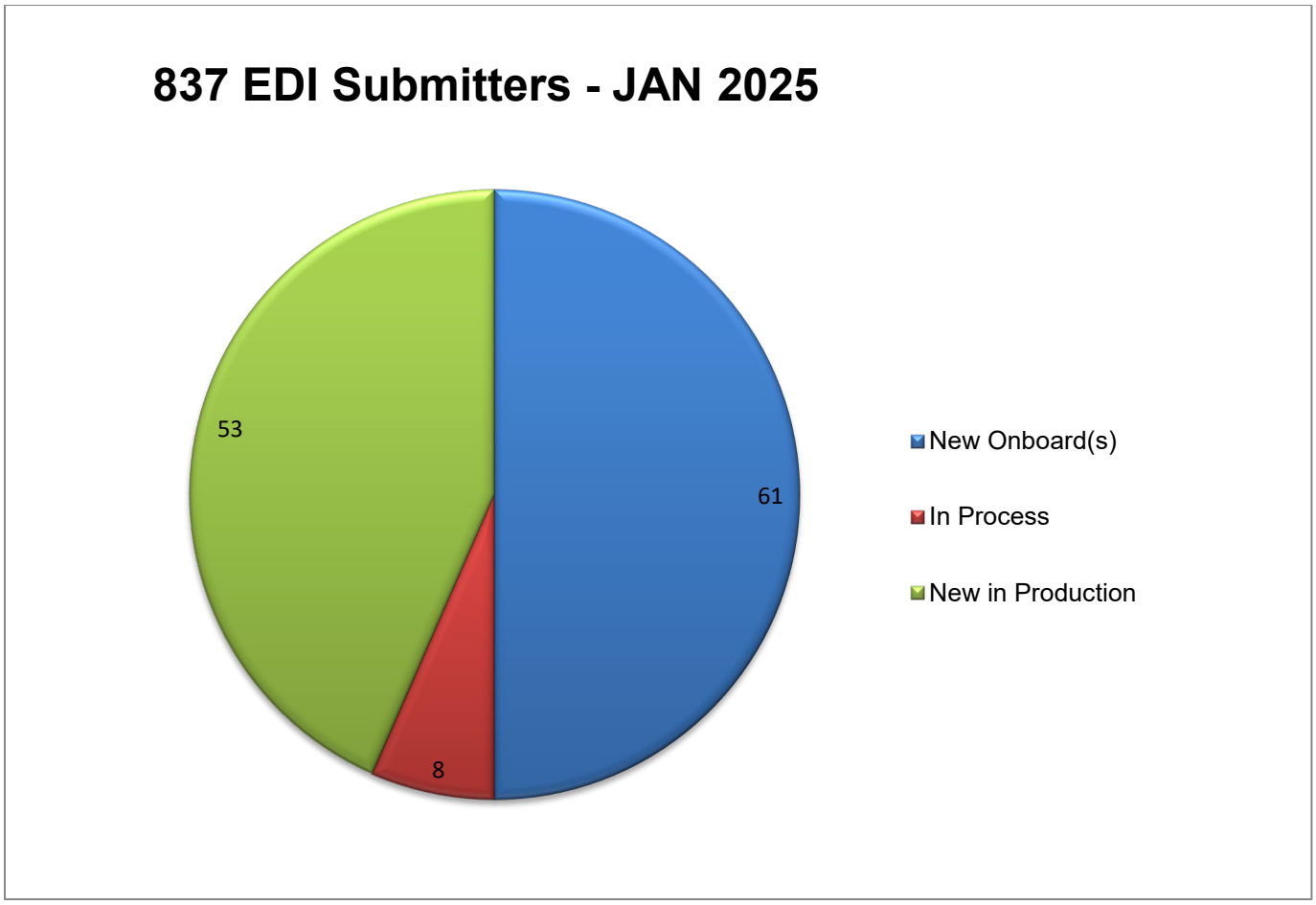


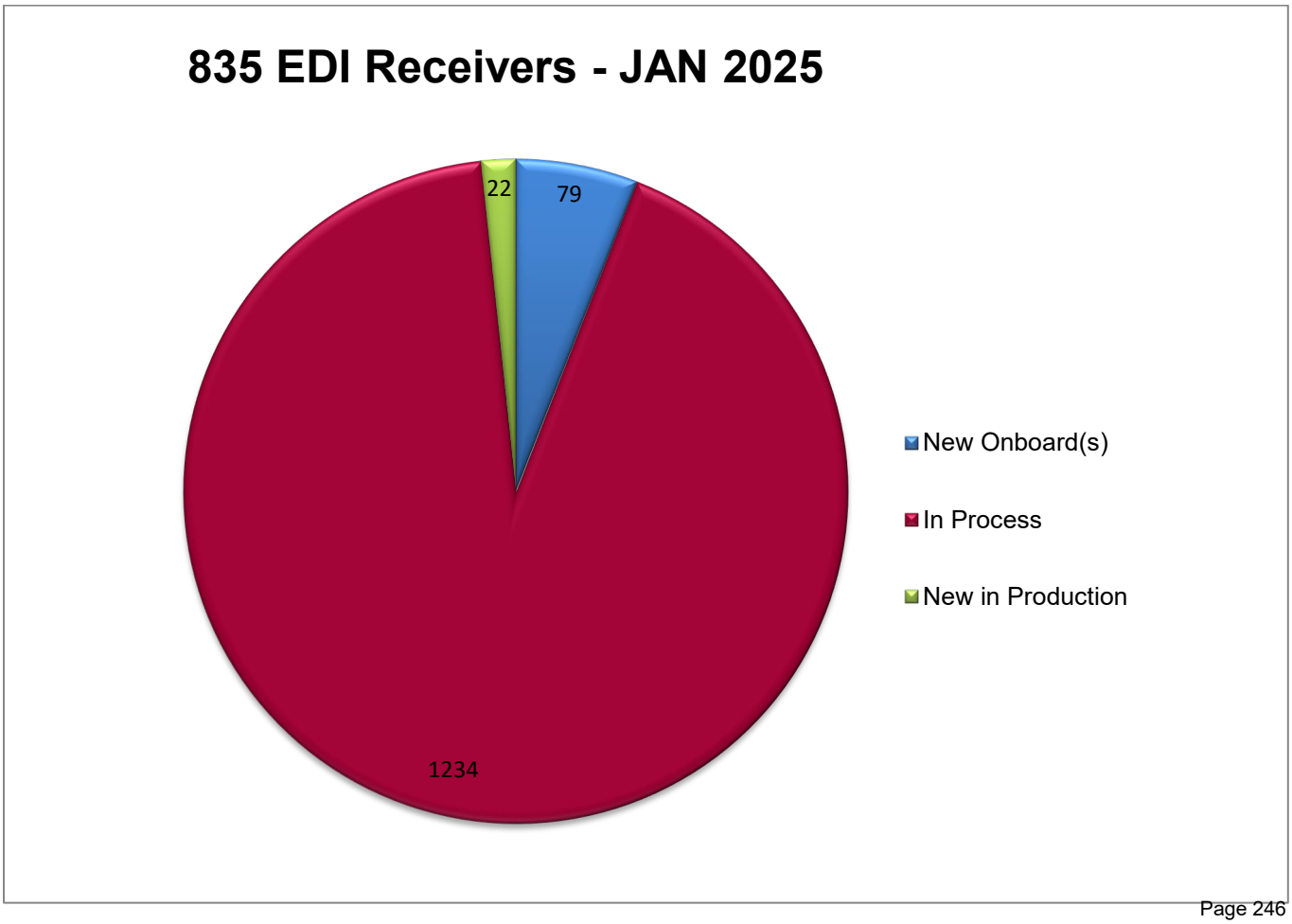
Onboarding EDI Providers – Updates

- Jan 2025 EDI Claims:
  - A total of 2872 new EDI submitters have been added since October 2015, with 53 added in January 2025.
  - The total number of EDI submitters is 3612 providers.

- Jan 2025 EDI Remittances (ERA):
  - A total of 1289 new ERA receivers have been added since October 2015, with 22 added in January 2025.
  - The total number of ERA receivers is 1276 providers.

	837				835			
	New on Boards	In Process	New In Production	Total in Production	New on Boards	In Process	New In Production	Total in Production
Feb-24	37	17	20	2814	59	783	27	937
Mar-24	111	25	86	2900	60	822	21	958
Apr-24	120	3	117	3017	83	851	54	1012
May-24	81	13	68	3085	63	874	40	1052
Jun-24	39	4	35	3120	50	908	16	1068
Jul-24	86	3	83	3203	54	937	25	1093
Aug-24	181	2	179	3382	62	982	17	1110
Sep-24	46	5	41	3423	73	1027	28	1138
Oct-24	60	4	56	3479	80	1071	36	1174
Nov-24	61	20	41	3520	89	1131	29	1203
Dec-24	61	22	39	3559	97	1177	51	1254
Jan-25	61	8	53	3612	79	1234	22	1276


837 EDI Submitters - JAN 2025
53
61
8
New Onboard(s)
In Process
New in Production


835 EDI Receivers - JAN 2025
22
79
1234
New Onboard(s)
In Process
New in Production

Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

- EDSRF Submission: Below is the total number of encounter files that AAH submitted in the month of **January** 2025.

File Type	Jan-25
837 I Files	31
837 P Files	149
Total Files	180

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Jan-25	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	92%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	88%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	95%	80%

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

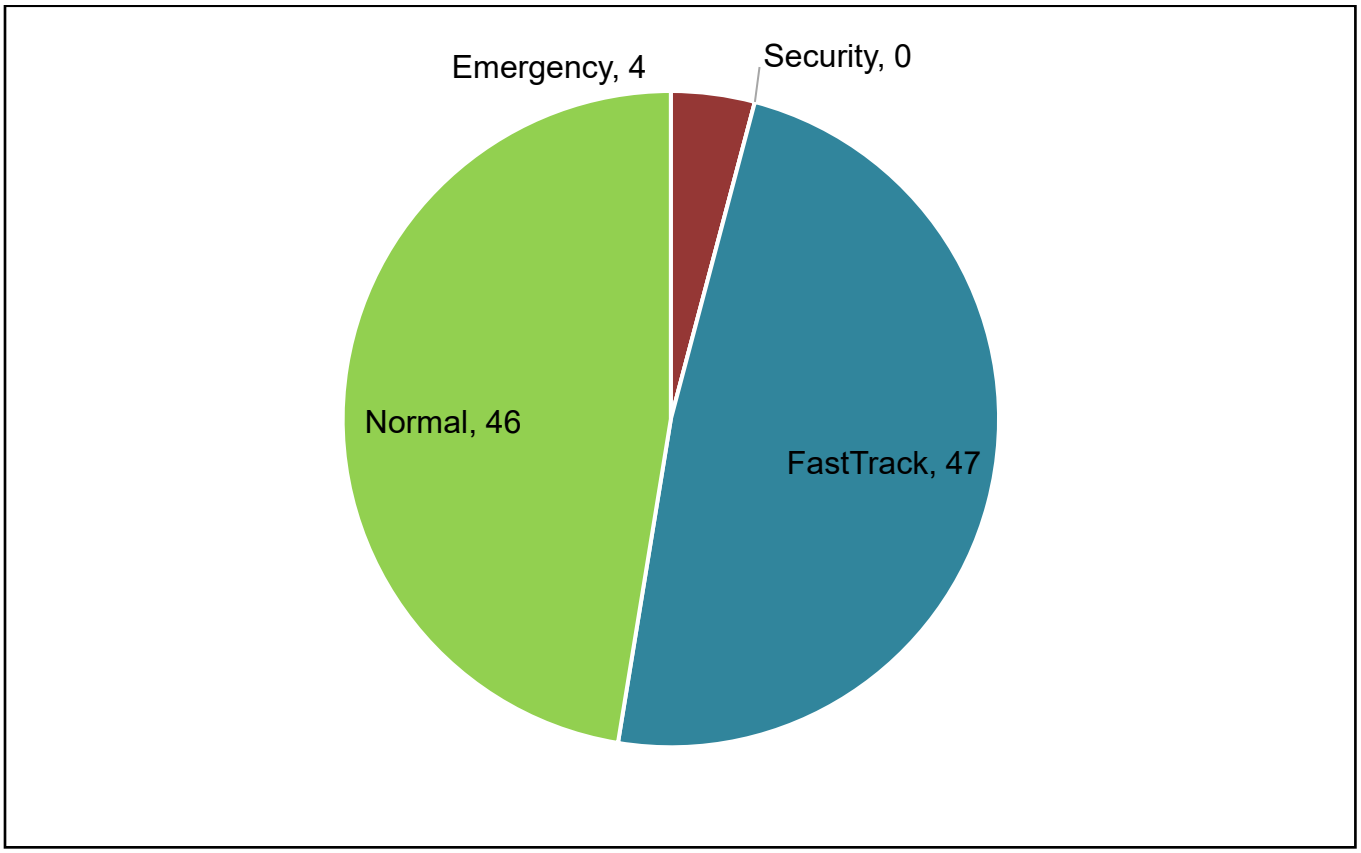
Encounter Data

In the month of **January** 2025, the Alliance submitted **180** encounter files to the Department of Health Care Services (DHCS) with a total of **368,504** encounters.

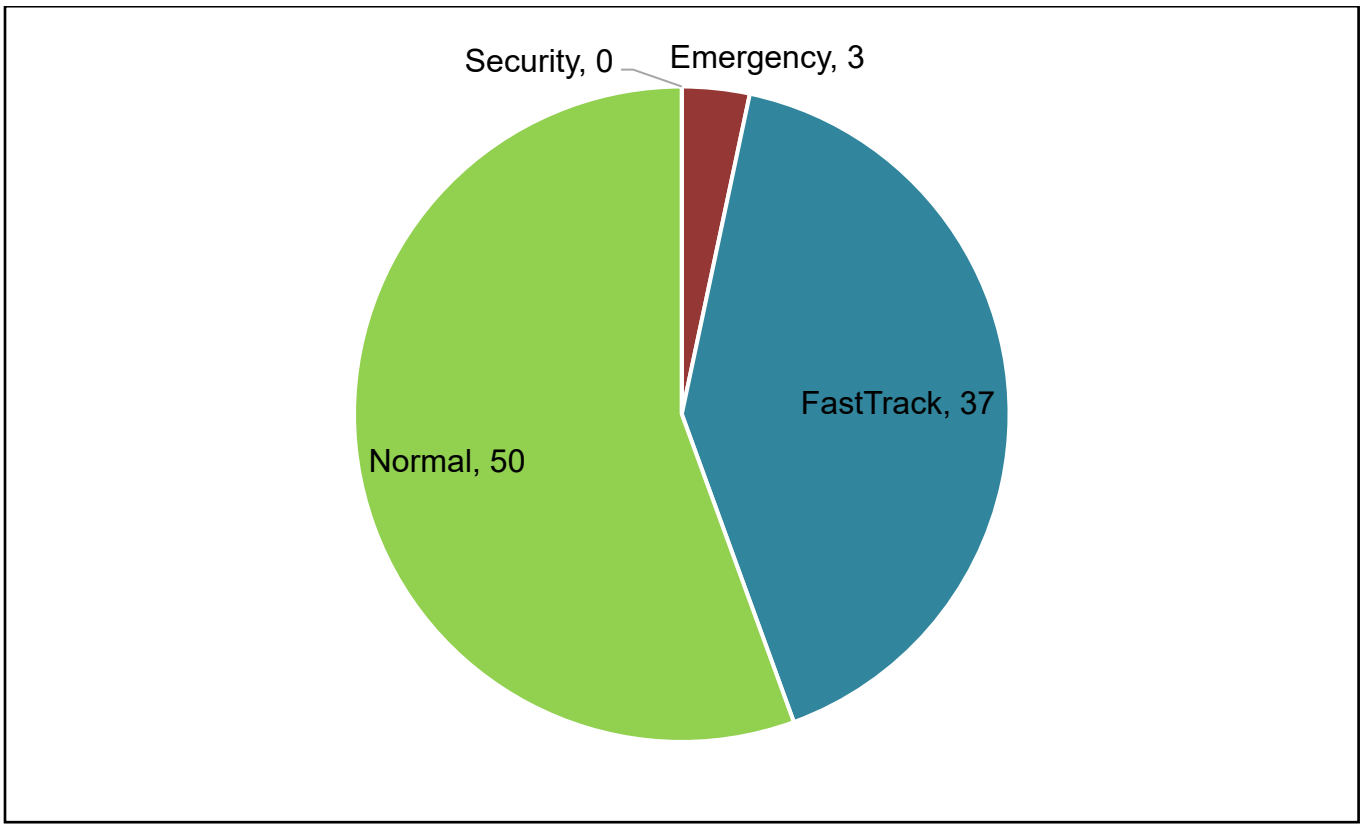
Change Management Key Performance Indicator (KPI)

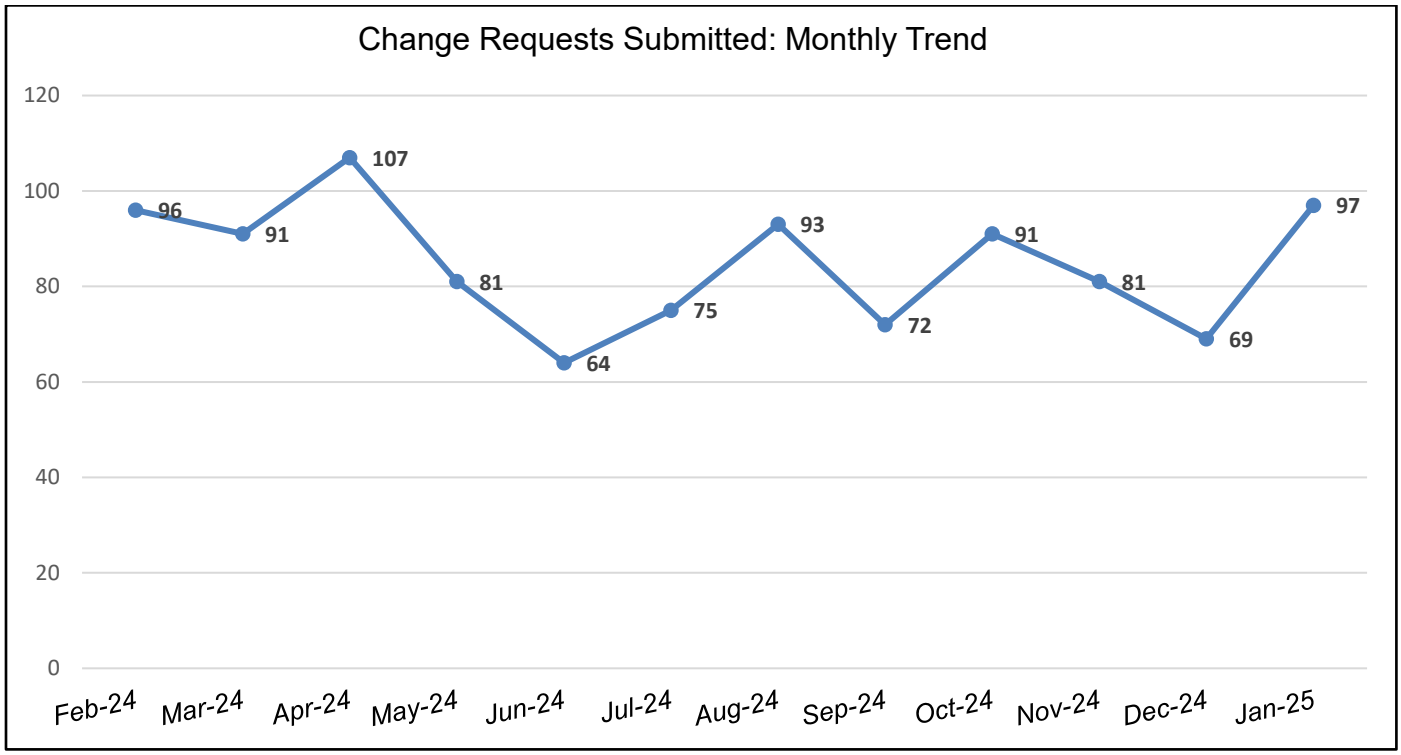
- Change Request Overall Summary in the month of January 2025 KPI:
  - 97 Changes Submitted.
  - 90 Changes Completed and Closed.
  - 93 Active Change Requests in pipeline.
  - 9 Change Requests Cancelled or Rejected.

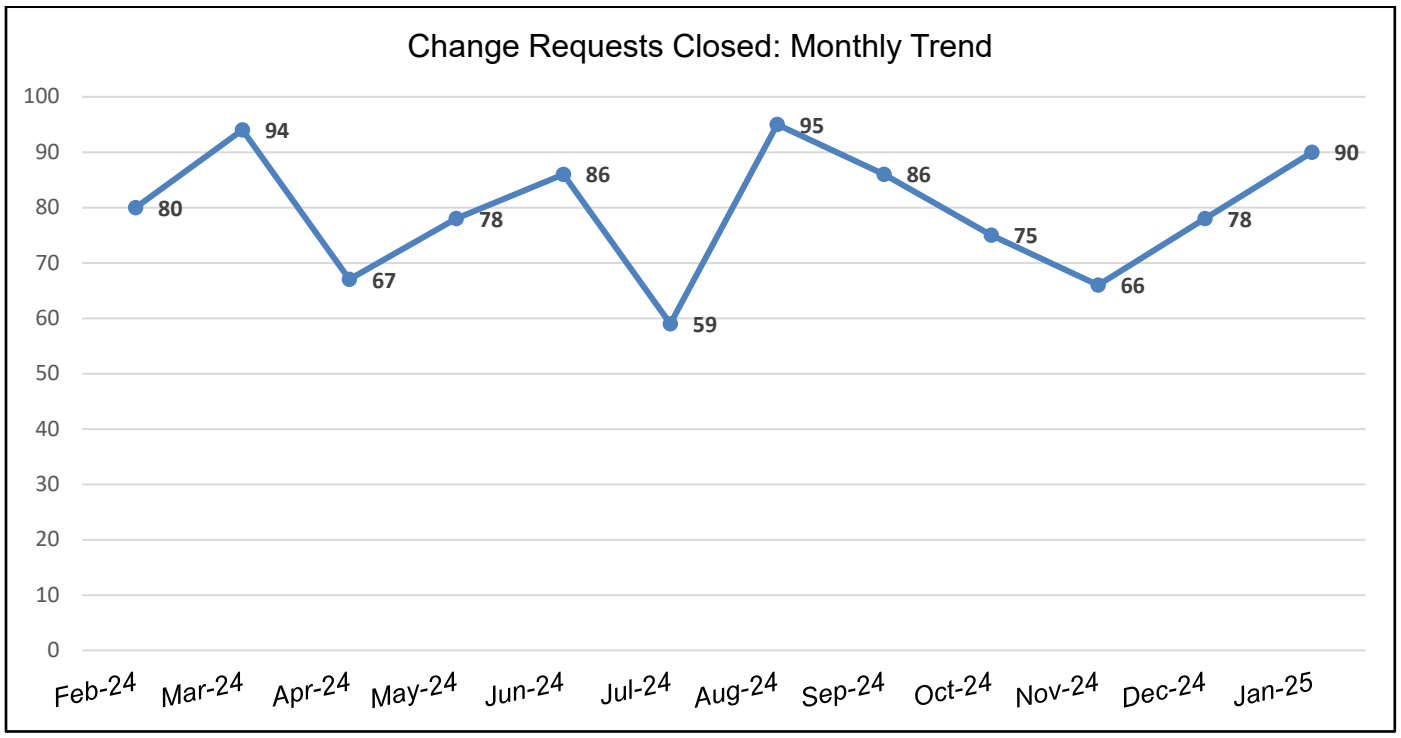
- 97 Change Requests Submitted/Logged in the month of January 2025



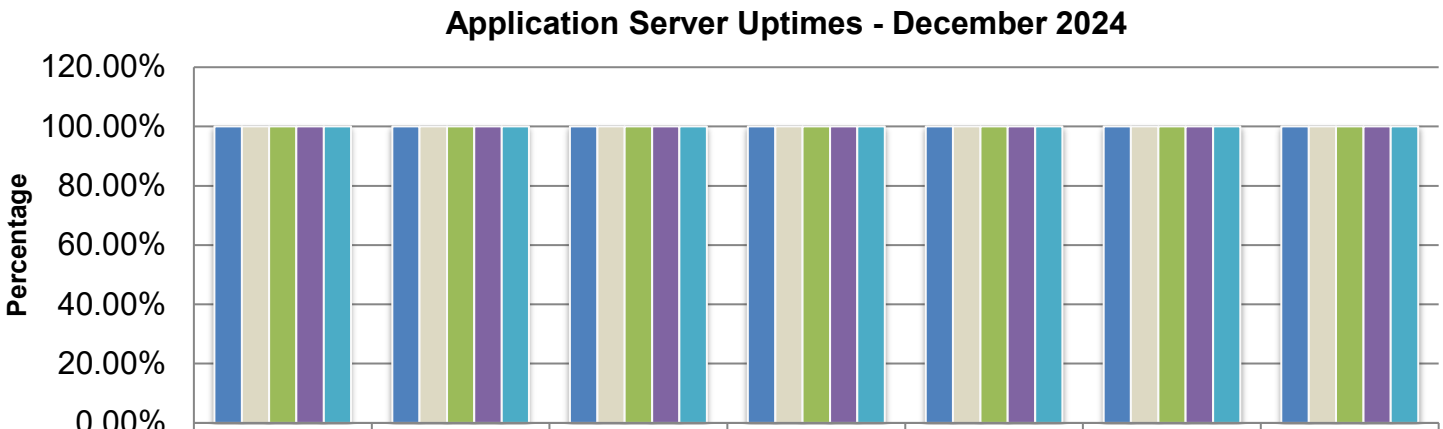
- 90 Change Requests Closed in the month of January 2025




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
96
91
107
81
64
75
93
72
91
81
69
97
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25


Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
80
94
67
78
86
59
95
86
75
66
78
90
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25

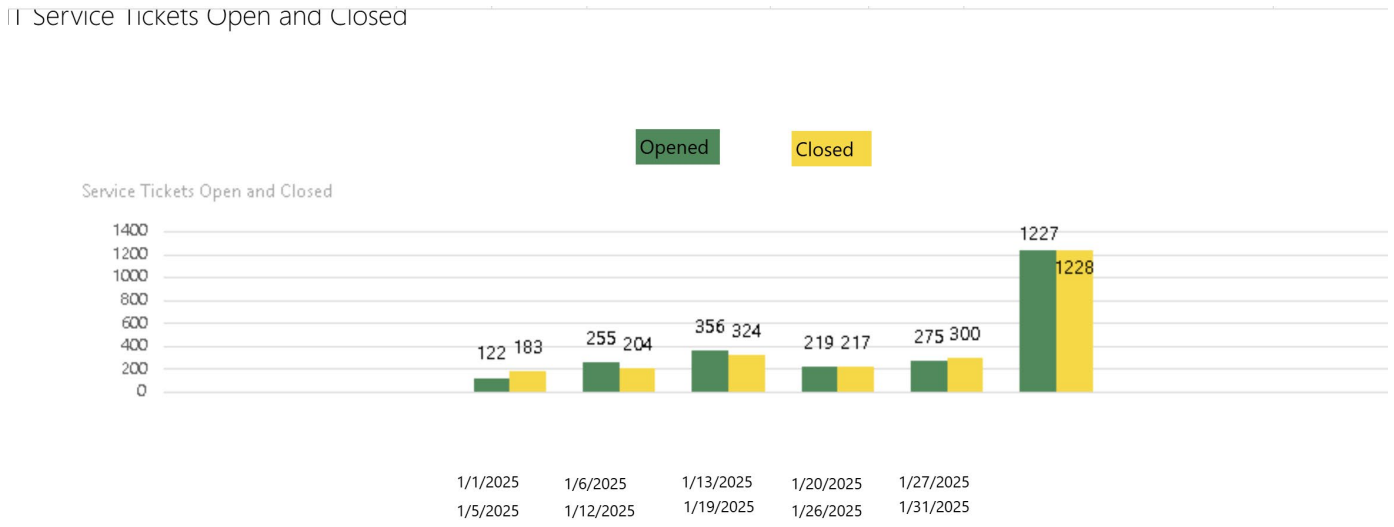
IT Stats: Infrastructure



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

- All mission critical applications are monitored and managed thoroughly.
- There were no outages experienced in the month of December.

IT Stats: Service Desk

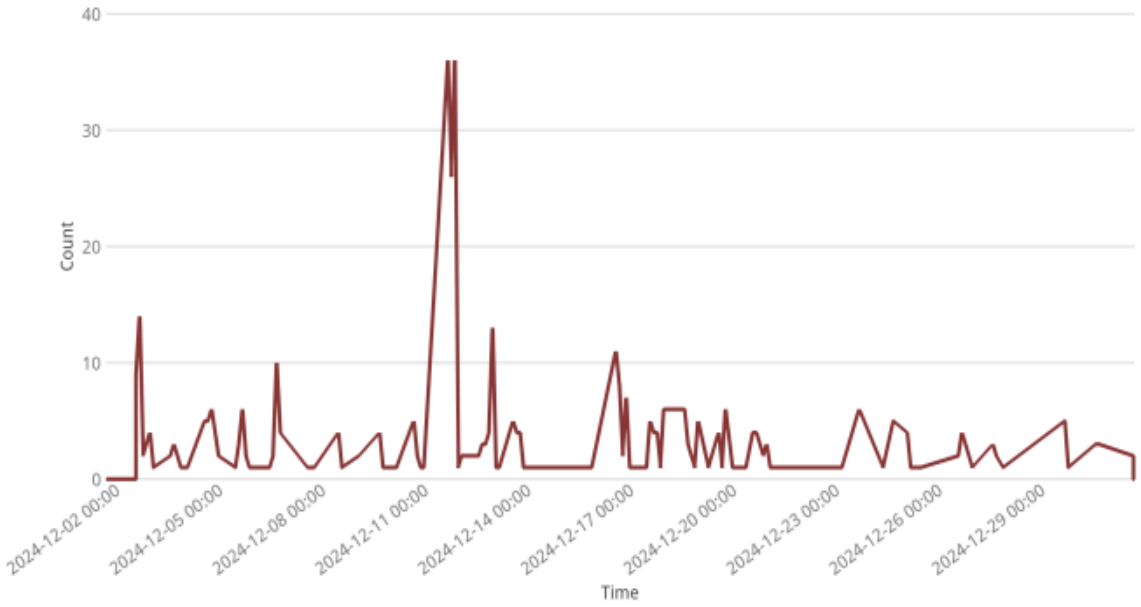


- 1227 Service Desk tickets were opened in the month of January 2025, which is 35.61% higher than the previous month (790) and 27.80% lower than the previous 3-month average of 886.
- 1228 Service Desk tickets were closed in the month of January 2025, which is 29.64% higher than the previous month (865) and 26.79% higher than the previous 3-month average of 889.

IT Stats: Network

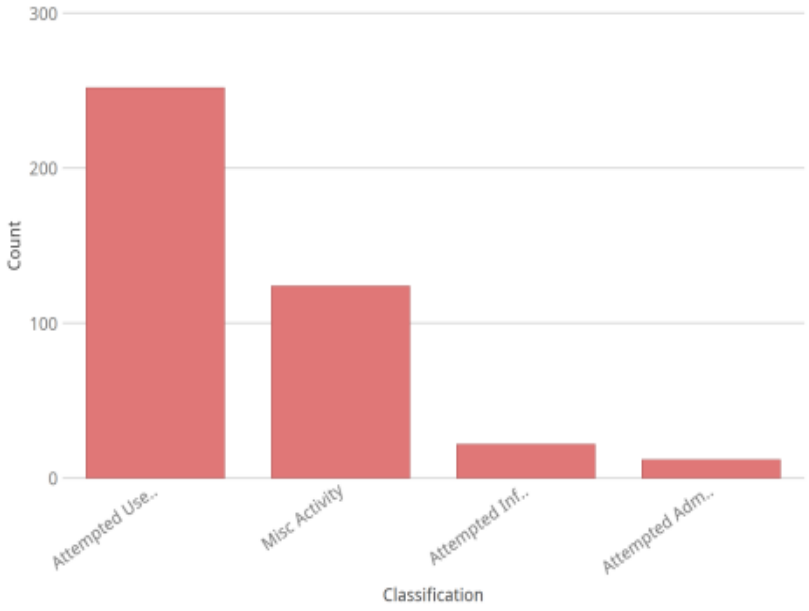
All Intrusion Events

Time Window: *2024-12-01 09:29:00 - 2024-12-31 09:29:00*



Dropped Intrusion Events

Time Window: *2024-12-01 09:30:00 - 2024-12-31 09:30:00*
Constraints: *Inline Result = !Alert,!Would **



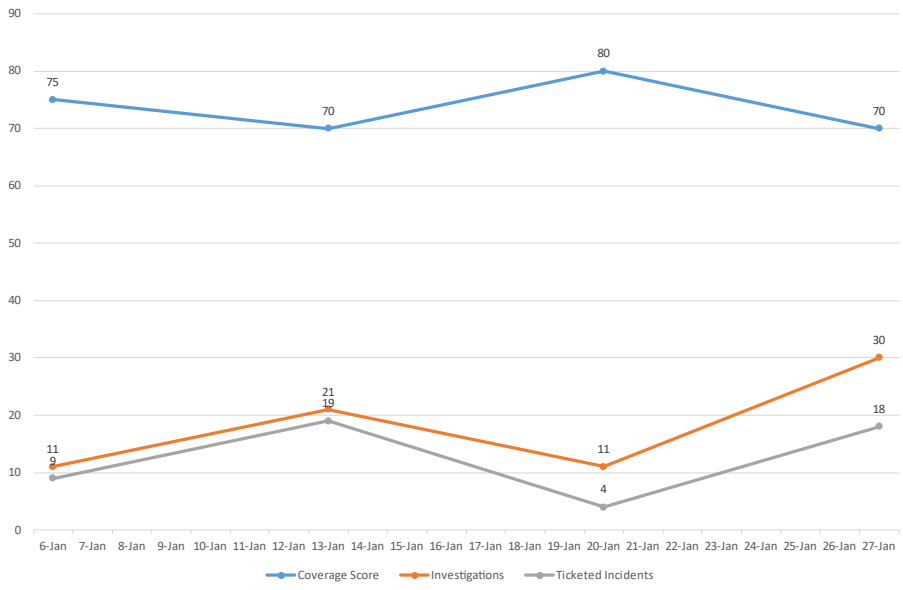
Classification	Count
Attempted User Privilege Gain	252
Misc Activity	124
Attempted Information Leak	22
Attempted Administrator Privilege Gain	12

Item / Date	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	*May-24*	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	*Nov-24*	*Dec-24*
Attempted Admin Privilege Gain	1	7	4	48	3	1	4	1	3	250	5	23	***12***
Attempted User Privilege Gain	48	69	330	526	569	554	474	17	8	329	337	302	***252***
Attempted Information Leak	50	65	51	72	57	46	66	0	46	118	11	12	***22***
Potential Corp Policy Violation	0	0	3	4	0	0	0	0	0	0	0	0	***0***
Network Scans Detected	0	0	0	0	0	0	0	0	0	0	0	0	***0***
Web Application Attack	4	1	0	0	5	3	4	0	0	15	0	0	***0***
Attempted Denial of Service	0	0	0	0	0	1	0	1	0	4	0	0	***0***
Misc. Attack	2,146	1	424	332	795	145	64	29	124	72	28	16	***124***

- All security activity data is based on the current month's metrics as a percentage. This is compared to the previous three month's average, except as noted.
- Attempted information leaks detected and blocked at the firewall is at 22 for the month of December 2024.
- Network scans returned a value of 0, which is in line with previous month's data.
- Attempted Admin Privilege Gain is lower at 12 from a previous six-month average of 49.
- Attempted User Privilege Gain is lower at 252 from a previous six-month average of 207.5.

IT Stats: Security

Arctic Wolf - *Security Review* Report
(Jan 6, 13, 20, 27)



- **Coverage Score**
  - Investigating dropped score due to lost log source.
- **Investigations**
  - Increase contributed to locked out accounts and out-of-country travel.
- **Ticketed Incidents**
  - Correlated to Investigations. Most FPs.

In-Progress

Areas	Item Status	Next Step(s)

Ops.	• **ProCircular Penetration Test Follow-up -** remediating captured items
	• **Vendor Risk Assessment –** completed 2 / reviewing 3
	• **SecureLink -** Maintenance
	• **Intentional Cyber (SRA) -** IT interviews completed
	• **Firewall** – granted access
	• Prioritizing items from Tim
		• **ProCircular**
		  • Meeting with ProCircular to get further information on results
		  • Return scanning device
		• **Intentional Cyber (SRA)**
		  • Final interview with HR

Projects	• **PKI Modernization** – on hold due to resource constraint
	• **Tenable Nessus**
	  ○ Resumed discovery scans for server + workstations
	  ○ Discovered additional VLANs
	• **Cert. Collection**
	  • Engagement to app owners in-process
	  • Cert. import process into IT Glue complete (Ed. D.)
		• **Tenable Nessus**
		  ○ Working with Infra to define and apply appropriate permissions on workstations and server for authenticated scans.
		  ○ Configuring scan on network switches and fw
		• **Cert. Collection**
		  • Collection process into IT Glue being finalized

GRC/Privacy/ PnP/SOP	• SOP finalized for MS App requests • SOP drafted for Out-of-Country • Completed Gen AI policy and Phishing SOP • Copilot SOP • In draft being reviewed by ITSec team and Debbie	

ALAMEDA Alliance FOR HEALTH

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

Analytics

Tiffany Cheang

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

From: **Tiffany Cheang, Chief Analytics Officer**

Date: **February 14th, 2025**

Subject: **Performance & Analytics Report**

Member Cost Analysis

The Member Cost Analysis below is based on the following 12-month rolling periods:

Current reporting period: Nov 2023 – Oct 2024 dates of service
Prior reporting period: Nov 2022 – Oct 2023 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 9.9% of members account for 89.1% of total costs.

- In comparison, the Prior reporting period saw no change at 9.9% of members accounting for 83.6% of total costs.

- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:

    - The SPD (non duals) and ACA OE categories of aid decreased to account for 55.3% of the members, with SPDs accounting for 20.7% and ACA OE's at 34.6%.
    - The percentage of members with costs >= $30K slightly decreased from 2.7% to 2.6%.
    - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.8%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 32.8%.
    - Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
    - However, the age distribution of the top 9.9% is more concentrated in the 45-66-year-old category (36.1%) compared to the overall population (20.7%).

Analytics

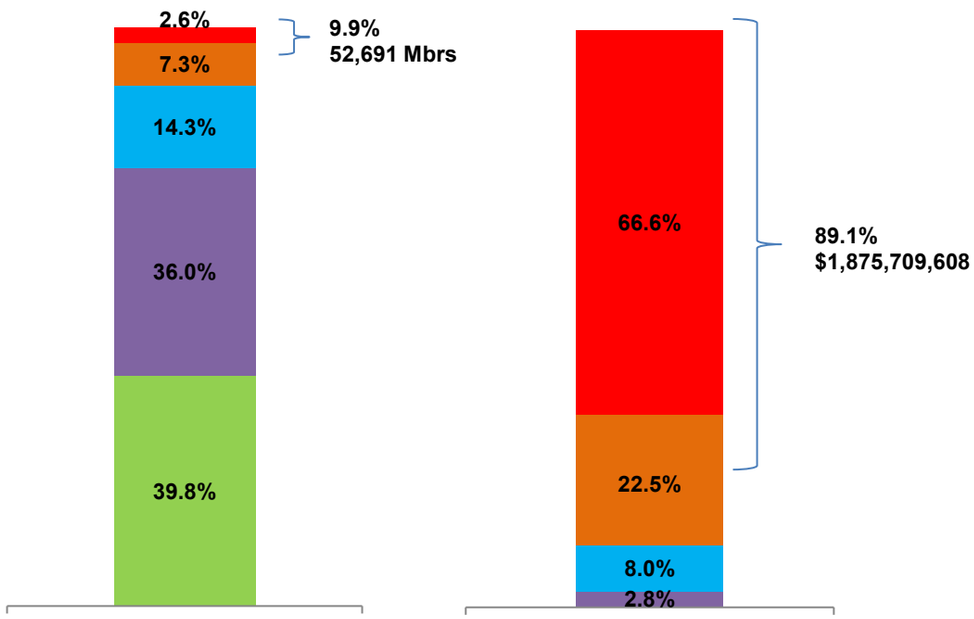
Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Nov 2023 - Oct 2024

Note: Data incomplete due to claims lag

Run Date: 01/28/2024

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	13,846	2.6%	$ 1,402,584,000	66.6%
$5K - $30K	38,845	7.3%	$ 473,125,608	22.5%
$1K - $5K	75,636	14.3%	$ 169,409,289	8.0%
< $1K	190,946	36.0%	$ 59,518,631	2.8%
$0	210,822	39.8%	$ -	0.0%
Totals	**530,095**	**100.0%**	**$ 2,104,637,528**	**100.0%**

Top 9.9% of Members = 89.1% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	4,279	0.8%	$ 878,926,413	41.8%
$75K to $100K	1,923	0.4%	$ 168,185,493	8.0%
$50K to $75K	2,686	0.5%	$ 164,247,105	7.8%
$40K to $50K	1,951	0.4%	$ 87,160,347	4.1%
$30K to $40K	3,007	0.6%	$ 104,064,642	4.9%
SubTotal	***13,846***	***2.6%***	***$ 1,402,584,000***	***66.6%***
$20K to $30K	5,405	1.0%	$ 131,892,681	6.3%
$10K to $20K	14,776	2.8%	$ 208,036,911	9.9%
$5K to $10K	18,664	3.5%	$ 133,196,016	6.3%
SubTotal	***38,845***	***7.3%***	***$ 473,125,608***	***22.5%***
Total	**52,691**	***9.9%***	**$ 1,875,709,608**	***89.1%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Oct 2024	406,203	$ 1,914,089,704
Dis-Enrolled During Year	123,892	$ 190,547,824
Totals	**530,095**	**$ 2,104,637,528**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
9.9% of Members = 89.1% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Nov 2023 - Oct 2024
Note: Data incomplete due to claims lag
Run Date: 01/28/2024

9.9% of Members = 89.1% of Costs
20.7% of members are SPDs and account for 27.2% of costs.
34.6% of members are ACA OE and account for 32.9% of costs.
8.4% of members disenrolled as of Oct 2024 and account for 9.1% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	185	895	1,080	2.0%
MCAL	MCAL - ADULT	1,211	7,215	8,426	16.0%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	598	3,666	4,264	8.1%
	MCAL - ACA OE	4,410	13,810	18,220	34.6%
	MCAL - SPD	3,799	7,098	10,897	20.7%
	MCAL - DUALS	1,012	3,038	4,050	7.7%
	MCAL - LTC	206	11	217	0.4%
	MCAL - LTC-DUAL	1,031	77	1,108	2.1%
Not Eligible	Not Eligible	1,394	3,035	4,429	8.4%
Total		**13,846**	**38,845**	**52,691**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 15,304,165	$ 10,345,278	$ 25,649,443	1.4%
MCAL	MCAL - ADULT	$ 113,277,359	$ 86,624,338	$ 199,901,697	10.7%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 45,388,651	$ 40,891,977	$ 86,280,628	4.6%
	MCAL - ACA OE	$ 449,786,042	$ 167,159,856	$ 616,945,898	32.9%
	MCAL - SPD	$ 417,335,255	$ 92,425,738	$ 509,760,993	27.2%
	MCAL - DUALS	$ 91,351,671	$ 35,932,883	$ 127,284,554	6.8%
	MCAL - LTC	$ 31,827,917	$ 207,032	$ 32,034,948	1.7%
	MCAL - LTC-DUAL	$ 105,302,932	$ 1,288,301	$ 106,591,232	5.7%
Not Eligible	Not Eligible	$ 133,010,009	$ 38,250,205	$ 171,260,214	9.1%
Total		**$ 1,402,584,000**	**$ 473,125,608**	**$ 1,875,709,608**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
30.9% of members are SPDs and account for 32.4% of costs.
27.4% of members are ACA OE and account for 32.1% of costs.
8.4% of members disenrolled as of Oct 2024 and account for 8.7% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	44	1.0%
MCAL	MCAL - ADULT	260	6.1%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	82	1.9%
	MCAL - ACA OE	1,172	27.4%
	MCAL - SPD	1,322	30.9%
	MCAL - DUALS	395	9.2%
	MCAL - LTC	156	3.6%
	MCAL - LTC-DUAL	490	11.5%
Not Eligible	Not Eligible	358	8.4%
Total		**4,279**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 8,033,653	0.9%
MCAL	MCAL - ADULT	$ 64,025,486	7.3%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 20,144,706	2.3%
	MCAL - ACA OE	$ 282,205,576	32.1%
	MCAL - SPD	$ 285,130,226	32.4%
	MCAL - DUALS	$ 52,305,431	6.0%
	MCAL - LTC	$ 28,069,295	3.2%
	MCAL - LTC-DUAL	$ 62,232,756	7.1%
Not Eligible	Not Eligible	$ 76,779,284	8.7%
Total		**$ 878,926,413**	**100.0%**

% of Total Costs By Service Type

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs
$100K+	5%	0%	1%
$75K to $100K	4%	0%	1%
$50K to $75K	4%	0%	2%
$40K to $50K	7%	0%	2%
$30K to $40K	10%	0%	2%
$20K to $30K	3%	1%	5%
$10K to $20K	0%	0%	11%
$5K to $10K	0%	0%	6%
Total	**4%**	**0%**	**3%**

Breakout by Service Type/Location

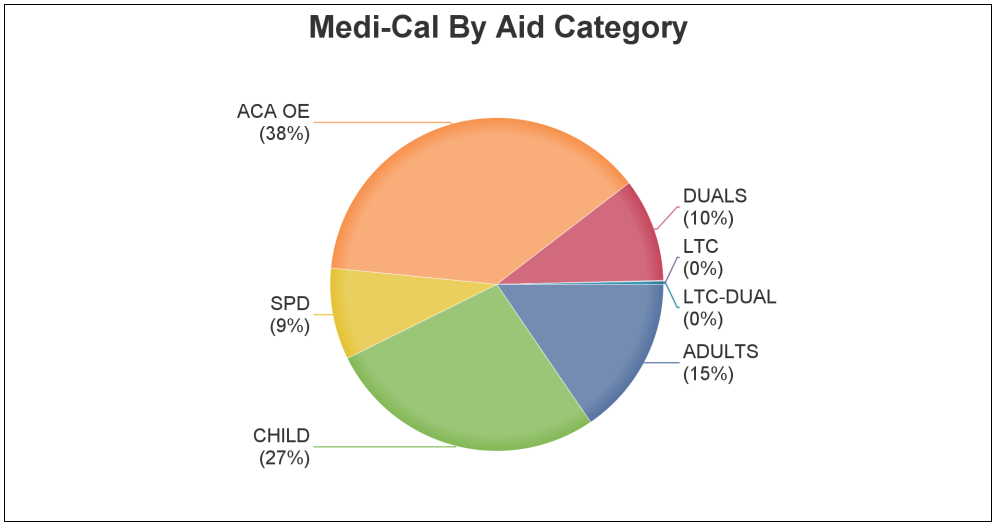
Cost Range	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	14%	39%	1%	11%	3%	2%	31%
$75K to $100K	16%	24%	2%	4%	3%	4%	46%
$50K to $75K	24%	29%	4%	7%	5%	4%	27%
$40K to $50K	33%	28%	8%	5%	6%	1%	19%
$30K to $40K	33%	22%	14%	5%	7%	1%	18%
$20K to $30K	36%	24%	7%	7%	7%	1%	19%
$10K to $20K	35%	24%	6%	9%	9%	1%	16%
$5K to $10K	31%	13%	11%	13%	13%	1%	19%
Total	**22%**	**30%**	**4%**	**9%**	**5%**	**2%**	**27%**

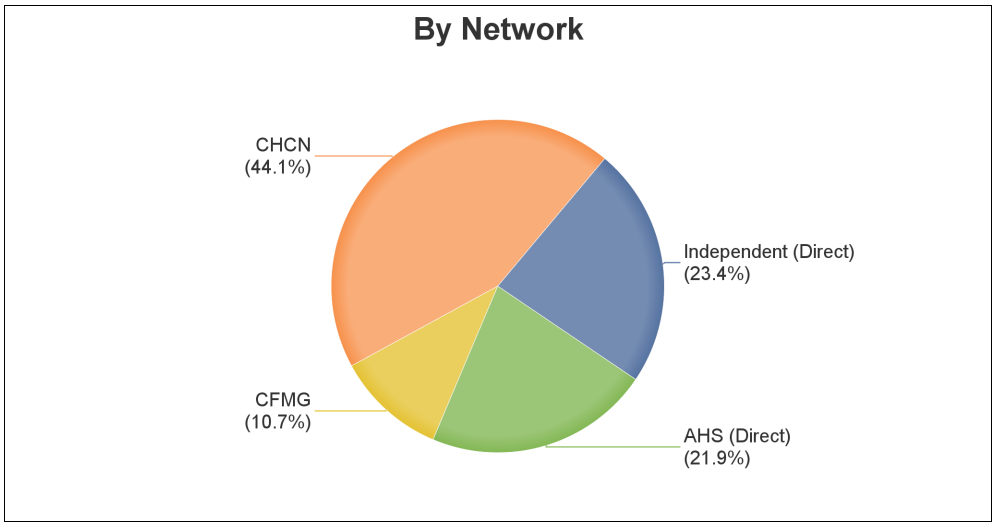
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

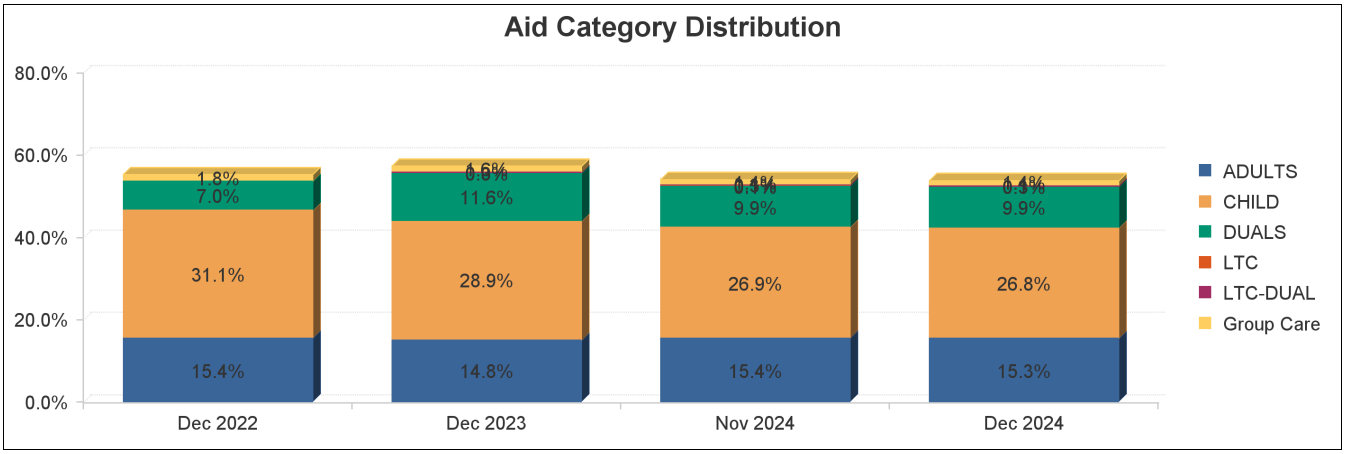
Category of Aid	Dec 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,957	15%	13,651	14,118	6	35,182
CHILD	110,547	27%	10,501	13,443	41,092	45,511
SPD	36,127	9%	12,122	5,685	1,433	16,887
ACA OE	154,565	38%	29,490	53,129	1,574	70,372
DUALS	40,812	10%	26,881	2,910	6	11,015
LTC	255	0%	240	7	0	8
LTC-DUAL	1,285	0%	1,284	0	0	1
Medi-Cal	406,548		94,169	89,292	44,111	178,976
Group Care	5,790		2,144	946	0	2,700
Total	**412,338**	**100%**	**96,313**	**90,238**	**44,111**	**181,676**
Medi-Cal %	98.6%		97.8%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.2%	1.0%	0.0%	1.5%
	Network Distribution		**23.4%**	**21.9%**	**10.7%**	**44.1%**
			% Direct:	**45%**	**% Delegated:**	**55%**





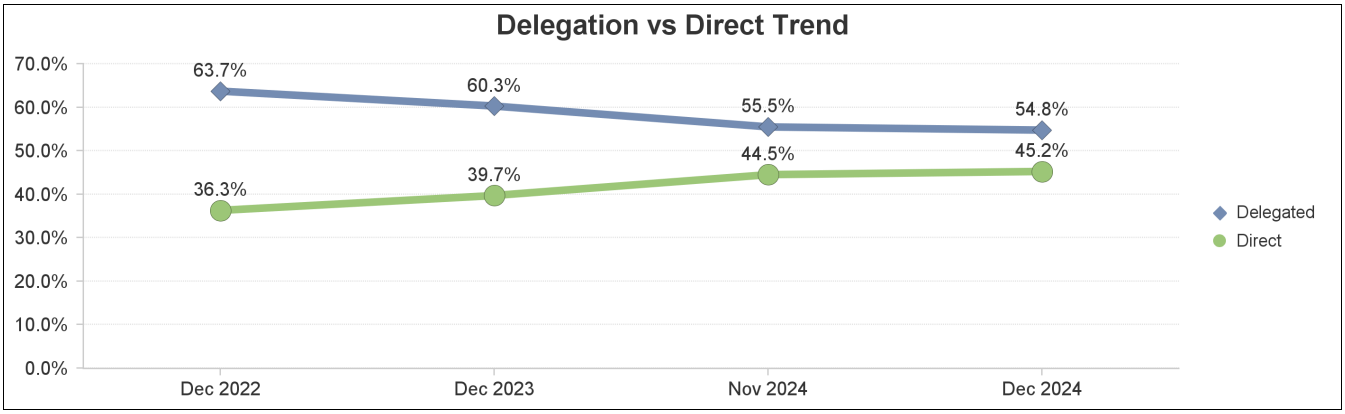
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
ADULTS	50,351	52,174	62,533	**62,957**	15.4%	14.8%	15.4%	15.3%	3.6%	20.7%	0.7%
CHILD	101,791	101,634	109,574	**110,547**	31.1%	28.9%	26.9%	26.8%	-0.2%	8.8%	0.9%
SPD	28,452	30,848	35,603	**36,127**	8.7%	8.8%	8.7%	8.8%	8.4%	17.1%	1.5%
ACA OE	118,397	119,669	151,559	**154,565**	36.1%	34.0%	37.2%	37.5%	1.1%	29.2%	2.0%
DUALS	23,028	40,976	40,360	**40,812**	7.0%	11.6%	9.9%	9.9%	77.9%	-0.4%	1.1%
LTC	0	135	255	**255**	0.0%	0.0%	0.1%	0.1%	0.0%	88.9%	0.0%
LTC-DUAL	0	951	1,269	**1,285**	0.0%	0.3%	0.3%	0.3%	0.0%	35.1%	1.3%
Medi-Cal	322,019	346,387	401,153	**406,548**	98.2%	98.4%	98.6%	98.6%	7.6%	17.4%	1.3%
Group Care	5,776	5,622	5,772	**5,790**	1.8%	1.6%	1.4%	1.4%	-2.7%	3.0%	0.3%
Total	**327,795**	**352,009**	**406,925**	412,338	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**7.4%**	**17.1%**	**1.3%**



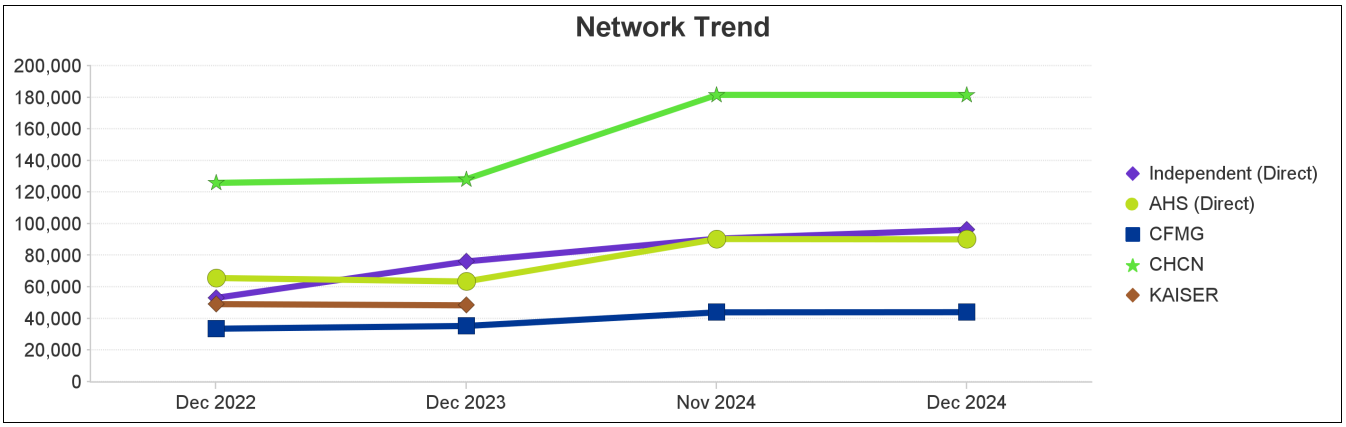
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
Delegated	208,881	212,220	225,785	**225,787**	63.7%	60.3%	55.5%	54.8%	1.6%	6.4%	0.0%
Direct	118,914	139,789	181,140	**186,551**	36.3%	39.7%	44.5%	45.2%	17.6%	33.5%	3.0%
Total	**327,795**	**352,009**	**406,925**	412,338	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**7.4%**	**17.1%**	**1.3%**



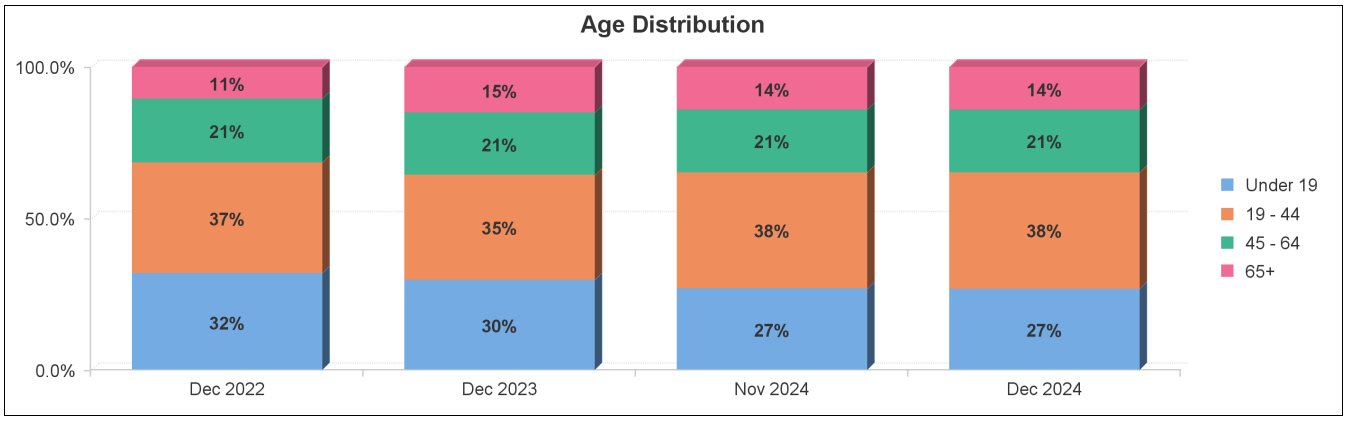
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
Independent (Direct)	53,143	76,241	90,681	**96,313**	16.2%	21.7%	22.3%	23.4%	43.5%	26.3%	6.2%
AHS (Direct)	65,771	63,548	90,459	**90,238**	20.1%	18.1%	22.2%	21.9%	-3.4%	42.0%	-0.2%
CFMG	33,648	35,401	44,031	**44,111**	10.3%	10.1%	10.8%	10.7%	5.2%	24.6%	0.2%
CHCN	126,009	128,342	181,754	**181,676**	38.4%	36.5%	44.7%	44.1%	1.9%	41.6%	0.0%
KAISER	49,224	48,477	0	**0**	15.0%	13.8%	0.0%	0.0%	-1.5%	-100.0%	0.0%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**7.4%**	**17.1%**	**1.3%**



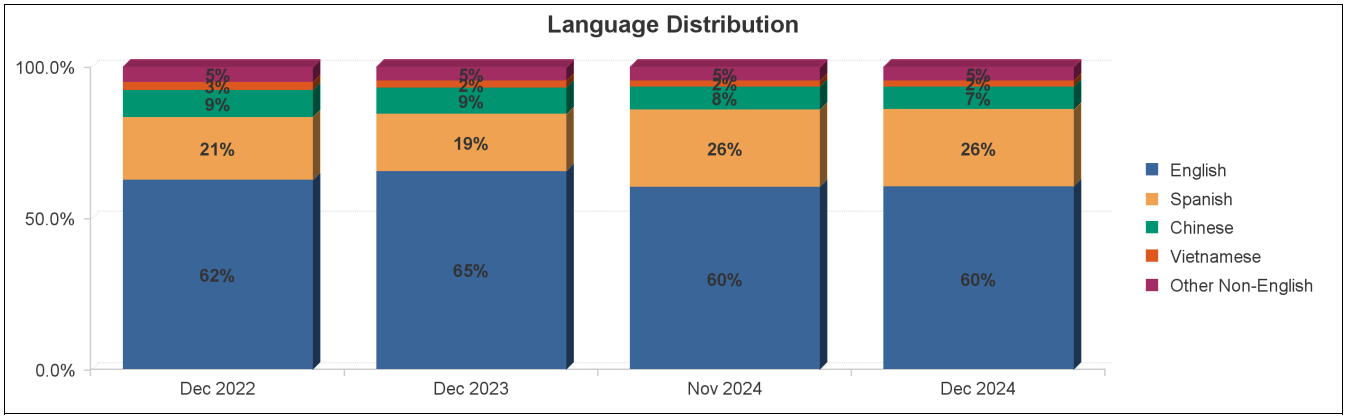
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
Under 19	104,022	104,062	108,407	**109,506**	32%	30%	27%	27%	0%	5%	1%
19 - 44	119,997	121,694	155,955	**158,707**	37%	35%	38%	38%	1%	30%	2%
45 - 64	68,606	72,612	84,411	**85,272**	21%	21%	21%	21%	6%	17%	1%
65+	35,170	53,641	58,152	**58,853**	11%	15%	14%	14%	53%	10%	1%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100%**	**100%**	**100%**	**100%**	**7%**	**17%**	**1%**



Language Trend

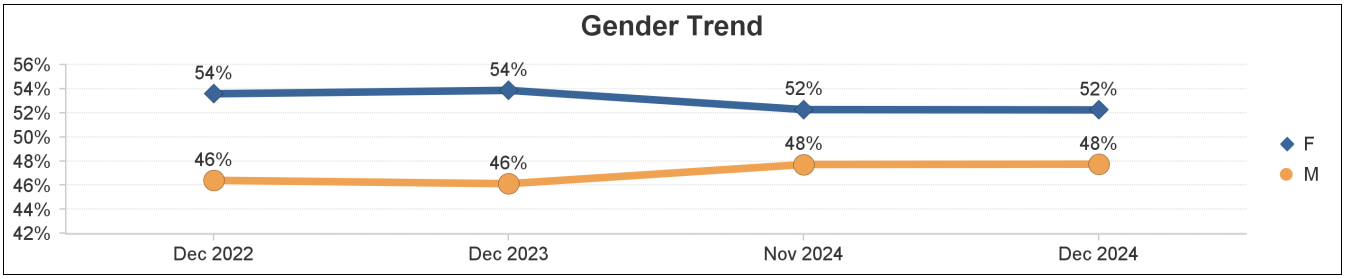
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Dec 2022	Dec 2023	Nov 2024	Dec 2024	ec 2022	ec 2023	Nov 2024	ec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
English	204,635	229,835	244,547	**248,451**	62%	65%	60%	60%	12%	8%	2%
Spanish	68,179	66,602	104,072	**105,234**	21%	19%	26%	26%	-2%	58%	1%
Chinese	29,182	30,505	30,682	**30,806**	9%	9%	8%	7%	5%	1%	0%
Vietnamese	8,904	8,507	8,223	**8,294**	3%	2%	2%	2%	-4%	-3%	1%
Other Non-English	16,895	16,560	19,401	**19,553**	5%	5%	5%	5%	-2%	18%	1%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100%**	**100%**	**100%**	**100%**	**7%**	**17%**	**1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

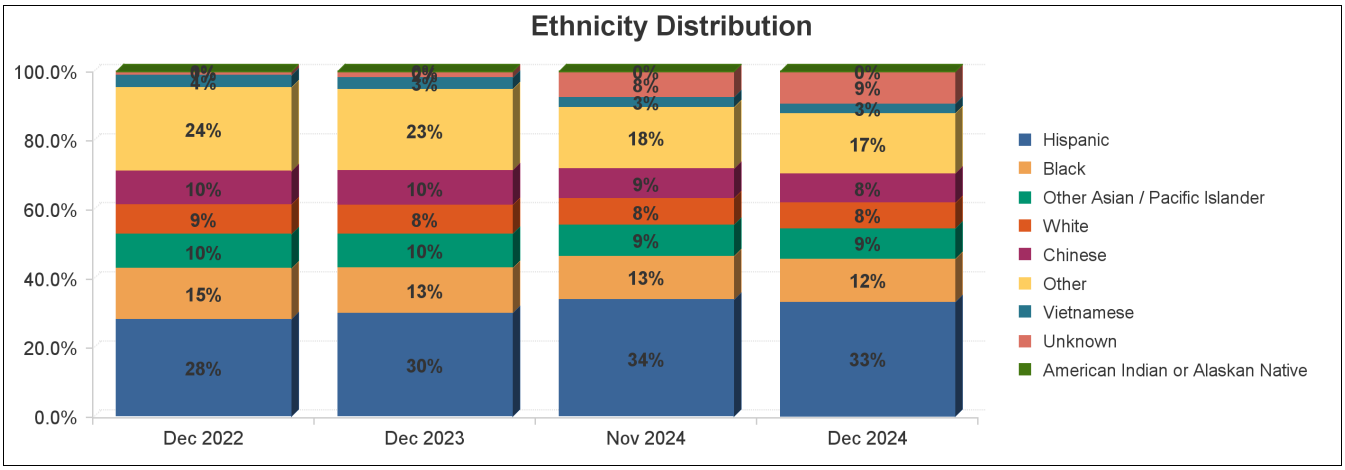
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
F	175,661	189,639	212,721	**215,451**	54%	54%	52%	52%	8%	14%	1%
M	152,134	162,370	194,204	**196,887**	46%	46%	48%	48%	7%	21%	1%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100%**	**100%**	**100%**	**100%**	**7%**	**17%**	**1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
Hispanic	92,030	104,945	137,424	**136,294**	28%	30%	34%	33%	14%	30%	-1%
Black	48,301	46,303	51,258	**51,323**	15%	13%	13%	12%	-4%	11%	0%
Other Asian / Pacific Islander	32,466	34,537	36,733	**36,322**	10%	10%	9%	9%	6%	5%	-1%
White	28,063	29,449	31,272	**30,931**	9%	8%	8%	8%	5%	5%	-1%
Chinese	31,839	35,470	34,944	**34,683**	10%	10%	9%	8%	11%	-2%	-1%
Other	79,375	82,447	72,555	**71,988**	24%	23%	18%	17%	4%	-13%	-1%
Vietnamese	11,505	11,943	11,441	**11,366**	4%	3%	3%	3%	4%	-5%	-1%
Unknown	3,531	6,228	30,524	**38,664**	1%	2%	8%	9%	76%	521%	27%
American Indian or Alaskan Native	685	687	774	**767**	0%	0%	0%	0%	0%	12%	-1%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100%**	**100%**	**100%**	**100%**	**7%**	**17%**	**1%**



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

Medi-Cal By City

City	Dec 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,231	40%	25,873	41,915	17,311	77,132
HAYWARD	65,187	16%	14,300	17,525	7,494	25,868
FREMONT	38,188	9%	16,105	6,638	2,252	13,193
SAN LEANDRO	33,420	8%	8,659	5,622	4,229	14,910
UNION CITY	14,789	4%	5,814	2,601	845	5,529
ALAMEDA	13,764	3%	3,382	2,444	2,038	5,900
BERKELEY	15,451	4%	4,479	2,274	1,760	6,938
LIVERMORE	13,237	3%	2,075	587	2,233	8,342
NEWARK	9,519	2%	2,855	4,099	553	2,012
CASTRO VALLEY	9,549	2%	2,754	1,555	1,422	3,818
SAN LORENZO	7,425	2%	1,541	1,662	860	3,362
PLEASANTON	7,807	2%	1,881	405	831	4,690
DUBLIN	7,641	2%	2,085	401	900	4,255
EMERYVILLE	2,887	1%	709	622	453	1,103
ALBANY	2,563	1%	698	302	570	993
PIEDMONT	482	0%	111	185	74	112
SUNOL	83	0%	24	14	6	39
ANTIOCH	63	0%	23	11	9	20
Other	2,262	1%	801	430	271	760
Total	406,548	100%	**94,169**	**89,292**	**44,111**	**178,976**

Group Care By City

City	Dec 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,825	32%	339	356	0	1,130
HAYWARD	664	11%	310	162	0	192
FREMONT	665	11%	442	80	0	143
SAN LEANDRO	609	11%	245	93	0	271
UNION CITY	289	5%	183	43	0	63
ALAMEDA	307	5%	88	27	0	192
BERKELEY	147	3%	48	10	0	89
LIVERMORE	100	2%	31	4	0	65
NEWARK	136	2%	80	31	0	25
CASTRO VALLEY	198	3%	86	31	0	81
SAN LORENZO	139	2%	45	28	0	66
PLEASANTON	71	1%	24	2	0	45
DUBLIN	119	2%	40	4	0	75
EMERYVILLE	35	1%	13	6	0	16
ALBANY	20	0%	10	1	0	9
PIEDMONT	8	0%	2	0	0	6
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	6	4	0	14
Other	433	7%	151	64	0	218
Total	**5,790**	**100%**	**2,144**	**946**	**0**	**2,700**

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

Total By City

City	Dec 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	164,056	40%	26,212	42,271	17,311	78,262
HAYWARD	65,851	16%	14,610	17,687	7,494	26,060
FREMONT	38,853	9%	16,547	6,718	2,252	13,336
SAN LEANDRO	34,029	8%	8,904	5,715	4,229	15,181
UNION CITY	15,078	4%	5,997	2,644	845	5,592
ALAMEDA	14,071	3%	3,470	2,471	2,038	6,092
BERKELEY	15,598	4%	4,527	2,284	1,760	7,027
LIVERMORE	13,337	3%	2,106	591	2,233	8,407
NEWARK	9,655	2%	2,935	4,130	553	2,037
CASTRO VALLEY	9,747	2%	2,840	1,586	1,422	3,899
SAN LORENZO	7,564	2%	1,586	1,690	860	3,428
PLEASANTON	7,878	2%	1,905	407	831	4,735
DUBLIN	7,760	2%	2,125	405	900	4,330
EMERYVILLE	2,922	1%	722	628	453	1,119
ALBANY	2,583	1%	708	303	570	1,002
PIEDMONT	490	0%	113	185	74	118
SUNOL	84	0%	25	14	6	39
ANTIOCH	87	0%	29	15	9	34
Other	2,695	1%	952	494	271	978
Total	412,338	100%	**96,313**	**90,238**	**44,111**	**181,676**

ALAMEDA Alliance FOR HEALTH

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

Human Resources

Anastacia Swift

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

From: **Anastacia Swift, Chief Human Resources Officer**

Date: **February 14th, 2025**

Subject: **Human Resources Report**

Staffing

- As of February 1st, 2025, the Alliance had 647 full time employees and 0-part time employee.

- On February 1st, 2025, the Alliance had 50 open positions in which 9 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 41 positions open to date. The Alliance is actively recruiting for the remaining 41 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by division:

Division	Open Position February 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	8	2	6
Operations	25	3	22
Healthcare Analytics	1	0	1
Information Technology	7	2	5
Finance	3	2	1
Compliance	3	0	3
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	50	9	41

- Our current recruitment rate is 7%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in January 2025 included:

  5 years:
  - Baljeet K (Case/Disease Management)
  - Mashon J (Vendor Management)

  6 years:
  - Jeffrey B (Pharmcy Services)
  - Chidananda M (IT - Apps Management, IT Quality & Process Improvement)
  - Yan X (Utilization Management)

  7 years:
  - Anastacia S (Human Resources)
  - Alice M (Utilization Management)

  9 years:
  - Deborah A (Finance)
  - Shruti G (Healthcare Analytics)
  - Jennifer K (Regulatory Readiness)

  10 years:
  - John S (IT – Development)

  12 years:
  - Lena L (Case/Disease Management)

  13 years:
  - Anthony T (Finance)
  - Raul C (IT)

  17 years:
  - Beza T (IT – Ops & Quality Apps Management)

  23 years:
  - Rachel C (Claims)