



Board of Governors PACKET

February 13th, 2026



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EXECUTIVE SUMMARY APPENDIX

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SUPPORTING MATERIALS APPENDIX

Please click on the hyperlink(s) below to direct you to
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CEO Update

Matthew Woodruff

To: Alameda Alliance for Health Board of Governors

From: Matthew Woodruff, Chief Executive Officer

Date: February 13th, 2026

Subject: CEO Report

○ **Financials:**

- **December 2025:** Net Operating Performance by Line of Business for the month of December 2025 and Year-To-Date (YTD):

	<u>December</u>	<u>YTD</u>
Medi-Cal	\$2.98M	\$29.2M
Group Care	(\$216K)	(\$842K)
Medicare	(\$1.8M)	(\$6.0M)
Total	\$968K	\$22.3M

- **Revenue was \$192.1 million in December 2025 and \$1.1 billion Year-to-Date (YTD).**
- Medical expenses were \$183.2 million in December and \$1.1 billion for the fiscal year-to-date; the medical loss ratio is 95.4% for the month and 94.1% for the fiscal year-to-date.
 - Administrative expenses were \$10.5 million in December and \$59.1 million for the fiscal year-to-date; the administrative loss ratio is 5.4% of net revenue for the month and 5.2% of net revenue year-to-date.
- **Tangible Net Equity (TNE):** Financial reserves are 238% of the required DMHC minimum, representing \$111.2 million in excess TNE.
- **Total enrollment in December 2025 was 401,124**, decreased by 2,315 Medi-Cal members compared to November 2025.

○ **Key Performance Indicators:**

○ **Regulatory Metrics:**

- The Claims team missed one processing timeline. The team processed 87% of claims within 30 calendar days. The State regulatory metric should be 90% to be considered compliant.
- Member grievances scored 89% processing time, which is below the 95% compliance mark.
- Expedited grievances were at 21% compliance. Six of the twenty-two grievances missed the 72 hour turnaround.
-

- **Non-Regulatory Metrics:**
 - All non-regulatory metrics were met for January.
- **Legislative Updates:**
 - State And Federal Updates
 - Legislative update attached.
- **Strategic Planning**
 - The CEO will be following up on the approved strategic plan, including deliverables, and next steps.
- **IT Workflow Automation - Quarterly Updates – Next Update March 2026**
- **Alliance in the Community – Quarterly Updates – Next Update March 2026**
- **Medicare Overview**
 - 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 86 projects, of which 58 are active, 27 requested, one (1) on hold, and 17 complete.
 - Medicare D-SNP product launched successfully on January 1st, 2026, which aligns with the Alliance 30th anniversary.
 - 165 effectuated enrollments occurred in January 2026.
 - Post deployment command center established to triage go-live situations.
 - Baywell Health from Community Health Center Network (CHCN) has joined the Medicare D-SNP pilot as an active participating health center.
 - Future road shows, MOC and Stars training will be planned for Q12026.
 - Provider facing Stars and Risk Adjustment tips and best practices documentation has been completed, posted online, and shared with providers. PY2027 Bid Design, project and program enhancements, and strategic initiatives are all underway for Medicare D-SNP.
 - Marketing and Sales vendor assessment is kicked off.
 - IT is continuing multiple deployments for various core systems, eligibility file exchanges with new vendors, CMS connection to various new databases, and other releases for enhancements/add-ons.



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Demographics

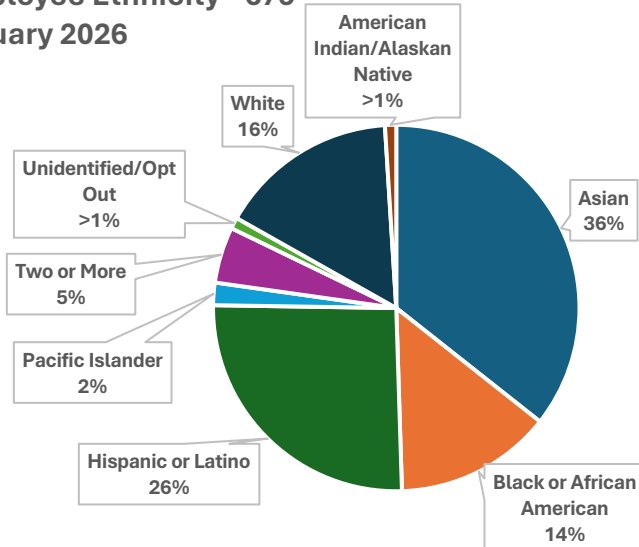
This report provides a comparative analysis of the demographic composition of Alameda Alliance for Health’s workforce in relation to the population profile of Alameda County. The evaluation focuses on key demographic indicators, including race/ethnicity, gender, and age distribution. The objective is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

The demographic data for Alameda County, including total population figures and detailed demographic breakdowns, is sourced from Healthy Alameda County, a centralized data repository of information related to Alameda County, sponsored by the Alameda County Public Health Department. This platform provides the most current county-level information, encompassing over 250 indicators of community wellbeing ([Healthy Alameda County :: Demographics :: County :: Alameda](#)). The county data referenced in this report reflects updates as of May 2025. Additionally, demographic data for Alameda Alliance for Health was last updated January 2026 and is collected and maintained internally, monthly, by the Human Resources Department.

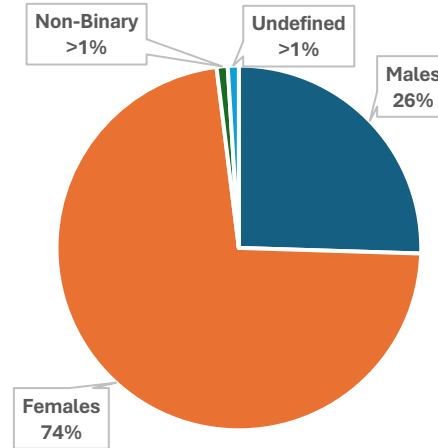
Category	Alameda Alliance for Health (Workforce information last updated January 2026)	Alameda County (Population Information last updated in May 2025)
Population/Total Employees	679	1,626,575
Race & Ethnicity		
Asian	36%	35.39%
Hispanic	26%	23.94%
White	16%	28.26%
Black/African American	14%	9.15%
Native Hawaiian/Pacific Islander	2%	0.82%
American Indian/Alaskan Native	>1%	1.18%
Two or More Races	5%	11.62%
Unidentified/Opt Out	>1%	-
Gender		
Male	26%	49.67%
Female	74%	50.33%
Non-Binary	>1%	-
Undefined	>1%	-
Age Distribution		
Under 25	>1%	8.33%
25-34	20%	13.92%
35-44	36%	16.13%
45-54	26%	13.59%
55-Older	18%	29.03%

AAH Employee Demographics Data Report January 2026

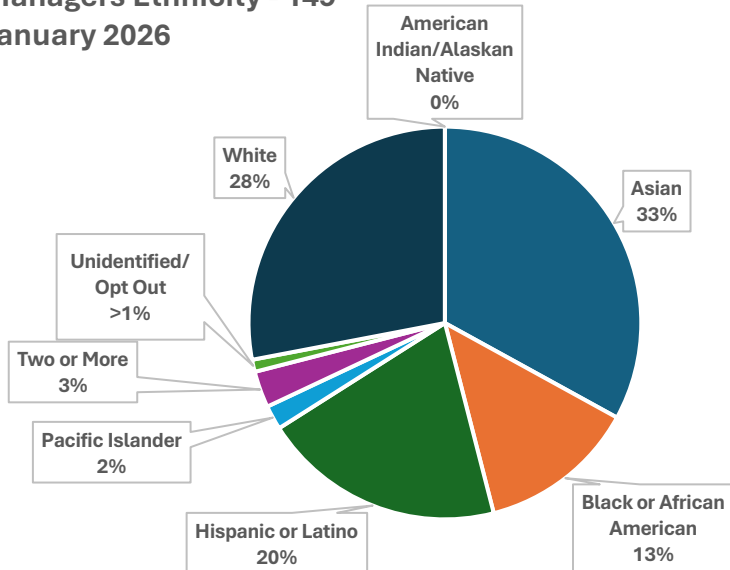
Employee Ethnicity - 679
January 2026



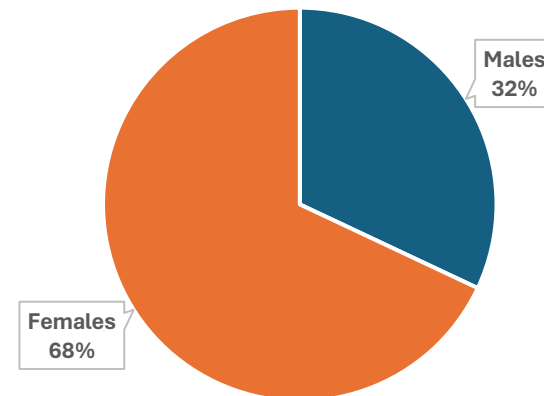
Employee Gender - 679
January 2026



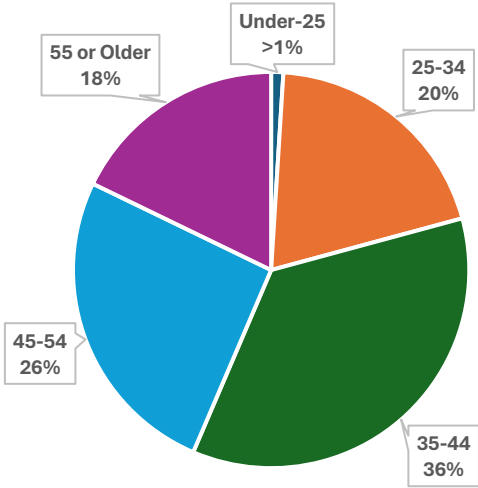
Managers Ethnicity - 149
January 2026



Managers Gender - 149
January 2026



Employee Age Demographics - 679
January 2026





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Legislative Tracking



February 2026 Legislative Update

Legislative Affairs and Media Relations Department

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

Federal Policy Update

After just a few days of a partial federal government shutdown, congressional members voted 217-214 to pass a fiscal year 2026 appropriations package that includes five appropriations bills, including Labor-US Department of Health and Human Services (HHS). The bill which became law on February 2, 2026, separated and extended funding for the Department of Homeland Security until February 12, 2026, as the White House, Republicans and Democrats work on a deal which could include new restrictions for ICE and CBP.

On January 27th, the Department of Health and Human Services (HHS) sent a letter to Governor Newsom requesting a comprehensive program integrity action plan with targeted questions in five identified areas including: 1) Fraud, Waste, Abuse, and Improper Payments, 2) Eligibility Determinations and Immigration Status Controls, 3) Provider Screening, Enrollment, and Validation, 4) Program Integrity Infrastructure and Accountability, and 5) IHSS Program Specific Oversight. CMS gave a deadline of February 17, 2026, to produce responses in the above areas.

On January 29th, 2026, CMS published the "*Medicaid Program: Preserving Medicaid Funding for Vulnerable Populations - Closing a Health Care-Related Tax Loophole*" final rule. The final rule outlines a transition timeline for states to come into compliance, which gives California a transition period through December 31, 2026.

The Alliance has continued to participate in various local coalitions with county partners, hospitals, clinics and other key healthcare partners working to coordinate and respond to the major policies impacting the Medi-Cal program due to H.R. 1 and the state budget. The focus continues to be on outreach to Medi-Cal members to encourage them to renew their coverage and will soon shift to planning for and mitigating the impact of work requirements and 6-month redeterminations.

State Legislative Update

The Alliance Legislative Affairs and Media Relations team attended the California Assembly Budget hearing on January 20, 2026, as well as the Assembly Committee on Health on January 27, 2026. During both hearings, the DHCS discussed anticipated consequences from H.R. 1 on

Medi-Cal enrollment and noted how 2026-27 Medi-Cal costs are partially offset by projected savings from:

- Work requirements: \$373.3M total funds; \$102.4M General Fund
- Medical Assistance Percentage for Emergency Services: for ACA Adult Expansion member with UIS (\$658M General Fund)
- Six-month redeterminations: \$463.3M total funds; \$74.1M General Fund
- Reduced retroactive coverage: \$23M total funds; \$9.6M General Fund
- Restrictions on Immigrant Eligibility: transitions individuals into restricted-scope Medi-Cal (\$786M GF in 2026-27 and \$1.1B GF ongoing)

Our team also attended the first Future of Medi-Cal Commission meeting on January 22, 2026. The Commission is an independent group of twenty-nine health care leaders (including Alliance Vice-Chair Dr. Noha Aboelata and La Clinica's CEO Jane Garcia) who are developing a 10-year vision and actionable roadmap to improve California's Medi-Cal program. The initial meeting focused primarily on introductions and stakeholder feedback on aligning the Commission's mission to address potential H.R. 1 impacts on the state.

On January 20, 2026, DHCS released their draft "[Implementation Plan for New Federal Eligibility and Enrollment Changes Under H.R. 1](#)" which outlines the state's approach to implementing new federal eligibility and enrollment changes under H.R. 1. The plan emphasizes improved automation to protect coverage, streamlined verification, targeted outreach and education, a simplified Medi-Cal renewal process, and enhanced training for county eligibility workers and DHCS coverage ambassadors.

Lastly, our team attended the DHCS all-comer webinar, "Implementation Plan for New Eligibility and Enrollment Changes under H.R. 1," on February 5, 2026. During the webinar, the DHCS outlined how the state plans to engage key partners including counties, managed care plans, Medi-Cal enrollees, community partners, and healthcare providers to raise awareness around H.R. 1 work and community engagement requirements. The DHCS also noted how the draft implementation plan will be updated as further federal guidance is released.

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

Priority Bill List

The 2026-27 legislative cycle began on January 5, 2026. Bills continue to be introduced and cover a wide range of topics from healthcare to climate change and transportation. Due to anticipatory federal funding restrictions under H.R. 1 and the ongoing state budget deficit, many proposed bills with significant fiscal implications are unable to advance through the Assembly and Senate committees and many are already being held or stalled. The last day for bills to be introduced is February 20, 2026.

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

Measure	Author	Topic	Summary
<u>AB 1126</u>	Patterson	Medi-Cal Managed Care Plans: Enrollees with Other Health Care Coverage	This bill requires DHCS implement several changes to help Medi-Cal managed care enrollees who have other health coverage (OHC) and for whom Medi-Cal is a payer of last resort to maintain their providers. AB 1126 requires DHCS limit administrative and contracting requirements for providers when billing Medi-Cal managed care plans for services provided, prohibits DHCS from requiring a provider that is enrolled as a Medi-Cal fee-for-service provider to also enroll as a Medi-Cal managed care provider to bill a managed care plan for covered services, and allows a Medi-Cal managed care plan to require a letter of agreement with a non-contracting provider, under specified circumstances.
<u>AB 1648</u>	Rodriguez	Public Health: California Epilepsy Program	This bill would require the State Department of Public Health to establish the California Epilepsy Program for the purposes of epidemiological assessments of the incidence and prevalence of epilepsy and seizures. The bill would require the department to convene an advisory panel comprised of specified individuals to provide support and advice for the implementation of the program. AB 1648 would authorize the department to seek private or public funding and to spend those funds for the purposes of the program, and would authorize the department to contract with various entities for the purposes of collecting and collating data. The bill would require the department to analyze available data, to prepare and publish reports on its internet website as necessary, and to publish on its internet website a listing of agencies that offer services to individuals affected by epilepsy, as specified.

AB 1682	Hart	Health care Coverage: Scalp Cooling	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires coverage by health care service plans and health insurers for various screening and treatment services with respect to cancer. This bill would require a health care service plan contract or health insurance policy, except as specified, that is issued, amended, delivered, or renewed on or after January 1, 2027, to provide coverage for scalp cooling, as defined, as prescribed by a health care provider in connection with chemotherapy for persons with cancer. Because a violation of these provisions with respect to a health care service plan would be a crime, this bill would impose a state-mandated local program.
AB 1672	Solache	Medi-Cal: Program of All-Inclusive Care for the Elderly: Rates	Existing law requires the department to pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods. Existing law requires the department to develop and pay capitation rates to entities contracted pursuant to the PACE program, using actuarial methods consistent with those provisions, with specified exceptions. Existing law requires the department to consult with those contracted entities in developing a rate methodology. This bill would delete the consultation-related requirement. Under the bill, and consistent with the requirements under federal law, capitation rates would be negotiated between the department and each contracting PACE organization. The bill would require the department, as part of this negotiation before submission for federal approval, to respond in writing to any comments made by a contracting PACE organization concerning prospective rates, provide the rationale for any assumptions or calculations concerning rates upon request, and make a good faith effort to reach agreement with the contracting PACE organization on capitation rates.

AB 1561	Krell	Medi-Cal: Complex Rehabilitation Technology	This bill would prohibit the department from requiring prior authorization for the repair of a CRT-powered wheelchair if the cost of the repair does not exceed \$1,250. Under the bill, a treatment authorization request for repair or replacement of a CRT-powered wheelchair would not require an individual prescription or documentation of medical necessity from the treating practitioner if the CRT-powered wheelchair has already been approved for use by the patient. For repair of a CRT-powered wheelchair, the bill would require the supplier to document and maintain records of the items being repaired, the reason for the repair, and the labor details, as specified, with the information being subject to a post payment audit by the department. The bill would set forth other recording requirements for the supplier.
AB 1366	Flora	Reimbursement for Pharmacist Services	This bill requires the Medi-Cal program, a health care service plan (health plan), and a health insurer reimburse an advanced practice pharmacist (APP) for medication therapy management (MTM) services. AB 1366 also requires DHCS seek federal approval of a state plan amendment to recognize pharmacists as health care providers at federally qualified health centers (FQHCs) for reimbursement under the Medi-Cal program and mandates DHCS implement an MTM reimbursement methodology for covered pharmacist services related to the use of qualified specialty drugs.
AB 1629	Haney	Dental Coverage	If a health care service plan or health insurer pays a contracting dental provider directly for covered services, this bill would require the plan or insurer to pay a noncontracting dental provider directly for covered services if the noncontracting provider submits to the plan or insurer a written assignment of benefits form signed by the enrollee or insured. The bill would require the plan or insurer to provide a predetermination or prior authorization to the dental provider and to reimburse the provider for not less than that amount, except as specified. The bill would require the plan or insurer to notify the enrollee or insured that the provider was paid and that the out-of-network cost may count towards their annual or lifetime maximum.

			The bill would require a noncontracting dental provider to make specified disclosures to an enrollee or insured before accepting an assignment of benefits.
AB 1649	Ahrens	Monthly Maintenance Amount: Personal and Incidental Needs	Existing law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. This bill would increase the monthly maintenance amount for personal and incidental needs from \$35 to \$50, and would require that the amount be increased annually, as specified. The bill would make these changes subject to receipt of necessary federal approvals.
SB 490	Umberg	Alcohol and drug programs	Existing law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal) and authorizes the department to enter a Drug Medi-Cal contract with each county for the provision of alcohol and drug use services within the county service area. This bill would require the department, if it determines whether it has authority over the allegation, to initiate that investigation within 10 days of receiving the allegation and, except as specified, complete the investigation within 60 days of initiating the investigation. The bill would require the department, if it receives a complaint that does not fall under its authority, to notify the complainant that it does not investigate that type of complaint. The bill would require the employee or agent to provide the notice described above within 10 days of the employee or agency submitting their findings to the department and to conduct a follow-up site visit to determine whether the facility has ceased providing services as required.

<u>SB 912</u>	Cervantes	Comprehensive Perinatal Services	This bill would require DHCS to oversee a statewide comprehensive community-based perinatal services program and enroll health care providers to deliver these services to Medi-Cal members and make conforming changes, but would maintain the State Department of Public Health’s role with related contracts, grants, and agreements. The bill would, among other things, require DHCS to develop training on administering comprehensive perinatal services, require all perinatal providers providing perinatal care to Medi-Cal members to attend the training, and require all Medi-Cal managed care plans to ensure providers receive the training.
<u>SB 944</u>	Wiener	Medi-Cal: Acupuncture	Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Existing law sets forth a schedule of benefits covered under the Medi-Cal program, including acupuncture, but only to the extent federal matching funds are provided for acupuncture. This bill would remove the limitation requiring federal matching funds for acupuncture to be a covered benefit, thereby making acupuncture a covered benefit under Medi-Cal.

<u>SB 950</u>	Weber Pierson	Health care coverage: dementia	This bill would require a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2027, to include coverage for all medically necessary treatments or medications, as determined by a health care provider, approved by the United States Food and Drug Administration (FDA) for the treatment of Alzheimer's disease or other related dementia. On and after January 1, 2027, the bill would prohibit a health care service plan or health insurer from imposing step therapy protocols as a prerequisite to authorizing that coverage, except as provided. The bill would require a health care service plan or health insurer that, as a medical benefit, covers nonself-administered treatments approved by the FDA for the treatment of Alzheimer's disease or other medical conditions affecting memory to also include those nonself-administered treatments as an outpatient prescription drug benefit.
<u>SB 964</u>	Smallwood- Cuevas	Prescription Drug Coverage: Dose Adjustments	This bill would authorize a licensed health care professional to request, and would require that they be granted, the authority to adjust the dose or frequency of a drug to meet the specific medical needs of the enrollee or insured without prior authorization if specified conditions are met. Under the bill, if the enrollee or insured has been continuously using a prescription drug selected by their prescribing provider for the medical condition under consideration while covered by their current or previous health coverage, the health care service plan or health insurance policy would be prohibited from limiting or excluding coverage of that prescription.



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Executive Dashboard

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Financials

Income & Expenses

DECEMBER 2025

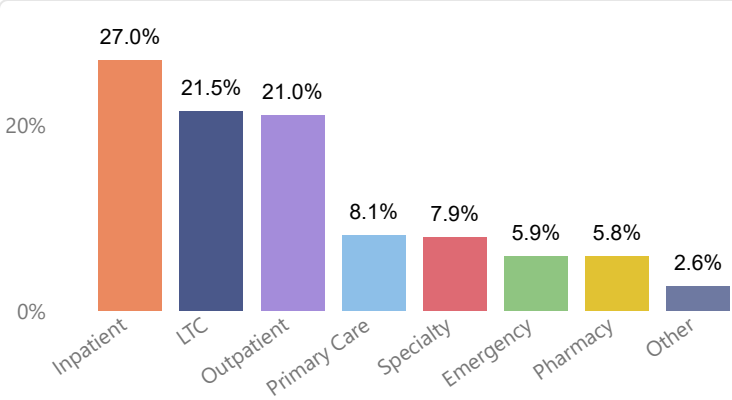
FISCAL YTD

REVENUE	\$ 256.3 M	\$ 1.5 B
MEDICAL EXPENSE	\$ (183.2) M	\$ (1.1) B
ADMIN EXPENSE	\$ (10.5) M	\$ (59.1) M
OTHER/TAX	\$ (61.8) M	\$ (373.7) M
NET INCOME	\$ 968 K	\$ 22.3 M

Medical Loss % (Fiscal YTD)

94.1%

Medical Expenses



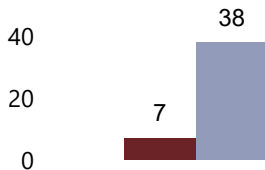
Liquid Reserves

Reinsurance Cases

TNE %
238.2%

TNE \$
\$191.6M

● New ● Submitted

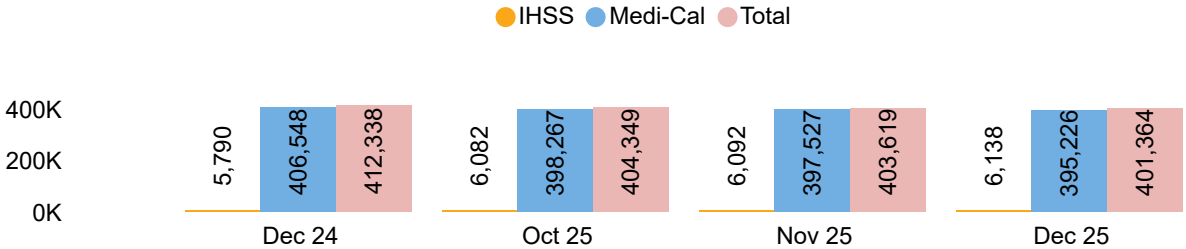


Balance Sheet

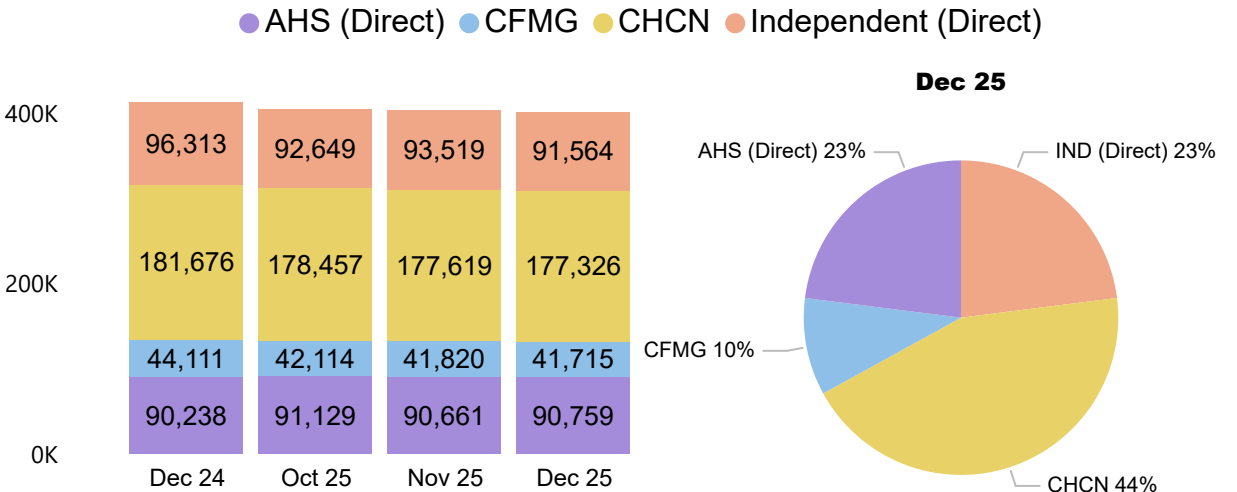
Cash Equivalents	\$756.9M	Current Ratio 1.12
Pass-Through Liabilities	\$334.1M	
Uncommitted Cash	\$422.7M	
Working Capital	\$137.7M	

Membership

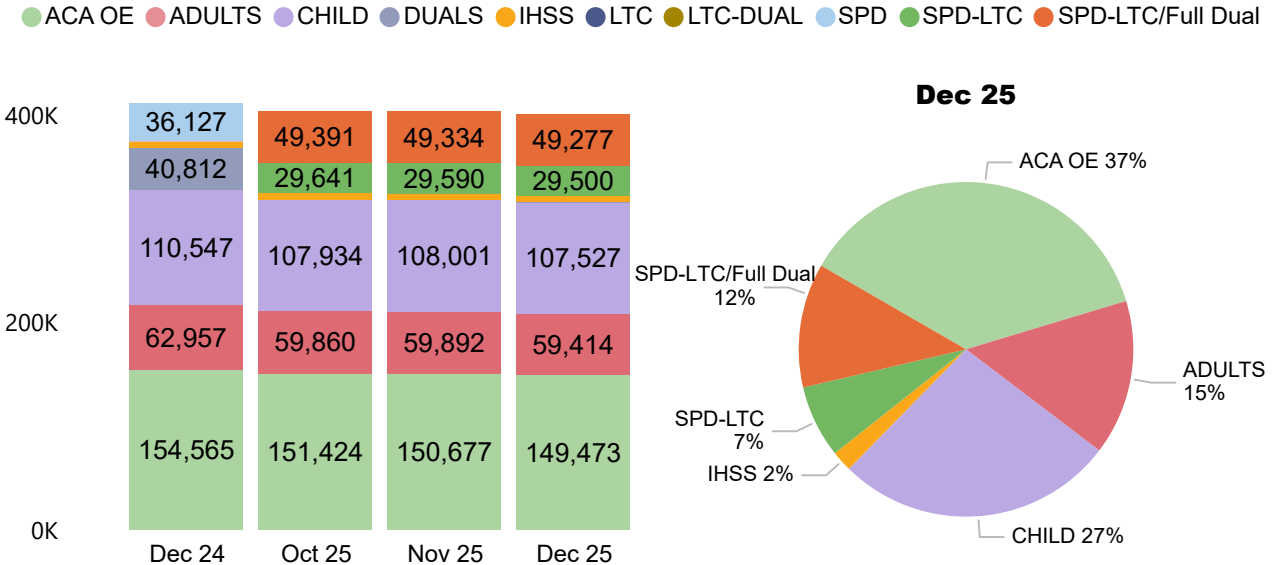
By Plan



By Network



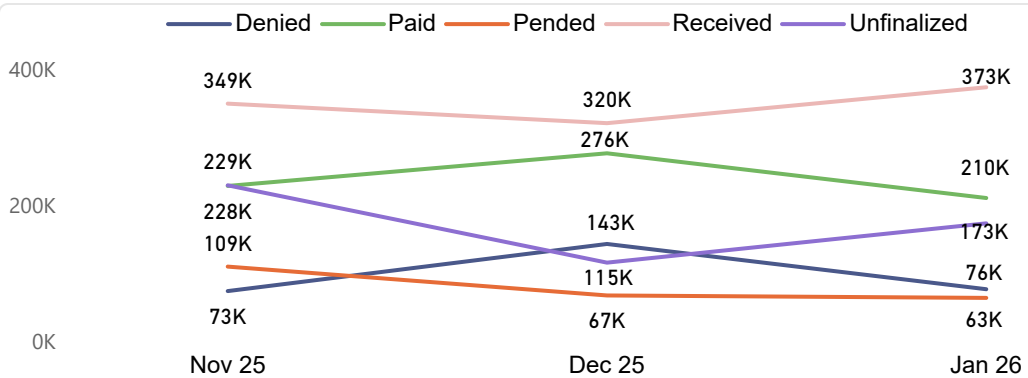
By Category



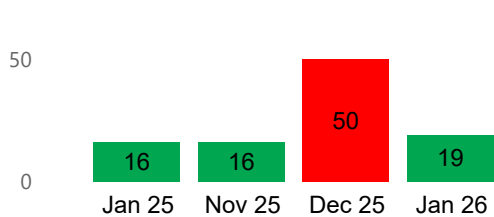
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Claims

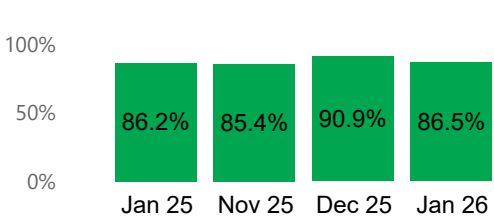
Claims Processing



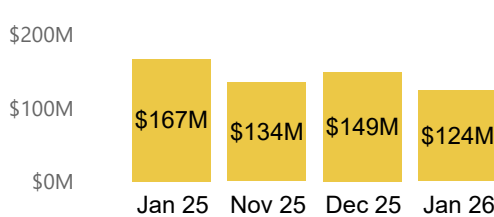
Average Payment TAT (Days)



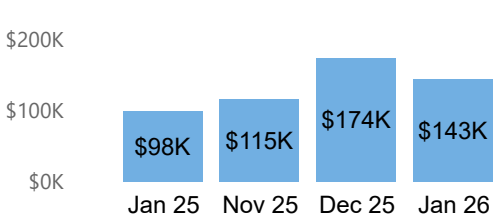
Auto Adjudication Rate (%)



Claims Paid (\$)

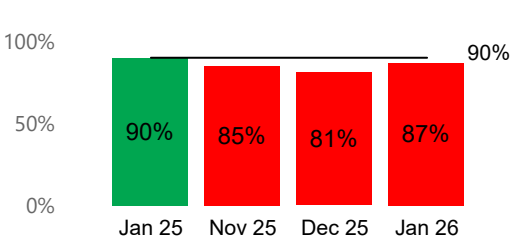


Interest Paid (\$)

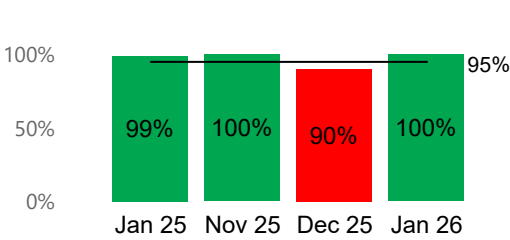


Claims Compliance

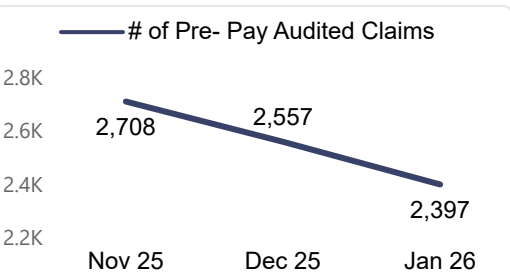
Processed 30 Cal Days (%)



Processed 45 Work Days (%)

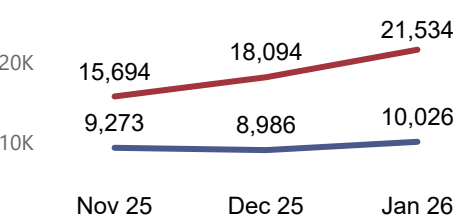


Claims Auditing

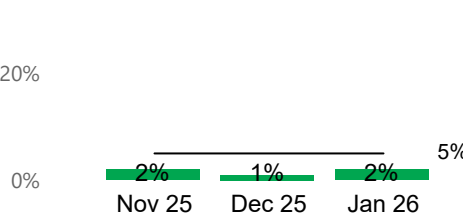


Member Services

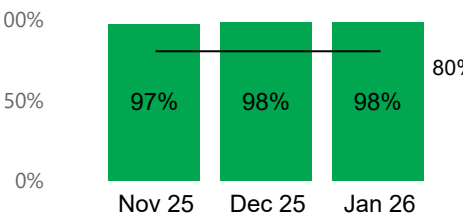
Inbound Calls Outbound Calls



Abandoned Call Rate (%)



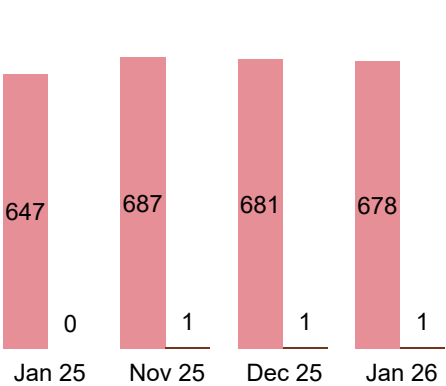
Calls Answered in 30 Seconds (%)



Average Call Times	Nov 25	Dec 25	Jan 26
Wait Time	00:07	00:07	00:07
Call Duration	06:47	06:38	07:02

Human Resources

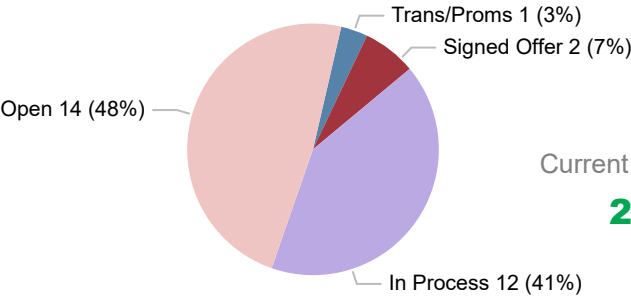
Full Time Part Time



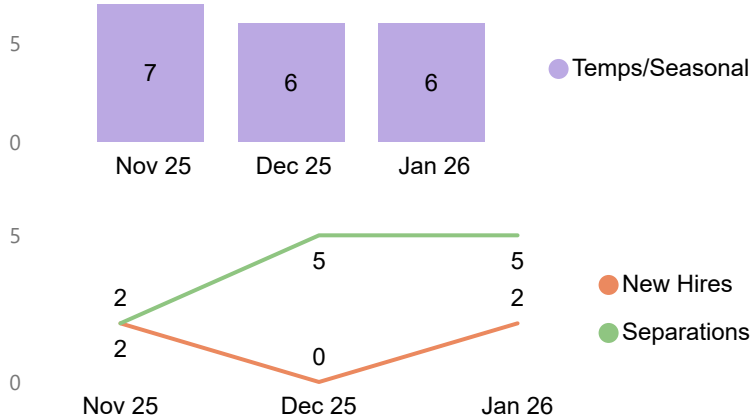
Recruiting Status

Jan 26

Trans/Proms Signed Offer In Process Open



Current Vacancy
2%



Provider Services

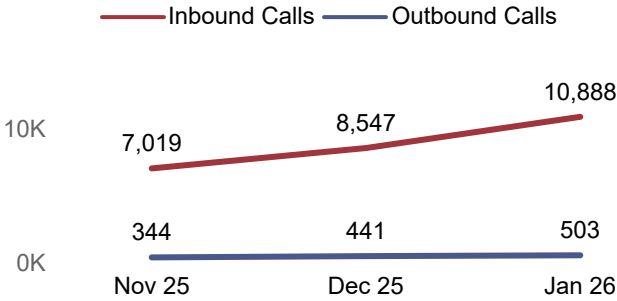
Provider Network

Hospital	17
Specialist	11,880
Primary Care Physician	793
Skilled Nursing Facility	107
Urgent Care	18
Health Centers (FQHCs and Non-FQHCs)	86
TOTAL	12,901

Provider Credentialing

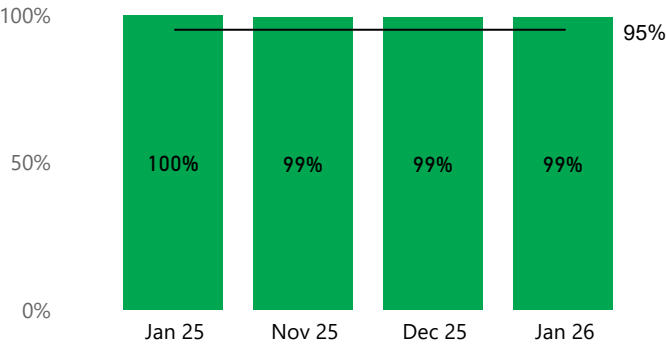
5,755

Provider Call Center



Provider Disputes & Resolutions

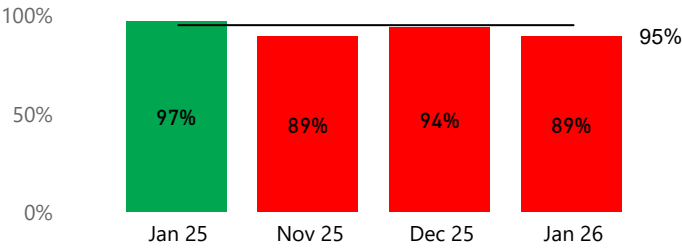
Turnaround Compliance (45 business days)



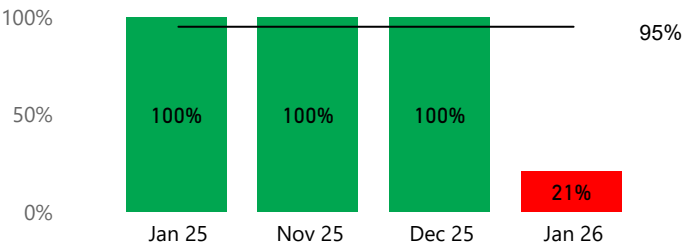
Compliance

Member Grievances

Standard (30 calendar days)

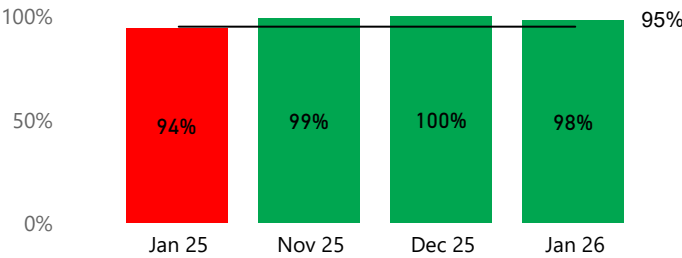


Expedited (3 calendar days)

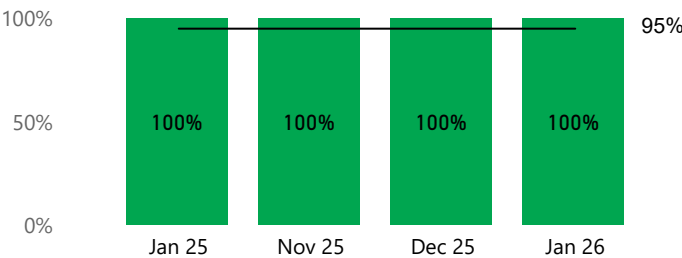


Member Appeals

Standard (30 calendar days)

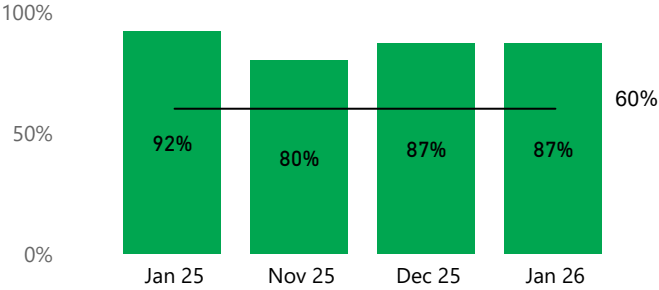


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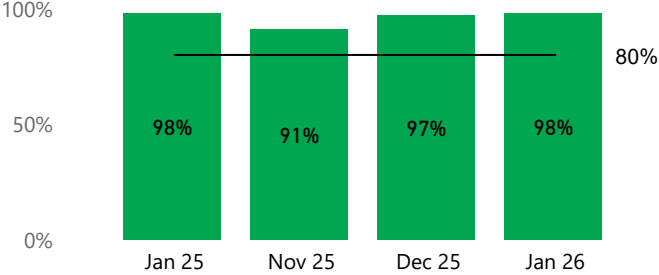


Encounter Data

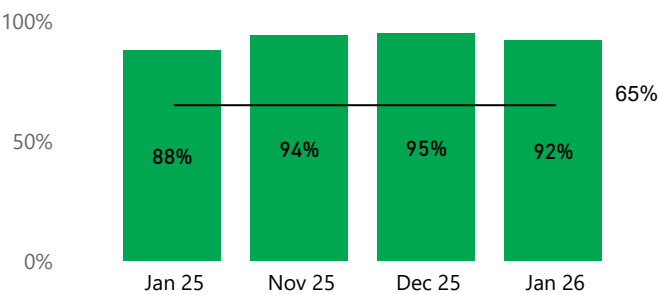
Institutional 0-90 days



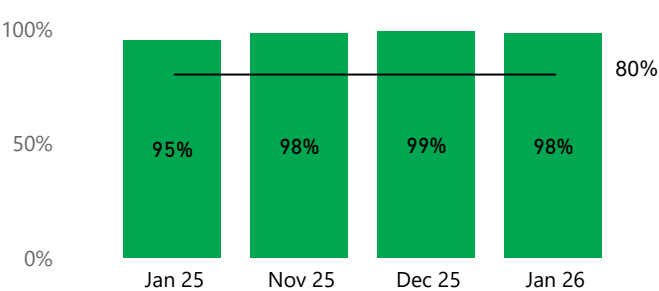
Institutional 0-180 days



Professional 0-90 days



Professional 0-180 days

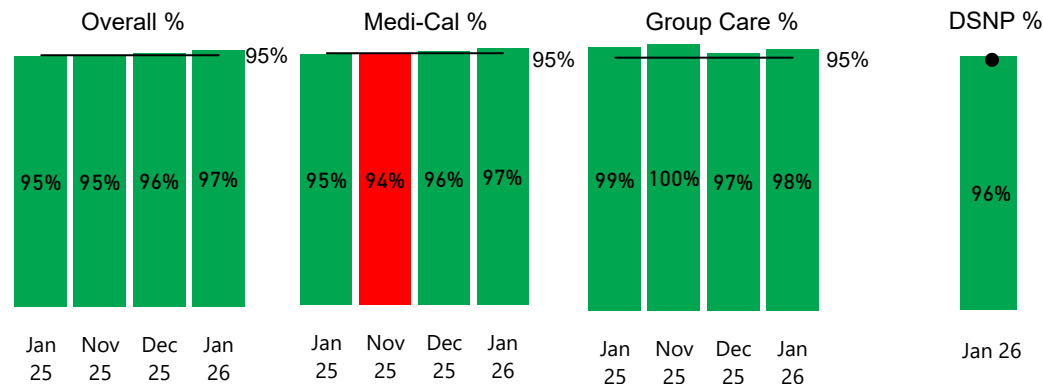


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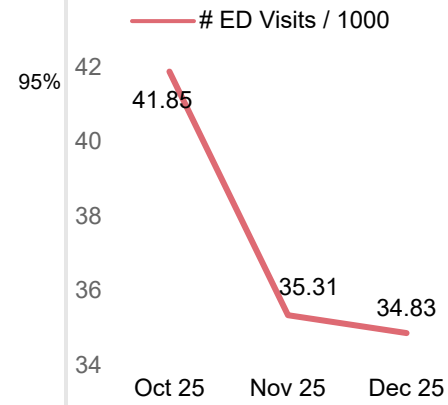
Health Care Services

Authorization Turnaround

TAT calculations were updated on 11/19/2025 to align with system configuration changes



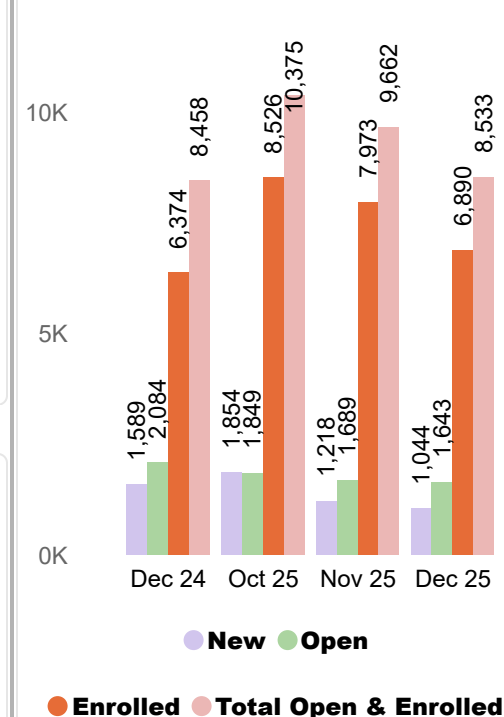
ED Utilization



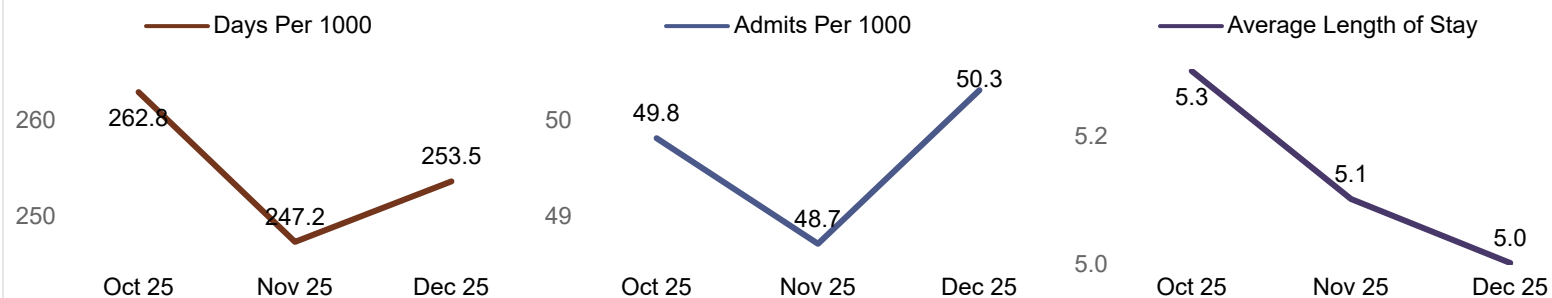
Case Management

Total Cases^

^ ECM Metrics since 2022



Inpatient Utilization

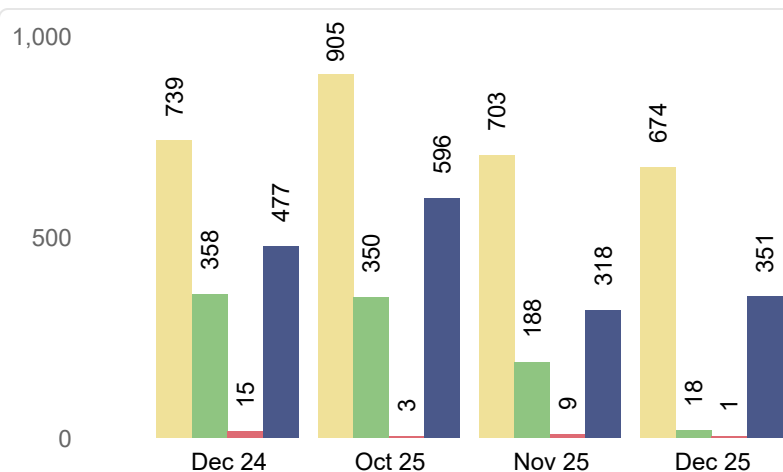


Case Management^

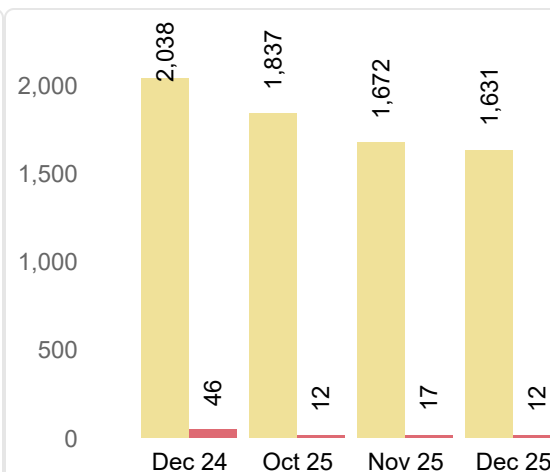
● Care Coordination ● Community Supports ● Complex Cases ● Enhanced Case Management

^ ECM Metrics since 2022

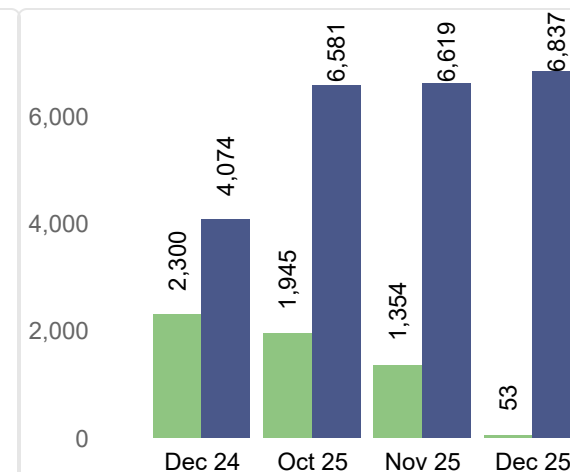
New Cases



Open Cases



Enrolled Cases



Technology (Business Availability)

Applications ▲	Jan 25	Nov 25	Dec 25	Jan 26
HEALTHsuite System	100.0%	100.0%	100.0%	99.9%
Other Applications	100.0%	99.9%	100.0%	99.9%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Jan 25	Nov 25	Dec 25	Jan 26
Denial Rate Excluding Partial Denials (%)	4.3%	3.9%	3.7%	3.4%
Overall Denial Rate (%)	5.0%	4.2%	4.1%	3.6%
Partial Denial Rate (%)	0.7%	0.3%	0.3%	0.3%
* IHSS and Medi-Cal Line Of Business				

Pharmacy Authorizations

Authorizations ▲	Jan 25	Nov 25	Dec 25	Jan 26
Approved Prior Authorizations	49	31	34	54
Closed Prior Authorizations	23	18	14	15
Denied Prior Authorizations	77	81	88	95
Total Prior Authorizations	149	130	136	164



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

Finance

Gil Riojas

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

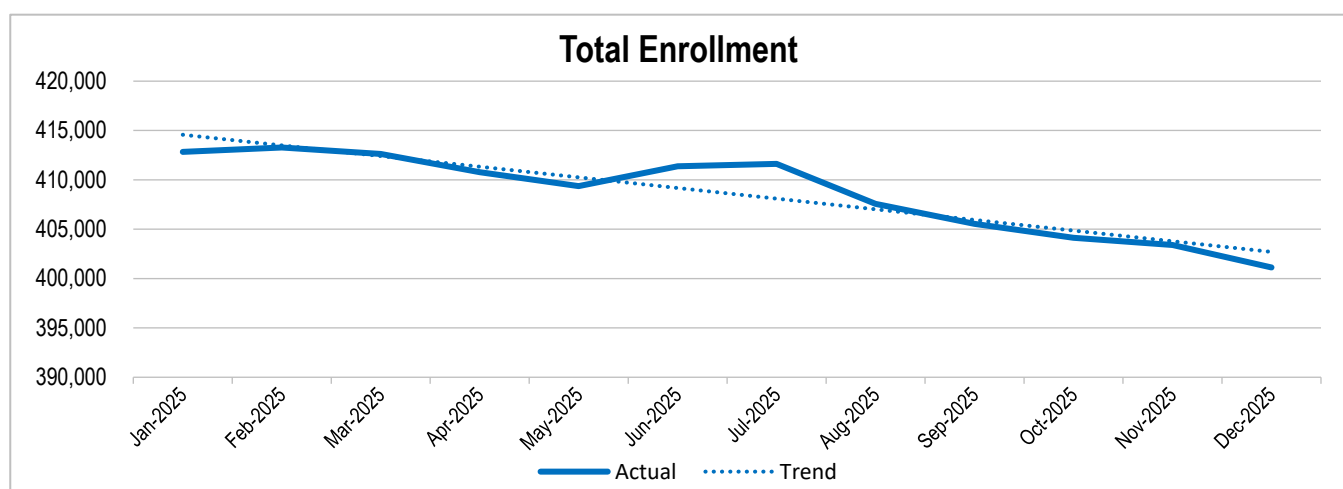
Date: February 13, 2026

Subject: Finance Report – December 2025 Financials

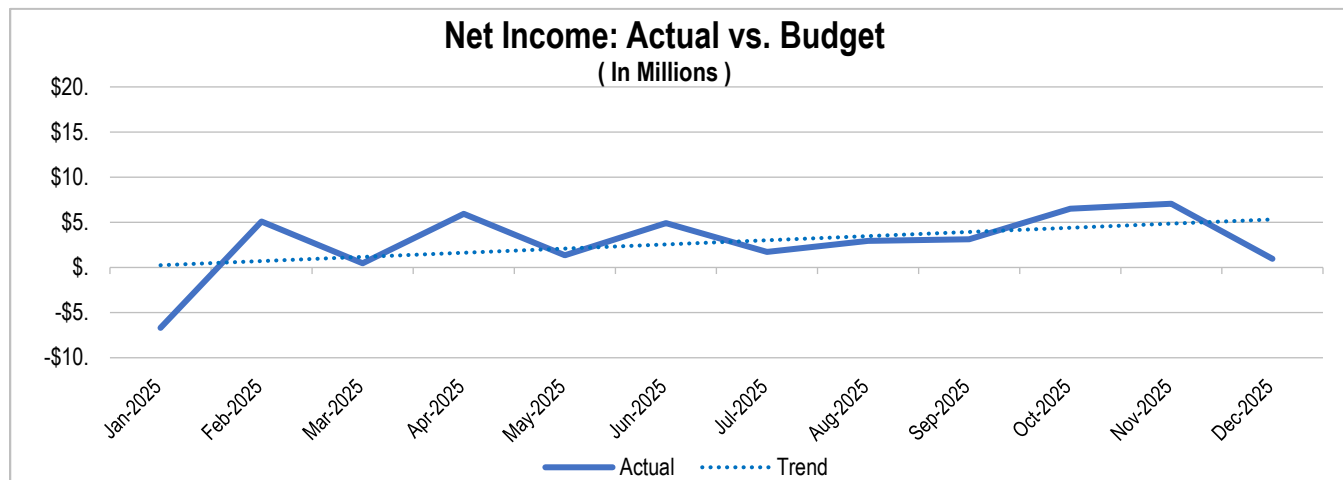
Executive Summary

For the month of December, the Alliance decreased in enrollment, down slightly to 401,124 members. Net Income of \$968,000 was reported, and the Plan's Medical Expenses represented 95.4% of Premium Revenue. Alliance reserves increased slightly to 238% of required and continue to remain above minimum requirements.

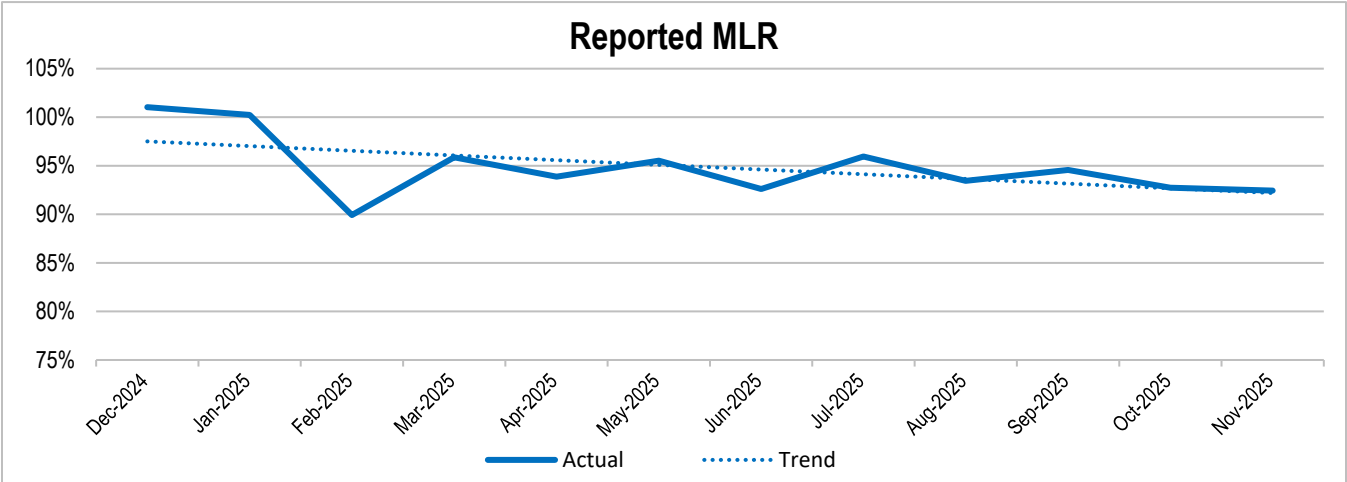
Enrollment – In December, Enrollment decreased by 2,269 members.



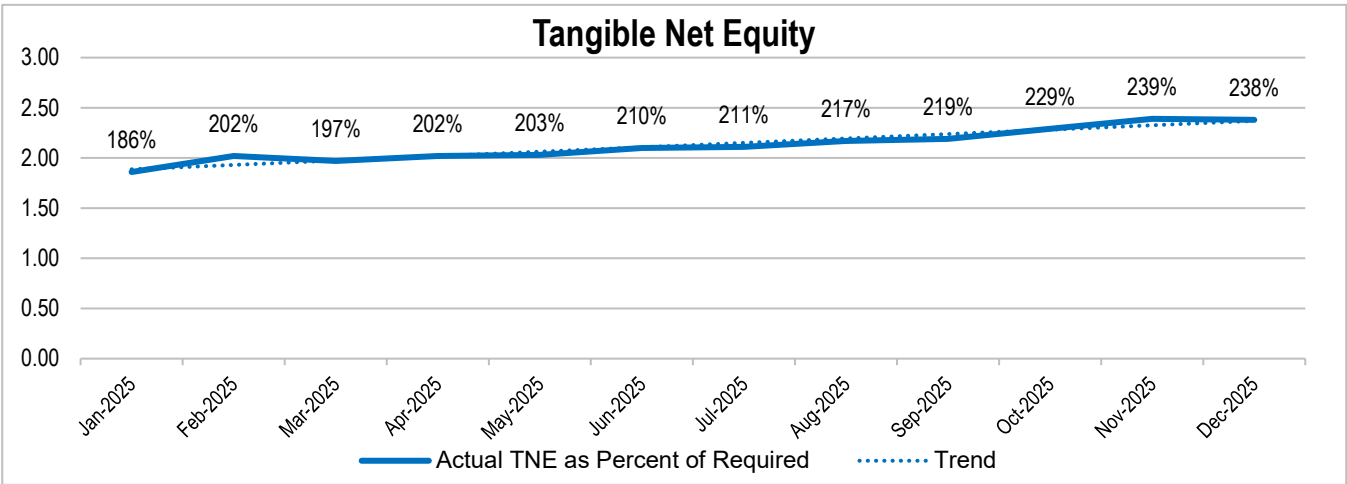
Net Income – For the month ended December, actual Net Income was \$968,000 vs. budgeted Net Loss of \$1.2 million. For the fiscal YTD, actual Net Income was \$22.3 million vs. budgeted Net Income of \$18.3 million. For the month, Premium Revenue was favorable to budget, actual Revenue was \$192.1 million vs. budgeted Revenue of \$191.4 million. Premium Revenue favorable variance of \$736,000 is primarily due to a favorable retroactive membership for November 2024 through October 2025.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 95.4% for the month, and 94.1% for fiscal YTD.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required \$80.4 million in reserves, we reported \$191.6 million. Our overall TNE remains above DMHC requirements at 238%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, investments show a gain of \$14.6 million and capital assets acquired are \$24,000.

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: February 13th, 2026

Subject: Finance Report – December 2025

Executive Summary

- For the month ended December 31st, 2025, the Alliance had enrollment of 401,124 members, a Net Income of \$968,000 and 238% of required Tangible Net Equity (TNE).

<u>Overall Results: (in Thousands)</u>		
	Month	YTD
Revenue	\$256,344	\$1,522,109
Medical Expense	183,162	1,066,978
Admin. Expense	10,459	59,076
MCO Tax Expense	64,249	388,258
Other Inc. / (Exp.)	2,494	14,536
Net Income	\$968	\$22,334

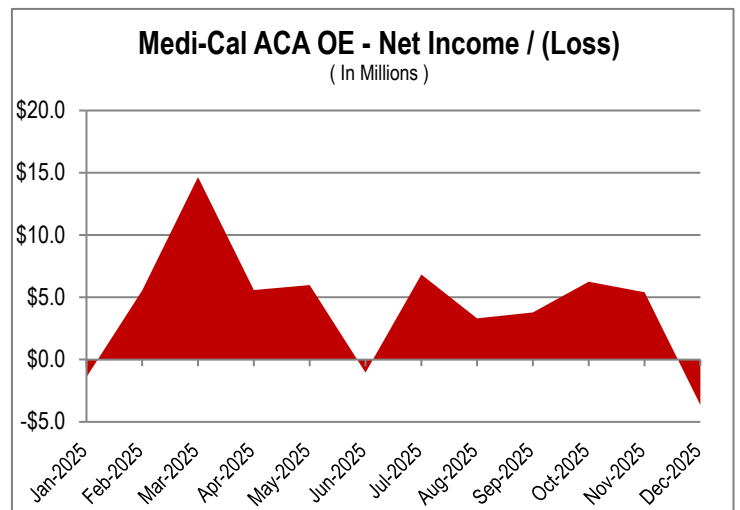
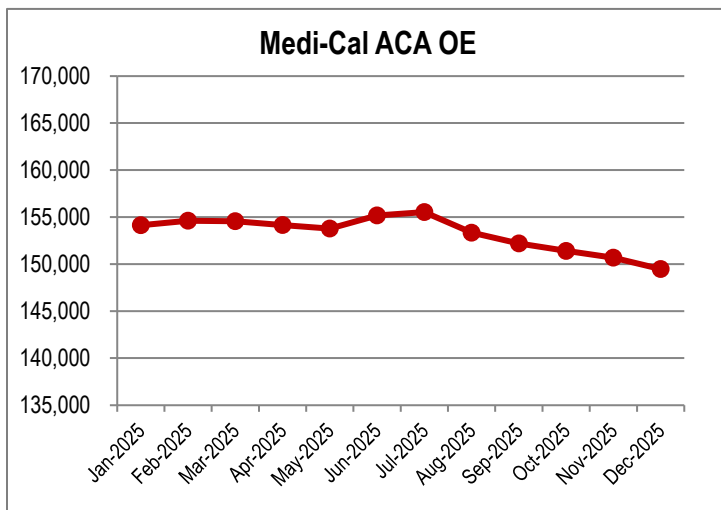
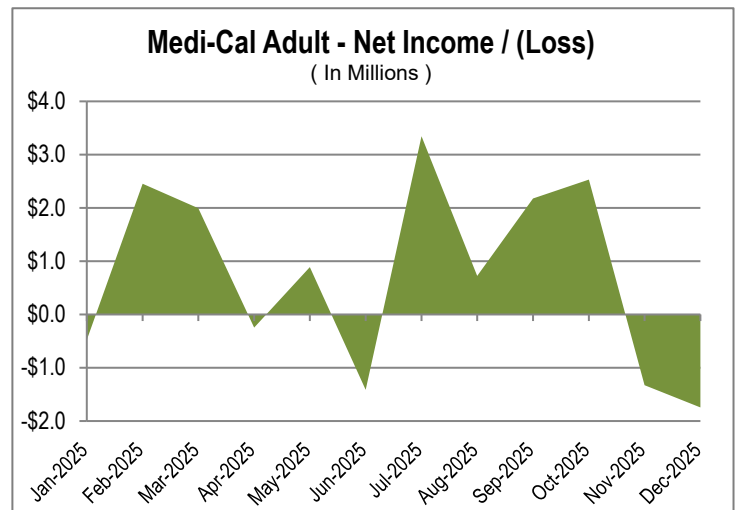
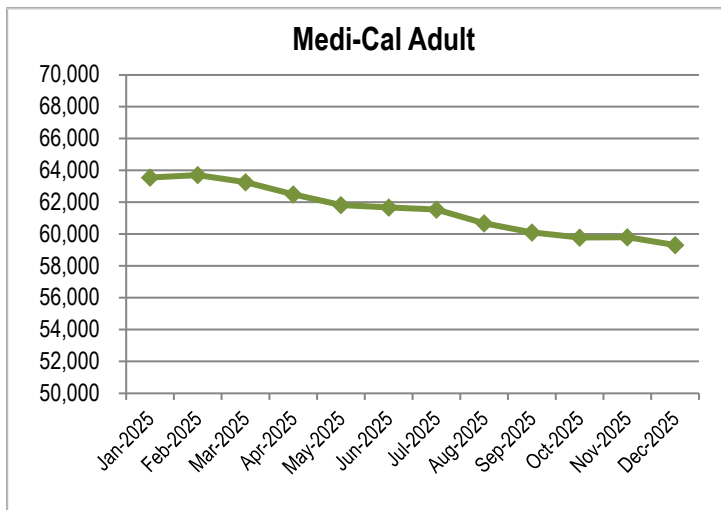
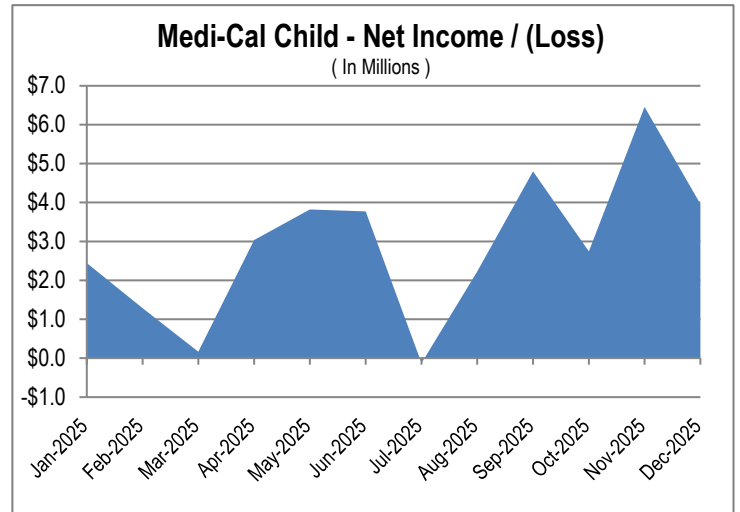
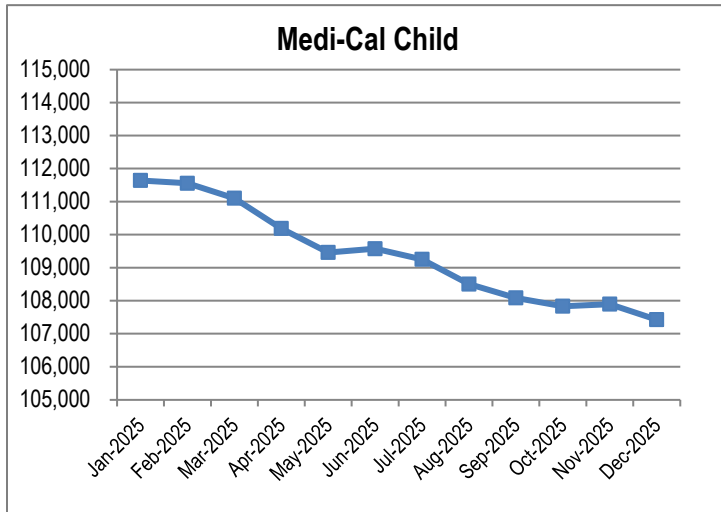
<u>Net Income by Program: (in Thousands)</u>		
	Month	YTD
Medi-Cal	\$2,981	\$29,170
Group Care	(216)	(842)
Medicare	(1,797)	(5,994)
	\$968	\$22,334

Enrollment

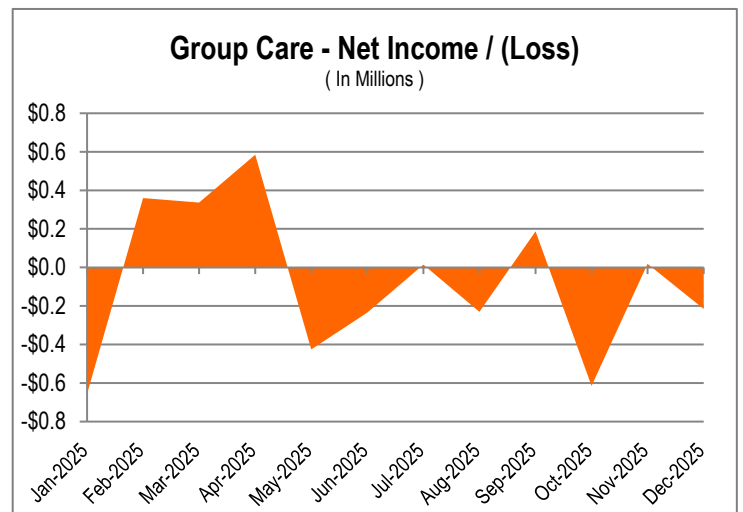
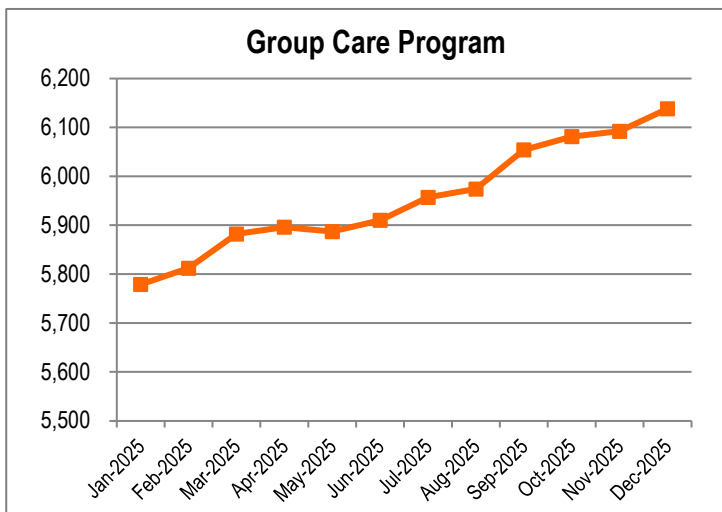
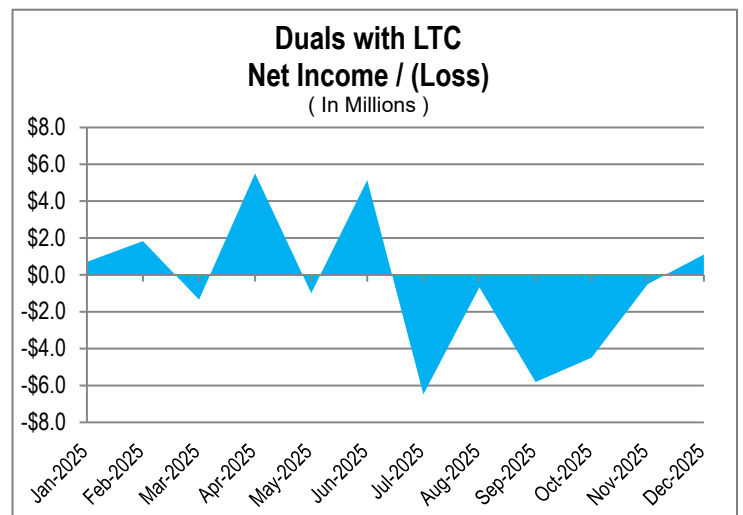
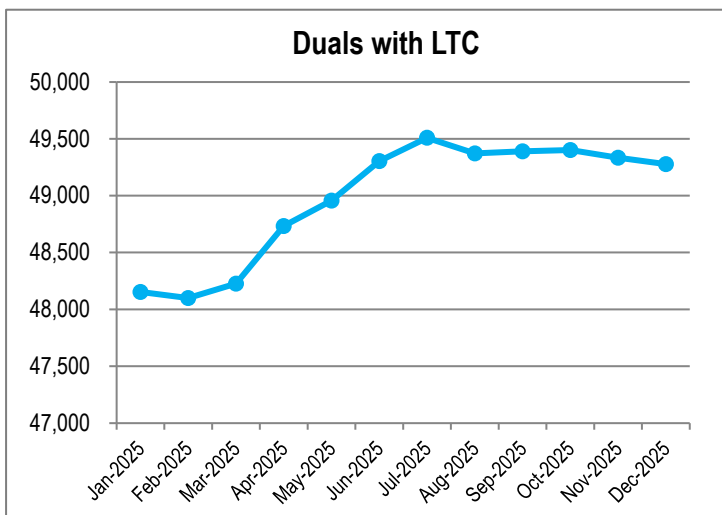
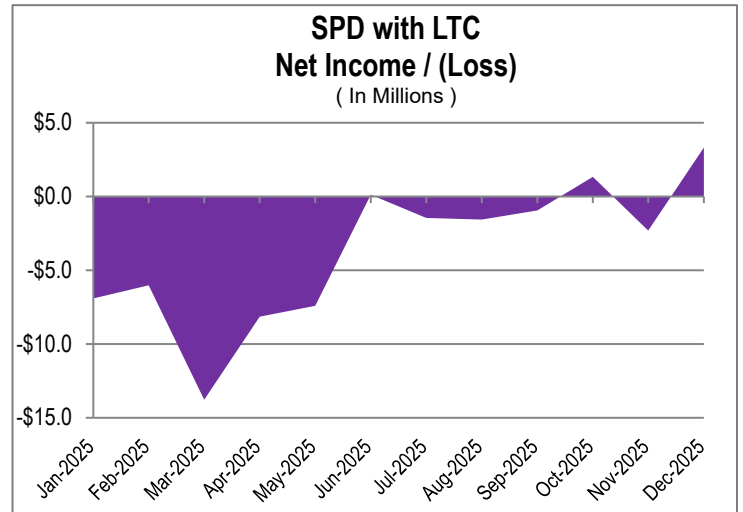
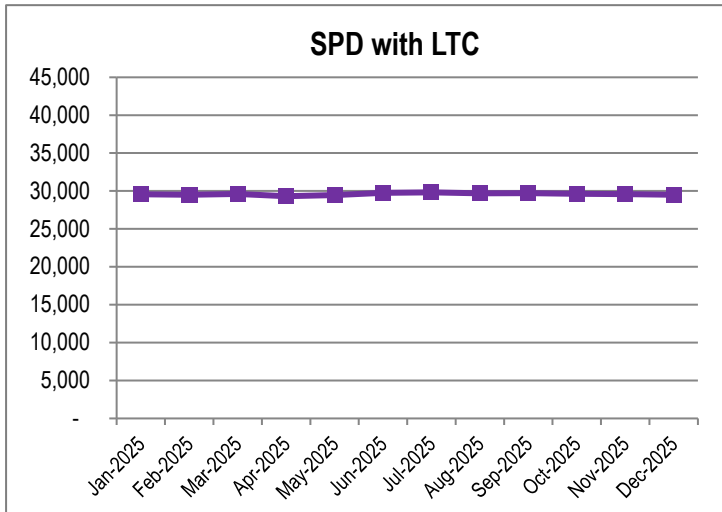
- Total enrollment decreased by 2,269 members since November 2025.
- Total enrollment decreased by 10,259 members since June 2025.

Monthly Membership and YTD Member Months									
Actual vs. Budget									
Enrollment				Medi-Cal:	Member Months				
Current Month					Year-to-Date				
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %	
107,424	107,014	410	0.4%		Child	648,986	648,305	681	0.1%
59,312	58,778	534	0.9%		Adult	361,219	360,180	1,039	0.3%
149,473	149,482	(9)	(0.0%)	ACA OE	912,631	912,424	207	0.0%	
29,500	29,456	44	0.1%	SPD with LTC	177,948	177,888	60	0.0%	
49,277	49,072	205	0.4%	Duals with LTC	296,282	295,938	344	0.1%	
394,986	393,802	1,184	0.3%	Medi-Cal Total	2,397,066	2,394,735	2,331	0.1%	
6,138	6,085	53	0.9%	Group Care	36,296	36,230	66	0.2%	
401,124	399,887	1,237	0.3%	Total	2,433,362	2,430,965	2,397	0.1%	

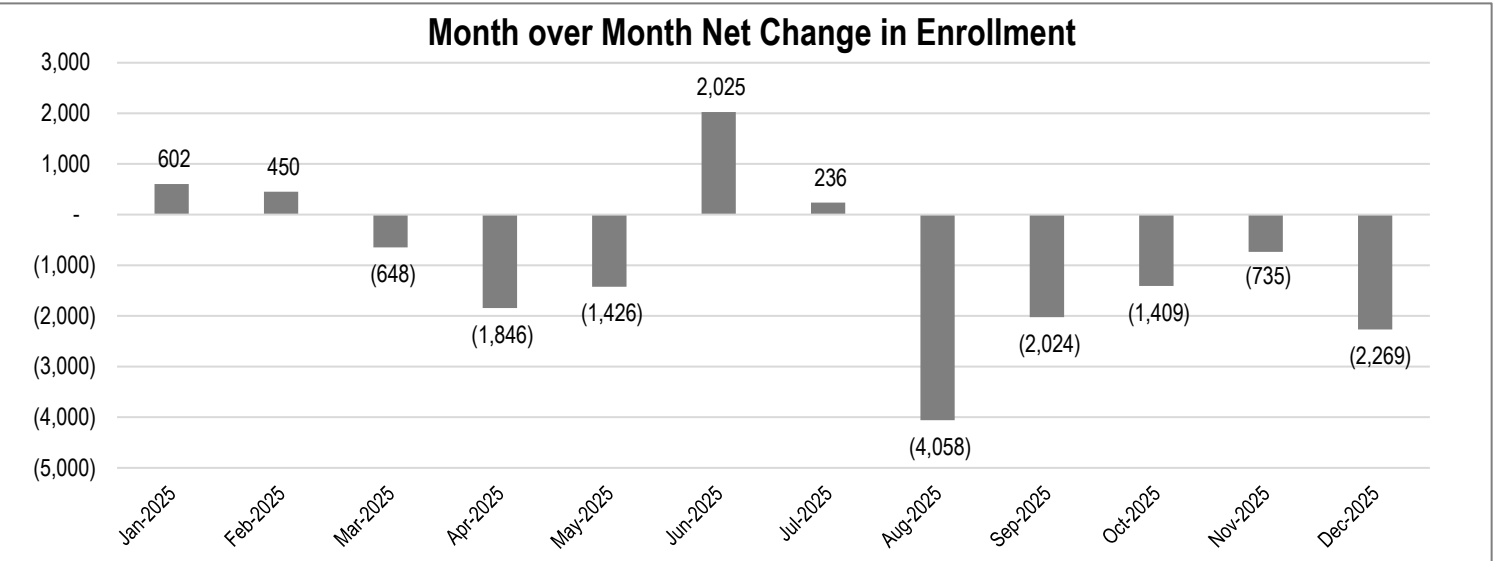
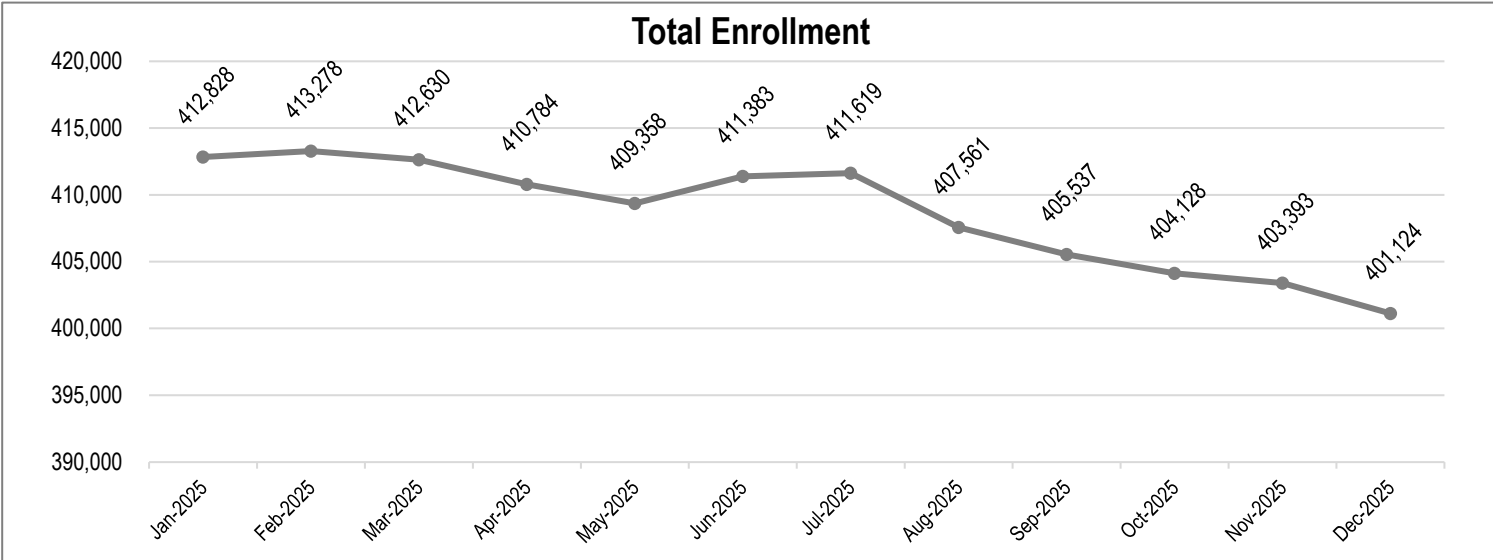
Enrollment and Profitability by Program and Category of Aid



Enrollment and Profitability by Program and Category of Aid

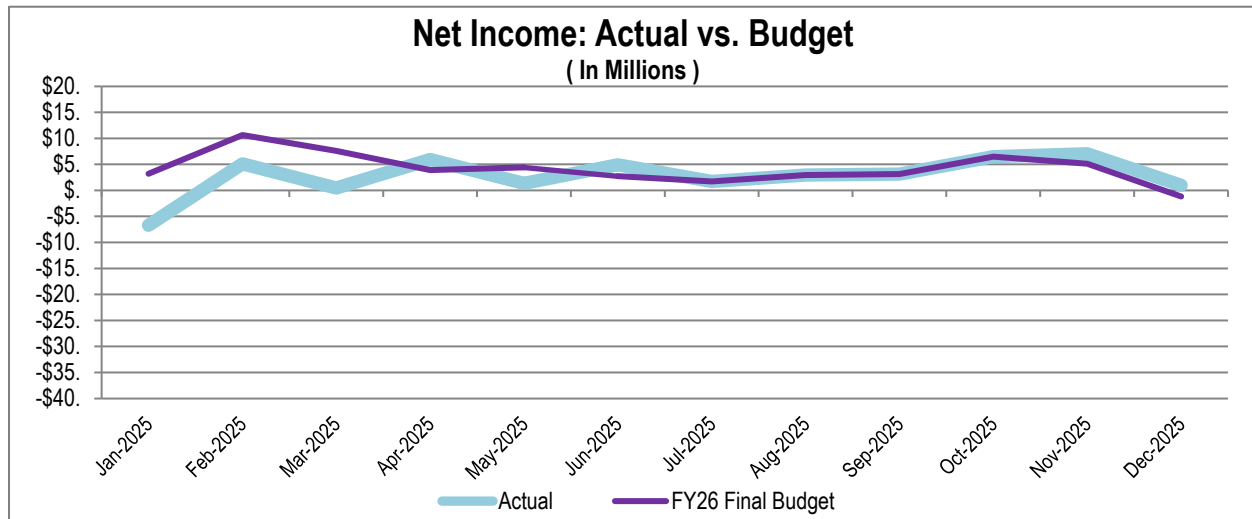


Enrollment and Profitability by Program and Category of Aid



Net Income

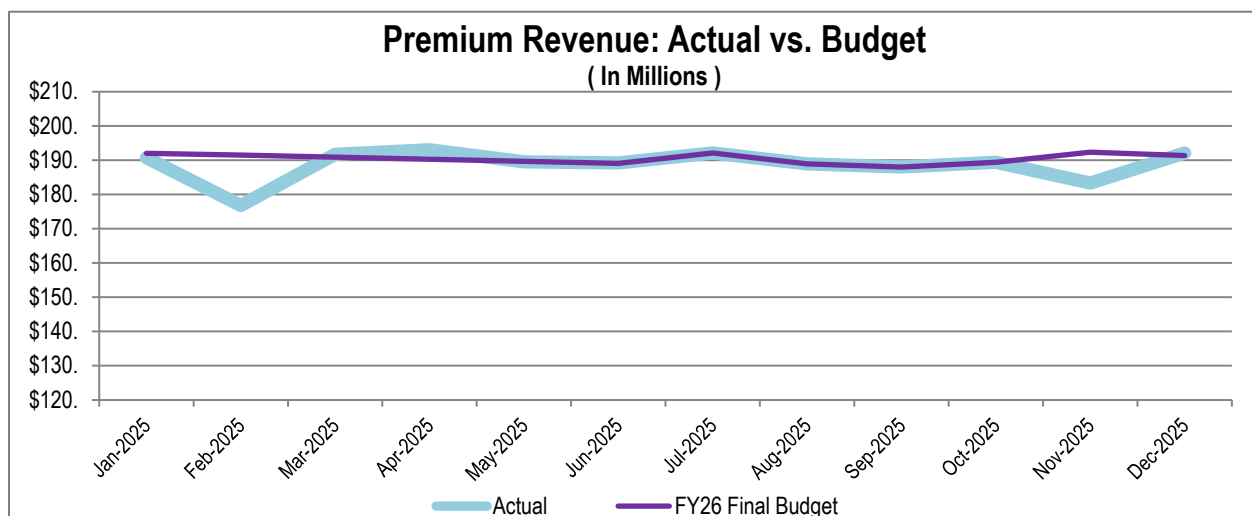
- For the month ended December 31st, 2025:
 - Actual Net Income: \$968,000.
 - Budgeted Net Loss: \$1.2 million.
- For the fiscal YTD ended December 31st, 2025:
 - Actual Net Income \$22.3 million.
 - Budgeted Net Income \$18.3 million.



- The favorable variance of \$2.1 million in the current month is primarily due to:
- Favorable \$2.7 million lower than anticipated Administrative Expense.
 - Unfavorable \$900,000 higher than anticipated Medical Expense.

Premium Revenue

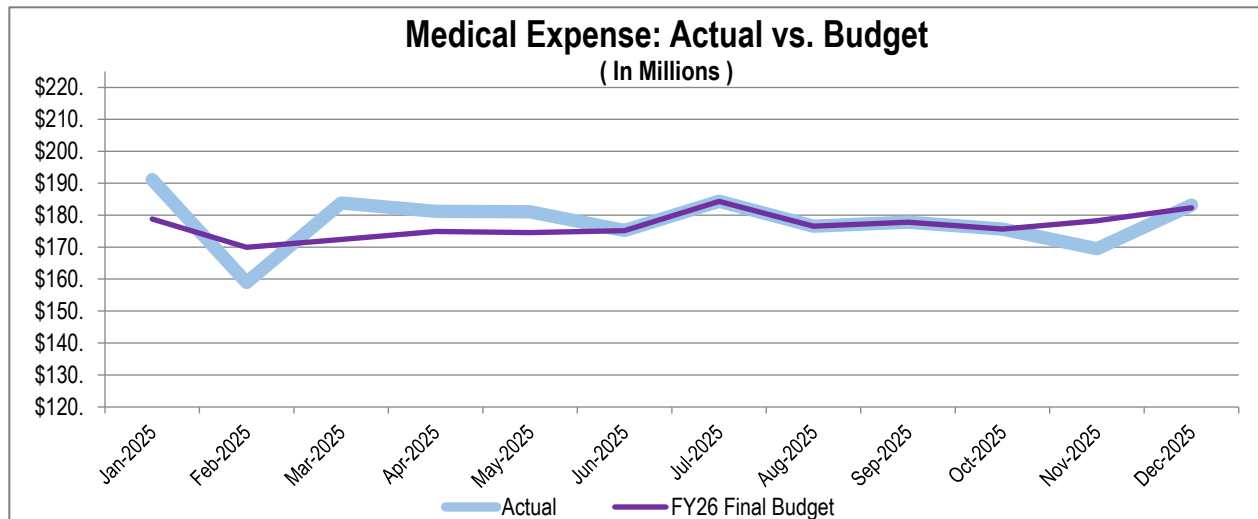
- For the month YTD ended December 31st, 2025:
 - Actual Revenue: \$192.1 million.
 - Budgeted Revenue: \$191.4 million.
- For the fiscal YTD ended December 31st, 2025:
 - Actual Revenue: \$1.1 billion.
 - Budgeted Revenue: \$1.1 billion.



- For the month ended December 31st, 2025, the favorable Premium Revenue variance of \$736,000 is primarily due to a favorable retroactive membership for November 2024 through October 2025.

Medical Expense

- For the month ended December 31st, 2025:
 - Actual Medical Expense: \$183.2 million.
 - Budgeted Medical Expense: \$182.3 million.
- For the fiscal YTD ended December 31st, 2025:
 - Actual Medical Expense: \$1.1 billion.
 - Budgeted Medical Expense: \$1.1 billion.



- Reported financial results include medical expense, which contains estimates for Incurred-But-Not-Paid (IBNP) claims. Calculation of monthly IBNP is based on historical trends and claims payment. The Alliance's IBNP reserves are reviewed by actuarial consultants.
- For December, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by \$338,000. Year to date, the estimate for prior years increased by \$4.6 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)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical Expense	\$112,116,851	\$0	\$112,116,851	\$112,166,794	\$49,943	0.0%
Primary Care FFS	\$17,546,224	\$10,066,062	\$27,612,286	\$31,379,691	\$13,833,467	44.1%
Specialty Care FFS	\$49,517,204	\$1,590,100	\$51,107,304	\$53,405,803	\$3,888,599	7.3%
Outpatient FFS	\$81,527,046	\$293,578	\$81,820,625	\$83,972,570	\$2,445,524	2.9%
Ancillary FFS	\$121,466,515	\$2,099,713	\$123,566,228	\$120,973,246	(\$493,268)	(0.4%)
Pharmacy FFS	\$68,393,726	(\$6,133,565)	\$62,260,161	\$61,511,570	(\$6,882,156)	(11.2%)
ER Services FFS	\$62,264,958	\$380,581	\$62,645,540	\$62,620,710	\$355,752	0.6%
Inpatient Hospital FFS	\$288,806,834	(\$603,836)	\$288,202,999	\$290,953,401	\$2,146,566	0.7%
Long Term Care & SNF FFS	\$232,671,159	(\$3,126,470)	\$229,544,689	\$228,505,923	(\$4,165,236)	(1.8%)
Other Benefits & Services	\$22,131,151	\$0	\$22,131,151	\$24,207,557	\$2,076,405	8.6%
Net Reinsurance	\$310,811	\$0	\$310,811	\$519,438	\$208,627	40.2%
Provider Incentive	\$5,659,099	\$0	\$5,659,099	\$4,659,099	(\$1,000,000)	(21.5%)
	\$1,062,411,578	\$4,566,164	\$1,066,977,742	\$1,074,875,801	\$12,464,223	1.20%

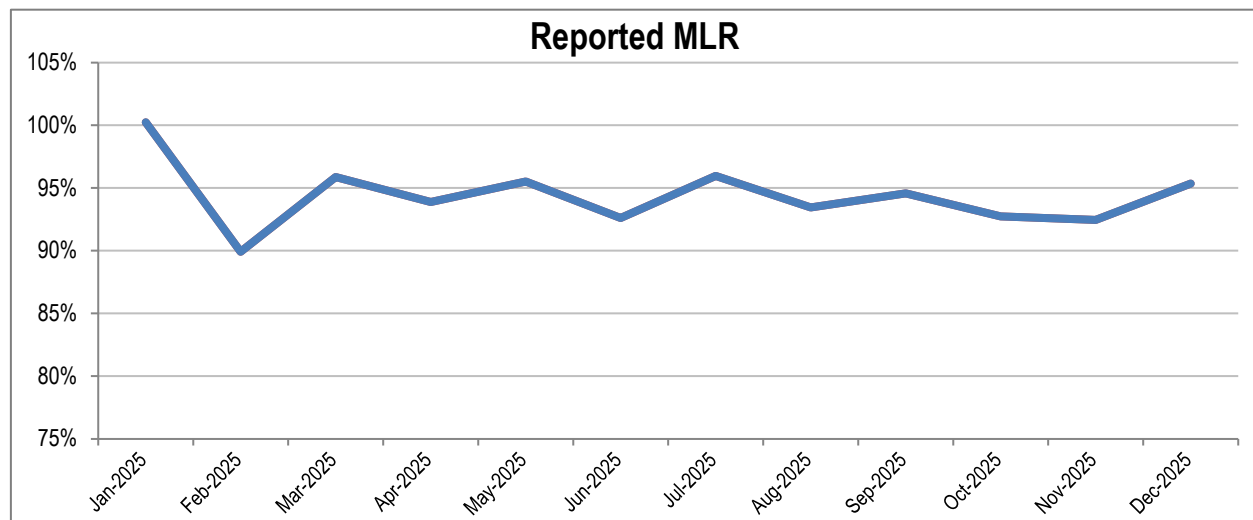
Medical Expense - Actual vs. Budget (Per Member Per Month)						
Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical Expense	\$46.07	\$0.00	\$46.07	\$46.14	\$0.07	0.1%
Primary Care FFS	\$7.21	\$4.14	\$11.35	\$12.91	\$5.70	44.1%
Specialty Care FFS	\$20.35	\$0.65	\$21.00	\$21.97	\$1.62	7.4%
Outpatient FFS	\$33.50	\$0.12	\$33.62	\$34.54	\$1.04	3.0%
Ancillary FFS	\$49.92	\$0.86	\$50.78	\$49.76	(\$0.15)	(0.3%)
Pharmacy FFS	\$28.11	(\$2.52)	\$25.59	\$25.30	(\$2.80)	(11.1%)
ER Services FFS	\$25.59	\$0.16	\$25.74	\$25.76	\$0.17	0.7%
Inpatient Hospital & SNF FFS	\$118.69	(\$0.25)	\$118.44	\$119.69	\$1.00	0.8%
Long Term Care & SNF FFS	\$95.62	(\$1.28)	\$94.33	\$94.00	(\$1.62)	(1.7%)
Other Benefits & Services	\$9.09	\$0.00	\$9.09	\$9.96	\$0.86	8.7%
Net Reinsurance	\$0.13	\$0.00	\$0.13	\$0.21	\$0.09	40.2%
Provider Incentive	\$2.33	\$0.00	\$2.33	\$1.92	(\$0.41)	(21.3%)
	\$436.60	\$1.88	\$438.48	\$442.16	\$5.56	1.3%

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is \$12.5 million favorable to budget. On a PMPM basis, medical expense is 1.3% favorable to budget. For per-member-per-month expense:
 - Capitated Expense is under budget, primarily driven by favorable Specialty Capitation FQHC expense.
 - Primary Care Expense is under budget due to TRI reclassifications across all populations except for Group Care.

- Specialty Care Expense is under budget, driven by low unit cost and utilization.
- Outpatient Expense is under budget due to lower facility other and dialysis utilization and unit cost.
- Ancillary Expense is under budget due to lower unit cost in the SPD with LTC, Child and ACA OE aid code categories.
- Pharmacy Expense is over budget driven by prior period expense related to overpayments made to UCSF last fiscal year. The offsetting accruals were already made in a prior accounting period.
- Emergency Expense is under budget driven by lower utilization in the ACA OE and Child aid code categories.
- Inpatient Expense is under budget driven by utilization in the SPD with LTC aid code category.
- Long Term Care Expense is over budget due to utilization and unit cost in the SPD with LTC and Duals with LTC Duals aid code categories.
- Other Benefits & Services is over budget, due to lower than expected employee, interpreter, professional services, community reinvestment, licenses, insurance and fees 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 95.4% for the month and 94.1% for the fiscal year-to-date.



Administrative Expense

- For the month ended December 31st, 2025:
 - Actual Administrative Expense: \$10.5 million.
 - Budgeted Administrative Expense: \$13.2 million.
- For the fiscal YTD ended December 31st, 2025:
 - Actual Administrative Expense: \$59.1 million.
 - Budgeted Administrative Expense: \$64.8 million.

Summary of Administrative Expense (In Dollars)									
For the Month and Fiscal Year-to-Date									
Current Month					Year-to-Date				
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %	
\$6,723,538	\$7,700,006	\$976,467	12.7%		Personnel Expense	\$38,340,250	\$40,017,146	\$1,676,896	4.2%
76,318	183,434	107,116	58.4%		Medical Benefits Admin Expense	334,653	576,372	241,719	41.9%
1,921,005	2,915,048	994,043	34.1%		Purchased & Professional Services	12,290,687	13,788,982	1,498,295	10.9%
1,737,920	2,376,862	638,942	26.9%		Other Admin Expense	8,110,202	10,413,205	2,303,003	22.1%
\$10,458,781	\$13,175,349	\$2,716,568	20.6%	Total Administrative Expense	\$59,075,792	\$64,795,704	\$5,719,912	8.8%	

The year-to-date variances include:

- Employee Expense ran favorably overall, driven by favorable Salary and Benefits as a result of hiring restrictions.
- Favorable in Purchased & Professional Services, primarily due to Consultant and Purchased Services, Legal Fees, IT-Licenses and Subscriptions, and other expenses running favorably to date.
- Favorable Licenses, Insurance & Fees primarily due to favorable Licenses and Subscriptions.
- Favorable Supplies and Other expenses primarily due to settlement costs.
- Favorable Printing/Postage/Promotions due to reduced volume and cost-saving measures.
- Favorable Benefit Administration Expense, primarily for the decreases in Behavioral Health Admin Fees and Telemedicine Admin Fees.
- Favorable Building Occupancy costs in equipment and maintenance.

The Administrative Loss Ratio (ALR) is 5.4% of net revenue for the month and 5.2% of revenue year-to-date. Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is \$1.1 million.

Other Income / (Expense)

Other Income & Expense is comprised primarily of investment income. Fiscal year-to-date net investments show a gain of \$14.6 million.

Managed Care Organization (MCO) Provider Tax

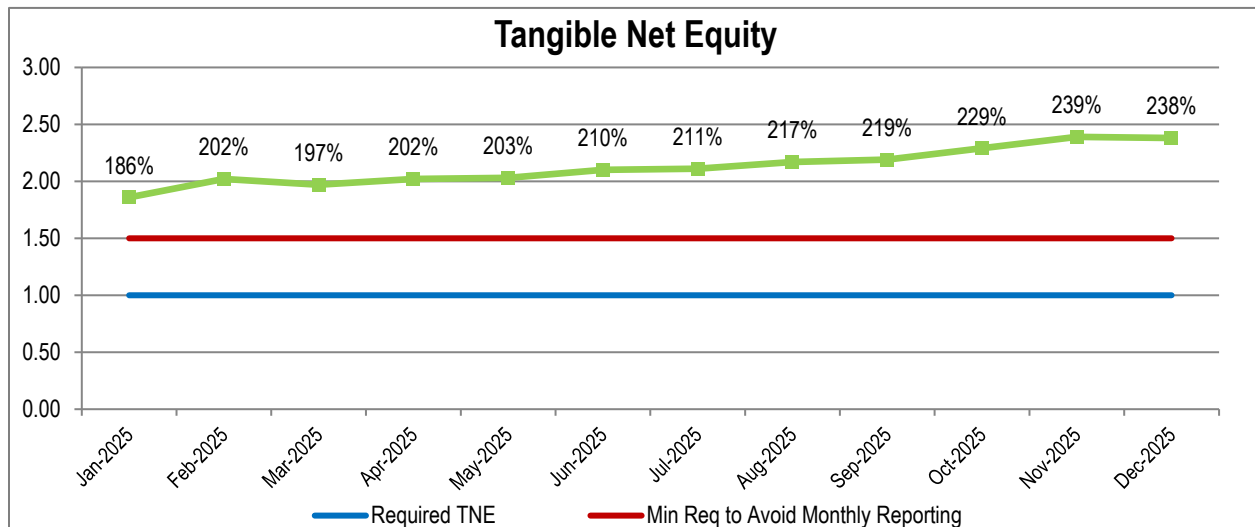
- Revenue:
 - For the month ended December 31st, 2025:
 - Actual: \$64.2 million.
 - Budgeted: \$63.6 million.
 - For the fiscal YTD ended December 31st, 2025:
 - Actual: \$388.3 million.
 - Budgeted: \$387.4 million.
- Expense:
 - For the month ended December 31st, 2025:
 - Actual: \$64.2 million.
 - Budgeted: \$63.6 million.

- For the fiscal YTD ended December 31st, 2025:
 - Actual: \$388.3 million.
 - Budgeted: \$387.4 million.

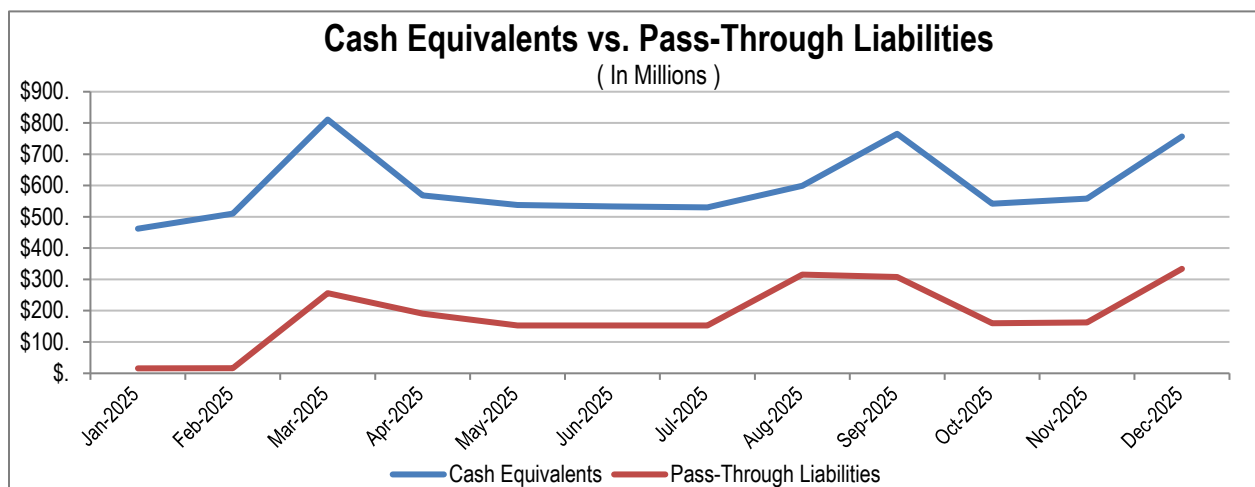
Tangible Net Equity (TNE)

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

- Required TNE \$80.4 million
- Actual TNE \$191.6 million
- Excess TNE \$111.2 million
- TNE % of Required TNE 238%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
 - Cash & Cash Equivalents \$756.9 million
 - Pass-Through Liabilities \$334.1 million



- | | |
|--------------------|-----------------------------------|
| ○ Uncommitted Cash | \$422.7 million |
| ○ Working Capital | \$137.7 million |
| ○ Current Ratio | 1.12 (regulatory minimum is 1.00) |

Capital Investment

- Fiscal year-to-date capital assets acquired: \$24,000.
- Annual capital budget: \$1.4 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

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

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED 31 DECEMBER, 2025

CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance	% Variance	Account Description	Actual	Budget	\$ Variance	% Variance
		(Unfavorable)	(Unfavorable)				(Unfavorable)	(Unfavorable)
MEMBERSHIP								
394,986	393,802	1,184	0.3%	1. Medi-Cal	2,397,066	2,394,735	2,331	0.1%
6,138	6,085	53	0.9%	2. GroupCare	36,296	36,230	66	0.2%
401,124	399,887	1,237	0.3%	3. TOTAL MEMBER MONTHS	2,433,362	2,430,965	2,397	0.1%
REVENUE								
\$192,094,203	\$191,357,966	\$736,237	0.4%	4. Premium Revenue	\$1,133,850,917	\$1,142,134,922	(\$8,284,005)	(0.7%)
\$64,249,397	\$63,622,651	\$626,746	1.0%	5. MCO Tax Revenue AB119	\$388,258,258	\$387,421,193	\$837,064	0.2%
\$256,343,600	\$254,980,617	\$1,362,983	0.5%	6. TOTAL REVENUE	\$1,522,109,175	\$1,529,556,115	(\$7,446,940)	(0.5%)
MEDICAL EXPENSES								
Capitated Medical Expenses								
\$15,763,341	\$15,831,271	\$67,931	0.4%	7. Capitated Medical Expense	\$112,116,851	\$112,166,795	\$49,943	0.0%
Fee for Service Medical Expenses								
\$52,347,879	\$54,143,281	\$1,795,402	3.3%	8. Inpatient Hospital Expense	\$288,202,999	\$290,953,401	\$2,750,402	0.9%
\$3,469,218	\$4,081,529	\$612,311	15.0%	9. Primary Care Physician Expense	\$27,612,286	\$31,379,691	\$3,767,406	12.0%
\$7,161,714	\$8,778,296	\$1,616,582	18.4%	10. Specialty Care Physician Expense	\$51,107,304	\$53,405,803	\$2,298,498	4.3%
\$22,375,752	\$20,496,809	(\$1,878,944)	(9.2%)	11. Ancillary Medical Expense	\$123,566,228	\$120,973,246	(\$2,592,981)	(2.1%)
\$12,817,509	\$12,808,709	(\$8,801)	(0.1%)	12. Outpatient Medical Expense	\$81,820,625	\$83,972,570	\$2,151,945	2.6%
\$11,529,178	\$10,735,949	(\$793,229)	(7.4%)	13. Emergency Expense	\$62,645,540	\$62,620,710	(\$24,829)	(0.0%)
\$16,342,044	\$13,038,790	(\$3,303,254)	(25.3%)	14. Pharmacy Expense	\$62,260,161	\$61,511,570	(\$748,591)	(1.2%)
\$36,764,783	\$37,095,910	\$331,127	0.9%	15. Long Term Care Expense	\$229,544,689	\$228,505,923	(\$1,038,766)	(0.5%)
\$162,808,076	\$161,179,271	(\$1,628,806)	(1.0%)	16. Total Fee for Service Expense	\$926,759,830	\$933,322,914	\$6,563,084	0.7%
\$4,102,662	\$4,682,443	\$579,781	12.4%	17. Other Benefits & Services	\$22,131,151	\$24,207,557	\$2,076,405	8.6%
\$488,106	\$607,476	\$119,370	19.7%	18. Reinsurance Expense	\$310,811	\$519,438	\$208,627	40.2%
\$0	\$0	\$0	0.0%	19. Risk Pool Distribution	\$5,659,099	\$4,659,099	(\$1,000,000)	(21.5%)
\$183,162,185	\$182,300,461	(\$861,723)	(0.5%)	20. TOTAL MEDICAL EXPENSES	\$1,066,977,742	\$1,074,875,801	\$7,898,059	0.7%
\$73,181,415	\$72,680,156	\$501,260	0.7%	21. GROSS MARGIN	\$455,131,432	\$454,680,314	\$451,119	0.1%
ADMINISTRATIVE EXPENSES								
\$6,723,538	\$7,700,006	\$976,467	12.7%	22. Personnel Expense	\$38,340,250	\$40,017,146	\$1,676,896	4.2%
\$76,318	\$183,434	\$107,116	58.4%	23. Benefits Administration Expense	\$334,653	\$576,372	\$241,719	41.9%
\$1,921,005	\$2,915,048	\$994,043	34.1%	24. Purchased & Professional Services	\$12,290,687	\$13,788,982	\$1,498,295	10.9%
\$1,737,920	\$2,376,862	\$638,942	26.9%	25. Other Administrative Expense	\$8,110,202	\$10,413,205	\$2,303,003	22.1%
\$10,458,781	\$13,175,349	\$2,716,568	20.6%	26. TOTAL ADMINISTRATIVE EXPENSES	\$59,075,792	\$64,795,704	\$5,719,912	8.8%
\$64,249,397	\$63,622,651	(\$626,746)	(1.0%)	27. MCO TAX EXPENSES	\$388,258,258	\$387,421,193	(\$837,064)	(0.2%)
(\$1,526,763)	(\$4,117,845)	\$2,591,082	62.9%	28. NET OPERATING INCOME / (LOSS)	\$7,797,383	\$2,463,416	\$5,333,967	216.5%
OTHER INCOME / EXPENSES								
\$2,494,420	\$2,957,980	(\$463,560)	(15.7%)	29. TOTAL OTHER INCOME / (EXPENSES)	\$14,536,272	\$15,817,815	(\$1,281,543)	(8.1%)
\$967,657	(\$1,159,865)	\$2,127,522	183.4%	30. NET SURPLUS (DEFICIT)	\$22,333,655	\$18,281,231	\$4,052,424	22.2%
95.4%	95.3%	(0.1%)	(0.1%)	31. Medical Loss Ratio	94.1%	94.1%	0.0%	0.0%
5.4%	6.9%	1.5%	21.7%	32. Administrative Expense Ratio	5.2%	5.7%	0.5%	8.8%
0.4%	(0.5%)	0.9%	180.0%	33. Net Surplus (Deficit) Ratio	1.5%	1.2%	0.3%	25.0%

**ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED 31 DECEMBER, 2025**

	12/31/2025	11/30/2025	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	\$28,224,474	\$16,838,857	\$11,385,617	67.6%
CNB Short-Term Investment	728,663,391	541,345,700	187,317,691	34.6%
Interest Receivable	4,087,216	4,063,416	23,800	0.6%
Premium Receivables	471,758,146	553,681,606	(81,923,461)	(14.8%)
Reinsurance Recovery Receivable	12,934,700	10,997,104	1,937,595	17.6%
Other Receivables	2,415,971	5,450,972	(3,035,001)	(55.7%)
Prepaid Expenses	1,067,483	1,124,162	(56,679)	(5.0%)
TOTAL CURRENT ASSETS	1,249,151,381	1,133,501,817	115,649,564	10.2%
OTHER ASSETS				
CNB Long-Term Investment	40,842,139	40,810,148	31,991	0.1%
CalPERS Net Pension Asset	(6,465,233)	(6,465,233)	0	0.0%
Deferred Outflow	15,271,214	15,271,214	0	0.0%
Restricted Asset-Bank Note	359,844	358,857	987	0.3%
GASB 87-Lease Assets (Net)	58,950	62,225	(3,275)	(5.3%)
GASB 96-SBITA Assets (Net)	2,185,114	2,716,991	(531,877)	(19.6%)
TOTAL OTHER ASSETS	52,252,027	52,754,201	(502,174)	(1.0%)
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,867,101	9,867,101	0	0.0%
Furniture And Equipment	13,400,309	13,400,309	0	0.0%
Leasehold Improvement	902,447	902,447	0	0.0%
Internally Developed Software	14,824,002	14,824,002	0	0.0%
Fixed Assets at Cost	38,993,858	38,993,858	0	0.0%
Less: Accumulated Depreciation	(33,764,781)	(33,702,522)	(62,259)	0.2%
PROPERTY AND EQUIPMENT (NET)	5,229,077	5,291,335	(62,259)	(1.2%)
TOTAL ASSETS	1,306,632,484	1,191,547,354	115,085,131	9.7%
CURRENT LIABILITIES				
Trade Accounts Payable	10,393,791	10,764,045	(370,253)	(3.4%)
Incurred But Not Reported Claims	386,464,720	384,468,960	1,995,761	0.5%
Other Medical Liabilities	134,107,422	132,718,854	1,388,568	1.0%
Pass-Through Liabilities	334,145,425	162,155,010	171,990,415	106.1%
MCO Tax Liabilities	237,301,905	298,635,842	(61,333,936)	(20.5%)
GASB 87 and 96 ST Liabilities	502,933	602,791	(99,857)	(16.6%)
Payroll Liabilities	8,548,221	7,812,419	735,802	9.4%
TOTAL CURRENT LIABILITIES	1,111,464,418	997,157,919	114,306,499	11.5%
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	314,745	503,770	(189,025)	(37.5%)
Deferred Inflow	3,240,306	3,240,306	0	0.0%
TOTAL LONG TERM LIABILITIES	3,555,051	3,744,076	(189,025)	(5.0%)
TOTAL LIABILITIES	1,115,019,469	1,000,901,995	114,117,474	11.4%
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	168,439,128	168,439,128	0	0.0%
Year-To-Date Net Surplus (Deficit)	22,333,655	21,365,998	967,657	4.5%
TOTAL NET WORTH	191,613,016	190,645,359	967,657	0.5%
TOTAL LIABILITIES AND NET WORTH	1,306,632,485	1,191,547,354	115,085,131	9.7%
Additional Information				
Cash Equivalents	756,887,865	558,184,557	198,703,308	35.6%
Pass-Through	334,145,425	162,155,010	171,990,415	106.1%
Uncommitted Cash	422,742,441	396,029,547	26,712,893	6.7%
Working Capital	137,686,963	136,343,898	1,343,065	1.0%
Current Ratio	112.4%	113.7%	(1.3%)	(1.1%)

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

December 31, 2025

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	\$3,370,952	\$10,020,464	\$19,848,490	\$19,848,490
GroupCare Receivable	(3,310)	3,291,529	(5,419)	(5,419)
Total	3,367,642	13,311,993	19,843,071	19,843,071
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	252,972,648	747,676,088	1,502,260,685	1,502,260,687
Premium Receivable	81,926,770	(46,554,958)	26,519,945	26,519,945
Total	334,899,418	701,121,130	1,528,780,630	1,528,780,632
Investment & Other Income Cash Flows				
Other Revenues	485,360	320,070	463,910	463,910
Interest Income	2,005,432	6,692,054	14,089,814	14,089,814
Interest Receivable	(23,800)	(1,384,976)	(500,258)	(500,258)
Total	2,466,992	5,627,148	14,053,466	14,053,466
Medical & Hospital Cash Flows				
Total Medical Expenses	(183,162,185)	(528,295,083)	(1,066,977,742)	(1,066,977,743)
Other Health Care Receivables	1,099,656	5,630,286	(5,159,430)	(5,159,430)
Capitation Payable	-	-	-	-
IBNP Payable	1,995,761	(27,011,240)	(25,652,575)	(25,652,575)
Other Medical Payable	173,378,984	42,124,174	196,799,283	196,799,283
Risk Share Payable	-	2,000,000	1,050,856	1,050,856
New Health Program Payable	-	-	-	-
Total	(6,687,784)	(505,551,863)	(899,939,608)	(899,939,609)
Administrative Cash Flows				
Total Administrative Expenses	(10,455,154)	(29,007,943)	(59,093,243)	(59,093,240)
Prepaid Expenses	56,680	(76,307)	(349,672)	(349,672)
Other Receivables	(2,251)	(179)	(10,115)	(10,115)
CalPERS Pension	-	-	-	-
Trade Accounts Payable	(370,254)	(1,798,243)	(1,123,132)	(1,123,132)
Payroll Liabilities	735,802	(1,154,495)	(815,694)	(815,694)
GASB Assets and Liabilities	246,270	325,097	645,765	645,765
Depreciation Expense	62,259	186,634	372,188	372,188
Total	(9,726,648)	(31,525,436)	(60,373,903)	(60,373,900)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(64,249,397)	(192,878,061)	(388,258,258)	(388,258,258)
MCO Tax Liabilities	(61,333,936)	4,503,061	11,483,502	11,483,502
Total	(125,583,333)	(188,375,000)	(376,774,756)	(376,774,756)
Net Cash Flows from Operating Activities	198,736,287	(5,392,028)	225,588,900	225,588,904

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

December 31, 2025

	MONTH	3 MONTHS	6 MONTHS	YTD
<u>CASH FLOWS FROM INVESTING ACTIVITIES</u>				
Investment Cash Flows				
Long Term Investments	(31,991)	(3,327,909)	(1,686,775)	(1,686,779)
Total	(31,991)	(3,327,909)	(1,686,775)	(1,686,779)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(987)	(2,985)	(5,978)	(5,978)
Total	(987)	(2,985)	(5,978)	(5,978)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	(24,453)	(24,453)	(24,453)
Purchases of Property and Equipment	-	(24,453)	(24,453)	(24,453)
Net Cash Flows from Investing Activities	(32,978)	(3,355,347)	(1,717,206)	(1,717,210)
Net Change in Cash	198,703,309	(8,747,375)	223,871,694	223,871,694
Rounding	-	-	-	-
Cash @ Beginning of Period	558,184,556	765,635,240	533,016,171	533,016,171
Cash @ End of Period	\$756,887,865	\$756,887,865	\$756,887,865	\$756,887,865
Variance	-	-	-	-

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

December 31, 2025

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	\$967,656	\$14,527,589	\$22,333,655	\$22,333,660
Add back: Depreciation & Amortization	62,259	186,634	372,188	372,188
Receivables				
Premiums Receivable	81,926,770	(46,554,958)	26,519,945	26,519,945
Interest Receivable	(23,800)	(1,384,976)	(500,258)	(500,258)
Other Health Care Receivables	1,099,656	5,630,286	(5,159,430)	(5,159,430)
Other Receivables	(2,251)	(179)	(10,115)	(10,115)
GroupCare Receivable	(3,310)	3,291,529	(5,419)	(5,419)
Total	82,997,065	(39,018,298)	20,844,723	20,844,723
Prepaid Expenses	56,680	(76,307)	(349,672)	(349,672)
Trade Payables	(370,254)	(1,798,243)	(1,123,132)	(1,123,132)
Claims Payable and Shared Risk Pool				
IBNP Payable	1,995,761	(27,011,240)	(25,652,575)	(25,652,575)
Capitation Payable & Other Medical Payable	173,378,984	42,124,174	196,799,283	196,799,283
Risk Share Payable	-	2,000,000.00	1,050,856	1,050,856
Claims Payable				
Total	175,374,745	17,112,934	172,197,564	172,197,564
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	735,802	(1,154,495)	(815,693)	(815,694)
GASB Assets and Liabilities	246,270	325,097	645,765	645,765
New Health Program	-	-	-	-
MCO Tax Liabilities	(61,333,936)	4,503,061	11,483,502	11,483,502
Total	(60,351,864)	3,673,663	11,313,574	11,313,573
Rounding	-	-	-	-
Cash Flows from Operating Activities	198,736,287	(5,392,028)	225,588,900	225,588,904
Variance	-	-	-	-

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

December 31, 2025

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	\$334,899,418	\$701,121,130	\$1,528,780,630	\$1,528,780,632
Medicare Revenue	\$0	\$0	\$0	\$0
GroupCare Premium Revenue	3,367,642	13,311,993	19,843,071	19,843,071
Other Income	485,360	320,070	463,910	463,910
Interest Income	1,981,632	5,307,078	13,589,556	13,589,556
Less Cash Paid				
Medical Expenses	(6,687,784)	(505,551,863)	(899,939,608)	(899,939,609)
Vendor & Employee Expenses	(9,726,648)	(31,525,436)	(60,373,903)	(60,373,900)
MCO Tax Expense AB119	(125,583,333)	(188,375,000)	(376,774,756)	(376,774,756)
Net Cash Flows from Operating Activities	198,736,287	(5,392,028)	225,588,900	225,588,904
Cash Flows from Investing Activities:				
Long Term Investments	(31,991)	(3,327,909)	(1,686,775)	(1,686,779)
Restricted Assets-Treasury Account	(987)	(2,985)	(5,978)	(5,978)
Purchases of Property and Equipment	0	(24,453)	(24,453)	(24,453)
Net Cash Flows from Investing Activities	(32,978)	(3,355,347)	(1,717,206)	(1,717,210)
Net Change in Cash	198,703,309	(8,747,375)	223,871,694	223,871,694
Rounding	-	-	-	-
Cash @ Beginning of Period	558,184,556	765,635,240	533,016,171	533,016,171
Cash @ End of Period	\$756,887,865	\$756,887,865	\$756,887,865	\$756,887,865
Variance	\$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	\$967,656	\$14,527,590	\$22,333,654	\$22,333,660
Add Back: Depreciation	62,259	186,634	372,188	372,188
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	82,997,065	(39,018,298)	20,844,723	20,844,723
Prepaid Expenses	56,680	(76,308)	(349,671)	(349,672)
Trade Payables	(370,254)	(1,798,243)	(1,123,132)	(1,123,132)
Claims Payable, IBNP and Risk Sharing	175,374,745	17,112,934	172,197,564	172,197,564
Deferred Revenue	0	0	0	0
Other Liabilities	(60,351,864)	3,673,663	11,313,574	11,313,573
Total	198,736,287	(5,392,028)	225,588,900	225,588,904
Rounding	-	-	-	-
Cash Flows from Operating Activities	\$198,736,287	(\$5,392,028)	\$225,588,900	\$225,588,904
Variance	\$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF DECEMBER 2025

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal ACA OE	Medi-Cal SPD with LTC	Medi-Cal Duals with LTC	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	107,424	59,312	149,473	29,500	49,277	394,986	6,138	-	401,124
Revenue	\$36,231,316	\$31,794,727	\$90,939,151	\$50,124,084	\$43,883,369	\$252,972,648	\$3,370,952	\$0	\$256,343,600
Medical Expense	\$14,337,004	\$23,332,875	\$68,155,380	\$40,026,774	\$33,744,983	\$179,597,016	\$3,426,164	\$139,005	\$183,162,185
Gross Margin	\$21,894,312	\$8,461,852	\$22,783,771	\$10,097,310	\$10,138,387	\$73,375,632	(\$55,212)	(\$139,005)	\$73,181,415
Administrative Expense	\$446,420	\$1,007,342	\$3,084,903	\$2,665,039	\$1,399,055	\$8,602,759	\$197,708	\$1,658,314	\$10,458,781
MCO Tax Expense	\$17,609,691	\$9,486,182	\$24,176,034	\$4,873,231	\$8,104,260	\$64,249,397	\$0	\$0	\$64,249,397
Operating Income / (Expense)	\$3,838,201	(\$2,031,672)	(\$4,477,166)	\$2,559,040	\$635,072	\$523,476	(\$252,920)	(\$1,797,319)	(\$1,526,763)
Other Income / (Expense)	\$121,222	\$287,999	\$820,940	\$759,504	\$467,579	\$2,457,244	\$37,176	\$0	\$2,494,420
Net Income / (Loss)	\$3,959,423	(\$1,743,673)	(\$3,656,226)	\$3,318,544	\$1,102,651	\$2,980,720	(\$215,744)	(\$1,797,319)	\$967,657
PMPM Metrics:									
Revenue PMPM	\$337.27	\$536.06	\$608.40	\$1,699.12	\$890.54	\$640.46	\$549.19	\$0.00	\$639.06
Medical Expense PMPM	\$133.46	\$393.39	\$455.97	\$1,356.84	\$684.80	\$454.69	\$558.19	\$0.00	\$456.62
Gross Margin PMPM	\$203.81	\$142.67	\$152.43	\$342.28	\$205.74	\$185.77	(\$9.00)	\$0.00	\$182.44
Administrative Expense PMPM	\$4.16	\$16.98	\$20.64	\$90.34	\$28.39	\$21.78	\$32.21	\$0.00	\$26.07
MCO Tax Expense PMPM	\$163.93	\$159.94	\$161.74	\$165.19	\$164.46	\$162.66	\$0.00	\$0.00	\$160.17
Operating Income / (Expense) PMPM	\$35.73	(\$34.25)	(\$29.95)	\$86.75	\$12.89	\$1.33	(\$41.21)	\$0.00	(\$3.81)
Other Income / (Expense) PMPM	\$1.13	\$4.86	\$5.49	\$25.75	\$9.49	\$6.22	\$6.06	\$0.00	\$6.22
Net Income / (Loss) PMPM	\$36.86	(\$29.40)	(\$24.46)	\$112.49	\$22.38	\$7.55	(\$35.15)	\$0.00	\$2.41
Ratio:									
Medical Loss Ratio	77.0%	104.6%	102.1%	88.5%	94.3%	95.2%	101.6%	0.0%	95.4%
Administrative Expense Ratio	2.4%	4.5%	4.6%	5.9%	3.9%	4.6%	5.9%	0.0%	5.4%
Net Income Ratio	10.9%	-5.5%	-4.0%	6.6%	2.5%	1.2%	-6.4%	0.0%	0.4%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE DECEMBER 2025

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal ACA OE	Medi-Cal SPD with LTC	Medi-Cal Duals with LTC	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	648,986	361,219	912,631	177,948	296,282	2,397,066	36,296	-	2,433,362
Revenue	\$211,187,862	\$193,434,355	\$548,988,745	\$291,343,115	\$257,306,608	\$1,502,260,685	\$19,848,490	\$0	\$1,522,109,175
Medical Expense	\$84,003,482	\$125,157,051	\$365,882,275	\$251,962,912	\$219,698,633	\$1,046,704,353	\$19,793,816	\$479,573	\$1,066,977,742
Gross Margin	\$127,184,380	\$68,277,304	\$183,106,469	\$39,380,203	\$37,607,975	\$455,556,332	\$54,674	(\$479,573)	\$455,131,432
Administrative Expense	\$2,667,440	\$6,036,692	\$18,723,481	\$16,267,310	\$8,752,862	\$52,447,786	\$1,113,470	\$5,514,537	\$59,075,792
MCO Tax Expense	\$105,166,084	\$58,218,162	\$147,263,872	\$29,177,456	\$48,432,683	\$388,258,258	\$0	\$0	\$388,258,258
Operating Income / (Expense)	\$19,350,855	\$4,022,451	\$17,119,116	(\$6,064,563)	(\$19,577,571)	\$14,850,288	(\$1,058,795)	(\$5,994,110)	\$7,797,383
Other Income / (Expense)	\$706,397	\$1,678,613	\$4,783,090	\$4,425,897	\$2,725,761	\$14,319,757	\$216,515	\$0	\$14,536,272
Net Income / (Loss)	\$20,057,252	\$5,701,063	\$21,902,206	(\$1,638,667)	(\$16,851,809)	\$29,170,045	(\$842,280)	(\$5,994,110)	\$22,333,655
PMPM Metrics:									
Revenue PMPM	\$325.41	\$535.50	\$601.55	\$1,637.24	\$868.45	\$626.71	\$546.85	\$0.00	\$625.52
Medical Expense PMPM	\$129.44	\$346.49	\$400.91	\$1,415.94	\$741.52	\$436.66	\$545.34	\$0.00	\$438.48
Gross Margin PMPM	\$195.97	\$189.02	\$200.64	\$221.30	\$126.93	\$190.05	\$1.51	\$0.00	\$187.04
Administrative Expense PMPM	\$4.11	\$16.71	\$20.52	\$91.42	\$29.54	\$21.88	\$30.68	\$0.00	\$24.28
MCO Tax Expense PMPM	\$162.05	\$161.17	\$161.36	\$163.97	\$163.47	\$161.97	\$0.00	\$0.00	\$159.56
Operating Income / (Expense) PMPM	\$29.82	\$11.14	\$18.76	(\$34.08)	(\$66.08)	\$6.20	(\$29.17)	\$0.00	\$3.20
Other Income / (Expense) PMPM	\$1.09	\$4.65	\$5.24	\$24.87	\$9.20	\$5.97	\$5.97	\$0.00	\$5.97
Net Income / (Loss) PMPM	\$30.91	\$15.78	\$24.00	(\$9.21)	(\$56.88)	\$12.17	(\$23.21)	\$0.00	\$9.18
Ratio:									
Medical Loss Ratio	79.2%	92.6%	91.1%	96.1%	105.2%	94.0%	99.7%	0.0%	94.1%
Administrative Expense Ratio	2.5%	4.5%	4.7%	6.2%	4.2%	4.7%	5.6%	0.0%	5.2%
Net Income Ratio	9.5%	2.9%	4.0%	-0.6%	-6.5%	1.9%	-4.2%	0.0%	1.5%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 December, 2025

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)								
\$6,723,538	\$7,700,006	\$976,467	12.7%	Personnel Expenses	\$38,340,250	\$40,017,146	\$1,676,896	4.2%
\$76,318	\$183,434	\$107,116	58.4%	Benefits Administration Expense	\$334,653	\$576,372	\$241,719	41.9%
\$1,921,005	\$2,915,048	\$994,043	34.1%	Purchased & Professional Services	\$12,290,687	\$13,788,982	\$1,498,295	10.9%
\$352,931	\$485,632	\$132,702	27.3%	Occupancy	\$2,739,350	\$2,897,121	\$157,771	5.4%
\$288,787	\$209,700	(\$79,087)	(37.7%)	Printing Postage & Promotion	\$1,287,064	(\$2,102,744)	(\$3,389,808)	161.2%
\$720,885	\$1,267,678	\$546,794	43.1%	Licenses Insurance & Fees	\$2,714,446	\$3,611,349	\$896,903	24.8%
\$375,318	\$413,852	\$38,534	9.3%	Other Administrative Expense	\$1,369,341	\$6,007,478	\$4,638,137	77.2%
\$3,735,243	\$5,475,343	\$1,740,101	31.8%	Total Other Administrative Expenses (excludes Personnel Expenses)	\$20,735,542	\$24,778,558	\$4,043,016	16.3%
\$10,458,781	\$13,175,349	\$2,716,568	20.6%	Total Administrative Expenses	\$59,075,792	\$64,795,704	\$5,719,912	8.8%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 December, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
4,510,188	4,867,527	357,339	7.3%	Salaries & Wages	25,377,248	26,290,401	913,153	3.5%
365,309	382,704	17,395	4.5%	Paid Time Off	2,466,984	2,530,616	63,632	2.5%
796	9,967	9,171	92.0%	Compensated Incentives	7,001	27,873	20,872	74.9%
0	400,000	400,000	100.0%	Severance	0	400,000	400,000	100.0%
70,848	70,813	(35)	(0.1%)	Payroll Taxes	415,753	419,281	3,528	0.8%
49,168	60,612	11,444	18.9%	Overtime	410,625	411,528	904	0.2%
323,712	319,183	(4,529)	(1.4%)	CalPERS ER Match	2,060,789	2,078,011	17,222	0.8%
1,197,352	1,190,119	(7,233)	(0.6%)	Employee Benefits	6,747,460	6,754,303	6,843	0.1%
4,096	0	(4,096)	0.0%	Personal Floating Holiday	1,530	819	(711)	(86.8%)
23,814	33,500	9,686	28.9%	Language Pay	136,150	166,772	30,622	18.4%
4,860	0	(4,860)	0.0%	Med Ins Opted Out Stipend	22,360	12,100	(10,260)	(84.8%)
104,796	0	(104,796)	0.0%	Sick Leave	286,735	77,895	(208,841)	(268.1%)
2,070	51,079	49,010	95.9%	Compensated Employee Relations	(217)	79,258	79,475	100.3%
21,220	24,990	3,770	15.1%	Work from Home Stipend	125,520	132,660	7,140	5.4%
1,145	4,660	3,515	75.4%	Mileage, Parking & Local Travel	7,051	13,898	6,847	49.3%
2,903	29,617	26,714	90.2%	Travel & Lodging	23,495	112,440	88,945	79.1%
28,633	182,152	153,519	84.3%	Temporary Help Services	133,865	288,535	154,670	53.6%
8,956	41,408	32,452	78.4%	Staff Development/Training	92,121	160,226	68,105	42.5%
3,673	31,675	28,002	88.4%	Staff Recruitment/Advertisement	25,780	60,531	34,750	57.4%
6,723,538	7,700,006	976,467	12.7%	Personnel Expense	38,340,250	40,017,146	1,676,896	4.2%
24,467	26,448	1,981	7.5%	Pharmacy Administrative Fees	156,431	156,427	(4)	0.0%
0	0	0	0.0%	Behavioral Hlth Administration	(136,422)	0	136,422	0.0%
0	105,000	105,000	100.0%	M3P Admin Fees	0	105,000	105,000	100.0%
51,850	51,985	135	0.3%	Telemedicine Admin. Fees	314,645	314,945	300	0.1%
76,318	183,434	107,116	58.4%	Benefits Administration Expense	334,653	576,372	241,719	41.9%
710,771	1,214,026	503,255	41.5%	Consultant Fees - Non Medical	3,251,038	3,852,627	601,589	15.6%
277,595	458,789	181,195	39.5%	Computer Support Services	2,565,817	2,682,566	116,749	4.4%
13,083	11,750	(1,333)	(11.3%)	Audit Fees	92,621	89,955	(2,666)	(3.0%)
0	0	0	0.0%	Consultant Fees - Medical	17,593	117,593	100,000	85.0%
214,117	285,415	71,298	25.0%	Other Purchased Services	1,220,604	1,450,809	230,205	15.9%
0	1,879	1,879	100.0%	Maint.&Repair-Office Equipment	0	3,758	3,758	100.0%
51,471	67,267	15,796	23.5%	Legal Fees	291,387	323,505	32,118	9.9%
0	0	0	0.0%	Member Health Education	(17)	(17)	0	0.0%
40,234	28,000	(12,234)	(43.7%)	Translation Services	354,205	299,523	(54,683)	(18.3%)
138,200	151,900	13,700	9.0%	Medical Refund Recovery Fees	1,118,629	1,129,950	11,321	1.0%
449,285	561,875	112,590	20.0%	Software - IT Licenses & Subsc	3,134,715	3,342,859	208,143	6.2%
22,729	73,746	51,017	69.2%	Hardware (Non-Capital)	220,750	358,121	137,371	38.4%
3,520	60,400	56,880	94.2%	Provider Credentialing	23,344	137,733	114,389	83.1%
1,921,005	2,915,048	994,043	34.1%	Purchased & Professional Services	12,290,687	13,788,982	1,498,295	10.9%
62,259	62,876	617	1.0%	Depreciation	372,188	372,299	112	0.0%
8,419	13,845	5,426	39.2%	Lease Rented Office Equipment	36,720	47,900	11,179	23.3%
25,060	19,965	(5,095)	(25.5%)	Utilities	110,603	107,023	(3,580)	(3.3%)
89,598	108,156	18,558	17.2%	Telephone	551,797	592,328	40,531	6.8%
19,973	30,790	10,817	35.1%	Building Maintenance	95,335	151,417	56,082	37.0%
147,623	250,000	102,377	41.0%	GASB96 SBITA Amort. Expense	1,572,707	1,626,154	53,447	3.3%
352,931	485,632	132,702	27.3%	Occupancy	2,739,350	2,897,121	157,771	5.4%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 December, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
70,896	43,110	(27,786)	(64.5%)	Postage	409,312	527,057	117,745	22.3%
9,350	5,700	(3,650)	(64.0%)	Design & Layout	34,034	30,942	(3,093)	(10.0%)
169,916	49,843	(120,073)	(240.9%)	Printing Services	685,562	779,008	93,446	12.0%
10,014	15,600	5,586	35.8%	Mailing Services	64,692	44,665	(20,027)	(44.8%)
8,792	13,827	5,035	36.4%	Courier/Delivery Service	37,714	50,019	12,305	24.6%
0	770	770	100.0%	Pre-Printed Materials & Public	0	840	840	100.0%
4,609	0	(4,609)	0.0%	Promotional Products	4,421	17,500	13,079	74.7%
0	5,150	5,150	100.0%	Promotional Services	358	5,658	5,300	93.7%
15,210	75,700	60,490	79.9%	Community Relations	50,971	(3,558,432)	(3,609,403)	101.4%
288,787	209,700	(79,087)	(37.7%)	Printing Postage & Promotion	1,287,064	(2,102,744)	(3,389,808)	161.2%
46,000	75,000	29,000	38.7%	Regulatory Penalties	46,000	150,000	104,000	69.3%
38,034	45,500	7,466	16.4%	Bank Fees	258,185	259,638	1,453	0.6%
0	200	200	100.0%	Insurance Premium	1,043,881	1,044,281	400	0.0%
597,692	1,073,745	476,053	44.3%	License,Permits, & Fee - NonIT	938,090	1,628,993	690,903	42.4%
39,158	73,233	34,075	46.5%	Subscriptions and Dues - NonIT	428,290	528,436	100,146	19.0%
720,885	1,267,678	546,794	43.1%	License Insurance & Fees	2,714,446	3,611,349	896,903	24.8%
1,873	6,885	5,012	72.8%	Office and Other Supplies	16,026	23,971	7,945	33.1%
0	1,000	1,000	100.0%	Furniture & Equipment	0	1,000	1,000	100.0%
11,277	12,599	1,321	10.5%	Ergonomic Supplies	70,112	94,967	24,855	26.2%
17,252	12,890	(4,362)	(33.8%)	Meals and Entertainment	85,006	92,492	7,485	8.1%
0	0	0	0.0%	Miscellaneous	(953,091)	(245,248)	707,843	(288.6%)
0	3,125	3,125	100.0%	Member Incentive	0	6,250	6,250	100.0%
173,249	210,687	37,438	17.8%	Provider Interest (All Depts)	1,131,286	1,264,121	132,835	10.5%
171,667	166,666	(5,001)	(3.0%)	Community Reinvestment Expense	1,020,002	4,769,926	3,749,924	78.6%
375,318	413,852	38,534	9.3%	Other Administrative Expense	1,369,341	6,007,478	4,638,137	77.2%
3,735,243	5,475,343	1,740,101	31.8%	Total Other Administrative ExpenseS (excludes Personnel Expenses)	20,735,542	24,778,558	4,043,016	16.3%
10,458,781	13,175,349	2,716,568	20.6%	TOTAL ADMINISTRATIVE EXPENSES	59,075,792	64,795,704	5,719,912	8.8%

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

	Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	\$ Variance Fav/(Unf.)
1. Hardware:						
Cisco Routers	IT-FY26-01	\$ -	\$ -	\$ -	\$ 45,000	\$ 45,000
Firewall AAH Location	IT-FY26-02	\$ -	\$ -	\$ -	\$ 110,000	\$ 110,000
Firewall Roseville Location	IT-FY26-03	\$ -	\$ -	\$ -	\$ 110,000	\$ 110,000
VPN Device	IT-FY26-04	\$ -	\$ -	\$ -	\$ 115,000	\$ 115,000
CISCO UCS Blades	IT-FY26-05	\$ -	\$ -	\$ -	\$ 300,000	\$ 300,000
CISCO UCS Blades	IT-FY26-05	\$ -	\$ -	\$ -	\$ 275,000	\$ 275,000
Pure Storage	IT-FY26-06	\$ -	\$ -	\$ -	\$ 150,000	\$ 150,000
Teams Meeting Hardware	IT-FY26-07	\$ -	\$ -	\$ -	\$ 100,000	\$ 100,000
Network Cabeling and WIFI Access	IT-FY26-08	\$ -	\$ -	\$ -	\$ 40,000	\$ 40,000
Hardware Subtotal		\$ -	\$ -	\$ -	\$ 1,245,000	\$ 1,245,000
3. Building Improvement:						
1240 Exterior lighting update	FA-FY26-01	\$ -	\$ -	\$ -	\$ 30,000	\$ 30,000
1240 Secured Fencing for Warehouse	FA-FY26-02	\$ 8,550	\$ -	\$ 8,550	\$ 30,000	\$ 21,450
1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	\$ -	\$ -	\$ -	\$ 10,000	\$ 10,000
1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	\$ -	\$ -	\$ -	\$ 5,000	\$ 5,000
1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	\$ -	\$ -	\$ -	\$ 10,000	\$ 10,000
1240 Exterior Landscaping	FA-FY26-04	\$ 903	\$ -	\$ 903	\$ 6,500	\$ 5,597
1240 Exterior Landscaping	FA-FY26-04	\$ 15,000	\$ -	\$ 15,000	\$ 15,000	\$ -
1240 Exterior Landscaping	FA-FY26-04	\$ -	\$ -	\$ -	\$ 15,000	\$ 15,000
Building Improvement Subtotal		\$ 24,453	\$ -	\$ 24,453	\$ 121,500	\$ 97,047
GRAND TOTAL		\$ 24,453	\$ -	\$ 24,453	\$ 1,366,500	\$ 1,342,047

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 12/31/25	\$ 38,993,858
Fixed Assets @ Cost - 6/30/25	\$ 38,969,405
Fixed Assets Acquired YTD	\$ 24,453

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
FOR THE MONTH AND FISCAL YTD ENDED DECEMBER 31, 2025

TANGIBLE NET EQUITY (TNE)

	QRT. END Jun-25	Jul-25	Aug-25	QRT. END Sep-25	Oct-25	Nov-25	Dec-25
Current Month Net Income / (Loss)	\$ 4,912,222	\$ 1,727,933	\$ 2,950,359	\$ 3,127,768	\$ 6,501,450	\$ 7,058,478	\$ 967,656
YTD Net Income / (Loss)	\$ (86,095,783)	\$ 1,727,938	\$ 4,678,300	\$ 7,806,066	\$ 14,307,514	\$ 21,365,998	\$ 22,333,655
Net Assets	\$ 169,279,360	\$ 171,007,298	\$ 173,957,660	\$ 177,085,426	\$ 183,586,874	\$ 190,645,358	\$ 191,613,015
Subordinated Debt & Interest	-	-	-	-	-	-	-
Total Actual TNE	\$ 169,279,360	\$ 171,007,298	\$ 173,957,660	\$ 177,085,426	\$ 183,586,874	\$ 190,645,358	\$ 191,613,015
Increase/(Decrease) in Actual TNE	\$ 4,912,222	\$ 1,727,933	\$ 2,950,359	\$ 3,127,768	\$ 6,501,450	\$ 7,058,478	\$ 967,656
Required TNE ⁽¹⁾	\$ 80,653,661	\$ 81,235,858	\$ 80,224,390	\$ 80,693,435	\$ 80,147,121	\$ 79,750,550	\$ 80,436,968
Min. Req'd to Avoid Monthly Reporting at 150% of Required TNE	\$ 120,980,491	\$ 121,853,786	\$ 120,336,585	\$ 121,040,152	\$ 120,220,681	\$ 119,625,824	\$ 120,655,452
TNE Excess / (Deficiency)	\$ 88,625,699	\$ 89,771,440	\$ 93,733,270	\$ 96,391,991	\$ 103,439,753	\$ 110,894,808	\$ 111,176,047
Actual TNE as a Multiple of Required	2.10	2.11	2.17	2.19	2.29	2.39	2.38

LIQUID TANGIBLE NET EQUITY

Net Assets	\$ 169,279,360	\$ 171,007,298	\$ 173,957,660	\$ 177,085,426	\$ 183,586,874	\$ 190,645,358	\$ 191,613,015
Less: Fixed Assets at Net Book Value	(5,576,811)	(5,514,960)	(5,453,108)	(5,391,257)	(5,329,406)	(5,291,335)	(5,229,076)
Net Lease Assets	(2,072,151)	(1,979,137)	(1,678,452)	(1,751,482)	(1,932,587)	(1,672,654)	(1,426,385)
CD Pledged to DMHC	(353,866)	(354,839)	(355,847)	(356,859)	(357,840)	(358,857)	(359,844)
Liquid TNE (Liquid Reserves)	\$ 161,276,532	\$ 163,158,362	\$ 166,470,253	\$ 169,585,828	\$ 175,967,041	\$ 183,322,512	\$ 184,597,710
Liquid TNE as Multiple of Required	2.00	2.01	2.08	2.10	2.20	2.30	2.29

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

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

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,251	108,503	108,083	107,831	107,894	107,424							648,986
Adult	61,536	60,679	60,106	59,780	59,806	59,312							361,219
ACA OE	155,533	153,348	152,196	151,404	150,677	149,473							912,631
SPD with LTC	29,833	29,686	29,708	29,631	29,590	29,500							177,948
Duals with LTC	49,509	49,371	49,390	49,401	49,334	49,277							296,282
Medi-Cal Program	405,662	401,587	399,483	398,047	397,301	394,986							2,397,066
Group Care Program	5,957	5,974	6,054	6,081	6,092	6,138							36,296
Total	411,619	407,561	405,537	404,128	403,393	401,124							2,433,362
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(323)	(748)	(420)	(252)	63	(470)							(2,150)
Adult	(133)	(857)	(573)	(326)	26	(494)							(2,357)
ACA OE	357	(2,185)	(1,152)	(792)	(727)	(1,204)							(5,703)
SPD with LTC	83	(147)	22	(77)	(41)	(90)							(250)
Duals with LTC	205	(138)	19	11	(67)	(57)							(27)
Medi-Cal Program	189	(4,075)	(2,104)	(1,436)	(746)	(2,315)							(10,487)
Group Care Program	47	17	80	27	11	46							228
Total	236	(4,058)	(2,024)	(1,409)	(735)	(2,269)							(10,259)
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	26.9%	27.0%	27.1%	27.1%	27.2%	27.2%							27.1%
Adult % of Medi-Cal	15.2%	15.1%	15.0%	15.0%	15.1%	15.0%							15.1%
ACA OE % of Medi-Cal	38.3%	38.2%	38.1%	38.0%	37.9%	37.8%							38.1%
SPD with LTC % of Medi-Cal	7.4%	7.4%	7.4%	7.4%	7.4%	7.5%							7.4%
Duals with LTC % of Medi-Cal	12.2%	12.3%	12.4%	12.4%	12.4%	12.5%							12.4%
Medi-Cal Program % of Total	98.6%	98.5%	98.5%	98.5%	98.5%	98.5%							98.5%
Group Care Program % of Total	1.4%	1.5%	1.5%	1.5%	1.5%	1.5%							1.5%
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 2026**

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

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	93,933	93,268	93,599	92,670	93,415	91,466							558,351
Alameda Health System	92,861	91,758	91,032	91,084	90,621	90,714							548,070
Directly-Contracted Subtotal	186,794	185,026	184,631	183,754	184,036	182,180							1,106,421
Delegated:													
CFMG	43,381	42,852	42,253	42,053	41,790	41,683							254,012
CHCN	181,444	179,683	178,653	178,321	177,567	177,261							1,072,929
Delegated Subtotal	224,825	222,535	220,906	220,374	219,357	218,944							1,326,941
Total	411,619	407,561	405,537	404,128	403,393	401,124							2,433,362
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(518)	(1,768)	(395)	(877)	282	(1,856)							(5,132)
Delegated:													
CFMG	(128)	(529)	(599)	(200)	(263)	(107)							(1,826)
CHCN	882	(1,761)	(1,030)	(332)	(754)	(306)							(3,301)
Delegated Subtotal	754	(2,290)	(1,629)	(532)	(1,017)	(413)							(5,127)
Total	236	(4,058)	(2,024)	(1,409)	(735)	(2,269)							(10,259)
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	45.4%	45.4%	45.5%	45.5%	45.6%	45.4%							45.5%
Delegated:													
CFMG	10.5%	10.5%	10.4%	10.4%	10.4%	10.4%							10.4%
CHCN	44.1%	44.1%	44.1%	44.1%	44.0%	44.2%							44.1%
Delegated Subtotal	54.6%	54.6%	54.5%	54.5%	54.4%	54.6%							54.5%
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 2026

FINAL BUDGET

	Budget Jul-25	Budget Aug-25	Budget Sep-25	Budget Oct-25	Budget Nov-25	Budget Dec-25	Budget Jan-26	Budget Feb-26	Budget Mar-26	Budget Apr-26	Budget May-26	Budget Jun-26	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,251	108,503	108,083	107,831	107,623	107,014	106,408	105,806	105,210	104,615	104,025	103,439	1,277,808
Adult	61,536	60,679	60,106	59,780	59,301	58,778	57,982	57,197	56,422	55,659	54,907	54,167	696,514
ACA OE	155,533	153,348	152,196	151,404	150,461	149,482	145,792	142,205	138,719	135,332	132,040	128,840	1,735,352
SPD with LTC	29,833	29,686	29,708	29,631	29,574	29,456	21,811	21,666	21,525	21,382	21,241	21,100	306,613
Duals with LTC	49,509	49,371	49,390	49,401	49,195	49,072	56,469	56,344	56,220	56,096	55,973	55,850	632,890
Medi-Cal Program	405,662	401,587	399,483	398,047	396,154	393,802	388,462	383,218	378,096	373,084	368,186	363,396	4,649,177
Group Care Program	5,957	5,974	6,054	6,081	6,079	6,085	6,079	6,085	6,091	6,097	6,103	6,109	72,794
Total	411,619	407,561	405,537	404,128	402,233	399,887	394,541	389,303	384,187	379,181	374,289	369,505	4,721,971

Month Over Month Enrollment Change:

Medi-Cal Monthly Change													
Child	(1,402)	(748)	(420)	(252)	(208)	(609)	(606)	(602)	(596)	(595)	(590)	(586)	(7,214)
Adult	(1,546)	(857)	(573)	(326)	(479)	(523)	(796)	(785)	(775)	(763)	(752)	(740)	(8,915)
ACA OE	3,222	(2,185)	(1,152)	(792)	(943)	(979)	(3,690)	(3,587)	(3,486)	(3,387)	(3,292)	(3,200)	(23,471)
SPD with LTC	(97)	(147)	22	(77)	(57)	(118)	(7,645)	(145)	(141)	(143)	(141)	(141)	(8,830)
Duals with LTC	2,092	(138)	19	11	(206)	(123)	7,397	(125)	(124)	(124)	(123)	(123)	8,433
Medi-Cal Program	2,269	(4,075)	(2,104)	(1,436)	(1,893)	(2,352)	(5,340)	(5,244)	(5,122)	(5,012)	(4,898)	(4,790)	(39,997)
Group Care Program	188	17	80	27	(2)	6	(6)	6	6	6	6	6	340
Total	2,457	(4,058)	(2,024)	(1,409)	(1,895)	(2,346)	(5,346)	(5,238)	(5,116)	(5,006)	(4,892)	(4,784)	(39,657)
													0

Enrollment Percentages:

Medi-Cal Program:													
Child % of Medi-Cal	26.9%	27.0%	27.1%	27.1%	27.2%	27.2%	27.4%	27.6%	27.8%	28.0%	28.3%	28.5%	27.5%
Adult % of Medi-Cal	15.2%	15.1%	15.0%	15.0%	15.0%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	15.0%
ACA OE % of Medi-Cal	38.3%	38.2%	38.1%	38.0%	38.0%	38.0%	37.5%	37.1%	36.7%	36.3%	35.9%	35.5%	37.3%
SPD with LTC % of Medi-Cal	7.4%	7.4%	7.4%	7.4%	7.5%	7.5%	5.6%	5.7%	5.7%	5.7%	5.8%	5.8%	6.6%
Duals with LTC % of Medi-Cal	12.2%	12.3%	12.4%	12.4%	12.4%	12.5%	14.5%	14.7%	14.9%	15.0%	15.2%	15.4%	13.6%
Medi-Cal Program % of Total	98.6%	98.5%	98.5%	98.5%	98.5%	98.5%	98.5%	98.4%	98.4%	98.4%	98.4%	98.3%	98.5%
Group Care Program % of Total	1.4%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.6%	1.6%	1.6%	1.6%	1.7%	1.5%
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 2026

FINAL BUDGET

	Budget Jul-25	Budget Aug-25	Budget Sep-25	Budget Oct-25	Budget Nov-25	Budget Dec-25	Budget Jan-26	Budget Feb-26	Budget Mar-26	Budget Apr-26	Budget May-26	Budget Jun-26	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	93,933	93,268	93,599	92,670	93,410	92,946	94,780	93,808	92,860	91,962	91,058	90,177	1,114,471
Alameda Health System	92,861	91,758	91,032	91,084	90,325	89,753	87,421	85,899	84,414	82,969	81,558	80,181	1,049,255
Directly-Contracted Subtotal	186,794	185,026	184,631	183,754	183,735	182,699	182,201	179,707	177,274	174,931	172,616	170,358	2,163,726
Delegated:													
CFMG	43,381	42,852	42,253	42,053	41,673	41,447	40,713	40,456	40,203	39,951	39,701	39,454	494,137
CHCN	181,444	179,683	178,653	178,321	176,825	175,741	171,893	169,510	167,183	164,918	162,694	160,518	2,067,383
Delegated Subtotal	224,825	222,535	220,906	220,374	218,498	217,188	212,606	209,966	207,386	204,869	202,395	199,972	2,561,520
Total	411,619	407,561	405,537	404,128	402,233	399,887	394,807	389,673	384,660	379,800	375,011	370,330	4,725,246

0

Direct/Delegate Month Over Month Enrollment Change:

Directly-Contracted													
Directly Contracted (DCP)	1,762	(665)	331	(929)	740	(464)	1,834	(972)	(948)	(898)	(904)	(881)	(1,994)
Alameda Health System	1,869	(1,103)	(726)	52	(759)	(572)	(2,332)	(1,522)	(1,485)	(1,445)	(1,411)	(1,377)	(10,811)
Directly-Contracted Subtotal	3,631	(1,768)	(395)	(877)	(19)	(1,036)	(498)	(2,494)	(2,433)	(2,343)	(2,315)	(2,258)	(12,805)
Delegated:													
CFMG	(640)	(529)	(599)	(200)	(380)	(226)	(734)	(257)	(253)	(252)	(250)	(247)	(4,567)
CHCN	(534)	(1,761)	(1,030)	(332)	(1,496)	(1,084)	(3,848)	(2,383)	(2,327)	(2,265)	(2,224)	(2,176)	(21,460)
Delegated Subtotal	(1,174)	(2,290)	(1,629)	(532)	(1,876)	(1,310)	(4,582)	(2,640)	(2,580)	(2,517)	(2,474)	(2,423)	(26,027)
Total	2,457	(4,058)	(2,024)	(1,409)	(1,895)	(2,346)	(5,080)	(5,134)	(5,013)	(4,860)	(4,789)	(4,681)	(38,832)

Direct/Delegate Enrollment Percentages:

Directly-Contracted													
Directly Contracted (DCP)	22.8%	22.9%	23.1%	22.9%	23.2%	23.2%	24.0%	24.1%	24.1%	24.2%	24.3%	24.4%	23.6%
Alameda Health System	22.6%	22.5%	22.4%	22.5%	22.5%	22.4%	22.1%	22.0%	21.9%	21.8%	21.7%	21.7%	22.2%
Directly-Contracted Subtotal	45.4%	45.4%	45.5%	45.5%	45.7%	45.7%	46.1%	46.1%	46.1%	46.1%	46.0%	46.0%	45.8%
Delegated:													
CFMG	10.5%	10.5%	10.4%	10.4%	10.4%	10.4%	10.3%	10.4%	10.5%	10.5%	10.6%	10.7%	10.5%
CHCN	44.1%	44.1%	44.1%	44.1%	44.0%	43.9%	43.5%	43.5%	43.5%	43.4%	43.4%	43.3%	43.8%
Delegated Subtotal	54.6%	54.6%	54.5%	54.5%	54.3%	54.3%	53.9%	53.9%	53.9%	53.9%	54.0%	54.0%	54.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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

	Variance Jul-25	Variance Aug-25	Variance Sep-25	Variance Oct-25	Variance Nov-25	Variance Dec-25	Variance Jan-26	Variance Feb-26	Variance Mar-26	Variance Apr-26	Variance May-26	Variance Jun-26	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	271	410							681
Adult	0	0	0	0	505	534							1,039
ACA OE	0	0	0	0	216	(9)							207
SPD with LTC	0	0	0	0	16	44							60
Duals with LTC	0	0	0	0	139	205							344
Medi-Cal Program	0	0	0	0	1,147	1,184							2,331
Group Care Program	0	0	0	0	13	53							66
Total	0	0	0	0	1,160	1,237							2,397
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	5	(1,480)							(1,475)
Alameda Health System	0	0	0	0	296	961							1,257
Directly-Contracted Subtotal	0	0	0	0	301	(519)							(218)
Delegated:													
CFMG	0	0	0	0	117	236							353
CHCN	0	0	0	0	742	1,520							2,262
Delegated Subtotal	0	0	0	0	859	1,756							2,615
Total	0	0	0	0	1,160	1,237							2,397

**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 DECEMBER, 2025**

CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
<u>CAPITATED MEDICAL EXPENSES</u>								
\$516,288	\$498,430	(\$17,858)	(3.6%)	PCP Capitation	\$14,079,073	\$14,036,502	(\$42,571)	(0.3%)
6,426,352	6,282,596	(143,757)	(2.3%)	PCP Capitation FQHC	45,180,755	44,859,306	(321,449)	(0.7%)
458,985	454,138	(4,847)	(1.1%)	Specialty Capitation	2,811,426	2,799,757	(11,668)	(0.4%)
5,271,837	5,550,797	278,960	5.0%	Specialty Capitation FQHC	30,858,490	31,382,062	523,572	1.7%
788,185	743,355	(44,830)	(6.0%)	Laboratory Capitation	4,777,451	4,689,078	(88,373)	(1.9%)
335,253	333,160	(2,093)	(0.6%)	Vision Capitation	2,033,317	2,029,280	(4,037)	(0.2%)
104,396	103,294	(1,103)	(1.1%)	CFMG Capitation	639,462	636,808	(2,654)	(0.4%)
839,186	848,527	9,341	1.1%	ANC IPA Admin Capitation FQHC	5,553,796	5,567,140	13,344	0.2%
(4,361)	0	4,361	0.0%	Kaiser Capitation	(16,872)	(12,511)	4,361	(34.9%)
1,027,220	1,016,974	(10,245)	(1.0%)	DME Capitation	6,199,953	6,179,372	(20,581)	(0.3%)
15,763,341	15,831,271	67,931	0.4%	7. TOTAL CAPITATED EXPENSES	112,116,851	112,166,795	49,943	0.0%
<u>FEE FOR SERVICE MEDICAL EXPENSES</u>								
1,267,987	0	(1,267,987)	0.0%	IBNR Inpatient Services	(16,297,406)	(20,241,559)	(3,944,153)	19.5%
38,039	0	(38,039)	0.0%	IBNR Settlement (IP)	(488,922)	(607,245)	(118,323)	19.5%
101,439	0	(101,439)	0.0%	IBNR Claims Fluctuation (IP)	(1,303,923)	(1,619,325)	(315,532)	19.5%
46,093,368	48,858,566	2,765,198	5.7%	Inpatient Hospitalization FFS	276,871,941	282,949,346	6,077,405	2.1%
3,531,328	3,556,028	24,700	0.7%	IP OB - Mom & NB	20,187,425	20,821,996	634,571	3.0%
306,616	160,432	(146,185)	(91.1%)	IP Behavioral Health	1,515,321	1,215,492	(299,829)	(24.7%)
1,009,102	1,568,255	559,153	35.7%	Inpatient Facility Rehab FFS	7,718,432	8,434,696	716,263	8.5%
52,347,879	54,143,281	1,795,402	3.3%	8. Inpatient Hospital Expense	288,202,999	290,953,401	2,750,402	0.9%
(354,335)	0	354,335	0.0%	IBNR PCP	1,379,874	3,433,331	2,053,457	59.8%
(10,631)	0	10,631	0.0%	IBNR Settlement (PCP)	41,395	103,000	61,605	59.8%
(28,347)	0	28,347	0.0%	IBNR Claims Fluctuation (PCP)	110,392	274,669	164,277	59.8%
2,472,682	2,846,095	373,413	13.1%	PCP FFS	18,053,543	19,967,876	1,914,332	9.6%
0	0	0	0.0%	Special Needs Medical Expense	278	278	0	0.0%
572,196	419,869	(152,328)	(36.3%)	PCP FQHC FFS	3,047,783	2,653,488	(394,295)	(14.9%)
0	0	0	0.0%	Prop 56 Physician Pmt	(3,778)	(3,778)	0	0.0%
15,819	0	(15,819)	0.0%	Prop 56 Hyde	96,138	64,417	(31,721)	(49.2%)
75,240	0	(75,240)	0.0%	Prop 56 Trauma Screening	454,088	303,469	(150,619)	(49.6%)
90,215	0	(90,215)	0.0%	Prop 56 Developmentl Screening	542,177	361,844	(180,333)	(49.8%)
636,379	815,565	179,186	22.0%	Prop 56 Family Planning	3,890,655	4,221,357	330,703	7.8%
0	0	0	0.0%	Prop 56 VBP	(259)	(259)	0	0.0%
3,469,218	4,081,529	612,311	15.0%	9. Primary Care Physician Expense	27,612,286	31,379,691	3,767,406	12.0%
(688,957)	0	688,957	0.0%	IBNR Specialist	(178,215)	(334,249)	(156,034)	46.7%
(20,670)	0	20,670	0.0%	IBNR Settlement (SCP)	(5,346)	(10,026)	(4,680)	46.7%
(55,116)	0	55,116	0.0%	IBNR Claims Fluctuation (SCP)	(14,261)	(26,743)	(12,482)	46.7%
636,872	0	(636,872)	0.0%	Psychiatrist FFS	3,937,114	2,739,633	(1,197,481)	(43.7%)
3,130,079	8,633,514	5,503,435	63.7%	Specialty Care FFS	20,854,071	32,170,673	11,316,602	35.2%
256,344	0	(256,344)	0.0%	Specialty Anesthesiology	1,842,560	1,349,666	(492,894)	(36.5%)
1,591,143	0	(1,591,143)	0.0%	Specialty Imaging FFS	10,044,908	6,999,284	(3,045,624)	(43.5%)
40,464	0	(40,464)	0.0%	Obstetrics FFS	315,826	236,824	(79,003)	(33.4%)
425,307	0	(425,307)	0.0%	Specialty IP Surgery FFS	2,793,571	1,954,243	(839,328)	(42.9%)
1,040,763	0	(1,040,763)	0.0%	Specialty OP Surgery FFS	6,363,831	4,456,894	(1,906,938)	(42.8%)
616,946	0	(616,946)	0.0%	Specialty IP Physician	4,125,784	2,930,480	(1,195,304)	(40.8%)
188,538	144,781	(43,756)	(30.2%)	Specialist FQHC FFS	1,027,460	939,124	(88,336)	(9.4%)
7,161,714	8,778,296	1,616,582	18.4%	10. Specialty Care Physician Expense	51,107,304	53,405,803	2,298,498	4.3%
(9,059)	0	9,059	0.0%	IBNR Ancillary (ANC)	(3,284,214)	(3,205,959)	78,255	(2.4%)
(272)	0	272	0.0%	IBNR Settlement (ANC)	(98,530)	(98,181)	2,349	(2.4%)
(725)	0	725	0.0%	IBNR Claims Fluctuation (ANC)	(262,738)	(256,479)	6,259	(2.4%)

**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 DECEMBER, 2025**

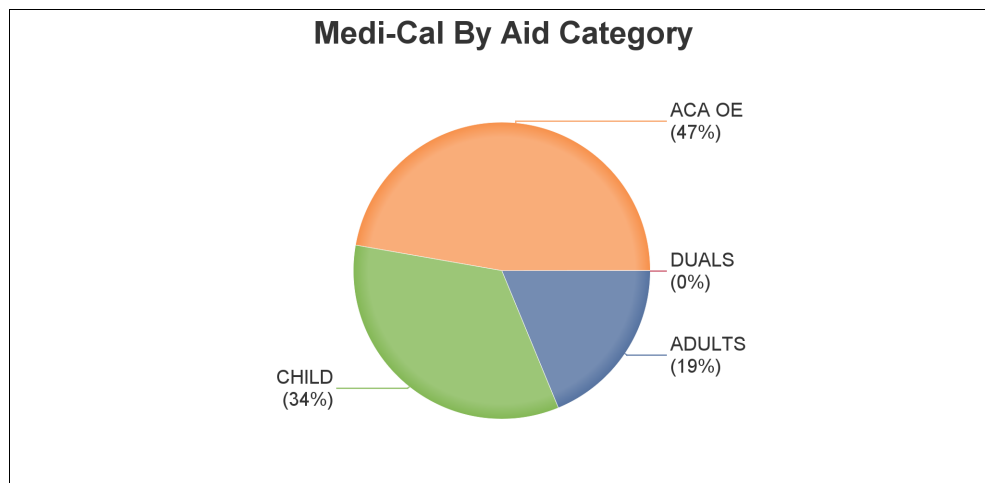
CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
(201,186)	0	201,186	0.0%	IBNR Transportation FFS	(191,759)	(320,108)	(128,349)	40.1%
3,357,851	2,699,931	(657,920)	(24.4%)	Behavioral Health Therapy FFS	18,973,538	18,143,097	(830,441)	(4.6%)
3,222,242	0	(3,222,242)	0.0%	Psychologist & Other MH Prof	16,382,905	10,562,380	(5,820,525)	(55.1%)
798,006	0	(798,006)	0.0%	Other Medical Professional	3,772,742	2,326,374	(1,446,369)	(62.2%)
161,193	0	(161,193)	0.0%	Hearing Devices	1,037,422	683,277	(354,146)	(51.8%)
29,583	0	(29,583)	0.0%	ANC Imaging	186,813	138,286	(48,527)	(35.1%)
101,275	0	(101,275)	0.0%	Vision FFS	488,893	330,028	(158,865)	(48.1%)
0	0	0	0.0%	Family Planning	5	5	0	0.0%
905,479	882,614	(22,866)	(2.6%)	Laboratory FFS	4,467,869	4,640,856	172,987	3.7%
166,614	0	(166,614)	0.0%	ANC Therapist	982,655	667,783	(314,872)	(47.2%)
1,895,481	1,827,944	(67,537)	(3.7%)	Transp/Ambulance FFS	10,784,168	10,805,638	21,469	0.2%
2,785,985	2,793,705	7,720	0.3%	Non-ER Transportation FFS	15,005,590	14,973,911	(31,679)	(0.2%)
1,280,291	2,311,250	1,030,960	44.6%	Hospice FFS	9,662,390	11,490,263	1,827,873	15.9%
2,513,154	3,406,572	893,418	26.2%	Home Health Services	15,544,452	16,622,439	1,077,987	6.5%
0	0	0	0.0%	Other Medical FFS	2,450	2,450	0	0.0%
299,189	0	(299,189)	0.0%	Medical Refunds through HMS	(843,634)	(883,969)	(40,335)	4.6%
17,252	2,047,518	2,030,266	99.2%	DME & Medical Supplies FFS	124,143	4,144,426	4,020,283	97.0%
2,571,414	2,385,981	(185,433)	(7.8%)	ECM Base/Outreach FFS ANC	15,522,489	15,106,221	(416,268)	(2.8%)
180,251	180,627	376	0.2%	CS Housing Deposits FFS ANC	1,038,741	1,033,059	(5,683)	(0.6%)
783,277	715,763	(67,514)	(9.4%)	CS Housing Tenancy FFS ANC	4,817,265	5,073,769	256,503	5.1%
430,736	429,995	(742)	(0.2%)	CS Housing Navi Servc FFS ANC	2,960,069	3,193,985	233,916	7.3%
209,260	384,909	175,649	45.6%	CS Medical Respite FFS ANC	1,713,772	2,092,571	378,799	18.1%
176,127	277,663	101,536	36.6%	CS Med. Tailored Meals FFS ANC	1,205,643	1,424,084	218,441	15.3%
21,447	21,680	233	1.1%	CS Asthma Remediation FFS ANC	146,068	142,474	(3,593)	(2.5%)
0	0	0	0.0%	MOT Wrap Around (Non Med MOT)	6,868	6,868	0	0.0%
1,846	2,625	779	29.7%	CS Home Modifications FFS ANC	1,846	5,205	3,359	64.5%
26,764	104,425	77,661	74.4%	CS P.Care & Hmker Svcs FFS ANC	380,895	469,889	88,994	18.9%
4,085	6,747	2,662	39.5%	CS Cgiver Respite Svcs FFS ANC	12,483	20,521	8,038	39.2%
0	19	19	100.0%	CS ST PostHospital Housing FFS	0	9	9	100.0%
370	1,007	637	63.3%	CS Housing Outreach	1,670	3,165	1,495	47.2%
630,428	0	(630,428)	0.0%	CommunityBased Adult Svc(CBAS)	2,904,293	1,519,540	(1,384,753)	(91.1%)
17,394	10,831	(6,563)	(60.6%)	CS LTC to ALF Transition FFS ANC	100,165	85,510	(14,655)	(17.1%)
0	5,003	5,003	100.0%	CS LTC to Home Transition FFS ANC	18,800	27,859	9,059	32.5%
22,375,752	20,496,809	(1,878,944)	(9.2%)	11. Ancillary Medical Expense	123,566,228	120,973,246	(2,592,981)	(2.1%)
224,998	0	(224,998)	0.0%	IBNR Outpatient	582,334	1,452,995	870,661	59.9%
6,750	0	(6,750)	0.0%	IBNR Settlement (OP)	17,468	43,588	26,120	59.9%
18,000	0	(18,000)	0.0%	IBNR Claims Fluctuation (OP)	46,588	116,241	69,653	59.9%
3,143,881	5,948,287	2,804,406	47.1%	Outpatient FFS	18,167,421	24,230,589	6,063,169	25.0%
2,717,846	0	(2,717,846)	0.0%	OP Ambul Surgery FFS	18,840,917	13,591,832	(5,249,085)	(38.6%)
2,839,869	3,674,964	835,095	22.7%	Imaging Services FFS	17,639,212	19,591,499	1,952,287	10.0%
129,806	0	(129,806)	0.0%	Behavioral Health FFS	756,683	493,539	(263,143)	(53.3%)
900,737	0	(900,737)	0.0%	Outpatient Facility Lab FFS	5,055,215	3,448,349	(1,606,866)	(46.6%)
233,459	0	(233,459)	0.0%	Outpatient Facility Cardio FFS	1,461,020	1,028,586	(432,433)	(42.0%)
103,346	0	(103,346)	0.0%	OP Facility PT/OT/ST FFS	683,070	461,172	(221,898)	(48.1%)
2,498,817	3,185,457	686,640	21.6%	OP Facility Dialysis Ctr FFS	18,570,699	19,514,180	943,481	4.8%
12,817,509	12,808,709	(8,801)	(0.1%)	12. Outpatient Medical Expense	81,820,625	83,972,570	2,151,945	2.6%
566,419	0	(566,419)	0.0%	IBNR Emergency	(1,899,294)	(2,513,669)	(614,375)	24.4%
16,992	0	(16,992)	0.0%	IBNR Settlement (ER)	(56,977)	(75,408)	(18,431)	24.4%
45,313	0	(45,313)	0.0%	IBNR Claims Fluctuation (ER)	(151,944)	(201,094)	(49,150)	24.4%
9,595,225	10,735,949	1,140,723	10.6%	ER Facility	57,399,542	60,459,103	3,059,561	5.1%
1,305,228	0	(1,305,228)	0.0%	Specialty ER Physician FFS	7,354,213	4,951,779	(2,402,434)	(48.5%)
11,529,178	10,735,949	(793,229)	(7.4%)	13. Emergency Expense	62,645,540	62,620,710	(24,829)	0.0%
913,155	0	(913,155)	0.0%	IBNR Pharmacy (OP)	(3,353,081)	(2,257,911)	1,095,170	(48.5%)
27,395	0	(27,395)	0.0%	IBNR Settlement Rx (OP)	(100,589)	(67,734)	32,855	(48.5%)

**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 DECEMBER, 2025**

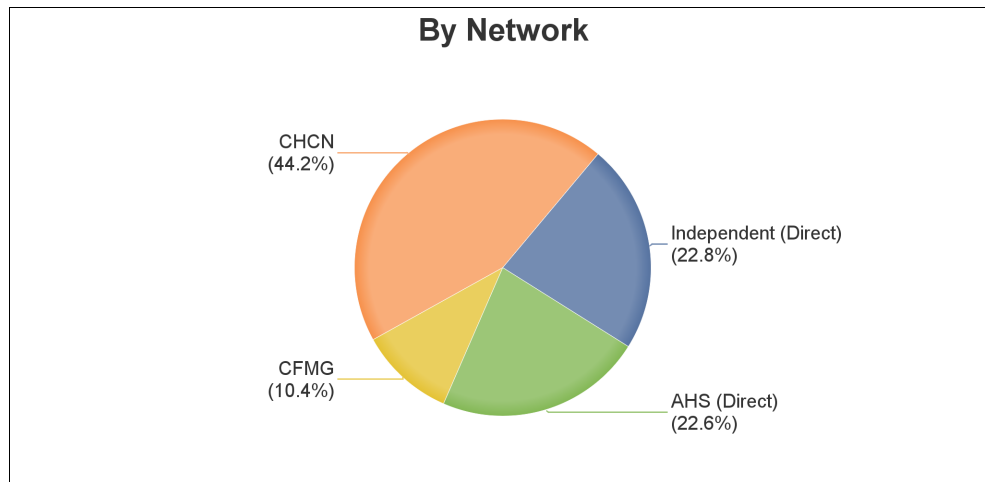
CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
73,052	0	(73,052)	0.0%	IBNR Claims Fluctuation Rx(OP)	(268,247)	(180,633)	87,614	(48.5%)
755,068	818,907	63,839	7.8%	Pharmacy FFS (OP)	4,443,170	4,582,445	139,275	3.0%
138,250	0	(138,250)	0.0%	Pharmacy Non PBM FFS Other-ANC	742,103	479,027	(263,076)	(54.9%)
10,004,154	12,309,125	2,304,971	18.7%	Pharmacy Non PBM FFS OP-FAC	40,108,889	46,291,389	6,182,500	13.4%
504,927	0	(504,927)	0.0%	Pharmacy Non PBM FFS PCP	1,906,619	1,140,883	(765,736)	(67.1%)
3,875,049	0	(3,875,049)	0.0%	Pharmacy Non PBM FFS SCP	18,779,410	11,779,726	(7,015,683)	(59.6%)
77,796	0	(77,796)	0.0%	Pharmacy Non PBM FFS FQHC	283,801	165,336	(118,465)	(71.7%)
13,198	0	(13,198)	0.0%	Pharmacy Non PBM FFS HH	115,631	78,426	(37,205)	(47.4%)
(40,000)	(89,243)	(49,243)	55.2%	Medical Expenses Pharm Rebate	(413,544)	(499,384)	(85,840)	17.2%
16,342,044	13,038,790	(3,303,254)	(25.3%)	14. Pharmacy Expense	62,260,161	61,511,570	(748,591)	(1.2%)
2,201,080	0	(2,201,080)	0.0%	IBNR LTC	1,697,536	(5,530,063)	(7,227,599)	130.7%
66,032	0	(66,032)	0.0%	IBNR Settlement (LTC)	50,925	(165,902)	(216,827)	130.7%
176,086	0	(176,086)	0.0%	IBNR Claims Fluctuation (LTC)	135,801	(442,407)	(578,208)	130.7%
1,753,979	1,912,037	158,058	8.3%	LTC - ICF/DD	11,436,096	11,725,978	289,883	2.5%
24,932,146	27,113,799	2,181,653	8.0%	LTC Custodial Care	164,060,784	170,245,196	6,184,412	3.6%
7,635,459	8,070,074	434,614	5.4%	LTC SNF	52,163,547	52,673,121	509,574	1.0%
36,764,783	37,095,910	331,127	0.9%	15. Long Term Care Expense	229,544,689	228,505,923	(1,038,766)	(0.5%)
162,808,076	161,179,271	(1,628,806)	(1.0%)	16. TOTAL FFS MEDICAL EXPENSES	926,759,830	933,322,914	6,563,084	0.7%
0	324,701	324,701	100.0%	Clinical Vacancy #102	0	524,716	524,716	100.0%
168,682	197,423	28,741	14.6%	Quality Analytics #123	888,060	1,329,912	441,851	33.2%
407,152	393,295	(13,856)	(3.5%)	LongTerm Services and Support #139	2,318,354	2,316,403	(1,951)	(0.1%)
1,002,116	977,029	(25,087)	(2.6%)	Utilization Management #140	5,679,452	5,696,566	17,113	0.3%
748,781	773,988	25,207	3.3%	Case & Disease Management #185	4,505,321	4,628,099	122,777	2.7%
(86,298)	(14,537)	71,761	(493.7%)	Medical Management #230	(1,190,509)	(1,117,561)	72,948	(6.5%)
1,328,969	1,315,927	(13,042)	(1.0%)	Quality Improvement #235	6,754,732	7,253,784	499,053	6.9%
383,030	445,787	62,757	14.1%	HCS Behavioral Health #238	2,326,169	2,489,404	163,234	6.6%
150,232	268,831	118,599	44.1%	Pharmacy Services #245	854,860	1,091,524	236,664	21.7%
0	0	0	0.0%	Regulatory Readiness #268	(5,289)	(5,289)	0	0.0%
4,102,662	4,682,443	579,781	12.4%	17. Other Benefits & Services	22,131,151	24,207,557	2,076,405	8.6%
(1,941,000)	(1,822,428)	118,572	(6.5%)	Reinsurance Recoveries	(14,432,696)	(14,225,493)	207,203	(1.5%)
2,429,106	2,429,904	798	0.0%	Reinsurance Premium	14,743,507	14,744,931	1,424	0.0%
488,106	607,476	119,370	19.7%	18. Reinsurance (Net)	310,811	519,438	208,627	40.2%
0	0	0	0.0%	P4P Risk Pool Provider Incenti	5,659,099	4,659,099	(1,000,000)	(21.5%)
0	0	0	0.0%	19. Risk Pool Distribution	5,659,099	4,659,099	(1,000,000)	(21.5%)
183,162,185	182,300,461	(861,723)	(0.5%)	20. TOTAL MEDICAL EXPENSES	1,066,977,742	1,074,875,801	7,898,059	0.7%

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend						
Category of Aid	Dec 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	59,414	15%	12,149	14,678	0	32,587
CHILD	107,527	27%	9,795	13,841	38,670	45,221
SPD	0	0%	0	0	0	0
ACA OE	149,473	38%	26,857	51,959	1,525	69,132
DUALS	35	0%	31	3	0	1
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,500	7%	8,597	5,530	1,520	13,853
SPD-LTC/Full Dual	49,277	12%	31,921	3,569	0	13,787
Other	0		0	0	0	0
Medi-Cal	395,226		89,350	89,580	41,715	174,581
Group Care	6,138		2,214	1,179	0	2,745
Total	401,364	100%	91,564	90,759	41,715	177,326
Other %	0.0%		0.0%	0.0%	0.0%	0.0%
Medi-Cal %	98.5%		97.6%	98.7%	100.0%	98.5%
Group Care %	1.5%		2.4%	1.3%	0.0%	1.5%
Network Distribution			22.8%	22.6%	10.4%	44.2%
			% Direct:	45%	% Delegated:	55%

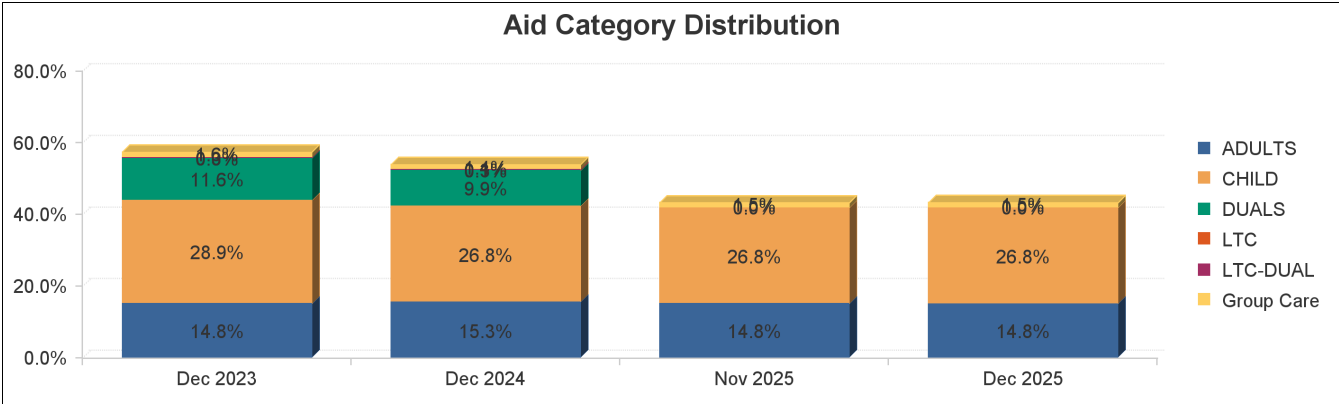


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

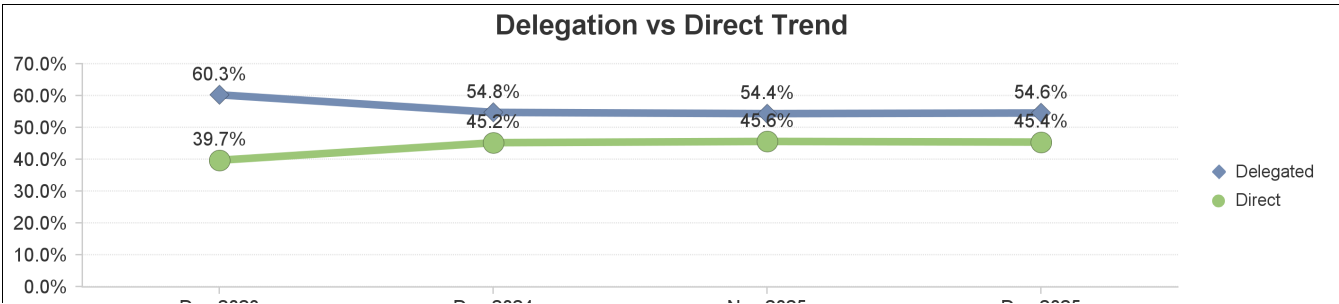


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend											
Category of Aid	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
ADULTS	52,174	62,957	59,892	59,414	14.8%	15.3%	14.8%	14.8%	17.1%	-6.0%	-0.8%
CHILD	101,634	110,547	108,001	107,527	28.9%	26.8%	26.8%	26.8%	8.1%	-2.8%	-0.4%
SPD	30,848	36,127	0	0	8.8%	8.8%	0.0%	0.0%	14.6%	0.0%	0.0%
ACA OE	119,669	154,565	150,677	149,473	34.0%	37.5%	37.3%	37.2%	22.6%	-3.4%	-0.8%
DUALS	40,976	40,812	33	35	11.6%	9.9%	0.0%	0.0%	-0.4%	-116,505.7%	5.7%
LTC	135	255	0	0	0.0%	0.1%	0.0%	0.0%	47.1%	0.0%	0.0%
LTC-DUAL	951	1,285	0	0	0.3%	0.3%	0.0%	0.0%	26.0%	0.0%	0.0%
SPD-LTC	0	0	29,590	29,500	0.0%	0.0%	7.3%	7.3%	0.0%	100.0%	-0.3%
SPD-LTC/ Full Dual	0	0	49,334	49,277	0.0%	0.0%	12.2%	12.3%	0.0%	100.0%	-0.1%
Other	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medi-Cal	346,387	406,548	397,527	395,226	98.4%	98.6%	98.5%	98.5%	14.8%	-2.9%	-0.6%
Group Care	5,622	5,790	6,092	6,138	1.6%	1.4%	1.5%	1.5%	2.9%	5.7%	0.7%
Total	352,009	412,338	403,619	401,364	100.0%	100.0%	100.0%	100.0%	14.6%	-2.7%	-0.6%



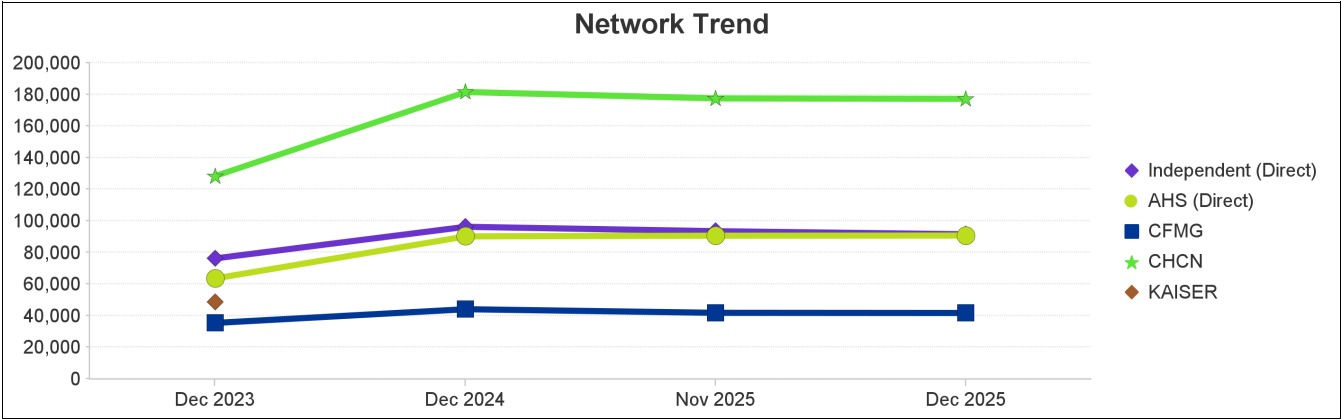
Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
Delegated	212,220	225,787	219,439	219,041	60.3%	54.8%	54.4%	54.6%	6.0%	-3.1%	-0.2%
Direct	139,789	186,551	184,180	182,323	39.7%	45.2%	45.6%	45.4%	25.1%	-2.3%	-1.0%
Total	352,009	412,338	403,619	401,364	100.0%	100.0%	100.0%	100.0%	14.6%	-2.7%	-0.6%



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

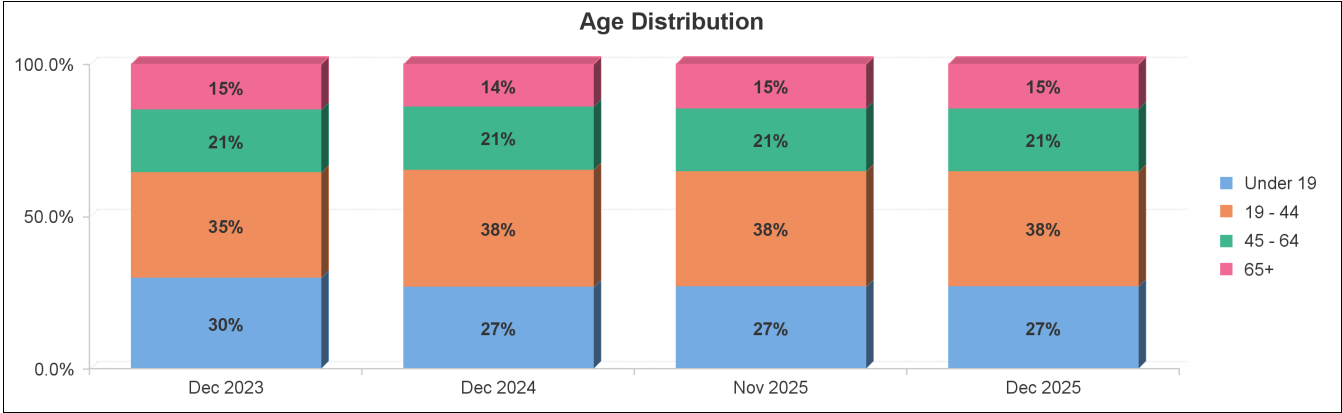
Dec 2023	Dec 2024	Nov 2025	Dec 2025
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Network Trend											
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
Independent (Direct)	76,241	96,313	93,519	91,564	21.7%	23.4%	23.2%	22.8%	20.8%	-5.2%	-2.1%
AHS (Direct)	63,548	90,238	90,661	90,759	18.1%	21.9%	22.5%	22.6%	29.6%	0.6%	0.1%
CFMG	35,401	44,111	41,820	41,715	10.1%	10.7%	10.4%	10.4%	19.7%	-5.7%	-0.3%
CHCN	128,342	181,676	177,619	177,326	36.5%	44.1%	44.0%	44.2%	29.4%	-2.5%	-0.2%
KAISER	48,477	0	0	0	13.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	352,009	412,338	403,619	401,364	100.0%	100.0%	100.0%	100.0%	14.6%	-2.7%	-0.6%

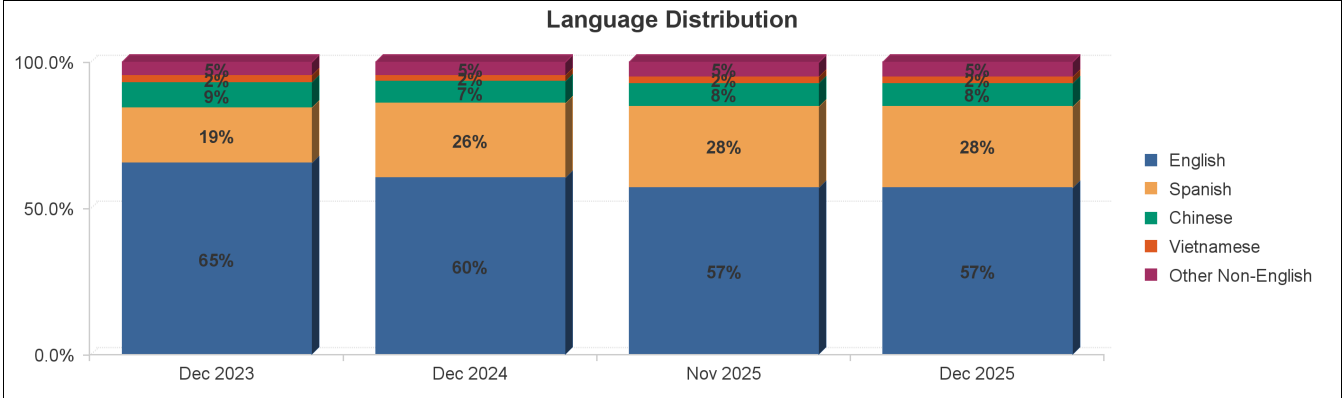


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Age Category Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
Under 19	104,062	109,506	107,820	107,339	30%	27%	27%	27%	5%	-2%	0%
19 - 44	121,694	158,707	152,698	151,400	35%	38%	38%	38%	23%	-5%	-1%
45 - 64	72,612	85,272	83,208	82,760	21%	21%	21%	21%	15%	-3%	-1%
65+	53,641	58,853	59,893	59,865	15%	14%	15%	15%	9%	2%	0%
Total	352,009	412,338	403,619	401,364	100%	100%	100%	100%	15%	-3%	-1%

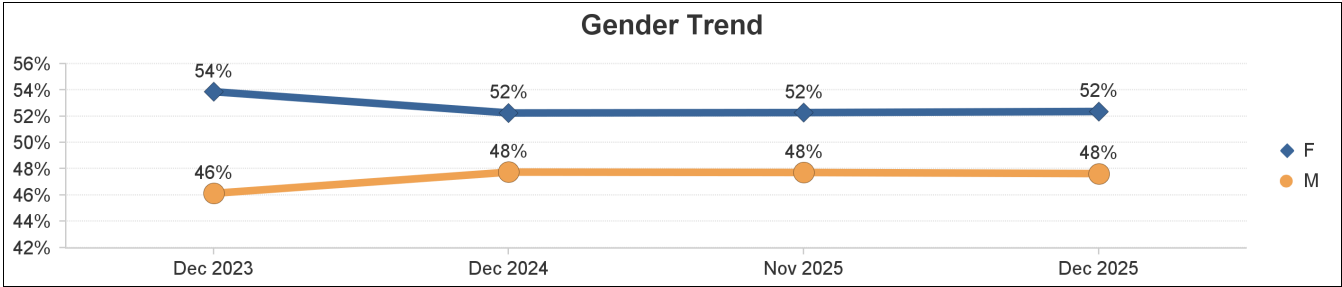


Language Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Dec 2023	Dec 2024	Nov 2025	Dec 2025	ec 2023	ec 2024	Nov 2025	ec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
English	229,835	248,451	229,585	228,253	65%	60%	57%	57%	7%	-9%	-1%
Spanish	66,602	105,234	112,007	111,394	19%	26%	28%	28%	37%	6%	-1%
Chinese	30,505	30,806	31,981	31,842	9%	7%	8%	8%	1%	3%	0%
Vietnamese	8,507	8,294	8,960	8,949	2%	2%	2%	2%	-3%	7%	0%
Other Non-English	16,560	19,553	21,086	20,926	5%	5%	5%	5%	15%	7%	-1%
Total	352,009	412,338	403,619	401,364	100%	100%	100%	100%	15%	-3%	-1%

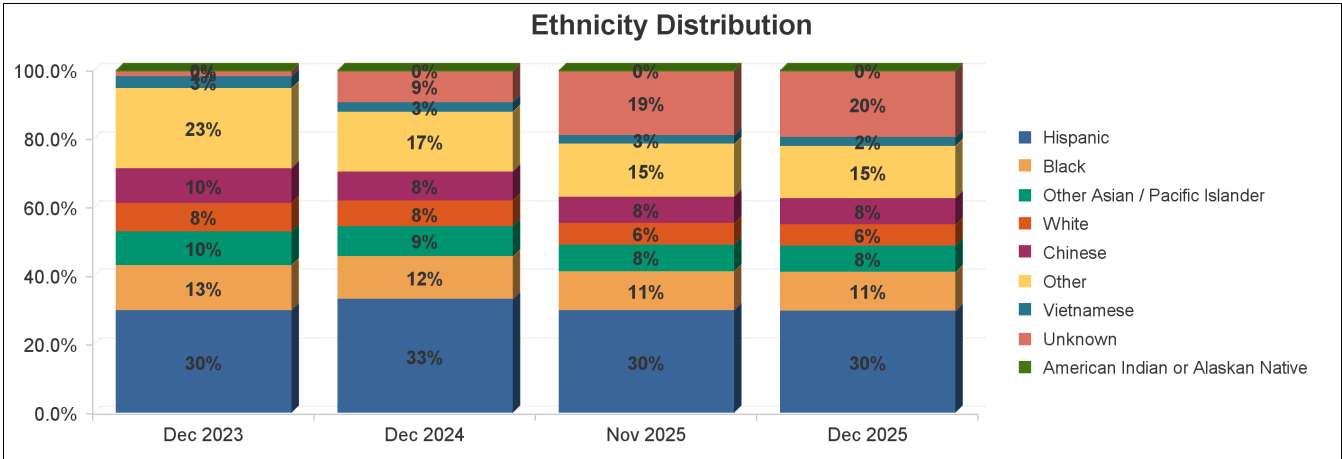


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Gender Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
F	189,639	215,451	211,017	210,175	54%	52%	52%	52%	12%	-3%	0%
M	162,370	196,887	192,602	191,189	46%	48%	48%	48%	18%	-3%	-1%
Total	352,009	412,338	403,619	401,364	100%	100%	100%	100%	15%	-3%	-1%



Ethnicity Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
Hispanic	104,945	136,294	120,200	118,827	30%	33%	30%	30%	23%	-15%	-1%
Black	46,303	51,323	46,008	45,499	13%	12%	11%	11%	10%	-13%	-1%
Other Asian / Pacific Islander	34,537	36,322	31,372	30,912	10%	9%	8%	8%	5%	-18%	-1%
White	29,449	30,931	25,360	24,783	8%	8%	6%	6%	5%	-25%	-2%
Chinese	35,470	34,683	30,984	30,635	10%	8%	8%	8%	-2%	-13%	-1%
Other	82,447	71,988	62,288	61,488	23%	17%	15%	15%	-15%	-17%	-1%
Vietnamese	11,943	11,366	10,119	10,034	3%	3%	3%	2%	-5%	-13%	-1%
Unknown	6,228	38,664	76,629	78,543	2%	9%	19%	20%	84%	51%	2%
American Indian or Alaskan Native	687	767	659	643	0%	0%	0%	0%	10%	-19%	-2%
Total	352,009	412,338	403,619	401,364	100%	100%	100%	100%	15%	-3%	-1%



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

Medi-Cal By City						
City	Dec 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	157,004	40%	23,442	42,614	16,438	74,510
HAYWARD	51,512	13%	11,578	14,832	5,454	19,648
FREMONT	38,104	10%	15,804	6,733	2,082	13,485
SAN LEANDRO	24,868	6%	6,777	4,181	3,031	10,879
UNION CITY	14,213	4%	5,655	2,579	783	5,196
ALAMEDA	13,527	3%	3,380	2,548	2,038	5,561
BERKELEY	16,275	4%	3,662	2,683	1,733	8,197
LIVERMORE	12,823	3%	2,007	415	2,024	8,377
NEWARK	9,154	2%	2,713	3,869	490	2,082
CASTRO VALLEY	11,078	3%	3,244	1,779	1,710	4,345
SAN LORENZO	6,006	2%	1,257	1,418	685	2,646
PLEASANTON	7,951	2%	2,283	316	833	4,519
DUBLIN	7,653	2%	2,505	326	858	3,964
EMERYVILLE	2,992	1%	585	698	501	1,208
ALBANY	2,540	1%	539	301	536	1,164
PIEDMONT	471	0%	102	190	72	107
SUNOL	87	0%	31	9	6	41
ANTIOCH	20	0%	8	6	4	2
Other	18,948	5%	3,778	4,083	2,437	8,650
Total	395,226	100%	89,350	89,580	41,715	174,581

Group Care By City						
City	Dec 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,862	30%	336	437	0	1,089
HAYWARD	711	12%	320	195	0	196
FREMONT	681	11%	433	93	0	155
SAN LEANDRO	666	11%	270	110	0	286
UNION CITY	297	5%	179	51	0	67
ALAMEDA	310	5%	88	38	0	184
BERKELEY	163	3%	40	18	0	105
LIVERMORE	105	2%	31	1	0	73
NEWARK	147	2%	83	39	0	25
CASTRO VALLEY	222	4%	97	33	0	92
SAN LORENZO	161	3%	44	40	0	77
PLEASANTON	81	1%	31	4	0	46
DUBLIN	134	2%	52	8	0	74
EMERYVILLE	44	1%	12	8	0	24
ALBANY	22	0%	11	2	0	9
PIEDMONT	5	0%	0	2	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	29	0%	9	9	0	11
Other	497	8%	177	91	0	229
Total	6,138	100%	2,214	1,179	0	2,745

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

Total By City						
City	Dec 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	158,866	40%	23,778	43,051	16,438	75,599
HAYWARD	52,223	13%	11,898	15,027	5,454	19,844
FREMONT	38,785	10%	16,237	6,826	2,082	13,640
SAN LEANDRO	25,534	6%	7,047	4,291	3,031	11,165
UNION CITY	14,510	4%	5,834	2,630	783	5,263
ALAMEDA	13,837	3%	3,468	2,586	2,038	5,745
BERKELEY	16,438	4%	3,702	2,701	1,733	8,302
LIVERMORE	12,928	3%	2,038	416	2,024	8,450
NEWARK	9,301	2%	2,796	3,908	490	2,107
CASTRO VALLEY	11,300	3%	3,341	1,812	1,710	4,437
SAN LORENZO	6,167	2%	1,301	1,458	685	2,723
PLEASANTON	8,032	2%	2,314	320	833	4,565
DUBLIN	7,787	2%	2,557	334	858	4,038
EMERYVILLE	3,036	1%	597	706	501	1,232
ALBANY	2,562	1%	550	303	536	1,173
PIEDMONT	476	0%	102	192	72	110
SUNOL	88	0%	32	9	6	41
ANTIOCH	49	0%	17	15	4	13
Other	19,445	5%	3,955	4,174	2,437	8,879
Total	401,364	100%	91,564	90,759	41,715	177,326

Department of Health Care Services Finance Topics

Rising Cost Trends Questioned

- ▶ DHCS is observing significant increases in per member per month costs across the State and questioning plans about the trends
 - ▶ Behavioral Health Treatment-30% increase
 - ▶ Hospice-58% increase
 - ▶ Transportation-46% increase
 - ▶ Community Supports-144% increase
 - ▶ Enhanced Care Management-119% increase
- ▶ Plans will be expected to explain rising costs and validate the reason for these increases.

ECM Encounter and Rate Update

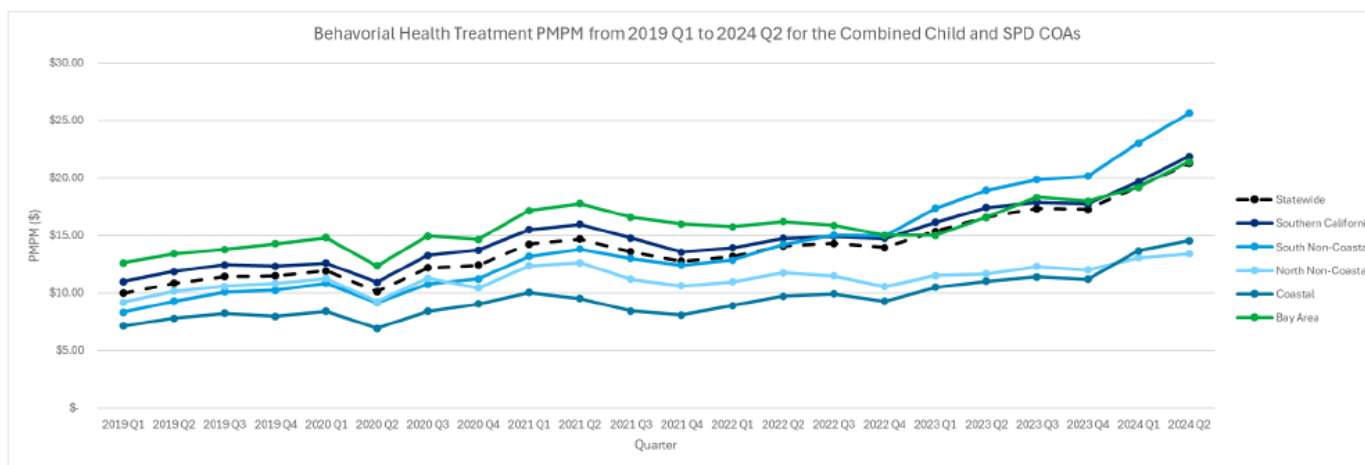
- ▶ DHCS will increase reliance on encounter data in performing Enhanced Care Management (ECM) Risk Corridor calculations.
- ▶ DHCS/Mercer have observed misalignment between MCP expenses and reported ECM services in encounter data reviews.
- ▶ Complete encounter data will be critical to ensuring the Alliance is fully credited for ECM costs. This means the Alliance should continue to ensure encounters are received before paying for ECM services.
- ▶ Calendar year 2026 ECM rates have been adjusted downwards by 1.1% (\$450K) after DHCS acuity adjustments.

Base Rate Clinical Efficiencies

- ▶ DHCS adding downward pressure on base rates by potentially adding new “Clinical Efficiencies” to measure in calendar year 2027 and beyond.
 - ▶ Readmissions
 - ▶ Cesarean Mix
 - ▶ Potentially Preventable Conditions
 - ▶ Short Stay Admissions
 - ▶ Outlier Utilization
- ▶ Methodology for evaluation of these efficiencies has not been shared.
- ▶ The result of these efficiencies will mean potential reductions to health plan rates.

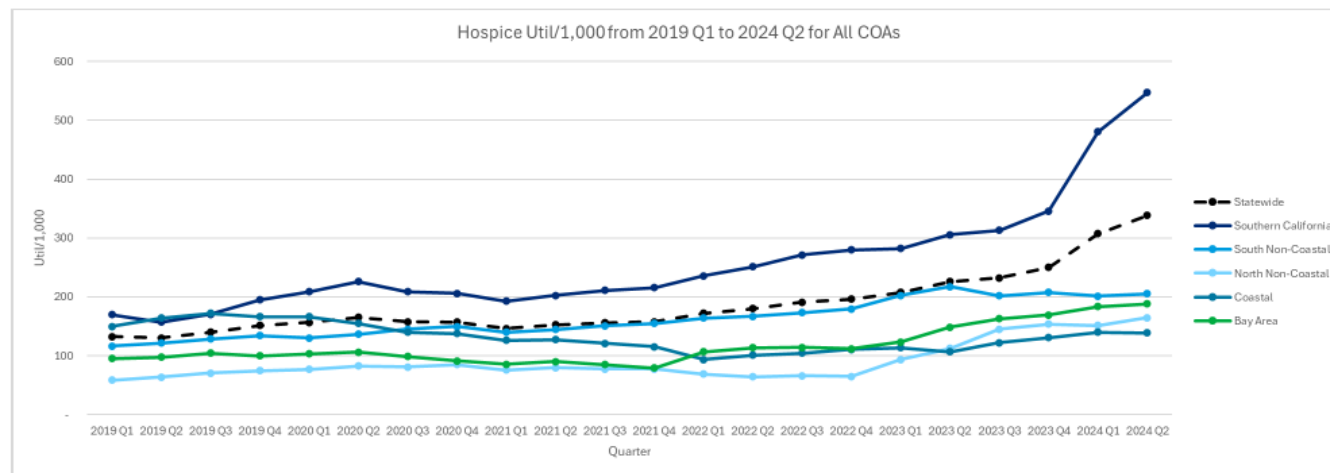
Supplemental Slides

Behavioral Health Treatment



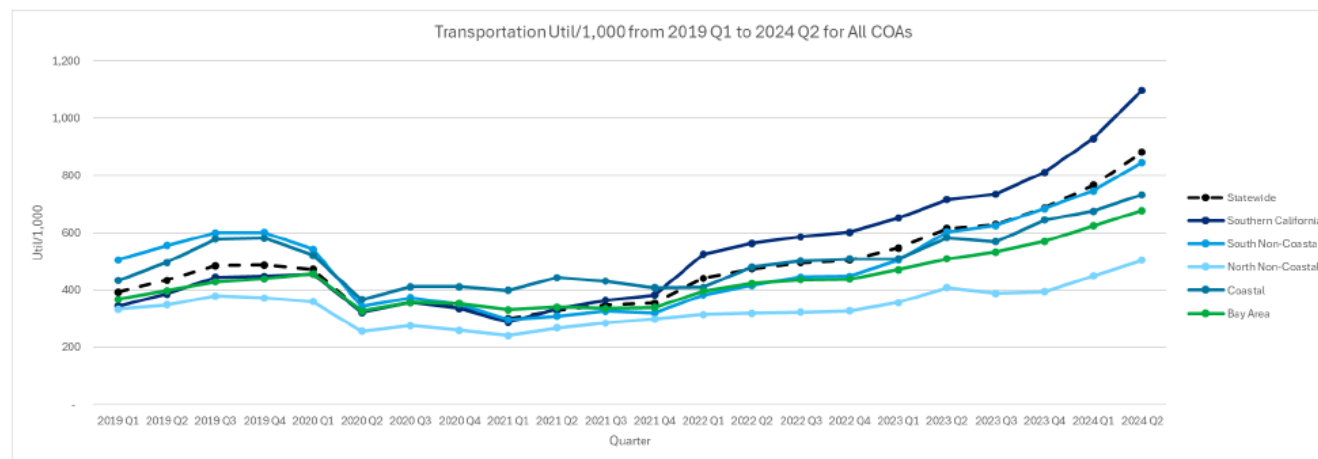
Trend Region	BHT Child + SPD PMPM						BHT Child + SPD Annualized Percent Change				
	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	1H 2024	CY 2019 to CY 2020	CY 2020 to CY 2021	CY 2021 to CY 2022	CY 2022 to CY 2023	CY 2023 to 1H 2024
Bay Area	\$ 13.52	\$ 14.19	\$ 16.86	\$ 15.71	\$ 16.96	\$ 20.28	5%	19%	-7%	8%	27%
Coastal	\$ 7.77	\$ 8.19	\$ 9.01	\$ 9.45	\$ 11.02	\$ 14.09	5%	10%	5%	17%	39%
N.Non-Coastal	\$ 10.18	\$ 10.56	\$ 11.69	\$ 11.19	\$ 11.87	\$ 13.22	4%	11%	-4%	6%	15%
S.Non-Coastal	\$ 9.48	\$ 10.51	\$ 13.10	\$ 14.28	\$ 19.07	\$ 24.32	11%	25%	9%	34%	38%
SoCal	\$ 11.90	\$ 12.64	\$ 14.94	\$ 14.59	\$ 17.29	\$ 20.76	6%	18%	-2%	18%	28%
Statewide	\$ 10.94	\$ 11.67	\$ 13.82	\$ 13.87	\$ 16.63	\$ 20.26	7%	18%	0%	20%	30%

Hospice



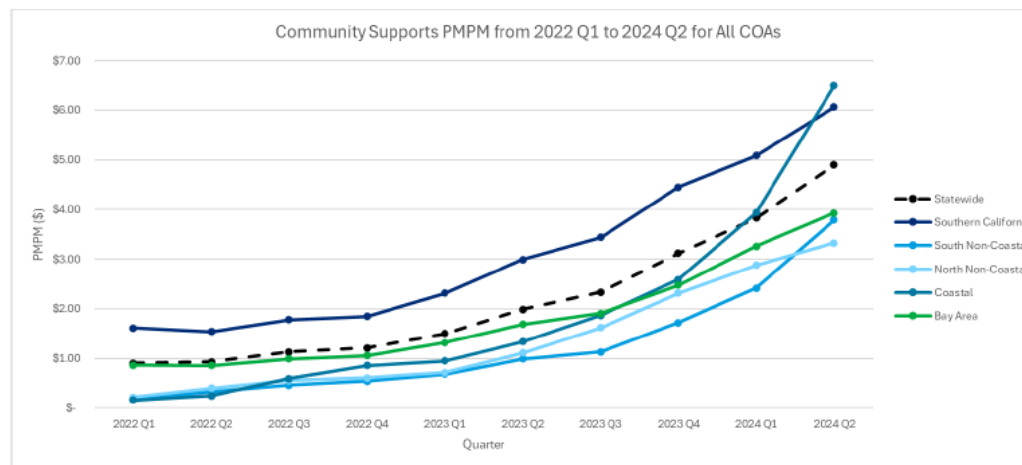
Trend Region	Hospice Utilization						Hospice Annualized Percent Change				
	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	1H 2024	CY 2019 to CY 2020	CY 2020 to CY 2021	CY 2021 to CY 2022	CY 2022 to CY 2023	CY 2023 to 1H 2024
Bay Area	99	99	85	111	151	186	0%	-15%	31%	35%	32%
Coastal	163	149	122	102	118	139	-8%	-18%	-16%	15%	25%
N.Non-Coastal	67	81	77	66	126	158	22%	-5%	-15%	91%	35%
S.Non-Coastal	125	141	148	171	207	203	12%	5%	16%	21%	-3%
SoCal	173	212	206	260	311	514	23%	-3%	26%	20%	95%
Statewide	138	159	153	185	229	323	15%	-4%	21%	24%	58%

Transportation



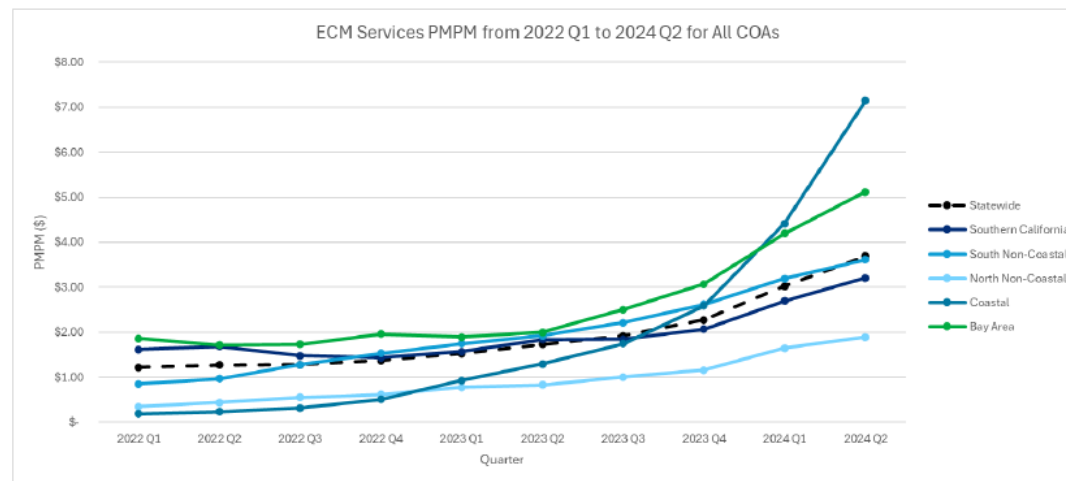
Trend Region	Transportation Util/1,000						Transportation Annualized Percent Change				
	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	1H 2024	CY 2019 to CY 2020	CY 2020 to CY 2021	CY 2021 to CY 2022	CY 2022 to CY 2023	CY 2023 to 1H 2024
Bay Area	408	372	337	423	521	651	-9%	-10%	26%	23%	35%
Coastal	522	427	420	476	576	704	-18%	-2%	13%	21%	31%
N.Non-Coastal	358	287	274	321	387	476	-20%	-5%	17%	21%	32%
S.Non-Coastal	565	400	314	424	604	795	-29%	-22%	35%	43%	44%
SoCal	405	367	343	569	727	1,012	-9%	-7%	66%	28%	55%
Statewide	449	372	333	479	619	823	-17%	-10%	44%	29%	46%

Community Supports (CS)



Trend Region	CS PMPM			CS Annualized Percent Change	
	CY 2022	CY 2023	1H 2024	CY 2022 to CY 2023	CY 2023 to 1H 2024
Bay Area	\$ 0.94	\$ 1.85	\$ 3.59	95%	143%
Coastal	\$ 0.47	\$ 1.68	\$ 5.20	258%	351%
N.Non-Coastal	\$ 0.45	\$ 1.44	\$ 3.10	220%	178%
S.Non-Coastal	\$ 0.38	\$ 1.13	\$ 3.10	195%	283%
SoCal	\$ 1.70	\$ 3.29	\$ 5.57	94%	102%
Statewide	\$ 1.04	\$ 2.23	\$ 4.36	114%	144%

Enhanced Care Management (ECM)



Trend Region	ECM PMPM			ECM Year-Over-Year Percent Change	
	CY 2022	CY 2023	1H 2024	CY 2022 to CY 2023	CY 2023 to 1H 2024
Bay Area	\$ 1.82	\$ 2.36	\$ 4.65	30%	147%
Coastal	\$ 0.31	\$ 1.63	\$ 5.77	423%	438%
North Non-Coastal	\$ 0.49	\$ 0.94	\$ 1.77	91%	133%
South Non-Coastal	\$ 1.16	\$ 2.12	\$ 3.40	83%	88%
Southern California	\$ 1.55	\$ 1.83	\$ 2.95	18%	89%
Statewide	\$ 1.29	\$ 1.86	\$ 3.35	45%	119%

Trend Region	Length of Continuous ECM Enrollment (percentage of ECM enrollment)			
	6 month	12 month	18 month	24 month
Bay Area	71%	47%	34%	27%
Coastal	82%	53%	39%	30%
North Non-Coastal	74%	46%	29%	19%
South Non-Coastal	79%	55%	35%	28%
Southern California	78%	53%	35%	27%
Statewide	77%	52%	35%	26%



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 13th, 2026

Subject: Operations Report

Member Services

- 12-Month Trend Blended Summary:
 - The Member Services Department received 21,534 calls in January 2026 compared to 21,834 in January 2025 and represents a 1.4% decrease in calls.
 - The abandonment rate for January 2026 was 2% compared to 5% in January 2025.
 - The Department's service level was 98% in January 2026, compared to 93% in January 2025. The average speed to answer (ASA) was seven seconds (00:07) compared to sixteen seconds (00:16) in January 2025. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
 - The average talk time (ATT) was seven minutes and two seconds (7:02) for January 2026 compared to seven minutes and thirty-four seconds (07:34) for January 2025.
 - 100% of calls were answered within 10 minutes for January 2026 and 100% of calls were answered within 10 minutes for January 2025.
 - Outbound calls totaled 10,026 in January 2026 compared to 9,584 in January 2025.
 - The top five (5) call reasons for January 2026 were 1) Eligibility/Enrollment, 2) Grievances/Appeals 3) Change of PCP, 4) Benefits, and 5) Provider Network Information. The top five (5) call reasons for January 2025 were: 1) Eligibility/Enrollment, 2) Change of PCP, 3) Benefits, 4) Grievances/Appeals, and 5) Provider Network Information.
 - January utilization for the member automated eligibility IVR system totaled 1,491 in January 2026 compared to 1,599 in January 2025.
 - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests, and in-person). The Department responded to 1,115 web-based requests in January 2026 compared to 1,530 in January 2025. The top three (3) web reason requests for January 2026 were: 1). Change of PCP, 2) ID Card Requests, and 3) Update Contact Information. In January 2026, 57 members were assisted in-person compared to 64 in January 2025.

- MS Behavioral Health:
 - The Member Services Behavioral Health (MS BH) Unit received a total of 1,017 calls in January 2026 compared to 1,1490 in January 2025.
 - The abandonment rate was 2% in January 2026 compared to 9% in January 2025.
 - The service level was 93% in January 2026 and 68% in January 2025.
 - The average speed to answer (ASA) was seventeen seconds (00:17) compared to one minute and twenty-four seconds (01:24) in January 2025.
 - Calls answered in 10 minutes were 100% in January 2026 compared to 99% in January 2025.
 - The Average Talk Time (ATT) was nine minutes and one second (9:01) compared to eight minutes and seven seconds (08:07) in January 2025. The MS BH Team utilizes the DHCS age-appropriate screening tools for Medi-Cal Mental Health Services to determine the appropriate delivery system for members who are not currently receiving mental health services when they contact the plan.
 - 1,570 outbound calls were completed in January 2026 compared to 1,337 in January 2025.
 - 113 screenings were completed in January 2026 compared to 150 in January 2025.
 - 26 referrals were made to the County (ACCESS) in January 2026 compared to 50 in January 2025.
 - 12 members were referred to Center Point for SUD services in January 2026 compared to 19 in January 2025.
- D-SNP Member Services blended:
 - The Member Services D-SNP Unit received a total of 742 calls.
 - The abandonment rate was 1%.
 - The Average Speed to Answer (ASA) was seven seconds (00:07).
 - The service level was 100%.
 - The Average Talk Time (ATT) was six minutes and thirty-five seconds (06:35).
 - The top five (5) call reasons were: 1) Eligibility/Enrollment, 2) Benefits, 3) Grievances/Appeals, 4) Provider Network Information,. and 5) Change PCP.

Claims

- 12-Month Trend Summary:
 - The Claims Department received 373,154 claims in January 2026 compared to 339,760 in January 2025.
 - The Auto Adjudication rate was 87% in January 2026 compared to 86% in January 2025.

- Claims compliance for the 30-day turn-around time was 86.7% in January 2026 compared to 90.1% in January 2025. The 45-day turn-around time was 99.6% in January 2026 compared to 98.9% in January 2025.
- Monthly Analysis:
 - In January, we received a total of 373,154 claims in the HEALTHsuite system, which represents a 16.5% increase from December 2025 when 320,327 claims were received. It is also 10% higher than the number of claims received in January 2025 (339,760 vs 373,154).
 - 90.2% of claims were received via EDI and 9.8% of claims via paper during January.
 - 86.7% of our claims were processed within the new regulatory requirement of 30 calendar days and 99.6% of our claims were processed within 45 working days during the month.
 - The Auto Adjudication rate was 86.5% for January.

Provider Dispute Resolution

- 12-Month Trend Summary:
 - In January 2026, the Provider Dispute Resolution (PDR) team received 3,160 PDRs versus 2,843 in January 2025.
 - The PDR team resolved 2,660 cases in January 2026 compared to 2,635 cases in January 2025.
 - In January 2026, the PDR team upheld 79% of cases versus 62% in January 2025.
 - The PDR team resolved 99.4% of cases within the compliance standard of 95% within 45 working days in January 2026, compared to 99.9% in January 2025.
- Monthly Analysis
 - In January 2026, the PDR team received 3,160 PDRs versus 3,121 in December 2025. This represents a modest increase of 1.3% over the number of PDRs received in December 2025, and an increase of 11% from January 2025.
 - In January 2026, 2,660 PDRs were resolved, with 2,098 upheld and 562 overturned.
 - 2,646 out of the 2,660 cases received were resolved within 45 working days, resulting in a 99.2% compliance rate.
 - The average turnaround time for resolving PDRs in January was 40 days.
 - There were 4,290 PDRs pending resolution as of 1/31/2026, with no cases older than 45 working days.
 - The overturn rate for PDRs was 21%, which meets our goal of 25% or less.

Grievances & Appeals

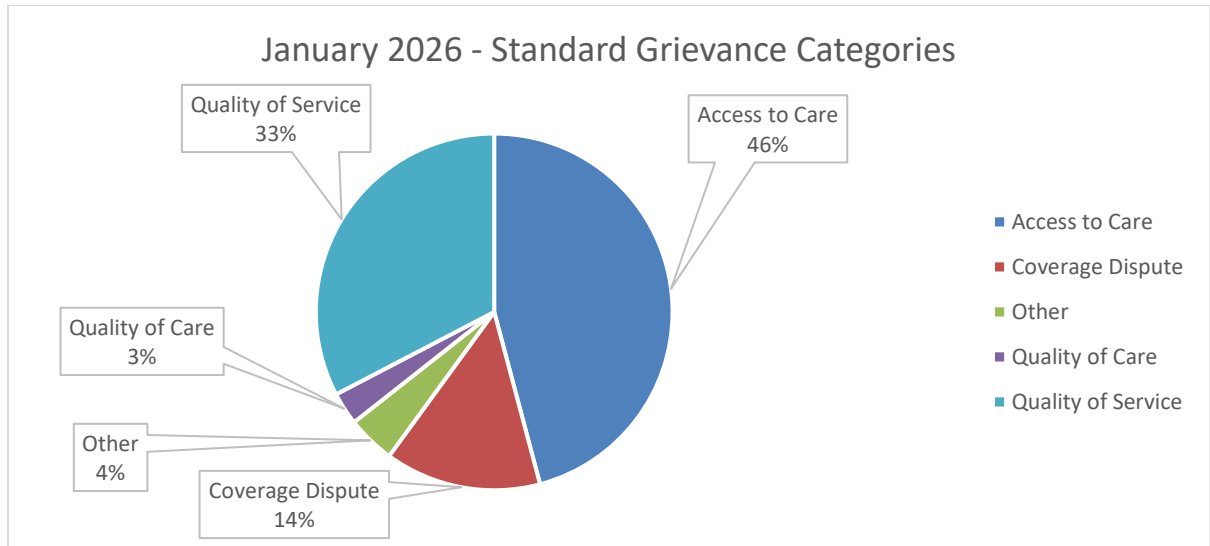
- Standard Grievance and Expedited Grievance cases were not resolved within the goal of 95% of regulatory timeframes.
- Exempt Grievance cases were resolved within the goal of 95% of regulatory timeframes.
- Standard Appeal and Expedited Appeal cases were resolved within the goal of 95% of regulatory timeframes.
- Total Unique grievances resolved in December were 8.49 complaints per 1,000 members.

January 2026 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,266	30 Calendar Days	95% compliance within standard	2,021	89.2%	4.55
Expedited Grievance	22	72 Hours	95% compliance within standard	6	27.3%	0.03
Exempt Grievance	1,781	Next Business Day	95% compliance within standard	1,780	99.9%	3.95
Standard Appeal	48	30 Calendar Days	95% compliance within standard	47	97.9%	0.12
Expedited Appeal	4	72 Hours	95% compliance within standard	4	100.0%	0.10
Total Cases:	4,121		95% compliance within standard	3,858	93.6%	8.49

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

Standard Grievances:

There were 1,794 unique grievance cases resolved during the reporting period, with a total of 2,294 grievances including 472 shadow cases.

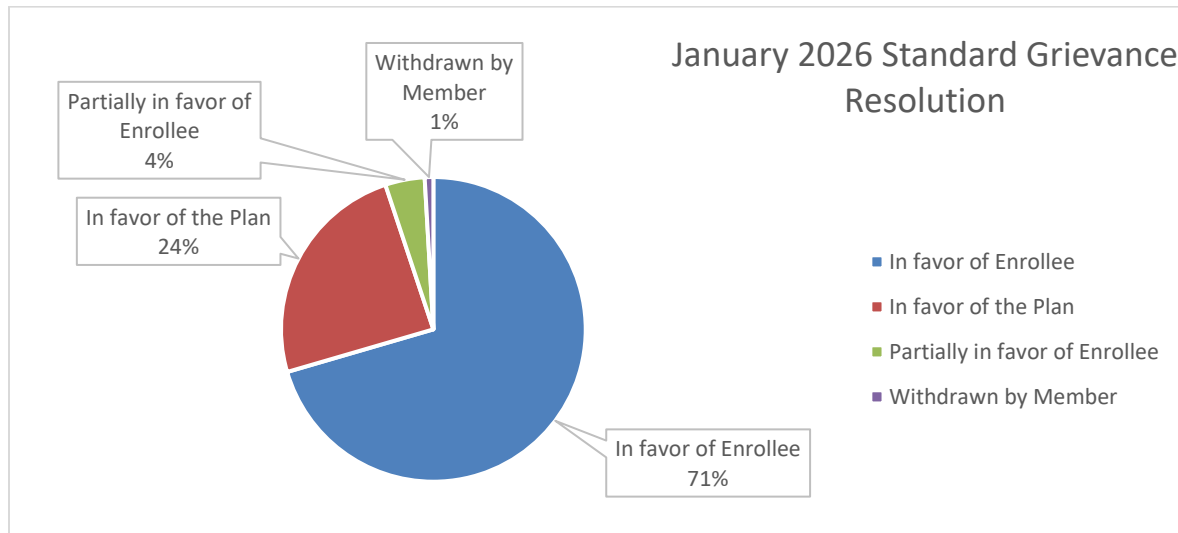


- **1,052** of 2,294 (46%) cases were related to Access to Care; the following are the top four (4) categories:
 - Technology/Telephone – 353
 - Timely Access – 312
 - Authorization – 138
 - Provider Availability – 106

- **749** of 2,294 (33%) cases were related to Quality of Service; the following are the top four (4) categories:
 - Plan Customer Service – 186
 - Provider/Staff Attitude – 153
 - Referral – 112
 - Authorization – 92

- **325** of 2,294 (14%) cases were related to Coverage Dispute; the following are the top two (2) categories:
 - Provider Direct Member Billing – 163
 - Provider Balance Billing – 93

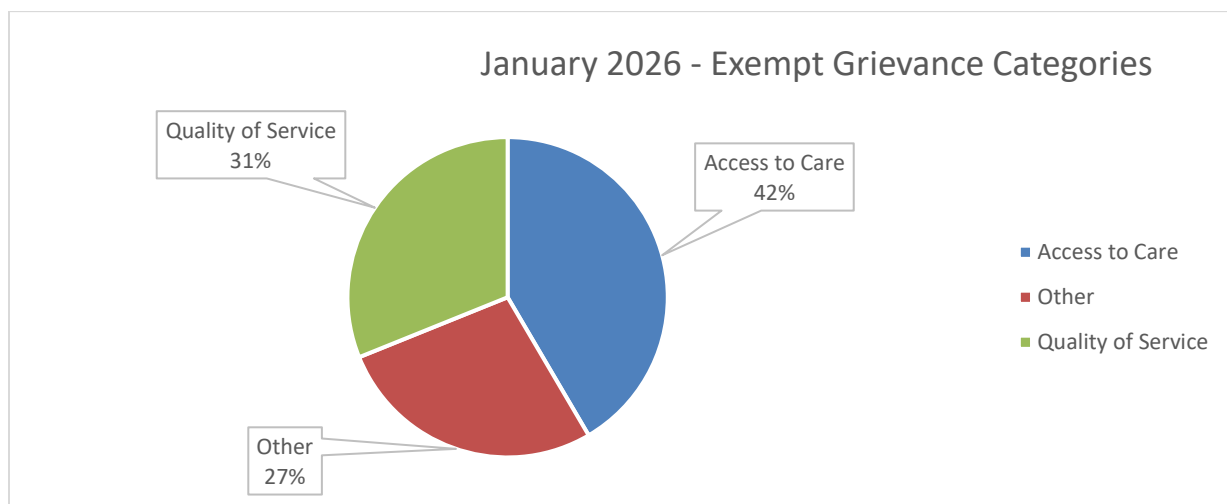
Resolution Determination:



- **1,617** of 2,294 (71%) cases were resolved In Favor of Enrollee.
- **560** of 2,294 (24%) cases were resolved In Favor of the Plan.
- **96** of 2,294 (4%) cases were resolved Partially in Favor of Enrollee.
- **21** of 2,294 (1%) cases were Withdrawn by Member.

Exempt Grievances:

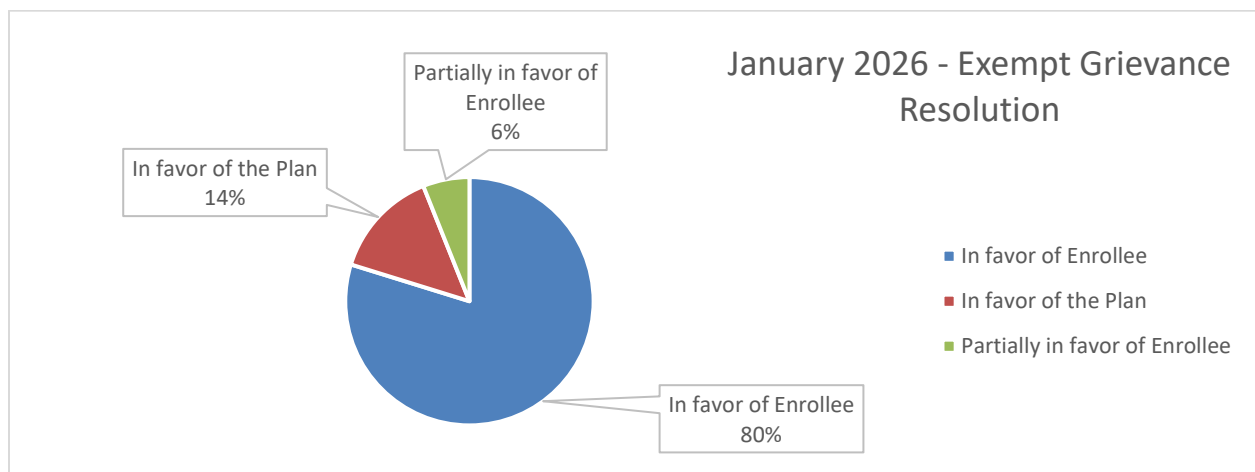
There were 1,561 unique exempt grievance cases resolved during the reporting period, with a total of 1,781 exempt grievances including 220 shadow cases.



- **740** of 1,781 (42%) cases were related to Access to Care; the following are the top three (3) categories:
 - Telephone/Technology – 437
 - Provider Availability – 148
 - Geographic Access – 93

- **554** of 1,781 (31%) cases were related to Quality of Service; the following are the top two (2) categories:
 - Plan Customer Service – 323
 - Provider/Staff Attitude – 171
- **487** of 1,781 (27%) cases were related to Quality of Service; the following are the top two (2) categories:
 - Enrollment – 424
 - Eligibility – 61

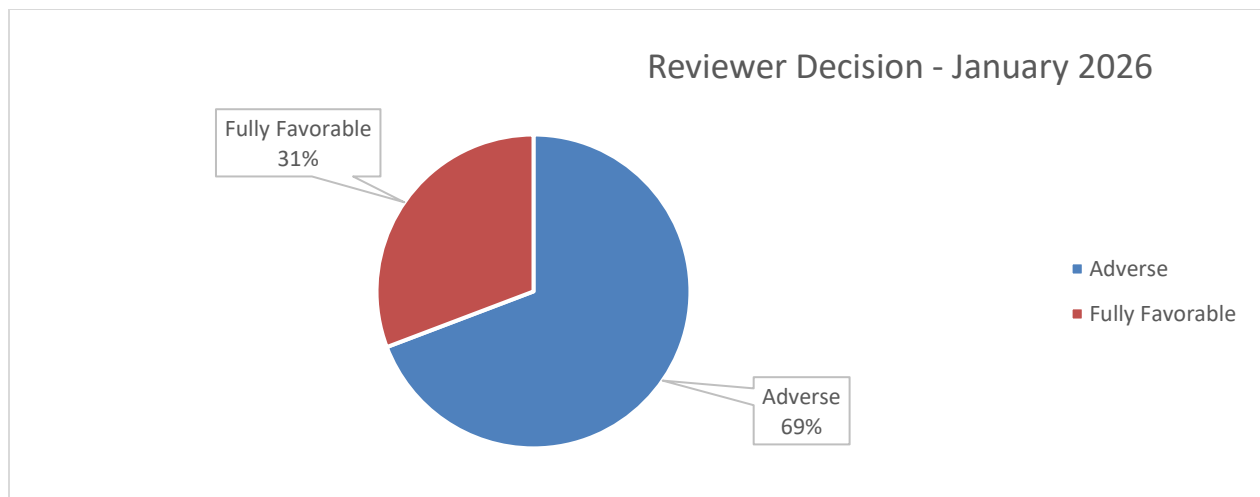
Resolution Determination:



- **1,421** of 1,781 (80%) cases were resolved In Favor of Enrollee.
- **252** of 1,781 (14%) cases were resolved In Favor of the Plan.
- **108** of 1,781 (6%) cases were resolved Partially in Favor of Enrollee.

Appeals:

The Alliance's goal is to have an overturn rate of less than 25%; for the reporting period of January 2026, we did not meet our goal with a 31% fully favorable (overturn) rate.



- **36** out of 52 (69%) cases had an adverse decision (upheld/denied) for the month of January 2026:
 - Disputes Involving Medical Necessity – 30
 - Out of Network – 6
- **16** out of 52 (31%) cases had a fully favorable decision (overturned) for the month of January 2026:
 - Disputes Involving Medical Necessity – 16

Provider Services

- 12-Month Trend Summary:
 - The Provider Services department's call volume in January 2026 was 10,888 calls compared to 10,977 calls in January 2025.
- Monthly Analysis:
 - The Provider Services department completed 465 calls/visits during January 2026.
 - The Provider Services department answered 7,534 calls for January 2026 and made 503 outbound calls.
 - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.

Credentialing

- Monthly Analysis:

- At the Peer Review and Credentialing (PRCC) meeting held on January 20th, 2025, there were 253 initial network providers approved; 10 primary care providers, 24 specialists, 25 ancillary providers, 29 midlevel providers, and 165 behavioral health providers. Additionally, 115 providers were re-credentialed at this meeting; 4 primary care providers, 17 specialists, 3 ancillary providers, 8 midlevel providers and 83 behavioral health providers.
- Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Community Relations and Outreach

- 12-Month Trend Summary:
 - In January 2026, the Alliance completed 636 member orientation outreach calls and 58 member orientations by phone.
 - The C&O Department reached 976 people (65% identified as Alliance members) during outreach activities, compared to 1,368 individuals (78% self-identified as Alliance members) in January 2025.
 - The C&O Department spent a total of \$5,000.00 on donations, fees, and/or sponsorships, compared to \$650.00 in January 2025.
 - The C&O Department reached members in 13 cities/unincorporated areas throughout Alameda County, and the Bay Area, compared to 14 cities in January 2025.
- Monthly Analysis:
 - In January 2026, the C&O Department completed 636 member orientation outreach calls and 58 member orientations by phone.
 - Among the 976 people reached, 65% identified as Alliance members.
 - In January 2026, the C&O Department reached members in 13 locations throughout Alameda County, and the Bay Area.
 - Please see attached **Addendum A**.

Incentives & Reporting

Current Incentive and Grant Programs

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

- The Alliance earned \$38M out of \$44M available under this program based on submission of deliverables and achievement of DHCS-defined metrics
 - \$25.5M has been awarded to our HHIP partners to date

- A HHIP funding opportunity was released in June 2024 to LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
 - The Alliance received applications from 10 LEAs totaling \$1.3M in requests; all submitted applications were approved and work on the funded programs continues
- In a separate HHIP-funded initiative, the Alliance awarded \$11.2M in funding to 10 community partners through a program that supports the HHIP goals of reducing and preventing homelessness
 - Projects continue with activities taking place through 2028 related to capacity building, innovation, diversity and health equity, and housing stability
- The Alliance continues to review partner project deliverables prior to payment and meet with partners to discuss program activities and barriers

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

- 2024-25 Program highlights:
 - Launched on June 1st, 2024
 - 15 applications received totaling \$6M in funding requests
 - \$400,145 has been awarded to our PRI partners to date
 - Five practices were reviewed for potential award retractions for not meeting the required deliverables within the designated timeframe; a retraction letter was sent to one practice on January 26th totaling \$85,000
 - PRI deliverable trackers, to assist with program requirements, were created and distributed to all awardees with signed MOUs
 - Approximately \$108,900 in unused funds for FY 2024-25 were not rolled over to the FY 2025-26 program
- 2025-26 Program status:
 - PRI program was renewed for FY 2025-26 and launched July 1st, 2025
 - Received \$2,135,375 in requests
 - 13 Applications received (only those eligible)
 - \$1,975,375 eligible for funding; \$1,890,375 in requests were approved
 - Applicants were notified of funding decisions; MOUs for all awardees have been fully executed
- FY 2024-25 and FY 2025-26 overview of funding:

Awards Funded	FY 2024-25	FY 2025-26
MD/DO	3	8
OB/GYN	3	0
NP/PA	8	2
BH	4	4
Community Health Workers	34	127

Medical Assistants	Not applicable	4
Bilingual Positions	5	4
Housing Relocation	0	1
Total Awarded*	\$1,820,750	\$1,890,375

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

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

- The original funding was \$700 million over five (5) years; however, due to state budget constraints, the funding was reduced to \$140 million over three (3) years
- Alameda Health System (AHS) was the only Alliance-associated applicant selected by DHCS to participate
 - The Population Health Learning Center (PHLC) requested MCPs sign a Data Sharing Agreement (DSA) so they can work with a third-party vendor to help calculate Healthcare Effectiveness Data and Information Set (HEDIS) rates; the DSA was fully executed on September 11th
 - The Analytics team submitted the required data to the secure site on September 18th and continues to support analytic requests from the EPT team
 - AHS submitted its latest set of deliverables in November 2025; the Alliance received confirmation that DHCS has processed the corresponding payment, which is pending confirmation prior to payment being processed
- At a September All MCP webinar, PHLC notified MCPs that beginning in January 2026, they will be paying MCPs via the monthly capitation to facilitate more timely payment to practices
 - The Alliance received notification of the payment via capitation on December 19th with confirmation of payment received January 6th; AHS was paid on January 16th
 - The Alliance met with AHS in January to discuss project activities and possible areas to invest remaining EPT dollars

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

- Scholarships are intended to offset costs related to the following:
 - Medi-Cal Provider Application and Validation for Enrollment (PAVE)
 - Contracting and credentialing with the Alliance
 - Continued education, training, and administrative and operational support required to be a Doula
- FY 2024-25 Program highlights:

- Scholarships of up to \$1,000 per person were available for Doulas both intending to contract with the Alliance and Doulas already contracted with the Alliance
- MOUs for the 20 scholarship awardees were signed, including seven (7) awards to support currently contracted Doulas and 13 awards for Doulas that intend to contract with the Alliance
- \$15,000 of the available \$20,000 in scholarships has been paid to program participants for completion of scholarship deliverables
 - Remaining payments will be funded through the FY 2025-2026 award cycle
 - One (1) awardee withdrew from the program and one (1) awardee indicated they would not complete the deliverables required for their final payment
- FY 2025-26 Program status:
 - I&R and Health Care Services launched a new funding cycle on October 31st, 2025
 - \$40,000 is available for Doulas that intend to contract with the Alliance with \$8,500 earmarked for outstanding deliverables from the FY 2024-25 program
 - \$7,000 in scholarships has been paid through December 2025 to program participants for completion of scholarship deliverables
 - 24 applications have been selected for funding to date, and the MOU process initiated

Grant Program Updates

- The Incentives and Reporting (I&R) team implemented a grant management software system, Submittable, to support the various grant and incentive programs the Alliance participates in
 - Submittable creates an online application process for community partners, an electronic evaluation process, reporting for fund management, and awardee deliverable tracking
 - The Alliance is working with Submittable to create a dashboard to manage and track program related deliverables, including fund distribution
 - Project activities kicked off on September 24th, 2025, and the dashboard has been created and is under final review until April 10th
- California Improvement Network – the Alliance was selected, along with 24 other partners, to participate in an opportunity through the California Improvement Network (CIN), which is a learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading good ideas, and implementing improvements
 - CIN participation provides the Alliance with an opportunity to partner and connect with other organizations that are also working to improve health equity



Health care you can count on.
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Integrated Planning

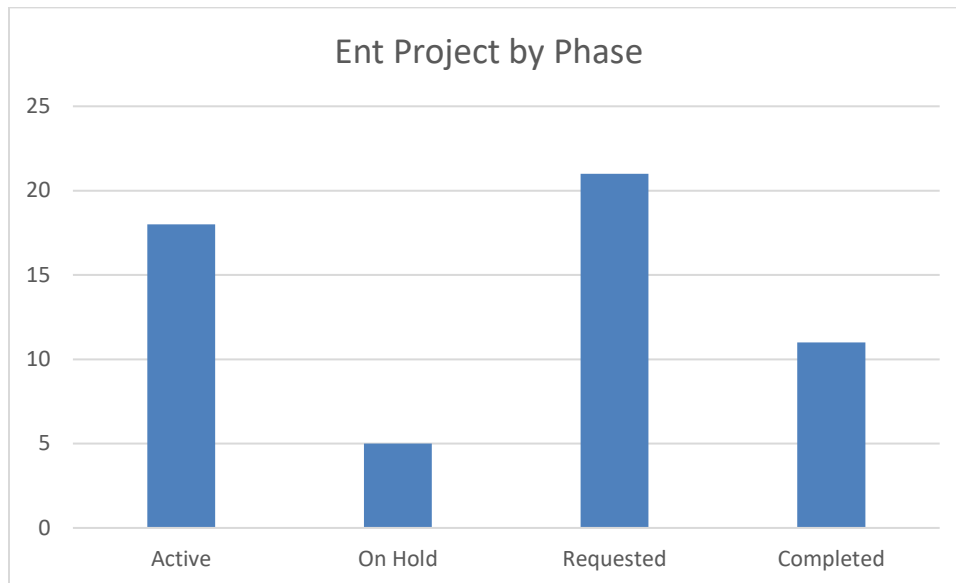
Ruth Watson

- The Director, Health Equity is participating in the equity focused learning network and leading project initiatives; I&R provides program management support
 - The Alliance received a \$4,500 grant to cover costs related to travel for participating in program activities; the grant award was received on September 22nd
- Participants of the CIN project were invited to apply for an Action Project award to support implementation efforts for partners
 - An application for a \$20,000 CIN Action Project grant was submitted on behalf of the Health Equity team on August 21st, and the Alliance was notified that the application was accepted on October 1st, 2025
 - The grant agreement with the California Health Care Foundation (CHCF) was fully executed on October 30th, 2025; the project's goals are to support efforts to improve Well Child-Care visits and immunization rates and decrease maternal depression for Black members through group classes with integrated pediatric visits
 - This project will be led by Dr. Simms-Mackey at Alameda Health System (AHS) with support from Health Equity
 - An MOU that outlines expectations and program requirements for the partnership was signed November 19th; the Alliance has provided payment to AHS Foundation to support this work
- The First 5 Alameda County was awarded a grant for \$1.1M, and the MOU related to the work, was fully executed in December 2025 for activities through June 2026
- On January 27th, Black Women Birthing Justice (BWBJ) was notified that they were selected for a grant through the California Maternal Health Innovation initiative
 - The Alliance I&R and HCS teams supported BWBJ in identifying and writing this application and will be an unfunded partner on the project; project activities kick-off in February 2026
 - As a part of this project, BWBJ will expand the doula workforce by partnering with Alliance subject matter experts to explore challenges related to credentialing and billing
 - The group will also look at opportunities to streamline contracting efforts with the Alliance

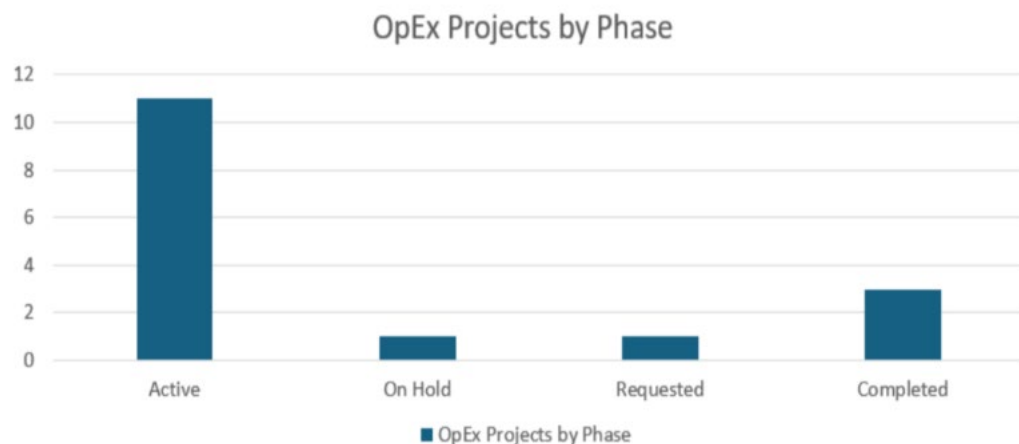
Integrated Planning

- Enterprise Portfolio
 - 45 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
 - 18 Active projects (discovery, initiation, planning, execution, warranty)
 - 5 On Hold projects

- 22 Requested and Approved Projects
- 11 Completed Projects (F-YTD)

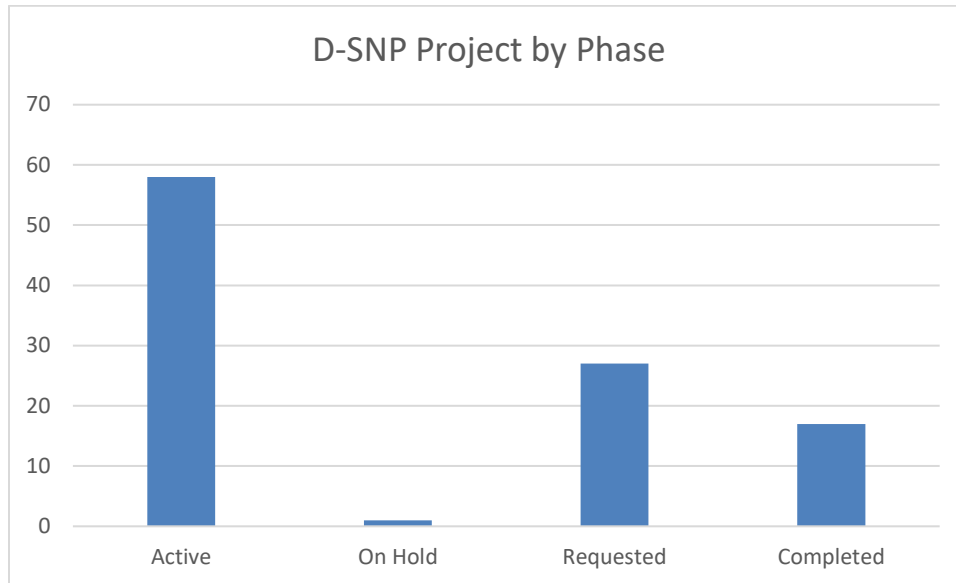


- Operational Excellence (OpEx) Portfolio
 - 16 projects currently on the Alameda Alliance for Health (AAH) OpEx portfolio
 - 11 Active projects (discovery, initiation, planning, execution, warranty)
 - 1 On Hold project
 - 1 Requested project
 - 3 Completed projects



- D-SNP Portfolio
 - 86 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio

- 58 Active projects (discovery, initiation, planning, execution, warranty)
- 1 On Hold
- 27 Requested Projects
- 17 Completed in Total



- DMHC Material Modification Submission – MA Service Area Expansion – March 2024 - COMPLETE
- DMHC Material Modification Submission – D-SNP Product – August 2024
- CMS Notice of Intent to Apply – November 2024 - COMPLETE
- CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025 - COMPLETE
- CMS Formulary & Bid Submission (Benefit Determination) – June 2nd, 2025 - COMPLETE
- Medication Therapy Management (MTM) program submission – June 4th, 2025 - COMPLETE
- CMS SMAC Submission – July 7th, 2025 - COMPLETE
- Rebate Allocation with CMS and Health Plan – July / August 2025 – COMPLETE
- Annual Enrollment Period (AEP) – October thru December 2025 – COMPLETE
- IT System Readiness – COMPLETE
- Open Enrollment Period (OEP) Begins – January 1st, 2026 – IN PROCESS

● **D-SNP Activities – December 2025**

- 01 – Provider Services & Contracting:
 - Provider Contracting

- Continued outreach to AAH provider network to complete the execution of the D-SNP Provider Amendments
 - As of January 28th, 306 contracts are fully executed, which equates to 88% completion
- The following D-SNP Hospital, IPA, and Lab amendments are fully executed
 - AHS Hospital
 - St. Rose Hospital
 - Stanford Valley Care Hospital
 - CHCN Medical Group
 - Foundation Labs
 - Central Valley Specialty Hospital
 - Kentfield Hospital
 - Sonoma Specialty Hospital
 - Valley Care (Tri Valley Stanford) Hospital
 - WHHS
 - Teladoc
 - Quest Diagnostics
- Provider Rates and Reimbursement
 - Continued development of the Pay4Performance (P4P) program
- 02 – Quality:
 - Model of Care - COMPLETE
 - Quality process in development for ongoing monitoring, evaluation and annual updates which is being managed in the Quality Workstream
 - MOC has been approved by both DHCS and CMS
 - 96.25% earning three (3) year approval
 - MOC Provider Training – Deck is completed and in Articulate – Content converted to Azure and URL developed for website
 - Communication and Outreach to upload to website by 12/5/2025
 - MOC Internal Training – Has been launched to staff with completion due date of 12/19/2025
 - Process created to incorporate changes into annual MOC updates
 - Quality Program – Post-Go Initiatives
 - Post-go live plan deployment
 - MOC – Annual review process under development
 - Chronic Care Improvement Project – Kick-off and project deployed
 - Quality Workplan
 - Core Metrics Dashboard for reporting created to align across multiple Quality, HCS, and Stars initiatives. All edits incorporated. Business owners are being identified

- Developing analytics requests for reporting requirements related to QI Workplan to align with above
 - Next steps are to submit Analytics Request for reports
- Quality Improvement Health Equity P&Ps Are completed and updates incorporated - **COMPLETED**
- 52 policies – Completed committee reviews - **COMPLETED**
- Establishing New Committees: **COMPLETED**
 - New D-SNP Utilization Management committee will align with QIHEC committee members and cadence. Awaiting final signoffs for structure
 - Templates being developed to document meeting agenda, minutes, and attendees for D-SNP
 - D-SNP Community Advisory Committee will be combined as a joint Medi-Cal and DSNP committee. Efforts continue to identify community members that will represent D-SNP population.
 - Charter redlines have been completed (Seven Quality Committees) and are in various stages of committee approval
- 03 - Health Care Services (HCS) and 04 - Behavioral Health (BH): Post-go live plan deployment
 - Case Automation in Tru-Care – Creation of processes for cases to auto-generate from member files when loaded into TC
 - Care Opportunities – Finalize configuration of care opportunities in TruCare
 - Staff Training Process – Develop process for ongoing staff training and new hire training
 - Staff Audit/Review Process – Develop process for UM/CM case reviews to align with policies and regulatory compliance
 - Staff Audit/Review Template – Develop audit tool for case reviews
 - HRA, ICT, and ICP
 - All policies are complete and under committee review. (130 policies). Awaiting final AOC and in alignment to have all policies approved during this session. **COMPLETED**
 - CM policies have been revised and drafted and under committee review. Final approvals awaiting AOC
 - UM policies moving through committee reviews. Final approvals awaiting AOC
 - UM Committee Charter presented at UMC on 09/24/2025. Revised to include D-SNP as a new service line. **COMPLETED**
 - Finalizing reporting requirements for UM, CM, and BH. Creating analytics requests and workflows. This is part of the Core Metrics Dashboard for Reporting Project
 - UM and CM letter inventory complete and under final review by C&O. **COMPLETED**

- Program Descriptions for UM and CM have been rolled out to Q1 2026 MOC will act as PD until revisions are made. Prior authorization code list has been finalized. The combined PA Code List + Benefit Criteria grid includes all 3 lines of business.
 - HRA Implementation Workgroup ongoing with Cotiviti. Identifying and defining data feeds/elements and assessment administration
 - Defining key components of how data will be exported from AAH to Cotiviti and how data will be ingested into TruCare from Cotiviti. **COMPLETED**
 - Cotiviti is in the process of configuring HRA - testing is underway for data transfer into TruCare. **COMPLETED**
 - HRA Cotiviti scripts continue to be finalized. Adult script is final for D-SNP. **COMPLETED**
 - Future State D-SNP CM Global Workflow complete – Continuing to define structure and new net processes for California Integrated Care Management (CICM) to include new requirements outlined in the CY2026 Program Guide. **COMPLETED**
 - D-SNP CM Assessment / HRA mapping to care plan for rules generation. **COMPLETED**
 - All CM assessments are completed and mapped in TruCare. Business rules for authorizations have been configured and tested. Finalizing Tru-Care Core Feeds SRD. **COMPLETED**
 - UM customer set up requirements for configuration has been finalized and configured into TruCare. **COMPLETED**
 - BH CM – D-SNP CM program structure has been finalized and will mirror PH CM. **COMPLETED**
 - BH workflows for UM and CM are complete. **COMPLETED**
 - Workflow was established to coordinate Medicare non-covered services with Alameda County Behavioral Health (ACBH). **COMPLETED**
 - BH programs policy and procedure development and revisions complete and approved in committees **COMPLETED**
 - BH call flows are completed to include intersections with Member Services. **COMPLETED**
 - D-SNP Member and Provider letters; additional letters created to support CMS and DHCS requirements. **COMPLETED**
 - Risk Stratification model alignment with Medi-Cal model. First RSS deployment will occur 1/25/2026. **COMPLETED**
 - Framework for identification of populations of focus for CICM, Palliative Care, and Most Vulnerable Populations have been completed and will deploy with RSS.
 - BH UM – additional levels of care established for D-SNP population and configured in TruCare. **COMPLETED**
 - Training continues for UM, CM and BH staff. **COMPLETED**
 - Continuing to develop SOPs. **COMPLETED**
- 05 – Finance:
- 5C – Financial Reconciliation and Reporting

- Continued development of required D-SNP reporting for CMS and internal reporting
- 06 – Product:
 - 6A – Bid and Benefit Design
 - Initiated project close
 - 6C – Enrollment and Eligibility
 - Continued monitoring of the enrollment confirmation files (DTRR) from CMS
 - Continued enrollment letter fulfillment monitoring following receipt of CMS’s enrollment file confirmation (DTRR)
 - Completed development of Enrollment Standard Operating Procedures (SOPs)
 - 6J – Liberty Dental
 - Dental plan is active and ready to start processing incoming Medicare dental claims
 - SSO integration: D-SNP members transition from AAH member portal to Liberty Dental portal to view claims This functionality is successfully deployed into Production.
 - Training materials developed for internal staff. Two meetings completed to educate AAH resources on Dental benefits offered.
 - Gap analysis underway to identify potential additions to Liberty network.
 - Project Team is waiting for paid dental claims to complete encounter testing with Optum
 - Liberty Dental requested approval for Subcontractor (Firstsource) to handle Call Center and Claims processing. Vendor Management is engaged and pre-delegation audit is in progress
- 07 – Compliance:
 - Initiated project close
- 08 - Operations (Claims / Member Services / Mailroom / IVR):
 - 8A – Claims
 - Continued HEALTHsuite configuration for all D-SNP provider amendments and new contracts.
 - Deployment of HEALTHsuite configuration supporting D-SNP claims processing.
 - 8B – Member Services / Call Center / IVR
 - Initiated project close
- 09 – Sales:
 - 9A – Sales Implementation
 - JD approved for second sales agent, targeting hire early to mid-January

- Interview process started for Medicare Field Sales Agent (bilingual).
- Target enrollments set for each partnered FQHC (20 member enrollments per site by 1/1/2026)
- Continued development of Standard Operating Procedures, completion date set to 1/1/2026
- Continued development of Cirrus reporting dashboards for enrollment and retention data
- Translation of all sale scripts in threshold languages
- Finesse “agent queue” functionality initiated
- PerformRx enhancements requested
- SOPs for Commission, Retention, and HRA payouts initiated
- Alameda Alliance for Health Caller ID implemented for higher connect rate with prospective members
- New PCP assignment process implemented during D-SNP enrollment
- Continued recruiting of second Medicare Field Sales and Community Agent
- Individual D-SNP Sales queues created within Finesse for improved prospective member experience
- 9D – Medicare Marketing & Brand Strategy
 - CMS 1/1 Required Materials / Content: Successfully published on the Alliance D-SNP public website for the 1/1 launch
 - Marketing Vendor Assessment & Selection: Marketing has identified a set of qualified vendors to conduct assessments to select preferred vendor and begin onboarding to ensure readiness for 7/1 implementation.
 - Enrollment and Onboarding Experience Improvement: Enhancements to the enrollment kit and welcome materials are underway to improve the overall enrollment and onboarding experience
- 9E – Retention
 - Continued development of retention reporting dashboard Retention reporting function finalized. Retention and HRA payment dates defined
- 10 – Pharmacy:
 - Post Go Live activities include daily huddles with PBM to continue to monitor performance and mistake proofing
 - M3P program in AAH is managed by ECHO through the PBM. Additional modifications to letters are in progress secondary to new material models published by CMS
 - CMS Part D Model materials and letters are under review with Pharmacy and C&O teams. English versions have been delivered and translations into threshold languages are complete
 - MTM program is live
 - Test files between PBM and AAH are in motion to support accumulator functionality in AAH claims platform

- AAH will delegate Part D appeals to the PBM and AAH will own Part D grievances; contract amendment is complete
 - D-SNP Policies and Procedures are complete and approved.
 - Development of standard operating procedures for D-SNP is in progress
 - D-SNP KPIs and reporting decisions have been completed by the pharmacy team
 - Development and documentation of Other Health Insurance (OHI) process in progress when checking eligibility and processing determinations
 - Development and documentation of Best Available Evidence (BAE) process are in progress as it pertains to completing a Medical Necessity process and final determinations
- 13 – Health Equity:
 - Policies approved and completed for D-SNP. **Completed**
 - SOPs completed for Quality and HE initiatives. **Completed**
 - Phase 2 of plan to develop monitoring processes and procedures that HE team will oversee
 - Gaps analysis completed and reviewed with workgroup. Interventions provided for D-SNP Health Equity Launch 01/01/2026. Working with business owners to establish responsibly
 - Health Equity Workplan for quality improvement interventions drafted and approved
 - Oversight policy and procedure 1st draft and workgroup review complete
- 15 - Grievance and Appeals:
 - Development of Standard operating procedures and KPI reporting for D-SNP in process
 - CMS five (5) levels of appeal are configured in QualitySuite
 - Grievances and CTMs have been received by the Health Plan and currently under review
 - The G&A team in collaboration with Analytics is currently developing reporting requirements
 - This project is in its Closing phase
- 16 – IT:
 - **TruCare:** Program is in closing phase. Core feeds (Member, Provider and Network) development is completed and deployed into Production environment. All configurations are promoted to Production enrollment.
 - **HEALTHsuite:**
 - HEALTHsuite platform is launched and successfully processing enrollments. Full administration Go-Live completed on time (claims, UM, provider)
 - Claims UAT and End-to-End Testing is in progress

- Perform Rx Accumulator file testing is in progress
 - Postproduction issue tracker is maintained by RAM team and updated regularly. Project Team meetings scheduled every week to review open issues and discuss resolution path
- **QualitySuite:**
 - Grievance module and CTM module deployment completed and validated. Working with Business stakeholders to start closing out this workstream and handover to Operations for support
- 16B – Enrollment Process & Nations Benefits / D-SNP Member Incentives Implementation
- **17 – Stars and Risk Adjustment:**
 - Optum and Episource implementation is underway to support Risk Adjustment CMS submissions and analytics
 - Encounter Data Submissions to CMS begin February 2026
 - Episource Analyst go live scheduled for March 2026
 - 3 Risk Adjustment Policy & Procedures approved by AOC and 2 are in progress
 - Phase 1 of Star strategy:
 - Identified initiatives for the HEDIS measures supported in the Medi-Cal line of business and Operational measures that will impact Star ratings on Day 1
 - Aligning interventions to Quality Workplan
 - Process flow documentation for the measures is underway with Quality, Health Care Services, and Analytics. We will plan to implement foundational initiatives to support Star gap closure
 - TruCare Star gap integration in process to track Admission, Discharge, and Transfer Star measures
 - Pay-for-Performance and Pay-for-Reporting program – Measure scope has been finalized. Confirmed with CHCN that they will not have their own P4P Program
 - Data feeds – This is already in production and will be slightly modified to ensure support for D-SNP measures
 - Prospective Chart Review – This is already in production and will be slightly modified to ensure support for D-SNP measures
 - Stars Education – Internal and external training to provide a clear understanding of how Star measures impact quality ratings. Internal training with key departments has been completed. Organizational training has been completed and received 100% completion with assigned teams. External training

- and quality discovery sessions with CHCN Clinic SMES have been completed
 - Provider facing Stars and Risk tips and best practices documentation has been completed and shared with providers.
- We plan to implement operational initiatives to support Star gap closure
 - Concierge Care Gap Closure Program – Beginning development of a member/provider outreach program for members with 2+ care gaps. Enterprise Member Outreach Dashboard has launched. It serves to document internal member touchpoints we have as an organization to reduce member abrasion
 - Awareness Campaign – Development of the Welcome Postcard with a checklist of preventative screenings has been completed and incorporated in the Member Welcome Kit
 - Preventive Physical Exam (IPPE) & Annual Wellness Visit (AWV) – Discussions continued to ensure providers are engaged in the development of the IPPE & AWV program to ensure members are seen for gap closure and accurate diagnosis capture
 - Individual sessions with each clinic have been completed. Clinics were introduced to new Star measures, discovery into clinical workflows, and HEDIS measures interventions that align with Star measures. Stars topics have been integrated in QI meetings with providers
 - Star measure tip sheets and best practice documents have been developed and shared with providers
 - Member incentive program went live on 1/1/26 and supports gap closure for Star measures
- **CalAIM Initiatives:**
 - Community Supports (CS)
 - Due to Budget Constraints, all CS enhancements and/or expansions are on hold
 - Justice-Involved (JI) Initiative:
 - CalAIM Re-entry (TDX: 1539): Project on hold pending direction from the State.
 - 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 were initiated in August 2024 and continued 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.
- CYBHI Fee Schedule (TDX: 4186):
 - 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
 - The Alliance was not selected to participate in the permanent ASO Model and will participate in an interim solution until further notice from Carelon and DHCS.
- MOU
 - Interim Model MOU has been executed by AAH CEO 4/29/2025 and returned to Carelon
 - AAH Finance Team shall receive Invoice File from Carelon for billing purposes via secured file transfer process and process payments manually. This includes checking member eligibility internally to deliver payments when services have been rendered
 - SFTP File Exchange template executed and resubmitted to Carelon 6/2/2025
 - Banking information with Carelon has been established and ready for invoice payments. Final stages of testing data with Carelon and DHCS
 - Test file from Carelon via SFTP picked up successfully
 - Project Close Activities
 - Upon completion of file transfer validation, the AAH business stakeholders propose closing this project
 - Anticipate project close in June 2025
 - Warranty period through end of July to monitor stabilization of potential incoming invoices

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
 - 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 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 2026
Incoming Calls (R/V)	21,534
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	21,155
Average Speed to Answer (ASA)	00:07
Calls Answered in 30 Seconds (R/V)	98%
Average Talk Time (ATT)	07:02
Calls Answered in 10 minutes	100%
Outbound Calls	10,026

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

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

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

Change PCP
ID Card Requests
Update Contact Information

Member Services Behavioral Health	January 2026
Incoming Calls (R/V)	1,017
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	1,001
Average Speed to Answer (ASA)	00:17
Calls Answered in 30 Seconds (R/V)	93%
Average Talk Time (ATT)	09:01
Calls Answered in 10 minutes	100%
Outbound Calls	1,570
Screenings Completed	113
ACBH Referrals	26
SUD referrals to Center Point	12

Blended Call Results

DSNP Blended Results	January 2026
Incoming Calls (R/V)	742
Abandoned Rate (R/V)	1%
Answered Calls (R/V)	731
Average Speed to Answer (ASA)	00:07
Calls Answered in 30 Seconds (R/V)	100%
Average Talk Time (ATT)	06:35
Calls Answered in 2 minutes	100%

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

Claims Department
December 2025 Final and January 2026 Final

METRICS

Claims Compliance	Dec-25	Jan-26
90% of clean claims processed within 30 calendar days	81.1%	86.7%
95% of all claims processed within 45 working days	89.8%	99.6%
Claims Volume (Received)	Dec-25	Jan-26
Paper claims	43,060	36,590
EDI claims	277,267	336,564
Claim Volume Total	320,327	373,154
Percentage of Claims Volume by Submission Method	Dec-25	Jan-26
% Paper	13.4%	9.8%
% EDI	86.6%	90.2%
Claims Processed	Dec-25	Jan-26
HEALTHsuite Paid (original claims)	276,032	210,264
HEALTHsuite Denied (original claims)	142,691	76,143
HEALTHsuite Original Claims Sub-Total	418,723	286,407
HEALTHsuite Adjustments	5,525	14,277
HEALTHsuite Total	424,248	300,684
Claims Expense	Dec-25	Jan-26
Medical Claims Paid	\$149,281,494	\$123,693,387
Interest Paid	\$173,533	\$143,402
Auto Adjudication	Dec-25	Jan-26
Claims Auto Adjudicated	380,455	247,802
% Auto Adjudicated	90.9%	86.5%
Average Days from Receipt to Payment	Dec-25	Jan-26
HEALTHsuite	50	19
Pended Claim Age	Dec-25	Jan-26
0-30 calendar days	37,006	34,901
HEALTHsuite		
31-61 calendar days	29,187	27,746
HEALTHsuite		
Over 62 calendar days	780	745
HEALTHsuite		
*Pended claims over 62 days are high due to investigation of Planned Parenthood		
Overall Denial Rate	Dec-25	Jan-26
Claims denied in HEALTHsuite	142,691	76,143
% Denied	33.6%	25.3%

Claims Department

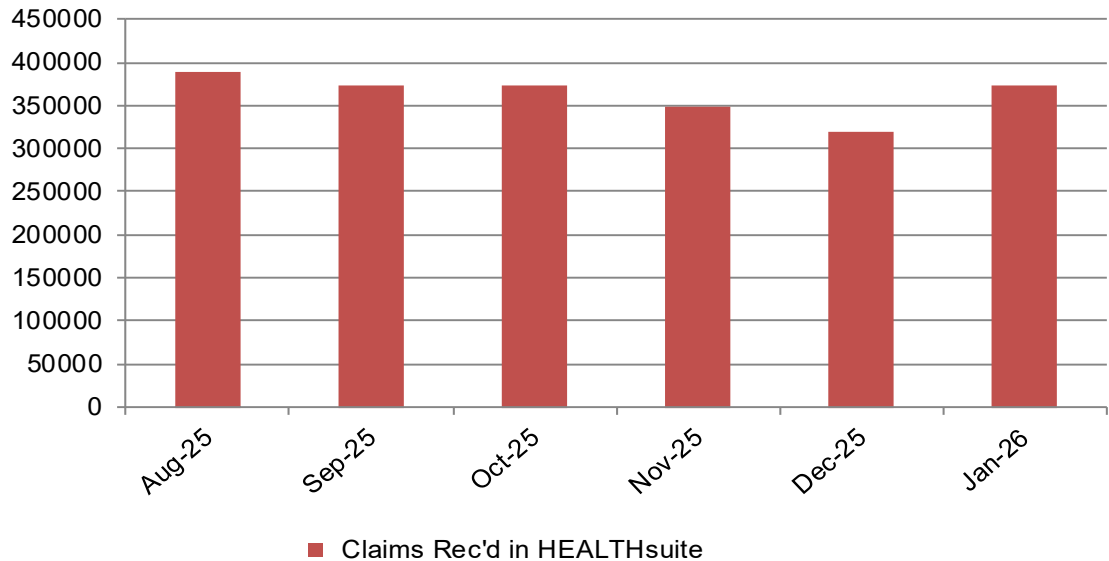
December 2025 Final and January 2026 Final

Jan-26

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	22%
Must Submit Paper Claim With Copy of Primary Payor EOB	14%
Non-Covered Benefit For This Plan	12%
No Benefits Found For Dates Of Service	9%
Laboratory Procedure That Is Not Eligible For Separate Reimbursement In Place Of Service	9%
% Total of all denials	66%

Claims Received By Month

	9/1/2025	10/1/2025	11/1/2025	12/1/2025	1/1/2026	2/1/2026
Claims Received Through	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Claims Rec'd in HEALTHsuite	389,082	373,025	372,246	349,052	320,327	373,154



Claims Year Over Year Summary

Claims Compliance - comparing January 2026 to January 2025 as follows: 30 Days - 86.7% (2026) vs 90.1% (2025) 45 Days - 99.6% (2026) vs 98.9% (2025) 90 Days - 99.9% (2026) vs 99.9% (2025)	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 373,154 claims in January 2026 vs 339,760 in January 2025	N/A	N/A
EDI - the volume of EDI submissions was 90.2% which falls within the normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 286,407 in January 2026 (22 working days) vs 345,327 in January 2025 (21 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in January 2026 was \$123,693,387 (4 check runs) vs \$166,817,056 in January 2025 (5 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in January 2026 was \$143,402 vs \$98,259 in January 2025	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in January 2026 was 86.5% vs 86.2% in January 2025	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in January 2026 was 19 days vs 16 days in January 2025	N/A	<= 25 days
Pended Claim Age - comparing January 2026 to January 2025 as follows: 0-30 calendar days - 34,901 (2026) vs 56,182 (2025) 31-61 calendar days - 27,746 (2026) vs 37,974 (2025) Over 62 calendar days - 745 (2026) vs 15,275 (2025) *Pended claims over 62 days are high due to Planned Parenthood	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 2026 to January 2025	N/A	N/A

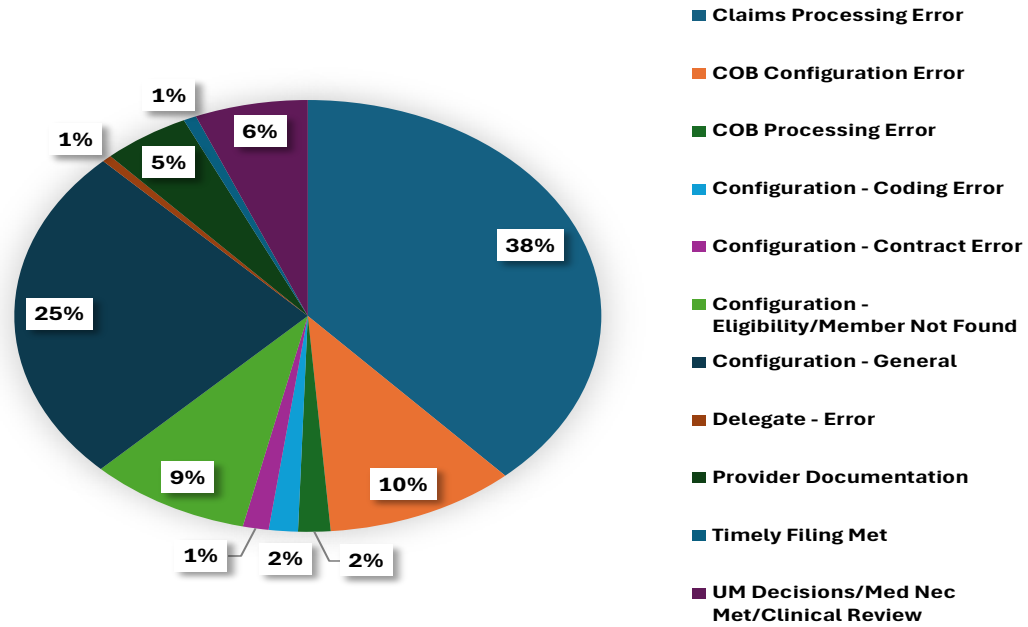
Provider Dispute Resolution		
December 2025 and January 2026		
METRICS		
PDR Compliance	Dec-25	Jan-26
# of PDRs Resolved	3,493	2,660
# Resolved Within 45 Working Days	3,467	2,646
% of PDRs Resolved Within 45 Working Days	99.2%	99.4%
PDRs Received	Dec-25	Jan-26
# of PDRs Received	3,121	3,160
PDR Volume Total	3,121	3,160
PDRs Resolved	Dec-25	Jan-26
# of PDRs Upheld	2,890	2,098
% of PDRs Upheld	83%	79%
# of PDRs Overturned	603	562
% of PDRs Overturned	17%	21%
Total # of PDRs Resolved	3,493	2,660
Average Turnaround Time	Dec-25	Jan-26
Average # of Days to Resolve PDRs	42	40
Oldest Resolved PDR in Days	183	227
Unresolved PDR Age	Dec-25	Jan-26
0-45 Working Days	4,600	4,290
Over 45 Working Days	0	0
Total # of Unresolved PDRs	4,600	4,290

Provider Dispute Resolution December 2025 and January 2026

Jan-26

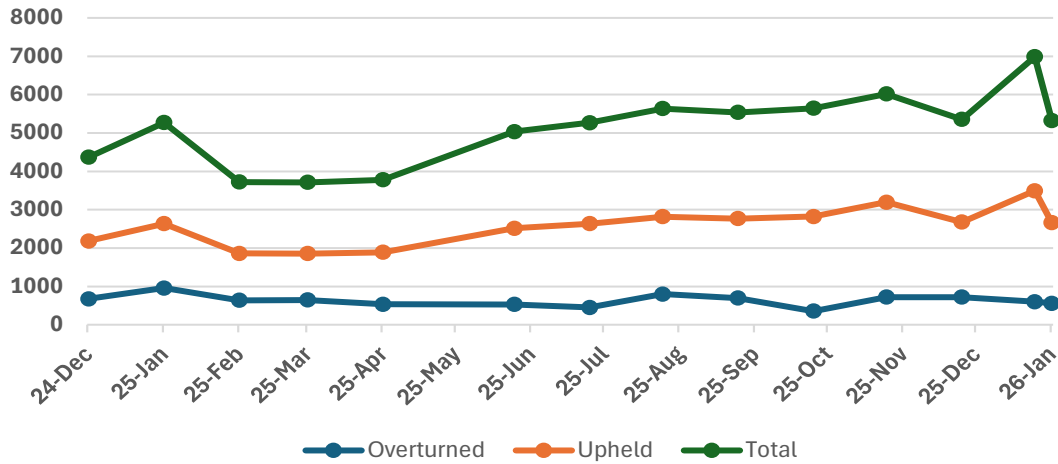
PDR Resolved Case Overturn Reasons

January 2026



Rolling 12-Month PDR Trend Line

January 2026



Provider Dispute Resolution Year Over Year Summary

# of PDRs Resolved - 2,660 in January 2026 vs 2,635 in January 2025	N/A	N/A
# of PDRs Received - 3,160 in January 2026 vs 2,843 in January 2025	N/A	N/A
# of PDRs Resolved within 45 working days - 2,646 in January 2026 vs 2,632 in January 2025	N/A	N/A
% of PDRs Resolved within 45 working days - 99.4% in January 2026 vs 99.9% in January 2025	95%	95%
Average # of Days to Resolve PDRs - 40 days in January 2026 vs 38 days in January 2025	N/A	30
Oldest Resolved PDR in Days - 227 days in January 2026 vs 242 days in January 2025	N/A	N/A
# of PDRs Upheld - 2,098 in January 2026 vs 1,678 in January 2025	N/A	N/A
% of PDRs Upheld - 79% in January 2026 vs 62% in January 2025	N/A	> 75%
# of PDRs Overturned - 562 in January 2026 vs 957 in January 2025	N/A	N/A
% of PDRs Overturned - 21% in January 2026 vs 36% in January 2025	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 38% (2026) vs 27% (2025) Configuration errors - 37% (2026) vs 47% (2025) COB - 12% (2026) vs 5% (2025) Clinical Review/UM Decisions/Medical Necessity Met - 13% (2026) vs 21% (2025)	N/A	N/A

Provider Relations Call Center Dashboard
Line of Businesses: D-SNP, Medi-cal, and Group Care

[illegible]

Provider Relations Call Reasons & Field Visits Dashboard

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

[illegible]

Field Visit Activity Details

[illegible]

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALIAED PRACTITIONERS - January 2026						
Practitioners		PCP 405	SPEC 793	AHP 823	BH/ABA 3,722	PCP/SPEC 12
Direct Network vs Delegated Network Breakdown			AAH 4,455	AHS 315	CHCN 627	COMBINATION OF GROUPS 358
Facilities	462					
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	67	10	Y	Y	Y	
Recred Files in Process	191	0	Y	Y	Y	
Expirables updated						
Insurance, License, DEA, Board Certifications					Y	
Files currently in process	258					
* 25 business days = 35 calendar days						
January 2026 Peer Review and Credentialing Committee Approvals						
Initial Credentialing	Number					
PCP	10					
SPEC	24					
ANCILLARY	25					
MIDLEVEL/AHP	29					
BH/ABA	165					
Sub-total	253					
Recredentialing						
PCP	4					
SPEC	17					
ANCILLARY	3					
MIDLEVEL/AHP	8					
BH/ABA	83					
Sub-total	115					
TOTAL	368					
January 2026 Facility Approvals						
Initial Credentialing	6					
Recredentialing	15					
Sub-total	21					
Facility Files in Process	57					
January 2026 Employee Metrics (6 FTEs)						
	Goal	Met (Y/N)				
File Processing	Timely processing within 3 days of receipt		Y			
Credentialing Accuracy	<3% error rate		Y			
DHCS, DMHC, CMS, NCQA Compliant	98%		Y			
MBC Monitoring	Timely processing within 3 days of receipt		Y			

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Adams	Johanna	BH/ABA-Telehealth	INITIAL	1/20/2026
Agarwal	Anita	Specialist	INITIAL	1/20/2026
Aguirre	Ricardo	Primary Care Physicia	INITIAL	1/20/2026
Akintunde	Celedor	BH/ABA-Telehealth	INITIAL	1/20/2026
Ali	Fatima	BH/ABA-Telehealth	INITIAL	1/20/2026
Anand	Anita	Allied Health	INITIAL	1/20/2026
Ascencio	Silvia	BH/ABA-Telehealth	INITIAL	1/20/2026
Azpiri Magallanes	Alicia	BH/ABA-Telehealth	INITIAL	1/20/2026
Badjatiya	Paridhi	Allied Health	INITIAL	1/20/2026
Bae	Jinyi	BH/ABA-Telehealth	INITIAL	1/20/2026
Bailey	Mark	Specialist	INITIAL	1/20/2026
Bakowsky	Diana	BH/ABA	INITIAL	1/20/2026
Barnes	Kari	BH/ABA	INITIAL	1/20/2026
Bassett	Stephanie	BH/ABA-Telehealth	INITIAL	1/20/2026
Bekeschus	Monique	BH/ABA-Telehealth	INITIAL	1/20/2026
Bone	Sierra	Ancillary	INITIAL	1/20/2026
Branch	Rebecca	BH/ABA-Telehealth	INITIAL	1/20/2026
Buch	Preema	Specialist	INITIAL	1/20/2026
Buckwold	Ashley	BH/ABA-Telehealth	INITIAL	1/20/2026
Burton	Dominica	BH/ABA-Telehealth	INITIAL	1/20/2026
Buttner	Gregory	BH/ABA-Telehealth	INITIAL	1/20/2026
Cabrera	Dannielle	BH/ABA-Telehealth	INITIAL	1/20/2026
Cabrera	John	BH/ABA-Telehealth	INITIAL	1/20/2026
Cadieux	Kristin	Allied Health	INITIAL	1/20/2026
Campos	Angelica	BH/ABA-Telehealth	INITIAL	1/20/2026
Capdevila	Kelsey	BH/ABA	INITIAL	1/20/2026
Carey	Allison	BH/ABA	INITIAL	1/20/2026
Carlson	Cassandra	BH/ABA	INITIAL	1/20/2026
Carrasco O'Connell	Dillon	Ancillary	INITIAL	1/20/2026
Chavez	Melissa	Allied Health	INITIAL	1/20/2026
Cehade	Hana	Ancillary	INITIAL	1/20/2026
Chen	Xinyue	Allied Health	INITIAL	1/20/2026
Chenette	Christie	BH/ABA-Telehealth	INITIAL	1/20/2026
Chorba	John	Specialist	INITIAL	1/20/2026
Cibrian-Aguilar	Natania	BH/ABA-Telehealth	INITIAL	1/20/2026
Clark	Tracy	BH/ABA-Telehealth	INITIAL	1/20/2026
Cochran	Kimberly	BH/ABA-Telehealth	INITIAL	1/20/2026
Colin	Rosa	BH/ABA	INITIAL	1/20/2026
Coplans	David	BH/ABA-Telehealth	INITIAL	1/20/2026
Cruz Martinez	Cecilia	Ancillary	INITIAL	1/20/2026
Dalizu	Alice	Allied Health	INITIAL	1/20/2026
Dixon	Elizabeth	Allied Health	INITIAL	1/20/2026
Doan	Dai	BH/ABA	INITIAL	1/20/2026
Donaldson	Breanna	BH/ABA	INITIAL	1/20/2026
Duong	Yasmine	BH/ABA-Telehealth	INITIAL	1/20/2026
Duval	Lisa	BH/ABA-Telehealth	INITIAL	1/20/2026
Ecklund	Marina	Allied Health	INITIAL	1/20/2026
Feibleman	Cary	Specialist	INITIAL	1/20/2026
Fernandez	Yajaira	BH/ABA	INITIAL	1/20/2026
Finney-Hennings	Drajwanee	BH/ABA-Telehealth	INITIAL	1/20/2026
Fleming	Imani	BH/ABA	INITIAL	1/20/2026
Forgeng	George	BH/ABA-Telehealth	INITIAL	1/20/2026
Franco	Kelly	Allied Health	INITIAL	1/20/2026
Frazier	Rhonda	Doula	INITIAL	1/20/2026
Fregoso	Antoinette	Allied Health	INITIAL	1/20/2026

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Freier	Mary-Catherin	BH/ABA-Telehealth	INITIAL	1/20/2026
Fresch	Silas	Primary Care Physicia	INITIAL	1/20/2026
Furtick	Victor	BH/ABA-Telehealth	INITIAL	1/20/2026
Gandy	Kimberly	Specialist	INITIAL	1/20/2026
Garcia	Josue	BH/ABA-Telehealth	INITIAL	1/20/2026
Gomez	India	BH/ABA	INITIAL	1/20/2026
Gonen	Oner	BH/ABA-Telehealth	INITIAL	1/20/2026
Gonsalves	Nicholas	Specialist	INITIAL	1/20/2026
Gonzaga	Jesse	Allied Health	INITIAL	1/20/2026
Grandis	Anna	Primary Care Physicia	INITIAL	1/20/2026
Guffey	Susanne	BH/ABA-Telehealth	INITIAL	1/20/2026
Gupta	Divya	Specialist	INITIAL	1/20/2026
Gupta	Nupur	Primary Care Physicia	INITIAL	1/20/2026
Habtetsion	Mereb	Ancillary	INITIAL	1/20/2026
Hamann	Christopher	Specialist	INITIAL	1/20/2026
Handleman	Scott	BH/ABA	INITIAL	1/20/2026
Harada	Yvonne	BH/ABA-Telehealth	INITIAL	1/20/2026
Hayashi	Takae	BH/ABA-Telehealth	INITIAL	1/20/2026
Hayden	Nanette	BH/ABA	INITIAL	1/20/2026
Hayes	Margaux	BH/ABA-Telehealth	INITIAL	1/20/2026
Hedemark	Charm	BH/ABA-Telehealth	INITIAL	1/20/2026
Herr	Sherry	BH/ABA-Telehealth	INITIAL	1/20/2026
Holguin-Mitchell	Alexis	BH/ABA-Telehealth	INITIAL	1/20/2026
Huang	Crystal	Allied Health	INITIAL	1/20/2026
Hudson	Ruth	BH/ABA-Telehealth	INITIAL	1/20/2026
Hudson Blue	Jessica	BH/ABA	INITIAL	1/20/2026
Inman	Annie	Allied Health	INITIAL	1/20/2026
Jain	Shaili	BH/ABA-Telehealth	INITIAL	1/20/2026
Jaiswal	Amee	BH/ABA-Telehealth	INITIAL	1/20/2026
Jakubowski	John	BH/ABA-Telehealth	INITIAL	1/20/2026
Jalal	Yema	Specialist	INITIAL	1/20/2026
Javier	Cresilyn	BH/ABA-Telehealth	INITIAL	1/20/2026
Jefferson	Autumn	BH/ABA-Telehealth	INITIAL	1/20/2026
Johnson	Kristine	BH/ABA-Telehealth	INITIAL	1/20/2026
Jones	Ilisten	Specialist	INITIAL	1/20/2026
Kane	Alexandra	BH/ABA	INITIAL	1/20/2026
Kasparian	Laura	BH/ABA-Telehealth	INITIAL	1/20/2026
Kaul	Anubhav	Primary Care Physicia	INITIAL	1/20/2026
Kelada	Andrew	Specialist	INITIAL	1/20/2026
Kemsley	Paola	BH/ABA-Telehealth	INITIAL	1/20/2026
Khanna	Ananya	BH/ABA-Telehealth	INITIAL	1/20/2026
Lam	Jenny	Specialist	INITIAL	1/20/2026
Latreille-Favre	Juliet	Allied Health	INITIAL	1/20/2026
Lavin	Tiana	Ancillary	INITIAL	1/20/2026
Lee	Justin	BH/ABA-Telehealth	INITIAL	1/20/2026
Lee	Shin Rong	Specialist	INITIAL	1/20/2026
Lepore	Carlie	Ancillary	INITIAL	1/20/2026
Lepreau	Renee	Doula	INITIAL	1/20/2026
Lewis	Kaila	BH/ABA-Telehealth	INITIAL	1/20/2026
Lindgren	Sophia	Doula	INITIAL	1/20/2026
Liu	Yi	Ancillary	INITIAL	1/20/2026
Lobo	Vanessa	BH/ABA-Telehealth	INITIAL	1/20/2026
Loh	Deanna	BH/ABA-Telehealth	INITIAL	1/20/2026
Long	Rachel	BH/ABA-Telehealth	INITIAL	1/20/2026
Lopez	Efren	BH/ABA-Telehealth	INITIAL	1/20/2026
Lowder	Michelle	BH/ABA-Telehealth	INITIAL	1/20/2026
Lowenburg	Benjamin	BH/ABA-Telehealth	INITIAL	1/20/2026

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Lumpkin	Christina	Allied Health	INITIAL	1/20/2026
Makoni	Bessa	Allied Health	INITIAL	1/20/2026
Manuel	Christina	Doula	INITIAL	1/20/2026
Manzi	Judith	Specialist	INITIAL	1/20/2026
Martinez	Jessica	BH/ABA-Telehealth	INITIAL	1/20/2026
Martinez	Krystal	Ancillary	INITIAL	1/20/2026
Martinez	Viviana	BH/ABA-Telehealth	INITIAL	1/20/2026
Mascharak	Smita	Specialist	INITIAL	1/20/2026
Mather	Jasper	BH/ABA-Telehealth	INITIAL	1/20/2026
Mbamalu	Kristine	BH/ABA-Telehealth	INITIAL	1/20/2026
McDaniel	Suzie	BH/ABA-Telehealth	INITIAL	1/20/2026
McIntyre	April	Allied Health	INITIAL	1/20/2026
McKay	DeLise	Allied Health	INITIAL	1/20/2026
Mentlik	Sara	BH/ABA-Telehealth	INITIAL	1/20/2026
Migirian-Tellez	Kristen	BH/ABA-Telehealth	INITIAL	1/20/2026
Montross	Lori	BH/ABA-Telehealth	INITIAL	1/20/2026
Mota	Alex	BH/ABA-Telehealth	INITIAL	1/20/2026
Nechay	Andrea	BH/ABA-Telehealth	INITIAL	1/20/2026
Ngo	Kimberly	Primary Care Physicia	INITIAL	1/20/2026
Nguyen	Ann	BH/ABA-Telehealth	INITIAL	1/20/2026
Nguyen	Cecilia	Allied Health	INITIAL	1/20/2026
Nunes	Jessica	Ancillary	INITIAL	1/20/2026
Nyampong	Kristen	Ancillary	INITIAL	1/20/2026
Oliver	Angie	Allied Health	INITIAL	1/20/2026
O'Neil	Jenny	BH/ABA-Telehealth	INITIAL	1/20/2026
Osegueda	Diana	BH/ABA-Telehealth	INITIAL	1/20/2026
Palacio	Trennell	BH/ABA-Telehealth	INITIAL	1/20/2026
Palmer	Katie	BH/ABA-Telehealth	INITIAL	1/20/2026
Paluzzi	Claire	BH/ABA-Telehealth	INITIAL	1/20/2026
Pan	Shu	Specialist	INITIAL	1/20/2026
Parker	Madeline	Allied Health	INITIAL	1/20/2026
Parks	Nicole	BH/ABA-Telehealth	INITIAL	1/20/2026
Patel	Dharuviben	BH/ABA-Telehealth	INITIAL	1/20/2026
Patel	Jigna	Allied Health	INITIAL	1/20/2026
Pavloski-Carter	Jackie	Ancillary	INITIAL	1/20/2026
Pharris	Carla	Primary Care Physicia	INITIAL	1/20/2026
Piurek	Christina	BH/ABA-Telehealth	INITIAL	1/20/2026
Pourreau	Lauren	BH/ABA-Telehealth	INITIAL	1/20/2026
Price	Jessica	Allied Health	INITIAL	1/20/2026
Protzman	Brittany	BH/ABA-Telehealth	INITIAL	1/20/2026
Quillen	David	Primary Care Physicia	INITIAL	1/20/2026
Radetsky	Martha	BH/ABA-Telehealth	INITIAL	1/20/2026
Radhakrishnan	Aruna	Ancillary	INITIAL	1/20/2026
Ram	Kanha	Allied Health	INITIAL	1/20/2026
Rasmussen	Kayla	Primary Care Physicia	INITIAL	1/20/2026
Ratnasoma	Dulip	Specialist	INITIAL	1/20/2026
Resendiz	Sindy	BH/ABA-Telehealth	INITIAL	1/20/2026
Richards	Sean	BH/ABA-Telehealth	INITIAL	1/20/2026
Ridge	Tamara	BH/ABA-Telehealth	INITIAL	1/20/2026
Rios	Sierra	BH/ABA-Telehealth	INITIAL	1/20/2026
Robbins Rios	Laura	BH/ABA-Telehealth	INITIAL	1/20/2026
Roberson	Tracie	BH/ABA-Telehealth	INITIAL	1/20/2026
Robertson	Angela	BH/ABA-Telehealth	INITIAL	1/20/2026
Robertson	Kristin	PCP_ECM	INITIAL	1/20/2026
Robinson	Mariesha	Doula	INITIAL	1/20/2026
Rodriguez	Crystal	BH/ABA-Telehealth	INITIAL	1/20/2026

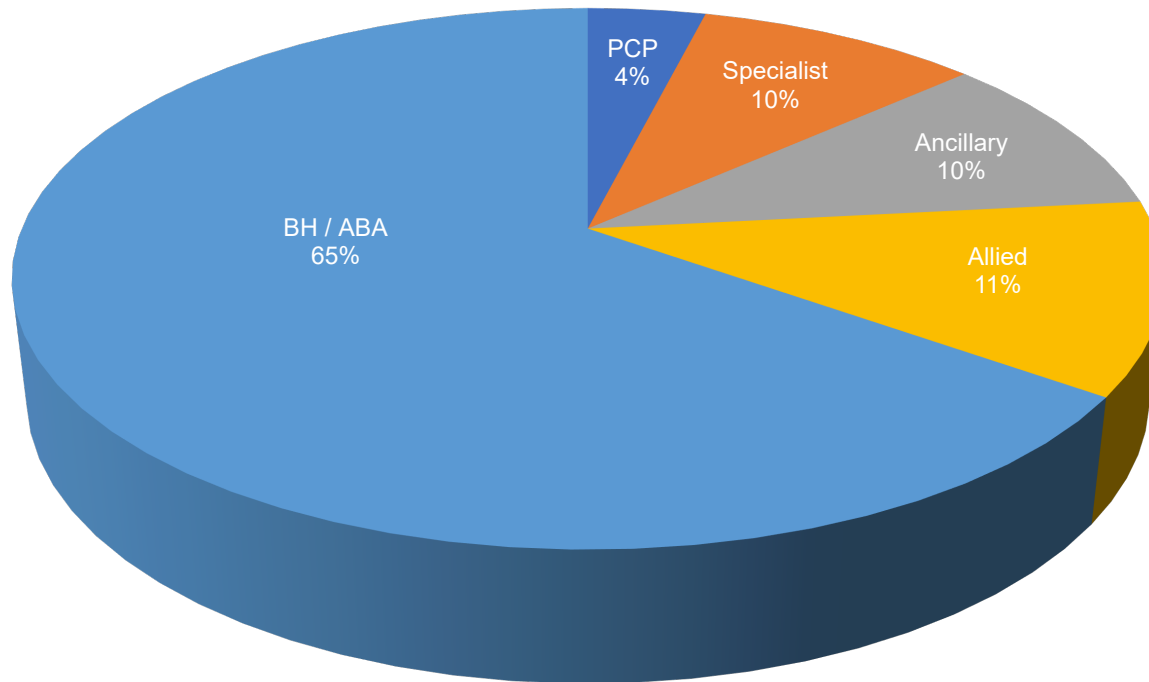
LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Rodriguez	Iliana	BH/ABA-Telehealth	INITIAL	1/20/2026
Rodriguez	Kayla	BH/ABA-Telehealth	INITIAL	1/20/2026
Rodriguez	Melissa	BH/ABA-Telehealth	INITIAL	1/20/2026
Rodriguez	Yvette	BH/ABA-Telehealth	INITIAL	1/20/2026
Roper	Amber	BH/ABA-Telehealth	INITIAL	1/20/2026
Rosenthal	Limor	BH/ABA-Telehealth	INITIAL	1/20/2026
Rowland	Kayla	BH/ABA-Telehealth	INITIAL	1/20/2026
Rubalcava	Sandra	BH/ABA-Telehealth	INITIAL	1/20/2026
Rubio	Lea Karlla	Allied Health	INITIAL	1/20/2026
Ruiz	Gabriela	BH/ABA-Telehealth	INITIAL	1/20/2026
Ruiz	Rahel	Primary Care Physicia	INITIAL	1/20/2026
Saenz	Jacqueline	BH/ABA-Telehealth	INITIAL	1/20/2026
Salazar	Amelia	BH/ABA-Telehealth	INITIAL	1/20/2026
Sampaolo	Amanda	BH/ABA-Telehealth	INITIAL	1/20/2026
Sanders	Melissa	BH/ABA-Telehealth	INITIAL	1/20/2026
Santiago	Alexandria	BH/ABA-Telehealth	INITIAL	1/20/2026
Santos	Judith	BH/ABA-Telehealth	INITIAL	1/20/2026
Santos	Nicole	BH/ABA-Telehealth	INITIAL	1/20/2026
Schear	Tracey	BH/ABA-Telehealth	INITIAL	1/20/2026
Schmall	Darienne	BH/ABA-Telehealth	INITIAL	1/20/2026
Semon	Sarah	Specialist	INITIAL	1/20/2026
Shah	Nadia	BH/ABA-Telehealth	INITIAL	1/20/2026
Sheehey	Alexandra	BH/ABA-Telehealth	INITIAL	1/20/2026
Siadat	Vaheed	BH/ABA-Telehealth	INITIAL	1/20/2026
Silver	Kara	BH/ABA-Telehealth	INITIAL	1/20/2026
Simkins	Maria Celestina	BH/ABA-Telehealth	INITIAL	1/20/2026
Simmons	Robert	BH/ABA-Telehealth	INITIAL	1/20/2026
Singh	Shauna	BH/ABA-Telehealth	INITIAL	1/20/2026
Sohal	Daljit	BH/ABA-Telehealth	INITIAL	1/20/2026
Sohrabpartovi	Tara	BH/ABA-Telehealth	INITIAL	1/20/2026
Solorio	Roberto	BH/ABA-Telehealth	INITIAL	1/20/2026
Solorzano	Amber	BH/ABA-Telehealth	INITIAL	1/20/2026
Sotelo	Mayra	BH/ABA-Telehealth	INITIAL	1/20/2026
Sowah-Quaye	Mary	BH/ABA-Telehealth	INITIAL	1/20/2026
Sran	Kirandeep	Allied Health	INITIAL	1/20/2026
Stamm	Jessica	Ancillary	INITIAL	1/20/2026
Stellhorn	Emily	BH/ABA-Telehealth	INITIAL	1/20/2026
Stone	Sarah	BH/ABA-Telehealth	INITIAL	1/20/2026
Takemoto	Sunisa	BH/ABA-Telehealth	INITIAL	1/20/2026
Tang	Yea-whei	BH/ABA-Telehealth	INITIAL	1/20/2026
Tanghal	Sharon	BH/ABA-Telehealth	INITIAL	1/20/2026
Tanji	Kristen	BH/ABA-Telehealth	INITIAL	1/20/2026
Taylor	Ian	BH/ABA-Telehealth	INITIAL	1/20/2026
Taylor	Meghed	BH/ABA-Telehealth	INITIAL	1/20/2026
Taylor	Sandra	Specialist	INITIAL	1/20/2026
Taylor Kester	Lara	BH/ABA-Telehealth	INITIAL	1/20/2026
Theus	Sean	BH/ABA	INITIAL	1/20/2026
Thomas	Daphne	BH/ABA-Telehealth	INITIAL	1/20/2026
Thompson	Candice	Specialist	INITIAL	1/20/2026
Thompson	Nicole	BH/ABA-Telehealth	INITIAL	1/20/2026
Thurman	Marquita	BH/ABA	INITIAL	1/20/2026
Tong	Shuyi	Ancillary	INITIAL	1/20/2026
Torcedo	Abigail	BH/ABA-Telehealth	INITIAL	1/20/2026
Torrez	Cassandra	BH/ABA-Telehealth	INITIAL	1/20/2026
Tse	Tonia	BH/ABA-Telehealth	INITIAL	1/20/2026

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Uhm	Suji	Specialist	INITIAL	1/20/2026
Urbano	Myla	BH/ABA-Telehealth	INITIAL	1/20/2026
Uribe	Nancy	BH/ABA-Telehealth	INITIAL	1/20/2026
Valdez	Alexyss	BH/ABA-Telehealth	INITIAL	1/20/2026
Van Ihinger	Alicia	Allied Health	INITIAL	1/20/2026
Vasquez	Cecilia	BH/ABA-Telehealth	INITIAL	1/20/2026
Vela	Tommie	BH/ABA-Telehealth	INITIAL	1/20/2026
Vera	Danielle	BH/ABA-Telehealth	INITIAL	1/20/2026
Villanueva	Marina	BH/ABA-Telehealth	INITIAL	1/20/2026
Vincent	Thelmisha	BH/ABA-Telehealth	INITIAL	1/20/2026
Vinogradova	Daria	Doula	INITIAL	1/20/2026
Vu	Angela	Ancillary	INITIAL	1/20/2026
Walsh	Constance	BH/ABA-Telehealth	INITIAL	1/20/2026
Walton	Kristine	BH/ABA-Telehealth	INITIAL	1/20/2026
Watkins	Kaitlyn	Allied Health	INITIAL	1/20/2026
Watts	Sharron	Doula	INITIAL	1/20/2026
Waymyers	Ashley	BH/ABA-Telehealth	INITIAL	1/20/2026
Wendt	Jamie	BH/ABA-Telehealth	INITIAL	1/20/2026
Williams	Erica	BH/ABA-Telehealth	INITIAL	1/20/2026
Williams	Pamela	BH/ABA-Telehealth	INITIAL	1/20/2026
Wisk	Jayson	Specialist	INITIAL	1/20/2026
Wochaski	Kelsea	BH/ABA-Telehealth	INITIAL	1/20/2026
Woodard	Theodore	BH/ABA-Telehealth	INITIAL	1/20/2026
Woods	Christine	Ancillary	INITIAL	1/20/2026
Yaghoobians	Pauline	BH/ABA-Telehealth	INITIAL	1/20/2026
Yang-Vue	Linda	BH/ABA-Telehealth	INITIAL	1/20/2026
Yin	Ophelia	Specialist	INITIAL	1/20/2026
Yusuf	Khadra	BH/ABA-Telehealth	INITIAL	1/20/2026
Zaragoza	Alejandra	BH/ABA-Telehealth	INITIAL	1/20/2026
Zervoulakos	Paula	Allied Health	INITIAL	1/20/2026
Abdon	Jia Qi	Allied Health	RECRED	1/20/2026
Abraham	Jonathan	Specialist	RECRED	1/20/2026
Aldaz-Perry	Victoria	Allied Health	RECRED	1/20/2026
Anyanwu	Adaeze	BH/ABA-Telehealth	RECRED	1/20/2026
Apfel	Jessica	BH/ABA	RECRED	1/20/2026
Aramandla	Indulatha	BH/ABA	RECRED	1/20/2026
Assaf	Heftsi	BH/ABA-Telehealth	RECRED	1/20/2026
Bahrani	Milad	Primary Care Physicia	RECRED	1/20/2026
Baldwin	Dawnae	BH/ABA-Telehealth	RECRED	1/20/2026
Banh	Co	Specialist	RECRED	1/20/2026
Barokov	Julia	BH/ABA	RECRED	1/20/2026
Barrie	Stacey	Specialist	RECRED	1/20/2026
Bennett	Nancy	BH/ABA	RECRED	1/20/2026
Bhimji	Altaf	BH/ABA	RECRED	1/20/2026
Bi	Susanna	BH/ABA-Telehealth	RECRED	1/20/2026
Borgo	Talia	Allied Health	RECRED	1/20/2026
Bozorgmehr	Jafar	BH/ABA-Telehealth	RECRED	1/20/2026
Bui	David	Specialist	RECRED	1/20/2026
Cangelosi	Caroline	BH/ABA-Telehealth	RECRED	1/20/2026
Carney	Megan	BH/ABA	RECRED	1/20/2026
Carroll	Charkeia	BH/ABA	RECRED	1/20/2026
Chan	Jordan	BH/ABA-Telehealth	RECRED	1/20/2026
Chavez	Nancy	BH/ABA-Telehealth	RECRED	1/20/2026
Cheever	Karen	Allied Health	RECRED	1/20/2026
Chege	James	BH/ABA	RECRED	1/20/2026

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Chien	Lai	BH/ABA	RECRED	1/20/2026
Cuestas	Dominique	BH/ABA-Telehealth	RECRED	1/20/2026
Cummings	Kataunya	BH/ABA	RECRED	1/20/2026
Daniels	Tara	BH/ABA	RECRED	1/20/2026
Dasgupta	Sunavo	Specialist	RECRED	1/20/2026
Derentz	Ann	BH/ABA	RECRED	1/20/2026
Dos Santos Kellum	Silvia	Ancillary	RECRED	1/20/2026
Eugene	Lessie	BH/ABA-Telehealth	RECRED	1/20/2026
Finn	Joseph	BH/ABA-Telehealth	RECRED	1/20/2026
Forrester	Bailey	BH/ABA-Telehealth	RECRED	1/20/2026
Gagnon	John	BH/ABA-Telehealth	RECRED	1/20/2026
Gangopadhyay	Thien	Allied Health	RECRED	1/20/2026
Garcia	Alexandria	BH/ABA-Telehealth	RECRED	1/20/2026
Gee	Garwood	Specialist	RECRED	1/20/2026
Holzapfel	Corbin	BH/ABA-Telehealth	RECRED	1/20/2026
Koo	Edward	BH/ABA	RECRED	1/20/2026
Kung	Evelyn	BH/ABA-Telehealth	RECRED	1/20/2026
Lam	Jenny	BH/ABA	RECRED	1/20/2026
Le	Amanda	Primary Care Physicia	RECRED	1/20/2026
Le	Kevin	BH/ABA	RECRED	1/20/2026
Lee	Thomas	Specialist	RECRED	1/20/2026
Leon-Martinez	Daisy	Specialist	RECRED	1/20/2026
Levine	Richard	BH/ABA	RECRED	1/20/2026
Longwell	Kathleen	BH/ABA	RECRED	1/20/2026
Lopez	Darien	BH/ABA-Telehealth	RECRED	1/20/2026
Lopez	Mia	BH/ABA-Telehealth	RECRED	1/20/2026
Lujan Perales	Alfredo	BH/ABA-Telehealth	RECRED	1/20/2026
Lukas	Brian	BH/ABA	RECRED	1/20/2026
Lull	Kelli	BH/ABA-Telehealth	RECRED	1/20/2026
Macalisang	Ma. Juim	BH/ABA	RECRED	1/20/2026
Magbiray	Sheena	BH/ABA-Telehealth	RECRED	1/20/2026
Maharaj	Amanda	Ancillary	RECRED	1/20/2026
Maharjan	Deenu	Primary Care Physicia	RECRED	1/20/2026
Malasky	Cynthia	BH/ABA	RECRED	1/20/2026
Marasigan-Paset	Jiarra	BH/ABA-Telehealth	RECRED	1/20/2026
Marchman	Danielle	BH/ABA	RECRED	1/20/2026
Markle	Donald	BH/ABA-Telehealth	RECRED	1/20/2026
Mayen	Vanessa	Allied Health	RECRED	1/20/2026
McFarland	Nancy	BH/ABA-Telehealth	RECRED	1/20/2026
Merchant	Reema	BH/ABA	RECRED	1/20/2026
Michel	Efrain	BH/ABA	RECRED	1/20/2026
Moni	Caleb	BH/ABA-Telehealth	RECRED	1/20/2026
Montague	Kelly	BH/ABA	RECRED	1/20/2026
Mukherjee	Uday	BH/ABA	RECRED	1/20/2026
Myers	Norma	BH/ABA	RECRED	1/20/2026
Nameth	Danielle	Primary Care Physicia	RECRED	1/20/2026
Nevin	Alyssa	Allied Health	RECRED	1/20/2026
Nguyen	Georgina	BH/ABA	RECRED	1/20/2026
Nguyen	John	BH/ABA-Telehealth	RECRED	1/20/2026
Nirva	Nicole	BH/ABA-Telehealth	RECRED	1/20/2026
Nolan	Patrick	BH/ABA-Telehealth	RECRED	1/20/2026
Ordone	Monique	BH/ABA	RECRED	1/20/2026
Orlino	Jon Christopher	Specialist	RECRED	1/20/2026
Patel	Divyang	Specialist	RECRED	1/20/2026
Peace	Elizabeth	BH/ABA-Telehealth	RECRED	1/20/2026

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RECRED	CRED DATE
Prasad	Sudeepthi	Specialist	RECRED	1/20/2026
Rahmany	Khalil	BH/ABA	RECRED	1/20/2026
Rajalakshmi	Shruthi	BH/ABA-Telehealth	RECRED	1/20/2026
Ralston	Scott	BH/ABA	RECRED	1/20/2026
Rasmussen	Angela	BH/ABA-Telehealth	RECRED	1/20/2026
Redding	Tamisha	BH/ABA-Telehealth	RECRED	1/20/2026
Reyder	Julia	BH/ABA-Telehealth	RECRED	1/20/2026
Reynolds	Shawna	BH/ABA	RECRED	1/20/2026
Roberts	Shaneeeka	BH/ABA-Telehealth	RECRED	1/20/2026
Robertson	Elizabeth	BH/ABA	RECRED	1/20/2026
Rodriguez Vieyra	Nicolas	BH/ABA	RECRED	1/20/2026
Rossi	Gladys	BH/ABA	RECRED	1/20/2026
Rowley	Kimberly	BH/ABA-Telehealth	RECRED	1/20/2026
Rubio	Nadia	BH/ABA-Telehealth	RECRED	1/20/2026
Salmo	Samer	BH/ABA	RECRED	1/20/2026
Sanchez-Arvizu	Marian	BH/ABA	RECRED	1/20/2026
Schiff	Steve	Allied Health	RECRED	1/20/2026
Scoggins	Radiant	BH/ABA	RECRED	1/20/2026
Sepehrband	Shirin	BH/ABA-Telehealth	RECRED	1/20/2026
Sheppard	Barry	Specialist	RECRED	1/20/2026
Siguenza	Merari	BH/ABA-Telehealth	RECRED	1/20/2026
Smith	Sheila	BH/ABA-Telehealth	RECRED	1/20/2026
Srivatsa	Arun	Specialist	RECRED	1/20/2026
Stephens	Michael	BH/ABA	RECRED	1/20/2026
Stills	Nadirah	BH/ABA	RECRED	1/20/2026
Suresh	Sandhya	BH/ABA	RECRED	1/20/2026
Tamboli	Kavita	Ancillary	RECRED	1/20/2026
Ton-That	Matthew	Specialist	RECRED	1/20/2026
Torres	Janelle	BH/ABA-Telehealth	RECRED	1/20/2026
Tran	Xuananh	Specialist	RECRED	1/20/2026
Tukenmez	Denise	Specialist	RECRED	1/20/2026
Turner	Cassie	BH/ABA	RECRED	1/20/2026
Vargas	Jose-Guadalupe	BH/ABA	RECRED	1/20/2026
Vargas	Suzanne	BH/ABA	RECRED	1/20/2026
Veerappan	Annamalai	Specialist	RECRED	1/20/2026

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



PCP	10
SPECIALIST	24
ANCILLARY	25
ALLIED	29
<u>BH/ABA</u>	<u>165</u>
TOTAL	253

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2025-2026 | JANUARY 2026 OUTREACH REPORT

ALLIANCE IN THE COMMUNITY

FY 2025-2026 | JANUARY 2026 OUTREACH REPORT

Alliance in the Community Events and Activities:

In January 2026, the Alliance completed **636** member orientation outreach calls among net new and non-utilizer members and conducted **56** net new member orientations and **2** non-utilizer member orientations (**9%** member participation rate). In addition, the Outreach team completed **6** service requests, **3** community events, and **2** member education events. The Alliance reached a total of **918** people and spent a total of **\$5000.00** on donations, fees, and/or sponsorships at the following events and activities*: 2026 Chinatown 34th Lunar New Year Bazaar, Oakland Unified School District (OUSD) Special Education Resource Fair, Laney’s Welcome Back Week Resource Fair, 2026 Winter Job & Resource Fair for Unhoused and Wellness & Health Fair Event.

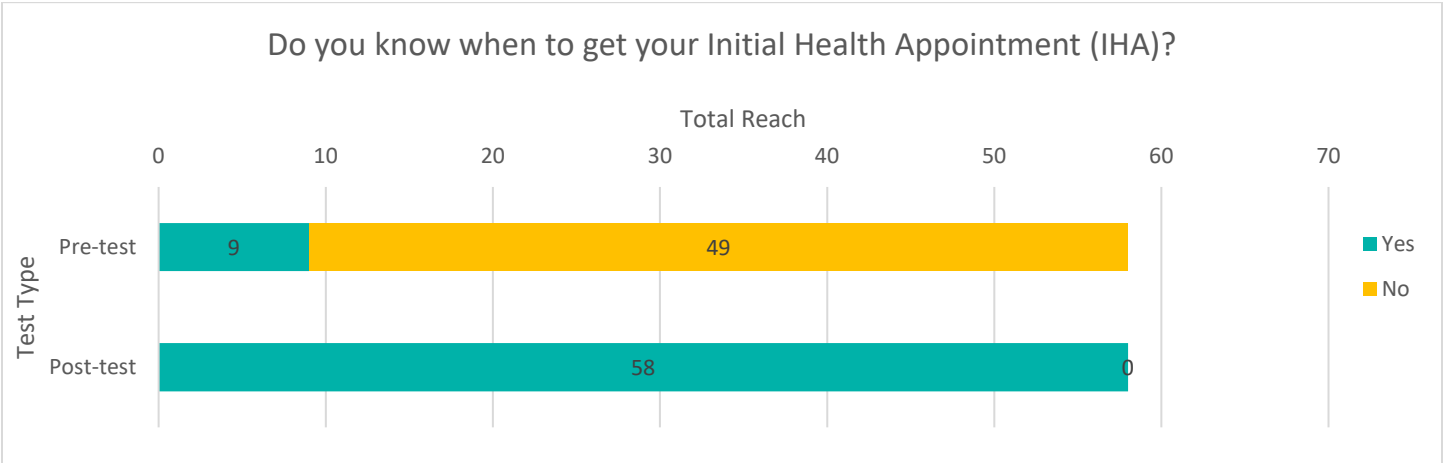
Since July 2018, **44,232** self-identified Alliance members have been reached during outreach activities.

Alliance Member Orientation Program:

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

On Wednesday, March 18, 2020, the Alliance began conducting member orientations by phone. As of January 31, 2026, the Outreach Team has completed **55,249** member orientation outreach calls and conducted **10,293** member orientations (**18.6%** member participation rate).

Between January 1, through January 31, 2026 (20 working days) – **58** members completed an MO by phone. After completing the MO, **100%** of members who completed the post-test survey in January 2026 reported knowing when to get their IHA, compared to only **15.5%** 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 25-26\Q3\January 2026**

ALLIANCE IN THE COMMUNITY

FY 2025-2026 | JANUARY 2026 OUTREACH REPORT

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	 Alameda Belmont Berkeley Castro Valley Dublin Emeryville Fremont Hayward Newark Oakland Pleasanton San Leandro San Lorenzo Union City 14 CITIES**	 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 TOTAL REACHED AT COMMUNITY TRAINING 1062 MEMBERS REACHED AT ALL EVENTS 1368 TOTAL REACHED AT ALL EVENTS	 \$650.00 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*
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FY 2025-2026 JANUARY 2026 TOTALS

 3 COMMUNITY EVENTS 2 MEMBER EDUCATION EVENTS 58 MEMBER ORIENTATIONS 0 MEETINGS/PRESENTATIONS 0 COMMUNITY TRAINING 5 TOTAL INITIATED/ INVITED EVENTS 63 TOTAL COMPLETED EVENTS	 Alameda Ashland Berkeley Castro Valley Dublin Fremont Hayward Newark Oakland San Diego San Leandro San Lorenzo Union City 13 CITIES**	 508 TOTAL REACHED AT COMMUNITY EVENTS 69 TOTAL REACHED AT MEMBER EDUCATION EVENTS 58 TOTAL REACHED AT MEMBER ORIENTATIONS 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS 0 COMMUNITY TRAINING 635 MEMBERS REACHED AT ALL EVENTS 976 TOTAL REACHED AT ALL EVENTS	 \$5000.00 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*
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**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.



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

Compliance

Richard Golfin III

To: Alameda Alliance for Health Board of Governors

From: Richard Golfin III, Chief Compliance & Privacy Officer

Date: February 13th, 2026

Subject: Compliance Division Report

Enterprise Audit Updates

- 2023 Department of Managed Health Care (DMHC) Health Equity and Quality Performance CAP
 - The Plan received the 2023 Health Equity and Quality Performance Findings Report from the Department of Managed Health Care (DMHC) on September 2nd, 2025. The Plan submitted its CAP response timely on December 1st, 2025. The Plan is awaiting DMHC's guidance.
- 2025 Department of Managed Health Care (DMHC) Routine Full Medical Survey
 - The Plan received the department's preliminary report on December 31st, 2025, identifying sixteen (16) findings, including two (2) repeat findings, across the following areas: Quality Assurance; Grievances and Appeals (repeat); Access and Availability of Services; Utilization Management; Prescription Drug Coverage (repeat); and Behavioral Health (SB 855). The Plan's CAP response is on track for February 14th, 2026, submission.
- 2025 Department of Managed Health Care (DMHC) Financial Examination
 - The DMHC conducted its fiscal survey of the Plan on August 4th, 2025. Following the Plan's CAP submission, the Department issued its final report on December 17th, 2025, identifying one (1) unresolved deficiency related to the oversight of forwarded claims.
 - The Plan submitted its follow-up CAP response on January 16th, 2026, which included drafts of the updated policies and procedures (pending Administrative Oversight Committee approval), along with the audit implementation dates. The Department confirmed receipt and is awaiting submission of the Plan's approved policies and procedures.
- 2025 Health Services Advisory Group (HSAG) Network Adequacy Validation (NAV)
 - On February 2nd, 2026, the Plan received the results of the 2025 Network Adequacy Validation, conducted by HSAG as required by DHCS. The Plan received "High Confidence" ratings for all applicable requirements, indicating that the network adequacy data and methodology were accurate, reliable, and

free of significant bias. All elements were found to be fully compliant, with no findings, deficiencies, or corrective actions identified. No follow-up action is required.

- 2026 Department of Health Care Services (DHCS) Routine Survey
 - The Plan received the audit notification from DHCS on December 8th, 2025. The audit will be conducted virtually from March 2nd, through March 13th, 2026, and will cover the review period of March 1st, 2025, through December 31st, 2025.
 - The Plan will be evaluated in the following areas: Utilization Management; Population Health Management and Coordination of Care; Network and Access to Care; Grievances, Appeals, and Member Rights; Quality Improvement and Health Equity Transformation; and Plan Organization and Administration.
 - The Plan submitted all Pre-Audit Information Requests by January 27th, 2026. Mock audit preparation interviews have been scheduled from February 3rd to February 13th, to prepare subject matter experts for the March interviews.

Compliance Program Activity

- Alameda Alliance Wellness (HMO D-SNP)
 - The Plan selected Knox Keene licensed specialty health plan, Vision Service Plan (VSP), as its vision services provider for both D-SNP and Medi-Cal lines of business. Both the Plan and VSP were required to submit Material modification e-Flings to the DMHC for approval. On January 22nd, 2026, DMHC sent comments. The Plan is currently collaborating with internal SMEs and VSP to prepare responses.
- Legislative & Regulatory Implementation (End of Year Initiatives)
 - On March 21st, 2025, the Plan provided its initial submission in response to the DMHC's 2024 Annual release of Newly Enacted Statutes – All Plan Letter (APL 24-023) filing. This APL includes seventeen (17) newly enacted statutes that impact the Plan's Medi-Cal and/or Group Care lines of business. The filing was closed by the Department on February 4th, 2026.
 - On December 19th, 2025, DMHC published APL 25-020 which provides guidance and outlines compliance requirements related to twelve (12) newly enacted statutes. The Compliance filing is due to DMHC on March 19th, 2026. The Compliance team is working with internal subject matter experts to prepare for this filing for timely submission.
 - On December 30th, 2025, DMHC published APL 25-021 which provides guidance and outlines compliance requirements related to SB 729 – Treatment

for Infertility and Fertility Services. The Compliance filing is due to DMHC on March 19th, 2026.

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

- Q4 2025 Privacy Team Executive Summary Report: HIPAA Incidents submitted to Richard Golfin III, Chief Compliance & Privacy Officer.
 - In Q4 2025, the Privacy Office saw a marked decline in incident volume and continued improvements in reporting timeliness and risk management. Twenty HIPAA incidents were logged, with no state or federal reportable breaches identified; the two matters sent to DHCS are being closed as non-breaches following four-factor risk assessments. Most incidents were low-risk, single-member events involving routine authorization or verification errors, misdirected communications, or unsecured emails that were contained without unauthorized disclosure. Although unsecured email events increased among certain providers and a business associate, internal controls detected and mitigated them promptly. Overall, Q4 results reflect stronger internal controls, better cross-departmental accountability, and a more proactive, risk-based privacy program.
- TriZetto Breach
 - On December 12th, 2025, the Plan Privacy Office was notified by CHCN of a cybersecurity incident involving OCHIN's downstream vendor, TriZetto Provider Solutions. An unauthorized actor accessed historical eligibility transaction reports from November 2024 to October 2nd, 2025, containing PHI such as names, dates of birth, member identifiers, Social Security numbers, and health insurance information. The impacted data resided in a vendor environment used by eight CHCN-affiliated Health Centers, which were acting as Covered Entities. As a result, CHCN and the Health Centers—not The Alliance—are responsible for all required notifications and breach reporting under DHCS Exhibit G. The Plan's role is limited to coordination and awareness, and the incident is being formally closed as a non-breach. CHCN continues to work with its Health Centers, legal counsel, and OCHIN on member segmentation, reporting templates, and any remaining obligations. The incident was reported to DHCS on December 12th, 2025, and the Plan will now request that DHCS close the matter as a non-breach.
- Statewide Privacy Collaboration Forum – Planning & Outreach Update
 - The Privacy Office launched outreach to organize an on-site Privacy Collaboration Forum in May, bringing together Privacy, Compliance, and Security leaders from California's public managed care plans for a full-day, peer-to-peer working session. The event is framed as a collaborative forum—not a conference—focused on shared challenges, best practices, and practical,

reusable solutions. Attendees were invited to help shape the agenda, propose topics, and volunteer as speakers.

- Privacy Training

- In January 2026, the Privacy Office delivered targeted privacy training for the Case Management team, reinforcing core HIPAA responsibilities, proper PHI access and use, and timely escalation of concerns. The session strengthened frontline awareness, aligned departmental practices with enterprise privacy standards, and reflected the program's proactive, prevention-focused approach to daily operations.
- In January 2026, the Privacy Office delivered targeted Privacy Responsibilities Training for the G&A team, emphasizing HIPAA awareness, timely escalation, and accurate identification of privacy incidents. The January 7th session focused on recognizing risk during grievance handling, proper escalation, and documentation standards. This quarterly training strengthens timely reporting, improves frontline risk detection, and reinforces the program's proactive, prevention-focused compliance approach.
- The Privacy Office presented at the January 2026 All-Staff meeting to reinforce organization-wide accountability for privacy and compliance. The session emphasized individual responsibility for safeguarding member information, early engagement with the Privacy Office, and viewing privacy as a proactive business partner. Leadership highlighted that privacy is embedded in daily operations across all departments, supporting a culture of prevention, transparency, and timely escalation.

Alameda Alliance Special Investigations Unit: Operational Updates

- Fraud, Waste, and Abuse Program Overview and Performance
 - The Special Investigations Unit (SIU) continues to investigate fraud, waste, and abuse referrals received through internal and external reporting channels.
 - In January 2026, the SIU received eleven (11) new referrals that were determined to be potentially FWA-related and reportable to DHCS.
 - The SIU continues to manage and report the seventy-one (71) active investigations carried into 2026 from the 2025 case load.
 - The SIU continues to enhance the reporting and case-identification tools implemented in 2025 to identify potential cases earlier in the review process, allowing for faster triage and prioritization of high-risk cases.
 - The cross-functional meetings with the SIU, Claims, Provider Services, Finance, and Analytics continued monthly to review high-risk patterns and ensure timely intervention and system improvements.

Enterprise Risk Management (ERM) and Operational Oversight Updates

- Enterprise Risk Management (ERM) continues to advance the development of the Alliance's Risk Taxonomy, including initial recommendations for risk ownership. ERM will continue to work across the organization to gather supporting facts and data for each identified risk, develop an initial risk ranking, and collaborate with key subject matter experts to validate and refine the risk assessment. This work is foundational to establishing a consistent, enterprise-wide view of risk.
- The Internal Audit (IA) Department continues to strengthen its operations and oversight capabilities. IA has recently updated its Policies and Procedures (P&P) and Standard Operating Procedures (SOPs) to align with updated processes. In addition, IA is finalizing enhanced reporting to improve visibility into audit activity, corrective action progress, and key metrics. IA has also begun formal monitoring efforts and is seeking access to critical reports and data in higher-risk areas to support ongoing oversight.

Compliance

Supporting Documents

COMPLIANCE DASHBOARD SUMMARY												
OVERALL FINDINGS	Resource	Type									TOTAL	% Completed
			2018	2019	2020	2021	2022	2023	2024	2025		
	DHCS	Total State Audit Findings	38	28	7	33	15	24	20	0	165	
		Total Self-Identified Issues	12	0	0	2	0	2	6	3	25	
		Total Findings	50	28	7	35	15	26	26	3	190	
		Total In Progress	0	0	0	0	0	3	4	2	9	95%
		Total Completed	50	28	7	35	15	23	22	1	181	
		Total Findings	50	28	7	35	15	26	26	3	190	
	DMHC	Total State Audit Findings			5	6	8	3		TBD	22	
		Total Self-Identified Issues			3	0	0	0		6	9	
		Total Findings			8	6	8	3		6	31	
		Total In Progress			0	0	0	3		6	9	71%
		Total Completed			8	6	8	0		0	22	
		Total Findings	NA	NA	8	6	8	3	NA	TBD	31	
DMHC Financial Services	Total State Audit Findings		5			4			2	11		
	Total Self-Identified Issues		0			0			0	0		
	Total Findings		5			4			2	11		
	Total In Progress		0			0			2	2	82%	
	Total Completed		5			4			0	9		
	Total Findings	NA	5	NA	NA	4	NA	NA	2	11		
STATE AUDIT FINDINGS		In Progress	0	0	0	0	0	9	4	2	15	92%
		Completed	38	33	12	39	27	18	16	0	183	
		Total Findings	38	33	12	39	27	27	20	2	198	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	0	9	9	74%
		Completed	12	0	3	2	0	2	6	0	25	
		Total Findings	12	0	3	2	0	2	6	9	34	
TOTAL OVERALL FINDINGS			50	33	15	41	27	29	26	11	232	

Compliance Dashboard Summary

COMPLIANCE DASHBOARD SUMMARY			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	198	85%
	Total Self-Identified Issues	34	15%
	Total Findings	232	
	Total In Progress	20	9%
	Total Completed	212	91%
	Total Findings	232	
STATE AUDIT FINDINGS	In Progress	15	8%
	Completed	183	92%
	Total Findings	198	
SELF-IDENTIFIED FINDINGS	In Progress	9	26%
	Completed	25	74%
	Total Findings	34	

2025 DMHC Fiscal Examination			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	2	100%
	Total Self-Identified Issues	0	0%
	Total Findings	2	
	Total In Progress	2	100%
	Total Completed	0	0%
	Total Findings	2	

Compliance Dashboard Summary

2025 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	0	0%
	Total Self-Identified Issues	3	100%
	Total Findings	3	
	Total In Progress	2	67%
	Total Completed	1	33%
	Total Findings	3	

2025 DMHC Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	0	0%
	Total Self-Identified Issues	6	100%
	Total Findings	6	
	Total In Progress	6	100%
	Total Completed	0	0%
	Total Findings	6	

Compliance Dashboard Summary

2024 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	20	77%
	Total Self-Identified Issues	6	23%
	Total Findings	26	
	Total In Progress	4	15%
	Total Completed	22	85%
	Total Findings	26	

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

Compliance Dashboard Summary

2023 DHCS Focused Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	9	100%
	Total Self-Identified Issues	0	0%
	Total Findings	9	
	Total In Progress	3	33%
	Total Completed	6	67%
	Total Findings	9	

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

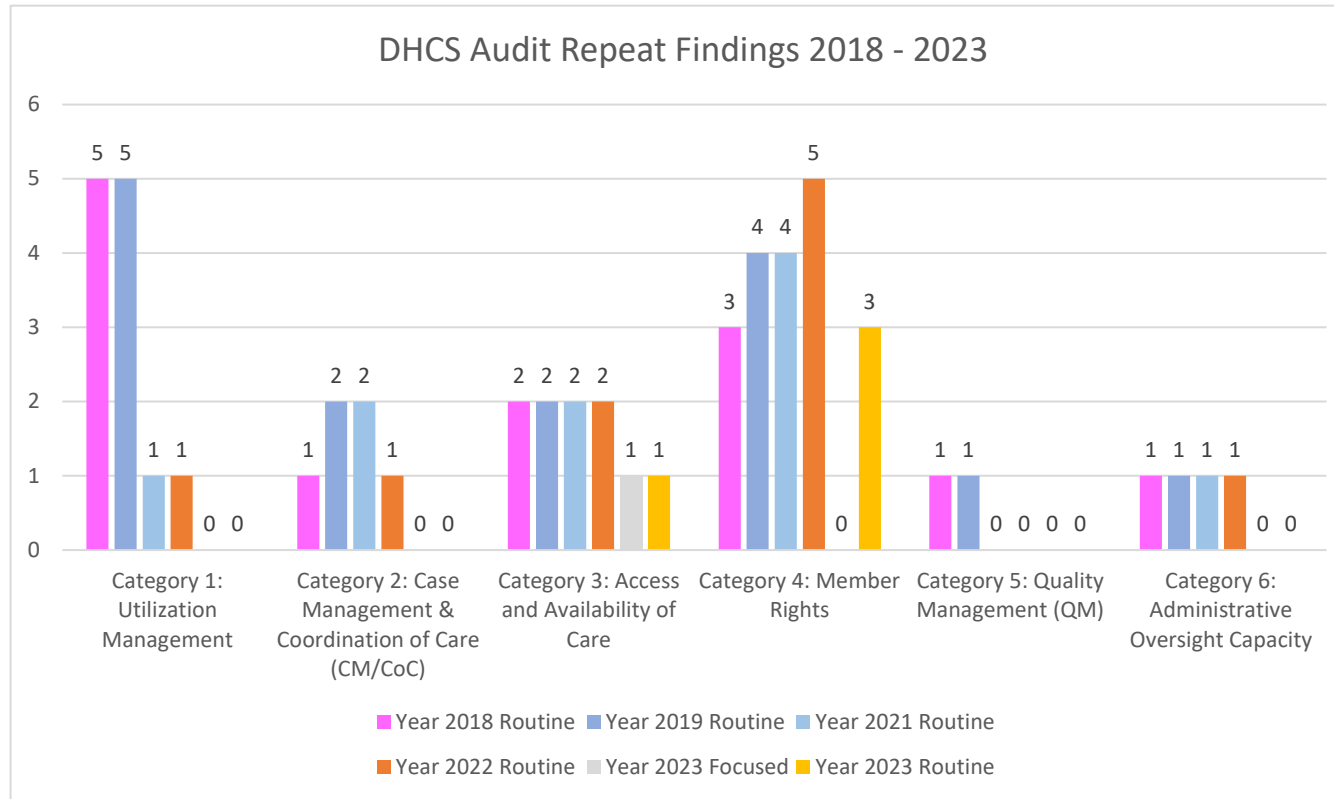
2018 DHCS Medical Services Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	38	76%
	Total Self-Identified Issues	12	24%
	Total Findings	50	
	Total In Progress	0	0%
	Total Completed	50	100%
	Total Findings	50	

Compliance Dashboard Summary

DHCS Audit Repeat Findings 2018 - 2023

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

Compliance Dashboard Summary

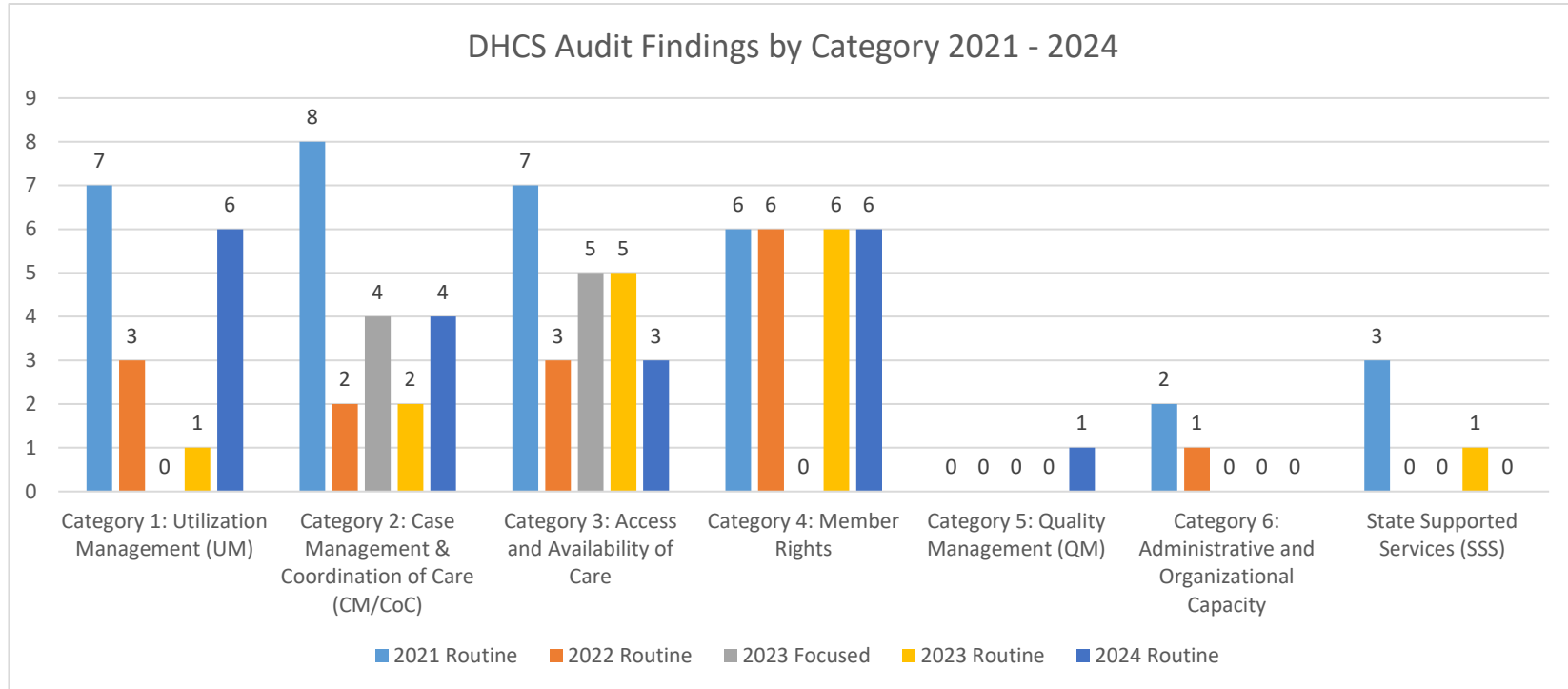


Compliance Dashboard Summary

DHCS Audit Findings by Category 2021 - 2024

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

Compliance Dashboard Summary



DHCS Repeat Findings by Year 2018 - 2023

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

**ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD**

KEY

Yellow = Plan Observations

Orange = Plan Observations (Not Included in the Preliminary Report)

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

R = Repeat Findings

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

#	Category	Preliminary Findings
1	Finance	The Department's examination disclosed that the Plan failed to pay interest on late claim payments related to Targeted Provider Rate Increases (TRI) issued after December 31, 2024. On June 20, 2024, The California Department of Health Care Services (DHCS) issued an All-Plan Letter (APL) 24-007 instructing Medi-Cal managed care plans to "achieve full compliance with this APL by December 31, 2024," including retroactive payment adjustments. Claim payments issued by the Plan after December 31, 2024, related to the TRI did not include interest on the late payments.
2	Finance	The Department's examination disclosed that the Plan failed to follow up with its capitated providers on two claims forwarded by the Plan to the capitated providers. The Plan did not check the status of the forwarded claims with the capitated providers, nor did it keep any records to indicate whether these forwarded claims were received and processed by the capitated providers. The Department's examination also indicated that the Plan does not have written policies and procedures to ensure that claims forwarded to the Plan's capitated providers are processed in compliance with the requirements of Sections 1371, 1371.35, and Rule 1300.71.

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2025 DHCS Audit - Audit Review Period 6/1/2024 - 2/28/2025 Audit Onsite Dates - March 3, 2025 to March 7, 2025							
#	Category	DHCS Exit Conference March 20,2025	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status
1	UM	(1.6.1) The Plan did not ensure that a medical director, or licensed physician acting on behalf of the Plan’s medical director, reviewed post-stabilization authorization requests to determine medical necessity of post-stabilization care services.	Medical Directors are available 24 hours a day, seven days a week. There is an on call Medical Directors schedule maintained to ensure there is always a Medical Director on call.	8/1/2025	Completed	UM	
2	UM	The Plan did not consistently obtain timely authorization for medically necessary Post Stabilization Care, or ensure contractors' compliance with APL 23-009.	The UM team has revised operational workflow to include in the process the input of a note and authorization in the clinical information system at the same time a post-stabilization request is received outside of business hours.	TBD	In progress	UM	
3	UM	The Plan did not transfer out-of-network hospitalized members to in-network providers as required.	Alliance contracted and non-contracted hospitals do have 24-hour access to the Alliance UM department to make authorization requests, and medical directors and RNs are available to facilitate the process to transfer to an in-network provider from the ER as needed.	TBD	In progress	UM	

ALAMEDA ALLIANCE FOR HEALTH
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2025 DMHC Audit - Audit Review Period 10/1/2022 - 9/30/2024 Audit Onsite Dates - March 3, 2025 to March 7, 2025					
#	Category	Plan Observations	Corrective Action Plan (CAP)	Completion Date	Department Responsible
1	Compliance	Corrective Action Plan (CAP) tracking, monitoring, and management.	The Plan's Compliance Team has enhanced its CAP form to facilitate a more efficient and streamlined review process. CAP items incorporated into meetings with delegates and subcontractors, ensuring thorough follow-up and reinforcing monitoring efforts. Additionally, the DO team oversees annual and ad hoc audit CAPs, reporting them to SDOC for review and closure, further strengthening compliance oversight. Finally, the DO team will conduct training for SMEs on CAP verification and monitoring, ensuring a timely and thorough review process.	Already in Place Already in Place Already in Place TBD	Compliance
2	UM	Communication and notification process for decision letters, delay notices, and notification letters.	UM departments have P&Ps that detail our notification processes, including the required timeframes, content, and enclosures for all letters.	Already in Place	UM
3	UM	Utilization Management policy and procedures regarding 24 hour, seven day a week availability for urgent / emergent requests regarding members.	Currently, Plan contracted and non-contracted hospitals do have 24-hour access to the Alliance UM department to make authorization requests through on-call Plan RNs and MDs.	Already in Place	UM
4	Grievance and Appeals	Appeal process for terminally ill members	Grievance and Appeals has policy and procedure for accepting and resolving expedited appeals.	Already in Place	UM G&A
5	Access and Availability	Accuracy of provider network and directory information	Provider Services has in place a process to proactively outreach to providers to verify provider directory information as well as what steps to take when provider directory inaccuracies are reported.	Already in Place	Provider Services
6	Member Rights	Monitoring of calls and member services for expressions of dissatisfaction.	The Member Services Department has a process in place to monitor calls to ensure all expressions of dissatisfaction are appropriately identified.	Already in Place	Member Services G&A

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2024 DHCS Audit - Audit Review Period 6/1/2023 - 5/31/2024 Audit Onsite Dates - June 17, 2024 - June 28, 2024							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency
1	UM	(1.2.1) Referral to Transplant Program Within 72 Hours The Plan did not directly refer an adult member to a transplant program for evaluation within 72 hours of the member's specialist identifying the member as a potential candidate for MOT.	1. The Plan's Standard Operating Procedures (SOP) were updated to reflect the 72 hours MOT TAT and all UM staff were re-trained on 6/20/2024. 2. The UM team instituted a formal internal review process to ensure all operating procedures align with Policy & Procedures. A Standard Operating Procedures (SOP) was developed and staff were trained on the internal review process. 3. Policy & Procedure Tracker developed to ensure at least annual and ad-hoc updates to P&Ps are monitored and aligned with regulatory guidance. The Plan monitors MOT turnaround times via daily operational reports.	1/15/2025	Completed	UM		State	DHCS
2	UM	(1.2.2) Centers of Excellence (COE) for Major Organ Transplants The Plan did not ensure that all MOT procedures were performed in a Medi-Cal approved COE transplant program. The Plan did not confirm that its COEs were unable to perform a MOT surgery before arranging the MOT at a transplant program that is not a Medi-Cal approved COE.	1. On 6/27/2024 The Plans Medical Directors were notified that Bone Marrow Transplant (BMT) and other regulatory Major Organ Transplants (MOT) are only managed in-network unless Continuity Of Care (COC) or related to urgent/emergent hospitalization. In addition, The Plan took the following actions: On 6/27/2024 the MOT workflows were updated to include Chief Medical Officer (CMO) Denial oversight. On 8/14/2024 The Plan conducted Delegate training for the new CHCN Medical Director and CHCN Utilization Management Director. On 8/1/2024 a copy of the current DHCS Centers Of Excellence list was distributed to staff. The Plan updated policy UM-071 and submitted to Utilization Management Committee on 8/30/2024. 2. The Plan updated Standard Operating Procedures to include DHCS Center Of Excellence requirements. 3. The UM team instituted a formal internal review process to ensure all operating procedures align with Policy & Procedures. A Standard Operating Procedures was developed, and staff were trained on the internal review process. <u>Update 2/15/2025:</u> Operation Major Organ Transplant reported created and being used to monitor the appropriate use of Medi-Cal COEs.	4/15/2025	Completed	UM		State	DHCS
3	UM	(1.3.1) Written Member Consent The Plan did not obtain members' written consent when providers requested appeals on behalf of members.	1. The Plan updated G&A-008 Adverse Benefit Determination Appeal Process to meet the requirements of Member Written Consent in accordance with The Plan's DHCS contract. The workflow was updated and staff training completed on 11/6/2024 2. Internal audits for requirement of written member consent started in January 2024 and will continue.	4/15/2025	Completed	G&A		State	DHCS
4	UM	(1.3.2) Appeals Letters: Nondiscrimination Notice (NDN) and Language Assistance Taglines (LAT) The Plan did not send NDN and LAT information that met the minimum requirements in APL 21-004 with member notifications for appeals.	1. CLS-003 Non-discrimination Language Assistance Services and Effective Communication for Individuals with Disabilities has been submitted and accepted by the MCO. 2. The Your Rights Package was updated with the current Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT). The NDN and LAT were added to the Member Rights package and updated in the G&A system. 3. The G&A Department in conjunction with the Compliance Department will review all enclosures on an annual basis to ensure compliance. G&A is completing an Internal Audit SOP that outlines the self monitoring / internal audit process. <u>5/9/2025:</u> G&A completed an internal audit Standard Operating Procedure (SOP) the outlines the self-monitoring / internal audit process. In addition, a focused audit tool that identifies NDN and LAT information has been implemented for internal monitoring to ensure that the NDN and LAT information is correct.	4/15/2025	Completed	G&A	✓	State	DHCS

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R = Repeat Findings

2024 DHCS Audit - Audit Review Period 6/1/2023 - 5/31/2024 Audit Onsite Dates - June 17, 2024 - June 28, 2024							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency
5	UM	(1.5.1) Overutilization of Subacute Level of Facility Care The Plan did not ensure that its delegate had mechanisms to detect overutilization of subacute level of facility care; the delegate inappropriately approved higher levels of subacute care for members who required lower levels of regular skilled nursing facility care.	1. The delegate reports over/under-utilization measures in their quarterly HICE report. The Plan has instituted a Standardized Operating Procedure that delineates roles and responsibilities for reviewing delegate reports, including a formal sign-off process, to be used in conjunction with P&P UM-060 Delegation Management and Oversight. 2. The Plan will request the delegate include post-acute cases in their annual UM audit universe and monthly internal UM audit reports. <u>Update 1/15/2025</u> : The Plan received the delegate's internal UM audit report submission on 12/27/2024 and completed a review of the delegate's audit results on 12/31/2024, and noted adequate strategies to address findings. 3. The Plan has requested the delegate include nursing facility utilization as part of their over/under utilization measures, reported in the Quarterly HICE report (auth volume by facility levels of care). The Q4 2024 HICE report is pending. <u>Update 5/9/2025</u> : The Q4 2024 HICE report has been submitted to the Plan for review that overutilization is being monitored. 4. The Plan shares all newly issued DHCS APLs and guidance, including billing instructions related to revenue codes, and collects attestations from delegates <u>Update 7/11/2025</u> : The Plan confirmed attestations for APLS 24-009 and 24-010 were received from the delegate and all revenue codes have been implemented	7/11/2025	Completed	UM		State	DHCS
6	UM	(1.5.2) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services The Plan did not ensure that its delegate provided medically necessary EPSDT services, care coordination, and appointment scheduling assistance to members under the age of 21.	1. The delegate created a new policy and procedure specific to EPSDT care coordination. This policy will be reviewed by the delegate's internal committee on 1/22/2025 and then the policy will be submitted to the Plan for review. <u>5/9/2025</u> : The Policy for EPSDT Services has been finalized. 2. The Plan requested the delegate identify EPSDT cases in their monthly internal Case Management audit reports, as well as identifying EPSDT cases in their annual UM audit universe and monthly internal UM audit reports. The Plan will audit EPSDT cases to evaluate whether members are receiving appropriate EPSDT services, care coordination, and appointment scheduling as needed. <u>Updated 1/15/2025</u> : The Plan received confirmation that the delegate updated their internal audit tool to include the appropriate EPSDT elements. The Plan will review the delegate's next internal audit to verify use of the revised audit tool. <u>Update 2/15/2025</u> : The Plan received the delegate's internal audit tool and has confirmed it reflects the EPSDT elements were added appropriately. 3. The Plan will report the delegate's CM and UM audit outcomes at the UM Committee, upon receipt of reports. <u>Update 7/11/2025</u> : The delegate's audit tool was revised for EPSDT elements and an audit was completed by the delegate and reviewed by the Plan for March. The Plan will continue to monitor new EPSDT audit elements.	7/11/2025	Completed	UM		State	DHCS
7	CM and CoC	(2.1.1) Provision of Blood Lead Screening The Plan did not ensure that blood lead screening tests were conducted for members up to six years of age.	1. The Plan updated Policy QI-125 to include a requirement for providers to follow up on lab orders. Policy QI-125 will be approved in Quality Committee by 2/30/2025 and the Administrative Oversight Committee by 4/16/2025. 2. Funding for point-of-care testing units was provided in January 2024 to the delegate. These units aim to eliminate the need for members to make an additional visit to the lab. The Plan conducted member outreach and member incentives; members were offered a gift card to complete their services at the lab. 3. The Plan continues to monitor the HEDIS lead screening rates. Monitoring includes tracking of the documentation of lead level results by providers for ordered blood lead tests and any necessary follow-up activities and services for members, which is done through IHA audits and facility site reviews. 4. The Plan has conducted provider education through webinars, 1:1 meetings, CLPP training 1) Healthcare Services All-Staff meeting, 2) Provider webinar (live) and video (posted on Alliance website) and Measure Highlight tools. 5. The Plan previously conducted annual IHA audits to review provider charts for completion of preventive screenings. The frequency of these audits has now increased to twice a year. Additionally, during Facility Site Reviews (FSRs), charts are monitored for lead screening compliance. An audit is conducted for Blood Lead Screening, and charts are reviewed for evidence of discussion, orders/refusal and results. When evidence of lead screening is not found, the Plan sends education letters to providers indicating the discrepancy. <u>Update 2/15/2025</u> : The Plan conducted an IHA audit Q3 2024 for IHA period 10/1/2023-05/31/2024. 6. Lead screening rates and IHA results are revied at the Quality Improvement Health Equity Committee meetings. <u>Update 5/9/2025</u> : The IHA audit was completed for Q3 2025	In Progress	Completed	QI		State	DHCS

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9	CM and CoC	(2.3.1) Provision of Behavioral Health Therapy (BHT) Services The Plan did not ensure the provision of BHT services in accordance with approved BHT treatment plans for members under the age of 21.	1. The Plan's existing policies support BHT services in accordance with BHT plans for members under the age of 21. The Plan insourced BHT services on 4/1/23 with the goal of increasing member access to care. The Plan has a dedicated team of care coordinators and BCBA's to support access to care. The Plan continues to explore opportunities to improve access to BHT care. This includes interventions to enhance the network and incentivize agencies to prioritize AAH members for services. The Plan continues to authorize out-of-network services whenever possible. 2. The Plan authorizes care within the required timeframes as requests are received. To monitor this issue, The Plan has established a metric to track the number of authorized hours to bill services. This functions as an indicator of the need for additional provider resources. This is a continuous process that started 5/10/2024. The Plan has ongoing efforts to onboard and contract additional BHT/ABA providers as additional resources are necessary. A monitoring and reporting process has been put in place to show the monthly authorized services for each member receiving BHT/ABA Treatment and for each QASP. The plan compares the # of authorized hours of BHT/ABA to the # of hours delivered based on claims data to monitor, track and report the % of authorized hours that are delivered. The plan reports these findings to the UM committee and identifies the QASPs with the lowest delivered services for outreach and intervention. <u>Update 5/9/2025</u>: Member utilization reports are being reviewed to measure utilization rates. The Plan works with providers who have low utilization to identify gaps or barriers preventing the fulfillment of authorized hours. <u>Update 7/11/2025</u>: Training for updated BHT-ABA Forms was completed on 4/30/2025 and BHT Utilization is being reported out at UM Committee. 3. The Plan has drafted parent advisement that is scripted and provided to each parent/guardian when BHT/ABA services are authorized that asks for parents/guardians to call the Alliance BHT/ABA case management team if they experience disruption or barriers in receiving the BHT/ABA services that have been authorized for their child.	7/11/2025	Completed	Behavioral Health		State	DHCS
8	CM and CoC	(2.3.2) Timely Access to Behavioral Health Therapy (BHT) Services The Plan did not arrange and coordinate BHT services for members under the age of 21 within 60 calendar days.	1. The Plan established an EPSDT Policy & Procedure QI-135. The Plan established care coordination guidelines for staff providing care coordination with expectations. The Plan has a dedicated team of care coordinators and BCBA's to support access to care. The Plan has increased staffing to better support member' access to care. 2. BH Navigators are required to conduct monthly follow-up with parents or guardians to inform them of the status of Mental Health (MH), Behavioral Health Treatment (BHT), or Comprehensive Diagnostic Evaluation (CDE) referrals. This process ensures timely communication and continuity of care for families. 3. Mandatory training was provided to the BH Navigators with written standard work. 4. The Plan is developing a report that will be utilized in an ongoing manner to monitor compliance with current case management protocols and DHCS requirements. The implementation is scheduled for the end of the first quarter of 2025. <u>Update 2/15/2025</u>: Fields are undergoing validation to ensure accuracy with a goal to have a functional report ready by March 31, 2025 for monitoring and oversight. <u>Update 5/9/2025</u>: Draft Caregiver Update Report created that outlines criteria and dashboard. <u>Update 7/11/2025</u>: SOP created for monitoring and auditing process for timely caregiver updates 5. BH will conduct biweekly reviews to confirm that follow-ups are performed consistently and on-schedule. Feedback loops will be established to address any barriers encountered during follow-ups and adjust the protocol accordingly. BH Navigators will undergo mandatory training to reinforce the importance of consistent monthly follow-ups, effective communication with parents, and accurate documentation. <u>Update 5/9/2025</u>: The standard operating procedure for the monitoring and auditing process for timely caregiver updates has been created. <u>Update 7/11/2025</u>: The monitoring and auditing report has been successfully deployed and is now utilized for monitoring and oversight.	7/11/2025	Completed	Behavioral Health		State	DHCS
10	CM and CoC	(2.4.1) Notice of Action (NOA) Letters for Continuity of Care (COC) Requests The Plan did not ensure that NOAs for COC requests that were sent to members contained a clear explanation of the reason for the denial decision.	1. Policy UM-054 Notice of Action supports the process to ensure NOAs contain clear explanations of denial reasons. SOPs were updated to reflect utilization of new CoC NOA in a single letter, Medical Directors were trained, and all impacted staff were notified on 8/14/2024. 2. The Plan will include CoC denial notices in the monthly operational NOA audits, reported quarterly at UMC. <u>Update 5/9/2025</u>: Two CoC audit tools have been created to monitor appropriate processing of the CoC requests, which includes a review of NOAs, and a more specific audit tool to look at each element of the NOA. <u>Update 7/11/2025</u>: Policies have been updated to correspond with the monthly audits, and regular monitoring and oversight are now in process.	7/11/2025	Completed	UM		State	DHCS

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11	Access and Availability	(3.1.1) Appointment Waitlist Timeliness The Plan did not ensure members were able to obtain medically necessary appointments within established timely access standards. One of the Plan's medical groups placed members on an appointment waitlist and had members waiting up to six months to make an appointment.	1. The Plan worked with the provider to close their panel in September, preventing additional wait listed members. (9/1/2024). The Plan met with the provider related to access in an On-going manner during Joint Operating Meetings (JOM) and Plan/provider Access Meetings. The provider actively outreached to members on the wait list. Progress reports were reviewed at Plan/provider Access meetings. In September 2024 the provider brought in two new providers to support with provider wait list. In review of grievances data, the number of grievances declined for timely access at this provider's location. The Plan has implemented QI initiatives to improve access to care, including pay for performance (P4P), extended office hours incentives and provider recruitment/retention incentives (AAH provider grant live as of 6/1/2024). 2. Provider access data shows outreach efforts have been effective in getting new members schedule for appointments and off the waitlist. The Plan is working on outreach reports from the provider to show continues self-monitoring as well as written procedures to support. Update 5/9/2025: Outreach reports have been obtained from the provider, and an analysis of grievance data for this provider show that timely access related grievances have declined.	4/15/2025	Completed	QI		State	DHCS
12	Access and Availability	(3.1.2) Monitoring In-Office Wait Times for Specialty and Behavioral Health Services The Plan did not monitor in-office wait time for specialists and behavioral health providers.	1. The Plan added in-office wait times measure to CG-CAHPS survey for BH providers on 5/6/2024. The finalized report was presented at the Access & Availability Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025. The final report is expected to be completed by Q2, 6/30/2025 QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of in-office wait times for specialist and behavioral health providers.	4/15/2025	Completed	Behavioral Health		State	DHCS
13	Access and Availability	(3.1.3) Monitoring Telephone Calls for Specialty and Behavioral Health Services The Plan did not monitor wait times for specialty and behavioral health providers to answer and return telephone calls.	1. The Plan added telephone wait times measure to CG-CAHPS survey for BH providers. The finalized report was presented at the Access & Availability Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025. The final report is expected to be completed by Q2, 6/30/2025. QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of telephone wait times for specialist and behavioral health providers	4/15/2025	Completed	Behavioral Health		State	DHCS
14	Member Rights	(4.1.1) Grievances Involving Clinical Issues The Plan did not ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues.	1. Policy G&A-003 Grievance and Appeals Receipt, Review, and Resolution was updated to require grievances with clinical issues, such as access or QOS grievances with clinical issues, to be resolved by the Medical Director. 2. The G&A Department will provide additional training to ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues. The Timeline will also need to be updated to include the contractual language. Update 5/9/2025: Training was completed in February 2025. 3. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for grievances involving clinical issues is being met. Update 5/9/2025: Internal audits were started in February 2025. Update 7/11/2025: Internal audits are now in progress and findings are shared with the G&A supervisor for retraining and coaching 4. The G&A Department will provide an Internal Audit Standard Operating Procedure that outlines our self-monitoring/internal auditing processes. Update 5/9/2025: The SOP for the self-monitoring process was completed.	7/11/2025	Completed	G&A		State	DHCS
15	Member Rights	(4.1.2) Resolution of Grievances The Plan did not completely resolve the members' grievances.	1. The QA Grievance Audit Tool was reviewed to outline the future monitoring process to ensure that all grievances are resolved prior to being closed. 2. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for resolution of grievances is being met. Update 5/9/2025: Internal audits started in February 2025 Update 7/11/2025: Audits are continuing monthly and findings are shared with the G&A supervisor for retraining and coaching if needed	TBD	1. Completed 1/15/2025 2. In Progress 3. Completed 2/15/2025	G&A		State	DHCS
16	Member Rights	(4.1.3) Clear and Concise Resolution Letters The Plan's written resolution did not contain a clear and concise explanation of the Plan's decision.	1. The QA Grievance Audit Tool was reviewed to outline the future monitoring process to ensure that all grievances have clear and concise resolution letters prior to being closed. The G&A Department will provide additional training to ensure that the Plan's written resolution contains a clear and concise explanation. Update 5/9/2025: Internal audit tools and SOP governing the internal review were created. 2. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for Clear and Concise Resolution Letters is being met Update 5/9/2025: Internal audits started in February 2025. Update 7/11/2025: Audits are continuing monthly and findings are shared with the G&A supervisor for retraining and coaching if needed	TBD	1.Completed 2/15/2025 2. In Progress	G&A		State	DHCS

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17	Member Rights	(4.1.4) Grievance Letters: Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT) The Plan did not include updated NDN and LAT information with grievance acknowledgement and resolution letters.	1. Current LAT and NDN were added to the Member's Rights package and updated in the G&A system. 2. The G&A Department in conjunction with the Compliance Department will review all enclosures on an annual basis to ensure compliance. <u>Update 5/9/2025</u> : Internal audits started in February 2025. <u>Update 7/11/2025</u> : Audits are continuing monthly and findings are shared with the G&A supervisor for retraining and coaching if needed	8/1/2025	Completed	G&A	✓	State	DHCS
18	Member Rights	(4.2.1) Monitoring of Linguistic Performance The Plan did not assess the performance of its vendors' staff that provided linguistic services such as interpreter services.	1. The Plan has completed updates of Policy and Procedure (P&P) CLS-011-CLS Program Monitoring to include additional language on monitoring information collected and reporting. The Plan anticipates approval date of the updated draft by Alliance Administrative Oversight Committee (AOC) for 4/16/2025. <u>Update 5/9/2025</u> : The updated policy CLS-011 was approved by AOC on 4/16/2025. 2. The Plan anticipates that updates to vendor contracts to include reporting requirements for vendor interpreter qualifications and cadence will be implemented by 3/31/2025. <u>Update 5/9/2025</u> : Reporting amendments for the contracts were submitted for the vendors 3. The Plan anticipates the implementation of monthly vendor interpreter qualifications reporting by 1/31/2025. The Plan anticipates implementation of a monthly attestation of monthly vendor interpreter qualifications review by 1/31/2025. The Plan will review and address concerns with vendor interpreter qualifications at Quarterly Vendor Joint Operations Meeting (JOM) by 3/31/2025. The Plan will report and address concerns with vendor interpreter qualifications at Quarterly Cultural and Linguistic Services Subcommittee (CLSS) meeting by 4/30/2025. <u>Update 5/9/2025</u> : The monthly reporting and attestation process has been implemented, and discussions began at JOMs in April.	7/11/2025	Completed	Cultural and Linguistic Services		State	DHCS
19	Member Rights	(4.3.1) Notification to DHCS The Plan did not notify DHCS within 24 hours upon discovery of any suspected breach or security incident, unauthorized access, use or disclosure of PHI or PI.	1. The Plan updated CMP-013 "HIPAA Privacy Reporting" in September 2024 to include verbiage addressing the gap that contributed to the audit finding: "Referrals must be made immediately upon discovery, and no later than 24 hours after." Additional updates included a Corrective Action section to address late referrals: "Corrective actions will be taken for delayed referrals, including but not limited to education, training, and / or Corrective Action Plans (CAP)." CMP-013 also states, "The Alliance will investigate the incident and submit an Initial Privacy Incident Report (PIR) to DHCS within 24 hours of discovery of a breach, suspected breach or security incident." Verbiage of Privacy Incident Investigation and Reporting Procedure updated to formalize education and corrective action for late referrals. 2. Implement new monitoring process to address the gap in referrals from G&A and internally within Compliance that contributed to the audit finding: "The Privacy Office will monitor the Compliance inbox, Compliance hotline, Privacy Compliance Inbox, and HealthSuite system for referral of any HIPAA Privacy reporting incidents. Each will be checked daily at minimum." 3. The Privacy Office is conducting weekly audits of HealthSuite referrals to ensure privacy concerns reported by members are appropriately categorized by the Member Services Department. Appropriate categorization will enable timely reporting of privacy incidents. <u>Update 7/11/2025</u> : Annual Plan wide training was completed, and ad hoc training and escalation is done in the case of late reporting. 4. The Plan will include review of the Internal Audit results at the Compliance Committee meetings.	7/11/2025	Completed	Compliance		State	DHCS

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20	Quality Management	(5.3.1) Notification of Provider Terminations The Plan did not meet DHCS reporting and member notification requirements for provider terminations.	1. The Plan will review and update the following impacted P&Ps as needed: PRV-005 & CRE-002. <u>3/14/2025</u> : PRV-005 was reviewed and confirmed the information was present in the policy and no additional updates were identified. 2. The Plan will provide an advisory to delegates and/or providers that delegated for credentialing functions about timely reporting requirements. <u>3/14/2025</u> : The Plan notified providers delegated for Credentialing functions about timely adverse termination reporting requirements by email and provided a PowerPoint Reminder Notice and a Adverse Reporting Template. In addition, the information was also shared with Teladoc during the Q1 2025 Joint Operations Meeting (JOM) on 02/04/2025. 3. The Plan conducts monthly review of the exclusion and suspension lists and this is an ongoing process that will support ongoing monitoring and the identification and reporting of adverse provider termination. This is ongoing. There are no changes to the Plan's provider notice templates and member notice templates. 4. The Plan's provider manual will be updated in Q1 2025. <u>Update 5/9/2025</u> : The provider manual was updated 5. The Plan will develop a log that will track Provider terminations, provider notification, and member notification including date of reports received and submitted to DHCS and date members were notified <u>Update 5/9/2025</u> : The log was completed. <u>Update 7/11/2025</u> : The Plan is now leveraging Potential Provider Terminations log and Adverse Event Report for tracking provider terminations 6. The Plan will develop a reporting template/instruction for Providers/Delegate/Subcontractor for reporting adverse terminations to the Plan. <u>2/15/2025</u> : The Plan has developed a reporting template that includes instructions on how to complete for providers/delegates to use when reporting adverse terminations. The information was shared with providers delegated for Credentialing functions on 02/07/2025. 7. The Plan will review the quarterly HICE Credentialing report and confirm against the adverse termination log to determine if provider suspended/termed for quality of care has been reported during the month of termination. During this review, if providers are identified as having been suspended or terminated due to quality of care, the Plan will confirm submission of the 805 report to DHCS. 8. The Plan will include review of the reports/logs during Subcontractor Delegation Oversight Committee meetings. 9. The Plan will include review of the Internal Audit results at the Compliance Committee meetings.	In Progress	1.Completed 4/15/2025 2. Completed 4/15/2025 3.Completed 4/15/2025 4. Completed 4/15/2025 5.Completed 4/15/2025 6. Completed 4/15/2025 7. In Progress 8. In Progress 9. In Progress	Operations		State	DHCS

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

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

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
7	NMT & NEMT	(3.3) Transportation Liaison The Plan did not have a direct line to the transportation liaison that it provided to providers and members, and the transportation liaison did not process authorizations after business hours. Recommendation: Revise and implement policies and procedures to ensure there is a direct line to the transportation liaison and authorizations are processed after business hours.	To improve member access to transportation services and ensure that after-hours authorizations are being properly handled, the Plan will implement the following measures: Inclusion of Transportation Liaison Contact Information: The Plan will include the transportation liaison's phone number in the member handbook and on the Health Plan's website. This will ensure that members have easy access to contact information for transportation-related inquiries and support. Reporting of After-Hours Trip Reservations: The Plan will require subcontractors to report any trip reservations that could not be completed or authorized during after-hours periods. This reporting requirement will help the Plan track issues and address them effectively. Follow-Up with Members: The Transportation Liaison and the Case Management Team will follow up with members regarding any issues related to trip reservations that were not completed or authorized after hours. This proactive approach will ensure that members receive the support they need and that any problems are resolved in a timely manner. <u>Update 12/13/2024:</u> On track and awaiting publication of the new edition of member handbook with liaison contact number. <u>Update 5/9/2025:</u> Member handbook and Providers Manual with liaison contact information published to public site.	4/9/2025	Completed	CM
8	NMT & NEMT	(3.4) <u>R</u> Physician Certification Statement Forms The Plan did not ensure that members had the required PCS forms for NEMT services, nor did the Plan ensure that PCS forms contained all required components. Recommendation: Implement policies and procedures to ensure PCS forms are on file for all members receiving NEMT services and that the forms contain all the required components.	1. The PCS form intake was insourced beginning 3/1/2023, and AAH staff was hired to coordinate the PCS form effort and transportation.	3/1/2023	Completed	CM
9	NMT & NEMT	(3.5) Ambulatory Door-to-Door The Plan did not ensure its delegate, provided the appropriate level of service for members requiring ambulatory door-to-door service. Recommendation: Revise and implement policies and procedures to ensure its delegate provides the appropriate level of service for members requiring ambulatory door-to-door service.	. Remediating this involves an Alliance policy update and additional training of our transportation vendor. The Transportation Vendor has training and oversight in place in the form of repeat random audits of their transportation providers. Since the 2023 audit, this process was updated by the transportation provider. Additionally, the Plan will participate in at least five (5) transportation trips per quarter with the broker to ensure door-to-door assistance is being provided when applicable. <u>Update 12/13/2024:</u> The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips. <u>Update 3/14/2025:</u> Q1 2025 field audit and training completed. No additional training was needed based on the observed field observations.	3/4/2025	Completed	Vendor Management

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

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	UM	(1.5.1) Notice of Action (NOA) Letters The Plan did not ensure a delegate sent NOA letters to providers and members.	The Plan received the delegate's Root Cause Analysis (RCA) and CAP on 04/14/2023. After review and evaluation of the delegate's document the Plan issued a formal CAP on 05/31/2023 and received the delegate's CAP response on 06/27/2023. The initial corrective actions completed by the delegate includes updating their IT script and ensuring the identified missing NOA letters were sent out to the members and that outreach was completed to confirm that services approved or had denial modification authorizations were utilized by members. The delegate also developed workflows to detect and mitigate failures. The CAP includes the delegate's implementation of a remediation plan. The remediation plan includes updates in their workflow, training, and an internal monthly audit- with results submitted to The Alliance for review. The Plan reviewed and evaluated the delegate's CAP implementation and progress during the interim and provided guidance. The CAP was approved and closed on 09/25/2023. (Completed) The delegate is expected to continue its internal monthly audit for the NOA letters and fax confirmation. The Plan will continue to monitor the audit results for compliance. Please see document 1.5.1_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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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
2	QI	(2.1.1) Provision of an Initial Health Assessment (IHA) The Plan did not ensure the provision of a complete IHA for new members.	1. Update IHA policy QI-124 (On Track) 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
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

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
5	Family Planning and State Supported Services	(3.6.1) Non-contracted Provider Payments The Plan did not pay non-contracted providers at the appropriate Medi-Cal fee-for-service rate.	A Change Request was entered to change non-contract mid-level providers reimbursements to 100% of the Medi-Cal rate moving forward. (Completed)	11/16/2023	Completed	Claims		State	DHCS	2023
6	Family Planning and State Supported Services	(3.6.2) Proposition 56 Family Planning Payments The Plan did not distribute add-on payments for institutional family planning service claims as required by APL 22-011.	1. P&P has been revised to ensure that Family Planning services paid on institutional claims are paid As part of Prop 56 payments. 1a. The Plan's Analytics Team is in the midst of preparing the payment details for the retro payment on the FP institutional data and looking to complete by 11/30/2023 timeline. (On Track) 2. The Analytics dept has calculated the retroactive payments due to facilities as a result of finding 3.6.2, APL 22-011 and APL 23-008. (On Track) 2a. Payments will be distributed to providers prior to or latest by Nov 30, 2023. (On Track) 2b. Facility providers with qualifying Family Planning services as per APL 23-008 will be included as part of our monthly Prop 56 payment processing going forward starting Dec 2023. (On Track)	1/15/2024	Completed	Claims		State	DHCS	2023
7	NMT & NEMT	(3.8.1) 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	Validation Status	State/Self Identified	Agency	Year
9	Member Rights	(4.1.1) R Grievance Acknowledgement and Resolution Letter Timeframes The Plan did not send acknowledgement and resolution letters within the required timeframes.	A grievance processing timeline was created to outline the grievance 30 calendar day process, day by day. The timeline outlines that by day 5, acknowledgement letters will be sent out. We will continue to monitor the daily aging report to ensure that acknowledgement letters are sent in a timely manner. The timeline also outlines that on Day 20, "If response is not received, after at least two follow-up attempts, task to a Medical Director in Quality Suite." Complying with this process will ensure that the Medical Director has sufficient time to reach out to the provider or facility to assist in obtaining a response. The Grievance and Appeals staff were trained on the new timeline on 8/1/2023, copies of the timeline were distributed to the department. (Completed and Ongoing)	8/1/2023	Completed	G&A		State	DHCS	2023
10	Member Rights	(4.1.2) R Grievance Letters in Threshold Languages The Plan did not send acknowledgement, resolution delay, and resolution letters in threshold languages.	The Plan's Grievance and Appeals Department has created a reporting mechanism in our daily aging reports to monitor what cases are still pending translation and when was the request for translation sent out, this was implemented on 4/12/2023. We have then assigned one specific team member to be responsible for following up on translation letters to ensure that they are getting the attention that they need to be completed in a timely manner. The Grievance Processing Timeline will be updated to include when a request for translation needs to be sent out and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted on 10/10/2023. (Completed and ongoing)	10/10/2023	Completed	G&A		State	DHCS	2023
11	Member Rights	(4.1.3) R Written Notification of Grievance Resolution Delays The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days and did not resolve grievances by the estimated resolution date in the delay letters.	The Plan's Grievance and Appeals Department will be updating our system, Quality Suite, to better capture data on if and/or when a delay letter is sent out. Once the system is updated, we will be able to create a reporting mechanism in our daily aging reports to monitor for when a case needs a delay letter and if the letter was sent out. The Grievance Processing Timeline will also be updated to include the process for sending out a delay letter and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted. (Completed and Ongoing)	12/1/2023	Completed	G&A		State	DHCS	2023
12	Member Rights	(4.1.4) Grievance Delay Timeframes The Plan inappropriately utilized a 14 calendar day delay timeframe for grievance resolutions.	In review of our current policy and procedures, and workflows; they were in line with the APL requirements. There was miscommunication in the staff training to use 14 calendar days instead of an estimated resolution date in the delay letters. There was a refresher training for the Grievance and Appeals staff held on 4/18/2023, the staff was provided the requirement and were reminded to provide an estimated resolution date in the delay letters if a resolution is not reached within 30 calendar days. (Completed)	4/18/2023	Completed	G&A		State	DHCS	2023
13	Member Rights	(4.1.5) Exempt Grievance Resolution The Plan did not resolve exempt grievances by close of the next business day.	In conjunction with the Grievance Department, the Member Services Grievance Guide was revised on 10/9/2023. (Completed) Training was provided to all Member Services staff on these revisions by 11/1/2023. (Completed)	11/1/2023	Completed	Member Services		State	DHCS	2023
14	Member Rights	(4.1.6) Grievance Identification The Plan did not process and resolve all member expressions of dissatisfaction as grievances.	Member Services has implemented a process to identify expressions of dissatisfaction that were not classified appropriately. (Completed) A Member Services Supervisor works with the agent to ensure the case is classified accurately and resolved in a timely manner. (Completed)	3/15/2023	Completed	Member Services		State	DHCS	2023
15	State Supported Services	(\$SS.1) Minimum Proposition 56 Payments The Plan did not distribute minimum payments for a State Supported Services claim as described in APL 19 013.	The claims system configuration team has corrected the fee schedule for the provider and adjusted the impacted claims to pay the correct rate. (Completed)	4/26/2023	Completed	Claims		State	DHCS	2023
16	CM	(2.2) PCP and members are not consistently notified of Case Management case closures	Configuration made in TruCare to ensure consistent notification	4/26/2023	Completed	Case Management		Self	DHCS	2023

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

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

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

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

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2022 DMHC FINANCIAL SERVICES : Audit Review Period 1/1/2022 - 3/31/2022							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Provider Dispute Resolutions	The Department’s examination disclosed that the Plan failed to timely acknowledge receipt of 12 out of 71 provider disputes reviewed.	1. Policies and procedures, including internal claims audit procedures, implemented to ensure provider disputes are acknowledged timely. <u>Update 2/13/2023</u> : Policy updated and will be approved at Committee 3/25/2023 2. Staff training completed January 2023 and created a audit workflow effective 01/01/2023. 3. Claims Operations Support Manager and PDR Supervisor. PDR Supervisor will monitor all incoming PDR mail. A daily audit will be conducted before the 15th due date to assure all cases are acknowledged timely.	2/24/2023	Completed	Claims		State	DMHC	2022
2	Claims	The Department’s examination disclosed that, due to systemic issues, claims were not reimbursed accurately, including interest and penalties.	CORRECTIVE ACTION TAKEN DURING EXAMINATION The Plan submitted evidence on October 28, 2022, that the Plan reprocessed and paid claims previously paid incorrectly. This correction and remediation resulted in the additional payment of \$5,742.29, plus interest of \$7,675.43, on 742 claims. In addition, the Plan submitted evidence on October 28, 2022, that the Plan reprocessed and paid claims previously denied incorrectly. This correction and remediation resulted in the additional payment of \$64,718.77, plus interest of \$6,002.98, on 750 claims. The Plan corrected the deficiencies noted above and completed the required remediation during the course of the examination; therefore, no additional response is required.	10/28/2022	Completed	Claims		State	DMHC	2022
3	Changes in Plan Personnel	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: <i>Audit Review Period 1/1/2021 - 3/31/2022</i>							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	G&A	(1.3.1) The Plan did not send acknowledgement letters for standard appeals within the required timeframe of five calendar days.	1. The Daily Clerk Report is received daily by Grievance & Appeals Clerks and Leadership. The report will be reviewed by the Grievance & Appeals Leadership team to ensure acknowledgment letters are mailed timely. 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement letters.	10/1/2022	Completed	G&A		State	DHCS	2022
2	G&A	(1.3.2) The Plan did not comply with existing APLs to notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days in addition to the initial 120 days allowed to request a SFH.	1. Your Rights enclosure was updated to reflect enrollees have 240 days to request a State Fair Hearing 2. Policy & Procedure G&A-007 State Hearings has been updated to reflect the member has 240 calendar days to request a State Hearing. The policy will go to committee for review and approval in December. <u>Update 03/10/2022</u> : Plan submitted draft policy G&A-007 State Fair Hearings that reflects current timeframe to request a SFH (240 calendar days) per the PHE. Policy pending internal committee approval. Plan will need to monitor end of PHE in order to revise policy to reflect normal regulatory requirement of 120 calendar days. PHE was extended through 1/11/23. <u>Update 4/14/2023</u> : The updated policy was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022
3	Provider Relations	R(1.5.1) The Plan did not ensure that its subcontractors submitted complete ownership and control disclosure information.	1. The Alliance has made updates to its Provider Services Standard Operating Procedure (SOP) – Ownership and Control Disclosure Reviews for Delegates. This includes an additional layer of review from the Alliance Compliance Department when ownership and control forms are received from delegates. The SOP and tracking sheet has been updated. 2. The findings specifically mentioned two (2) forms: - The delegate who provided the Alliance with the email confirming that the form they submitted to the Alliance is the same form that it files with DHCS. According to the delegate, DHCS confirmed acknowledgement of the form with no additional feedback. - Another delegate who does not have a sole owner and provided a list of their leadership team with the FEIN for each of the clinics. The Alliance will notify the impacted delegates of the findings to receive forms that meet requirements by DHCS. 3. The Alliance will collect the new forms starting Q1 2023 <u>Update 03/10/2023</u> : Delegate has submitted an updated form and delegate is currently working toward completion of the form for submission to the Plan. Provider Services and Compliance will review to validate all fields are complete once all forms are received. <u>Update 4/15/2023</u> : The other delegate's form received on 3/2/2023, and two levels of review completed 3/10/2023.	3/10/2023	Completed	Provider Relations		State	DHCS	2022

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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. <u>Update 5/12/2023</u>: Fulfillment Report created to track mailing of member Orientation reports that contain reminder to schedule IHA to new members. Member Orientation Service Request tracking report tracks outreach attempts to members to complete new member orientation, which includes communication about scheduling IHAs 3. The plan will create workflows for informing members of the IHA. <u>Update 5/12/2023</u>: Clinical QI Program Coordinator will review IVR reports to determine all new members have received an outreach call. 4. The plan will update the IHA P&P to reflect the updated workflows. <u>Update 3/10/2023</u>: Draft policy QI-124 completed, IVR outreach is pending DHCS approval of script. Upon DHCS approval we will continue to develop the process for IVR outreach and develop desktop procedures. <u>Update 4/15/2023</u>: The updated P&P was approved at Compliance Committee 3/21/2023 5. The plan will create a phone call campaign, create a script, and work with the state for approval. <u>Update 3/10/2023</u>: Awaiting DHCS approval of script. <u>Update 6/9/2023</u>: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreach attempts via providers, by reviewing documentation as part of FSRs.	9/8/2023	Completed	QI		State	DHCS	2022
5	CM	R (2.5.1) The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.	1. The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with the MHP to review redline changes to the MOU. The MHP is currently under review of the redline changes and will notify the Alliance when they can move forward with signing the MOU. The MHP MOU vetting process includes County Board of Supervisor (BOS) approval. Therefore, the Alliance is hoping to execute the MOU by the end of 2022.	12/31/2023	Completed	Provider Relations		State	DHCS	2022
6	Provider Relations	R (3.1.1) The Plan did not monitor the network providers' compliance with requirements for when appointments were extended.	1. The Provider Manual was edited to update the requirements, providers were advised in the Quarterly Provider Packet, and The Alliance Provider Representatives advised providers during PCP visits. Additionally, fax blasts were sent to providers regarding the updated requirements, and the Provider Education document was updated to reflect the requirements. 2. Edit P&P and Quality of Access Workflow to ensure all cases are reviewed by a QI Nurse. If a case is determined to be related to access, QI / A&A staff will review data for ED / Inpatient Stays as a result of delay in appointment. If the member does have an ED / IP Claim, the QI RN will then work the case up as a PQI / Quality of Care. This will be reviewed by the Medical Director and follow the PQI process. Finally, all QOA cases with available MRs will be reviewed to ensure the appropriate provider documentation. <u>Update 03/10/2023</u>: Policy QI-114 has been updated and is awaiting approval at committee <u>Update 4/14/2023</u>: P&P 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: <i>Audit Review Period 1/1/2021 - 3/31/2022</i>							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
7	Claims	(3.6.1) The Plan improperly denied emergency services claims.	1. Case #7 – The claim was paid on 8/11/2021. The vendor was notified of the finding on 5/19/2022 and asked to review their internal process to ensure that codes on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. 2. Case #20 –The vender was notified of the issue on 5/19/2022 and asked to review their internal process to ensure that dates on clams are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. In addition, an edit was enhanced to ensure that the date range order is correct. 3. The claim was paid on 1/5/2022 correctly. The Claims Processor was shown the claim finding for review along with the correct workflow document that shows the correct process to help ensure moving forward this does not occur again. This workflow was also reviewed by the Claim Processor team and training occurred.	10/11/2022	Completed	Claims		State	DHCS	2022
8	Access and Availability	R (3.8.1) The Plan did not use PCS forms for NEMT services.	1. The Plan will educate providers on PCS requirements. Update 3/10/2023: Provider Alert PCS Form Reminder and Form was sent out to Providers in a fax blast on Tuesday, 12/27/22. 2. Refine PCS workflows to meet all regulatory requirements. Update 3/10/2023: Workflow updated. 3. The Plan will conduct staff trainings on process workflow changes. <u>Update 4/15/2023</u>: Training completed 1/31/2023. 4. The Plan will ensure that the transportation subcontractor trains their staff on the PCS process workflow changes. The transportation subcontractor will provide training materials and sign in sheets. <u>Update 4/15/2023</u>: Training completed 1/31/2023. 5. The Plan will develop reports on PCS form outcomes using both transportation subcontractor information and the Plan's process to obtain PCS forms. <u>Update 4/15/2023</u>: Reports developed and presented at UM Committee Q4 2022. 6. The Plan will monitor process workflows from the transportation subcontractor and the Plan to obtain missing PCS forms <u>Update 4/15/2023</u>: Reports developed and presented at UM Committee Q4 2022. 7. The Plan will analyze trends in provider practices and provide feedback to providers regarding PCS form requirements. <u>Update 4/15/2023</u>: Reports developed and presented at UM Committee Q4 2022, where trends analyzed. 8. The plan will evaluate whether to continue having the transportation subcontractor manage the PCS forms or take the direct management of PCS forms back into the Plan. <u>Update 4/15/2023</u>: Reports developed and presented at UM Committee Q4 2022. Will continue to analyze quarterly. 9. The Plan will provide a quarterly report to UM Committee <u>Update 4/15/2023</u>: Reports developed and presented at UM Committee Q4 2022.	4/1/2023	Completed	UM		State	DHCS	2022
9	Member Rights	R (4.1.1) The Plan did not send acknowledgement and resolution letters within the required timeframes.	1. The G & A Department Leadership and Quality Assurance Specialist will reference the daily reports to ensure the 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. <u>Update 4/15/2023</u> : P&P G&A-003 was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022
12	Member Rights	R (4.1.4) The Plan did not thoroughly investigate and resolve grievances prior to sending resolution letters.	1. The Alliance will review resolution letters prior to mailing to the member. 2. The Alliance provided training to the Grievance & Appeals staff to ensure the resolution letter clearly addresses all of the member's concerns 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/2022	Completed	G&A		State	DHCS	2022
13	Member Rights	R (4.3.1) The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes.	The Plan has created an interdepartmental team to work in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify HIPAA and FWA incidents and the method for immediate reporting to compliance. <u>Update 03/10/2023</u> : Training created and provided to The Alliance staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022
14	Member Rights	(4.3.2) The Plan did not notify the DHCS Program Contract Manager and DHCS ISO of suspected security incidents or unauthorized disclosure of PHI or PI.	Due to human error, reporting to the three (3) entities at DHCS; DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer was not completed for all possible HIPAA incidents. Reporting Policy CMP-013 has been updated to reflect the current reporting email address for possible HIPAA incidents to DHCS incidents@dhcs.ca.gov. This change was reviewed and approved by the Compliance Committee on 11/23/2021.	11/23/2021	Completed	Compliance		State	DHCS	2022
15	Fraud and Abuse	R (6.2.1) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness. <u>Update 03/10/2023</u> : Training created and provided to The Alliance staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022

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2021 DMHC JOINT AUDIT FINDINGS : <i>Audit Review Period 11/1/2018 - 10/31/2020</i>							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: •~~4~~A_GroupCare NOA template •~~5~~A_GroupCare NOA template •~~6~~A_Full Group Care Formulary/Template <u>12/30/2022</u>:Template letters completed and submitted to DMHC	12/30/2022	Completed	G&A Member Services UM Rx		State	DMHC	2021
4	Prescription (Rx) Drug Coverage	The Plan's prescription drug denial and modification letters to enrollees do not include accurate information about their grievance rights.	The plan will update/ensure prescription drug denial and modification letters to the enrollees include accurate information about their grievance rights. Templates are being drafted and copies will be provided on December 30, 2022. <u>12/30/2022</u> :Template letters completed and submitted to DMHC	12/30/2022	Completed	Rx		State	DMHC	2021
5	Prescription (Rx) Drug Coverage	The Plan does not inform enrollees of their right to seek an external exception request review in formulary exception request denial letters.	The plan will insert external exception request review in formulary exception request denial letters as seen below: "EXTERNAL REVIEWS You have the right to request an external review when the Alliance denies a prior authorization request for a drug that is not covered by the plan or for an investigational drug or therapy. A request for an external review will not prevent you from filing a Grievance or Independent Medical Review (IMR) with the California Department of Managed Health Care. You may request an external review through the Alliance contact information listed above." •~~7~~Templates are being drafted and copies will be provided on December 30, 2022. <u>12/30/2022</u>:Template letters completed and submitted to DMHC	12/30/2022	Completed	Rx		State	DMHC	2021
6	Prescription (Rx) Drug Coverage	The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.	The Plan will update formularies in a manner consistent with the Department's standard formulary template. <u>12/30/2022</u> : The formulary template has been updated.	12/30/2022	Completed	Rx		State	DMHC	2021

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
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R = Repeat Findings

2021 DHCS JOINT AUDIT FINDINGS: <i>Audit Review Period 6/1/2019 - 3/31/2021</i>								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. <u>Update 10/8/2021</u> : 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. <u>Update 11/12/2021</u> : The report request has been submitted, estimated completion is 11/15/2021. <u>Update 12/10/2021</u> : Report has been created and is being completed weekly. 4. The Plan will monitor PA requests for Speech Therapy on a quarterly basis. <u>Update 11/12/2021</u> : The report request has been submitted, estimated completion is 11/15/2021. <u>Update 12/10/2021</u> : Requests for Speech Therapy are being monitored quarterly. 5. The Plan will report results quarterly to UMC. <u>Update 12/10/2021</u> : The first report will be given to the UMC in January 2022. <u>Update 09/09/2022</u> : Speech therapy is now being tracked on a quarterly basis and was reported out at the Q1 2022 UMC Committee	Medium	Q1 2022	Completed	UM		State	DHCS	2021
2	UM	(1.2.2) The Plan did not ensure that a qualified health care professional reviewed dental anesthesia prior authorization requests which includes a review of clinical data. The Plan did not ensure the use of appropriate criteria/guidelines when reviewing dental anesthesia requests.	1. The Plan developed workflow outlining standard review process for dental anesthesia Prior Authorization (PA) requests. 2. The Plan will develop mitigation plan until auto auth programming is removed. <u>Update 10/8/2021</u> : Mitigation plan developed and put into place 9/29/2021 3. The Plan will conduct a staff training on the mitigation plan to identify and use standard UM review process for dental anesthesia (DA) and include it in new staff training. <u>Update 10/8/2021</u> Training complete 9/29/2021 4. The Plan's UM and IT teams will collaborate to remove DA requests from Auto Authorization programming in TruCare (TC). <u>Update 12/10/2021</u> : DA requests have been removed from Auto Authorization programming in TruCare as of 10/1/2021 5. The Plan will develop a Tracking Report to capture and report on PA requests for Dental Anesthesia. <u>Update 12/10/2021</u> : The quarterly report (03127) Dental General Anesthesia Report will be utilized for monitoring 6. The Plan will monitor PA requests for Dental Anesthesia quarterly. <u>Update 10/14/2022</u> : PA requests for Dental Anesthesia are now being monitored quarterly 7. The Plan will report results quarterly to UMC. <u>Update 10/14/2022</u> : PA requests for Dental Anesthesia are now being tracked on a quarterly basis and was reported out at the Q1 2022 UMC Committee	High	Q1 2022	Completed	UM		State	DHCS	2021
3	UM	(1.5.1) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The Delegate inappropriately denied medical prior authorization requests.	1. The Plan will inform Delegate 1 of DHCS findings about inappropriately denied medical prior authorization requests. <u>Update 11/12/2021</u> : On 10/8/2021 a letter was sent to the delegate to advise of the audit findings. 2. The Plan will re-educate delegates on requirements for standard UM processes, including application of appropriate criteria guidelines. <u>Update 11/12/2021</u> : On 10/12/2021 a meeting was held with Delegate 1 leadership 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. <u>Update 2/11/2022</u> : The annual Delegate 1 delegation audit began 12/17/2021 and includes an audit of denied cases for appropriateness of denial elements. 4. The Plan will review denied cases at monthly Delegate 1 meeting for education. <u>Update 2/11/2022</u> : Denied cases are now being reviewed at the monthly Delegate 1 meeting for education. <u>Update 5/13/2022</u> : The Q1 2022 audit has commenced as of 5/5/2022. <u>Update 08/09/2022</u> : The Delegate 1 audit is in progress and is expected to be completed by 8/12/2022 <u>Update 09/06/2022</u> : The audit for Q2 2022 is in progress, preliminary findings have been submitted to Delegate 1. The audit for Q3 2022 is beginning. There will be four total quarters of reviews completed in order to close out this finding. <u>4/3/2023</u> : Four quarters of the audit have been completed. Results under review. <u>Update 6/9/2023</u> : A Trend Report for 2022 Quarterly Focused Audit findings regarding medical necessity denials was issued to Delegate 1 along with the Final Report for their Annual Audit on 4/11/23. Delegate 1 CAP response due 6/16/2023. <u>Update 9/8/2023</u> : The 2022 CAP is ongoing. Delegate 1's CAP included updates to UM workflows, staff training, and internal audits. The CAP is in progress. Workflows, trainings, and internal audits have been completed and are under review by Alliance SMEs.	Medium	Q4 2023	Completed	UM		State	DHCS	2021

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

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

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

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18	Access	(3.4.1) The Plan did not ensure standing referral determinations and processing were made within the required timeframes.	1. The Plan will develop a standing referral workflow. <u>11/12/2021</u> : Standing referral workflow has been developed 2. The Plan will update The Alliance system of record for UM and CM, TruCare (TC) to add user define field in order to identify standing referral status to ensure correct TAT, which would include a reportable field for monthly reporting. <u>Update 12/10/2021</u> : TruCare has been updated to add the user defined field. 3. The Plan will revise TruCare (TC) to capture timeframes for processing Standing Referrals. <u>Update 12/10/2021</u> : The reporting TAT has been scheduled to begin in December, with the first report, containing December data, due in January. 4. The Plan will revise Authorization Aging report for day to day management and to report on timeframes for Standing Referrals. <u>Update 01/14/2022</u> : Revision of aging report complete 5. The Plan will conduct staff training on standard work for Standing Referrals. <u>Update 01/14/2022</u> : Staff training on standing referrals completed 11/16/2021 6. The Plan will monitor Standing Referral timeframes with the daily Authorization Aging report. 7. The Plan will report results quarterly to UMC. 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. <u>Update 12/10/2021</u> : The notification letter was sent to the transportation broker on 12/1/2021, 2. The Plan will audit transportation broker providers to ensure drivers are enrolled in the Medi-Cal program. This was last completed August 27, 2021. Monitoring will be conducted on an annual basis.	Low	12/31/2022	Completed	Vendor Management		State	DHCS	2021
22	Access	(3.8.2) The Plan did not require PCS forms for NEMT services.	1. The Plan will require transportation broker to provide ongoing reports on rates of obtaining PCS forms from providers: <u>Update 11/12/2021</u> : UM Team working with Vendor Management and the transportation broker to obtain needed reports. <u>Update 12/10/2021</u> : The report was received from transportation broker on 10/28/2021. 2. The Plan will analyze trends in provider practices on a quarterly basis. <u>Update 12/10/2021</u> : The first report will be given at UMC in January 2022. <u>Update 2/11/2022</u> : Awaiting reports from the transportation broker 3. The Plan will educate providers on PCS requirements and provide data on their performance: <u>Update 2/11/2022</u> : Awaiting reports from the transportation broker 3.a. Provider newsletter. <u>Update 2/11/2022</u> : Awaiting reports from the transportation broker 3.b. Individual office contacts 4. The Plan will finalize process workflow to obtain missing PCS forms. <u>Update 11/12/2021</u> : UM Team working with Vendor Management and the transportation broker to obtain needed reports. <u>Update 12/10/2021</u> : The workflow has been finalized based on the reports received from the transportation broker 5. The Plan will conduct staff trainings on process workflow. <u>Update 12/10/2021</u> : Training was completed 11/8/2021. 6. The Plan will provide a quarterly report to UMC. <u>Update 01/14/2021</u> : Reporting will begin at UMC in Q1 2022. <u>Update 2/11/2022</u> : Awaiting reports from the transportation broker <u>Update 09/09/2022</u> : NEMT services are now being tracked and reported quarterly at the UM Committee.	Medium	12/31/2022	Completed	Vendor Management UM		State	DHCS	2021
23	Member Rights	(4.1.1) The Plan did not ensure that the medical director fully resolved QOC grievances prior to sending resolution letters.	1. The Plan updated G&A-003 Grievance and Appeals Receipt, Review and Resolution to include the process for the medical director's review and resolution of all levels of quality of care grievances prior to sending a resolution letter to members. The policy will be reviewed at the Health Care Quality Committee on November 18, 2021 and the Compliance Committee Meeting on November 23, 2021. <u>Update 12/10/2021</u> : G&A-003 was approved at the Compliance Committee meeting on 11/23/2021 2. The Plan will provide training to the medical directors to review G&A-003 Grievance and Appeals Receipt, Review and Resolution by November 30, 2021. <u>Update 3/11/2022</u> : Training was completed 1/12/2022	Medium	1/12/2022	Completed	G&A		State	DHCS	2021
24	Member Rights	(4.1.2) The Plan did not consistently implement its procedure for processing grievances. The Plan considered member's grievances resolved and classified as exempt without conducting investigation.	1. The Plan is updating its policy and procedures for processing Exempt Grievances to reflect its current process. The policy MBR-0024 will be reviewed at the Compliance Committee Meeting on November 23, 2021. <u>Update 12/10/2021</u> : MBR-024 was approved at Compliance Committee on 11/23/2021 2. The Plan will provide staff training by November 30, 2021. <u>Update 1/14/2022</u> : Training was completed 11/19/2021	Low	11/30/2021	Completed	Member Services		State	DHCS	2021
25	Member Rights	(4.1.3) The Plan did not send acknowledgement and resolution letters within the required timeframes. The Plan did not promptly notify the members that expedited grievances would not be resolved within the required timeframe.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-003 Grievance and Appeals Receipt, Review and Resolution and G&A-005 Expedited Review of Urgent Grievances. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent within the required timeframes, and to also notify members when expedited grievances would not be resolved within the required timeframe.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
26	Member Rights	(4.1.4) The Plan did not send acknowledgement and resolution letters in threshold languages.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description and CLS-003 Language Assistance Services. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent to members in their threshold languages.	Low	9/21/2021	Completed	G&A		State	DHCS	2021

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

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

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

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

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2020 DHCS STATE AUDIT FINDINGS - <i>Audit Review Period: 10/01/2018 - 9/30/2020</i>					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

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

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

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2019 DMHC AUDIT FINDINGS - <i>Audit Review Period: 10/1/2017-9/30/2019</i>						INTERNAL AUDITS					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
5	Control over Mailroom Claims Processing	Plan does not have sufficient control over its mailroom claims processing as the mailroom staff does not stamp the date of receipt on paper claims. In addition, the Plan's mailroom staff does not count the number of claims sent to vendors for further processing, impeding the Plan's ability to reconcile the number of claims received and processed.	The Plan has an established process for receiving claims in its onsite mailroom for capturing receipt dates. The Plan performs quality checks for reconciliations of claims count scanned and received to ensure all claims are captured for processing. The Plan has daily logs of professional and facility claims received and scanned. The logs have the original claim count, the claim count successfully scanned, the rejected claim count and the merged claim count. The Plan utilizes the daily log counts to perform reconciliation when the files are received and loaded. Included with the CAP response is the weekly reconciliation sample report and sample logs of claims as evidence of this quality internal control process for counting the number of claims.	4/1/2020	Completed	Support Services/ Claims	✓	State	DMHC	2019	Completed

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

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2019 DHCS AUDIT FINDINGS - Audit Review Period: 6/1/2018-5/31/2019						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
11	Appeals	The Plan's appeal notification letters did not comply with contractual regulations. NAR letters were not clear or concise, and contained inaccurate information	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. <u>Update as of 12/5/2019</u> ; Training conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
12	Case Management & Care Coordination - HRAs	The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members. The Plan did not ensure that HRAs were completed within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk, and within 105 calendar days of enrollment for those identified as lower risk.	HRA tracking had been implemented in early 2019, and continues at present. HRAs are sent out within the required timeframes. Robo calls are made to low risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls are made by CM staff on high risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log is kept to ensure that the required timelines are met.	No	9/16/2019	Completed	Case Management		State	DHCS	2019	Completed
13	Case Management & Care Coordination - Initial Health Assessment (IHA)	The Plan did not ensure that all providers documented all required components of an IHA. Preventive services identified as USPSTF "A" and "B" recommended services were not provided, or status of these recommended services were not documented	The QI Department revised its provider medical record request letter to include: all categories that support IHA completion; a hyperlink and/or copy of the SHA/IHEBA form; and sample documentation of a compliant SHA/IHEBA. Providers were re-educated on the SHA/IHEBA requirements.	No	9/30/2019	Completed	Quality		State	DHCS	2019	Completed
14	Complex Case Management (CCM)	(2.2.1) R The Plan did not implement its monitoring of the CCM program to address member needs. The Plan did not close its CCM cases after 90 days, or present them at Case Rounds as stated in its policy	Existing aging reports are being utilized by the Case Management Department in CCM Rounds to ensure that members' cases are either reviewed and closed, or extended past 90 days.	Yes	10/14/2019	Completed	Case Management	✓	State	DHCS	2019	Completed
15	Access & Availability	(3.1.1) R The Plan did not maintain an accurate provider directory.	The Plan will continue to verify 10 providers per week and has added the following two processes to continuously maintain an accurate provider directory: 1. Provider Data Comparison to manually review provider data received from our delegates started September 2019 and 2. Provider Data Validation Yearly Project to review directly contracted providers who appear in the Provider Directory. In addition, the Provider Relations Department includes a Provider Demographic form in all provider quarterly packets and work with providers to obtain the completed forms during provider visits.	Yes	11/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
16	Emerg Family Planning Claims/SSS	The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-For-Service rate. The Plan's claim system misclassified non-contracted family services as non-billable. The Plan is required to pay all covered family planning services regardless if these services are contracted with the Plan.	This finding is specific to one provider based on the list of services identified in the contract. No other provider was impacted by this issue. The claims system has been re-configured to reimburse services as follows: * services listed in the provider contract will be reimbursed at the contracted rate * covered Medi-Cal services not listed in the contract will be reimbursed at 100% of the prevailing Medi-Cal rate	No	9/5/2019	Completed	Claims	✓	State	DHCS	2019	Completed
17	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	(3.6.1) R The Plan did not monitor the provision of drugs prescribed in emergency situations.	The Pharmacy Department is working with the PBM to create routine monitoring reports of drugs prescribed in emergency situations. <u>Update as of 1/8/2020</u> : Internal meeting was conducted to ensure requirements are clear and next steps for updating policy and monitoring reports. <u>Update as of 2/11/2020</u> : Draft P&P and monitoring log have been created and are under review. <u>Update as of 4/10/2020</u> : The P&P and monitoring log were approved at the most recent P&T Committee meeting.	Yes	3/17/2020	Completed	Pharmacy	✓	State	DHCS	2019	Completed
19	Grievances	(4.1.1) R The Plan did not document review and final resolution of clinical grievances by a qualified health care professional	The G&A workflow for Quality of Care review was updated and implemented on 4/15/2019 to include the CMOs review and final resolution.	Yes	4/15/2019	Completed	G&A	✓	State	DHCS	2019	Completed
20	Grievances	(4.1.2) R The Plan's grievance system did not capture all complaints and expressions of dissatisfaction reported by members.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. <u>Update as of 12/5/2019</u> ; Training was conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
21	Grievances	(4.1.4) R The Plan's grievance system did not capture all complaints and expressions of dissatisfaction filed through Plan providers.	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. Clinics will be trained by the delegate to ensure that the Alliance is capturing all complaints. <u>Update as of 1/8/2020</u> : Medical group provided training sign in sheet. The delegate is working on next steps of educating providers. <u>Update as of 2/7/2020</u> : the delegate provided an attestation to complete its provider training by the end of Q1 2020. <u>Update as of 4/10/2020</u> : Meeting medical group week of 4/6 to discuss implementation. <u>Update as of 4/20/2020</u> : Process for forwarding complaints received by medical group has been implemented as of 4/20/2020.	Yes	3/31/2020 5/1/2020	Completed	G&A/Provider Services/ Compliance	✓	State	DHCS	2019	Completed
22	Grievances	4.1.4 The Plan sent member resolution letters without completely resolving all complaints.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. <u>Update as of 12/5/2019</u> ; Training was conducted on 11/14/2019.	Yes	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
23	Quality Program	The QIPD did not list the individuals' qualifications, which was inconsistent with Plan policy.	The 2019 Annual Quality Improvement Program Description (QIPD) was revised to include the leadership positions and their qualifications (Licensure, Education, Work Exp) The program description was presented and approved in the July 18, 2019 Health Care Service oversight committee.	No	7/18/2019	Completed	Quality	✓	State	DHCS	2019	Completed
24	Provider Training	(5.2.1) R The Plan did not ensure provider training was conducted within 10 working days	During the last review period of June 2017 through May 2018, the Plan acknowledged deficiencies in the NPO process to be corrected by the end of December 2018. Since January 2019, the plan is meeting its goal of conducting training with the 10 day working timeframe 100% of the time.	Yes	1/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
25	Fraud, Waste, and Abuse (FWA)	The Plan did not conduct preliminary investigations of all suspected cases of fraud and abuse.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. Staff training of the revised procedure will be completed by 12/01/2019. <u>Update as of 12/5/2019</u> : Staff training will be conducted on 12/11/2019 to review the updated procedure. <u>Update as of 1/8/2020</u> : Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed

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2019 DHCS AUDIT FINDINGS - Audit Review Period: 6/1/2018-5/31/2019						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
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. <u>Update as of 12/5/2019:</u> Staff training will be conducted on 12/11/2019 to review the updated procedure. <u>Update as of 1/8/2020:</u> Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
27	Fraud, Waste, and Abuse (FWA)	The Plan's compliance officer did not develop and implement fraud, waste, and abuse policies and procedures	The Plan's designated compliance officer will develop and attest to all new and updated policies and procedures prior to committee review.	No	12/13/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
28	State Supportive Services Claims	The Plan did not forward all misdirected claims within 10 working days.	The post-adjudication script that adds the forwarding action was corrected and deployed.	No	7/11/2019	Completed	IT/ Claims	✓	State	DHCS	2019	Completed

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

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

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

ALAMEDA ALLIANCE FOR HEALTH COMPLIANCE DASHBOARD											
2018 DHCS FINAL AUDIT REPORT FINDINGS - <i>Audit Review Period: 6/1/2017-5/31/2018</i>						INTERNAL AUDITS					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
12	Utilization Management	The Plan did not have a clear process for peer-to-peer clinician discussions concerning denied services.	Steps Plan took or will take to correct deficiency: 1.Plan develop a desktop procedure on peer to peer discussion by 9/14/2018. 2. Plan to train physicians and pharmacists of desktop procedure and when and how to document peer-to-peer clinician discussions by 9/26/2018. 3.Plan has started a weekly meeting with physicians and pharmacist for peer to peer discussions as of 7/17/2018.	9/26/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed

DASHBOARD KEY

Internal CAP Status Performance Measures

Indicator

Criteria

Green

CAP responses have been completed and fully address the findings

Notes

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

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
1	1/1/2026	DHCS	26-001	Initial Health Appointment	MEDI-CAL, D-SNP	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding the requirements of the Initial Health Appointment (IHA) beginning January 1, 2023. This APL supersedes APL 22-030. This APL update provides technical fixes only.
2	1/2/2026	DMHC	26-001	National Committee for Quality Assurance Accreditation Compliance Filing	GROUP CARE	The purpose of this All Plan Letter (APL) is to inform health plans of the filing requirements for submitting the NCQA Accreditation Compliance Form (Form) and documentation of National Committee for Quality Assurance (NCQA) accreditation to demonstrate compliance with Health and Safety Code section 1399.871(d). Health plans must submit the Form and supporting documentation to the Department of Managed Health Care (DMHC), pursuant to the instructions below, no later than February 2, 2026.
3	1/15/2026	DMHC	26-002	Delegation of Risk for COVID-19 Testing or Immunizations	GROUP CARE	Senate Bill 510 (Pan, 2021), codified in Health and Safety Code section 1342.2, requires health plans to cover, without prior authorization or utilization management, COVID-19 testing and immunizations. Section 1342.2 further provides that a health plan may not delegate the financial risk for COVID-19 testing or immunizations to a provider unless the "parties have negotiated and agreed upon a new provision of the parties' contract pursuant to [Health and Safety Code] Section 1375.7."
4	1/29/2026	DMHC	26-003	Large Group Renewal Notice Requirements	GROUP CARE	This letter provides guidance to plans on the timing and content requirements for renewal notices to large group contractholders under HSC section 1374.21 and HSC section 1385.046.
5	1/30/2026	DMHC	26-004	Plan Year 2027 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department offers current and prospective Qualified Health and Dental Plans, Covered California for Small Business Issuers, and health plans offering nongrandfathered Individual and Small Group product(s) outside of the California Health Benefit Exchange (Covered California), guidance to assist in the preparation of Plan Year 2027 regulatory submissions, in compliance with the Knox-Keene Act at California Health and Safety Code sections 1340 et seq.



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

Health Care Services

Donna Carey, MD

To: Alameda Alliance for Health Board of Governors

From: Dr. Donna White Carey, Chief Medical Officer

Date: February 13th, 2026

Subject: Health Care Services (HCS) Report

Credentialing Committee

- At the Peer Review and Credentialing (PRCC) meetings held on January 20, 2026, there were two hundred and fifty-three (253) initial network providers approved; ten (10) primary care providers, twenty-four (24) specialists, twenty-five (25) ancillary providers, twenty-nine (29) midlevel providers, and one hundred and sixty-five (165) behavioral health providers.
- Additionally, one hundred and fifteen (115) providers were re-credentialed at this meeting; four (4) primary care providers, seventeen (17) specialists, three (3) ancillary providers, eight (8) midlevel providers, and eighty-three (83) behavioral health providers.

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

- Total authorization volume decreased month-over-month from December 2025 to January 2026

Total Authorization Volume (Medical Services)			
Authorization Type	November 2025	December 2025	January 2026
Inpatient	2,848	3,660	3,760
Outpatient	4,029	4,791	3,728
Long-Term Care	705	910	965
Total	7,582	9,361	8,453

Source: #02569_AuthTAT_Summary

Utilization Management: Outpatient

- Foster care CoC cases continue to average 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.
- The prior authorization and benefits grid revision was completed and the searchable code tool is now posted on the external website. The goal was to create a more provider-friendly reference document to delineate code-specific authorization rules..
- OP processed a total of 3,331 cases for the month of January. We also processed 381 CCS referrals, of which 104 cases were submitted to our regional CCS office for review. CBAS 5 CEDT, 6 Discharges, 6 ERS, 49 renewals.
- OP Turnaround times exceeded the threshold of 95% for the month of January 2026. The OP UM team, in collaboration with the MDs, continue to explore process improvements to streamline efficiency and reduce missed TATs.
- The top 5 categories remain unchanged Radiology, OP Rehab, TQ, Home Health and Outpatient facility. Radiology and Rehab represent >70% of this volume.
- The Home Health pilot launched in July continues to be effective, reducing the number of manual reviews for selected HH services and diagnoses. There has been a slow increase in providers now using the portal (now up to 7 providers from 5). The pilot is being monitored and will be expanded in the future.
- DSNP staff training has completed as of December, and the leadership team continues to check in with staff for any new questions and concerns.

Total Outpatient Authorization Volume			
Authorization Status	November 2025	December 2025	January 2026
Approvals	2,639	3034	3429
Partial Approvals	0	0	0
Denials	57	101	299
Total	2,696	3,135	3,728

Source: #02569_AuthTAT_Summary

Outpatient Authorization Denial Rates			
Denial Rate Type	October 2025	November 2025	December 2025*
Overall Denial Rate	3.5%	3.8%	3.4%

Denial Rate Excluding Partial Denials	3.7%	4.0%	3.7%
Partial Denial Rate	0.2%	0.2%	0.4%

Source: #03690_Executive_Dashboard - *data only available through December 2025

Outpatient Turn Around Time Compliance (benchmark: 95%)			
Line of Business	November 2025	December 2025	January 2026
Overall	99.5%	99.0%	99.5%
Medi-Cal	99.5%	99.0%	98.6%
IHSS	100%	99.1%	100%
Group Care	N/A	N/A	99.9%

Source: #02569_AuthTAT_Summary

Utilization Management: Inpatient

- Total inpatient auth volume (including all IP authorization types processed by department: Acute, LTACH, Skilled SNF, and OP auths related to discharge) increased slightly from 3719 in December to 3760 in January.
- Inpatient overall average LOS decreased from 5.1 in November, to 5.0 in December. Admits per thousand increased from 48.7 in November to 50.3 in December. Days per thousand also increased from 247.2 in November to 253.5 in December. The trend is consistent among Child, Adult, ACA and SPD categories.
- IP overall denial rate stayed about the same at 1.99%% in December and 2 % in January
- IP Auth TAT compliance surpassed 95% benchmark across all lines of business in December, 97.7% and January 98.7%.
- IP UM has successfully launched DSNP workflows, and is actively processing requests on behalf of DSNP members, in compliance with TAT, in alignment with Medicare guidelines and established processes.
- External hospital rounds are ongoing with UCSF, Stanford, Alameda Health System, Kindred LTACH, Kentfield LTACH, Washington, Eden, Alta Bates, and Summit, to review members' current active admissions discuss UM issues, address discharge barriers, offer other opportunities for supporting throughput and appropriate discharge.
- Alameda Alliance IP UM RN onsite nurse pilot has successfully launched at Washington Hospital. We look forward to sharing the results of the collaboration and direct engagement with our provider and interaction with members.

Total Inpatient Authorization Volume			
Authorization Status	November 2025	December 2025	January 2026
Approvals	2831	3639	3685
Partial Approvals	0	0	0
Denials	17	80	75
Total	2848	3719	3760

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	October 2025	November 2025	December 2025*
Authorized LOS	5.3	5.1	5.0
Admits/1,000	49.8	48.7	50.3
Days/1,000	262.8	247.2	253.5

Source: #01034_AuthUtilizationStatistics – *data only available through December 2025

Inpatient Authorization Denial Rates			
Denial Rate Type	November 2025	December 2025	January 2026
Full Denials Rate	3.2%	0%	0%
Partial Denials	0%	0%	0.6%
All Types of Denials	3.2%	1.99%	2.0%

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance (benchmark: 95%)			
Line of Business	November 2025	December 2025	January 2026
Overall	98.7%	97.7%	98%
Medi-Cal	98.7%	97.7%	98%
IHSS	100%	100%	95%
DSNP	N/A	N/A	100%

Utilization Management: Long-Term Care

- LTC census during January 2026 was 2,226 members. This is a decrease of 4% (93 members) from December 2025.
- Month to Month, the admissions and length of stays seem consistent through 2025, but the days shows a pretty significant decrease from January-December of 84%. Some of this could be due to a lag in claims data being available

Totals	October 2025	November 2025	December 2025
Admissions	147	132	81
Days	929	718	382
Readmissions	24	34	12

*Source: #14236_LTC_Dashboard

- LTC Staff continue to participate in SNF collaboratives around the county to ensure that our facility partners are updated with processes and program enhancements.
- Having virtual rounds with AHS, San Leandro, Kyakameena, Elmwood, Jones Convalescent and Eden LTC facilities to coordinate on complex cases
- LTC Team continues to meet individually with multiple facilities to discuss collaboration with discharge planning and submitting proper documentation for requests.
- Quarterly rounds with Regional Center of Easy Bay to discuss any ICF/DD members.
- Continued internal Long Term Care rounds to discuss members coming into and leaving a long-term care setting.
- Social Workers continue visiting LTC facilities in person, on a monthly and quarterly basis depending on census, to assist with discharge planning and access to other resources. The team continues referrals to TCS and other internal/external programs to provide wraparound support to members preparing to discharge from an LTC custodial facility.
- LTSS Liaison is visiting and meeting with facilities to discuss any claims issues and educating on processes.
- Dedicated RN continue to assist with TCS for members coming back from an acute stay or transitioning from acute into long-term care. Currently, the Health Navigator position is vacant, interviews have started to backfill the position.
- Authorization processing turn-around time (TAT) has remained at 99%, which is exceeding the threshold of 95%.

Total LTC Authorization Volume			
Authorization Status	November 2025	December 2025	January 2026
Approvals	664	858	811
Partial Approvals	0	0	0
Denials	40	50	54
Total	704	908	865

Source: #02569_AuthTAT_Summary

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

LTC Turn Around Time Compliance (benchmark: 95%)			
Line of Business	November 2025	December 2025	January 2026
Medi-Cal	99%	99%	99%

Source: #02569_AuthTAT_Summary

Behavioral Health

In January, the Behavioral Health Department processed 682 authorizations, 460 Care Coordination referrals, and 251 mental health screenings and transition of care tools.

BH Authorization Volume			
	25-Nov	25-Dec	26-Jan
Approvals	502	584	668
Partial Approval	0	0	0
Denials	5	18	14
Total	507	597	682

Source: 14939_BH_AuthTAT

MH TAT			
<i>*Goal ≥95%</i>	25-Nov	25-Dec	26-Jan
Determination TAT%	98%	98%	97%
Notification TAT%	91%	96%	93%

New DSNP reporting mechanisms and operational processes have been implemented to strengthen oversight and enhance the efficiency of member referral workflows (DSNP Member Referrals).

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
<i>*Goal ≥95%</i>	25-Nov	25-Dec	26-Jan
Determination TAT%	99%	99%	99%
Notification TAT%	98%	100%	98%

Behavioral Health Denial Rates

<i>*Goal ≤ 5%</i> BH Denial Rates		
25-Nov	25-Dec	26-Jan
<1%	<1%	<1%

Mental Health Care Coordination

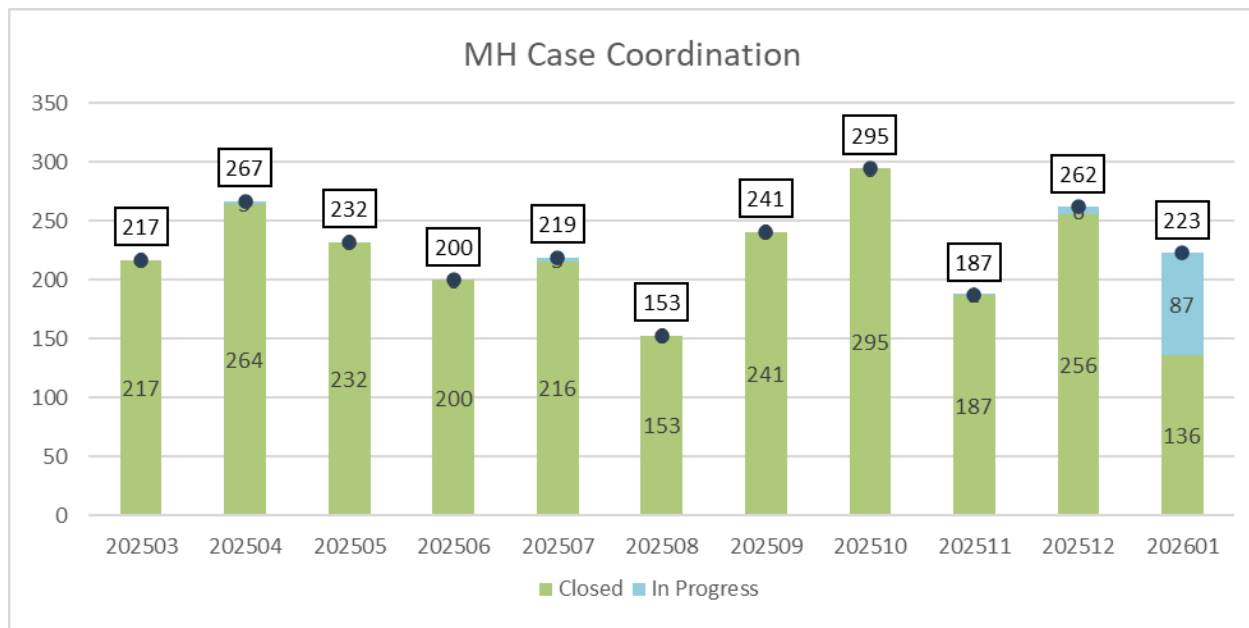
- In compliance with the No Wrong Door policy, the Alliance completes the DHCS-required screening tools when members are seeking to start new mental health services. The screening tools determine if members meet the criteria to be referred to ACBHD for Specialty Mental Health Services.

Total # Medi-Cal Screenings & TOC Tools			
	25-Nov	25-Dec	26-Jan
Youth Screenings	39	47	32
Adult Screenings	77	108	108

Incoming ACBH Referrals	138	178	109
Outgoing Referrals to ACBH	25	39	30
Transition of Care Tools to ACBH	2	0	2

Source: 16015_MH_Assessments, 16093_BH Referral Report

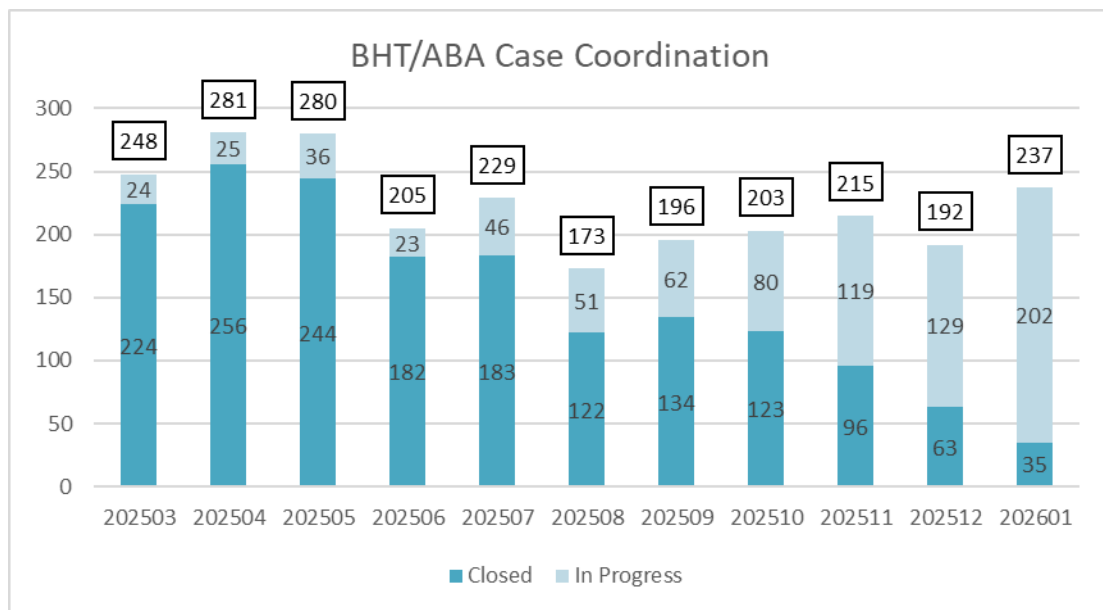
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA)

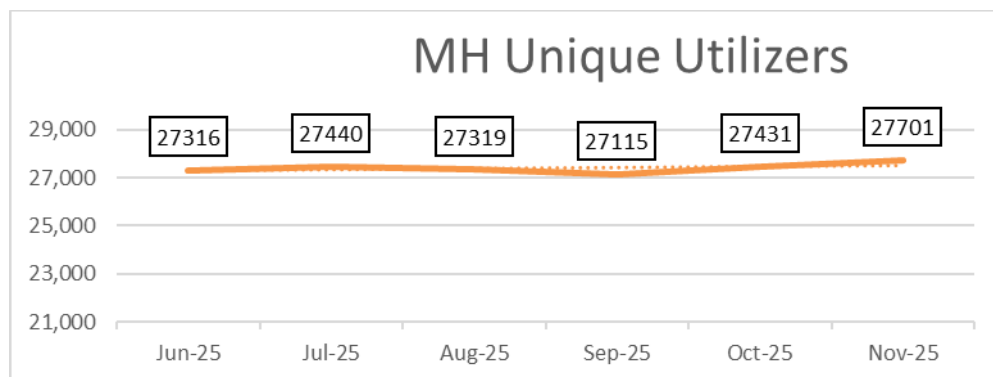
- Children and youth referred for BHT/ABA services, including Applied Behavioral Analysis (ABA) and Comprehensive Diagnostic Evaluations (CDE), require Care Coordination to access the services needed. The Alliance manages each child's unique needs and follows up with parents and caregivers to resolve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



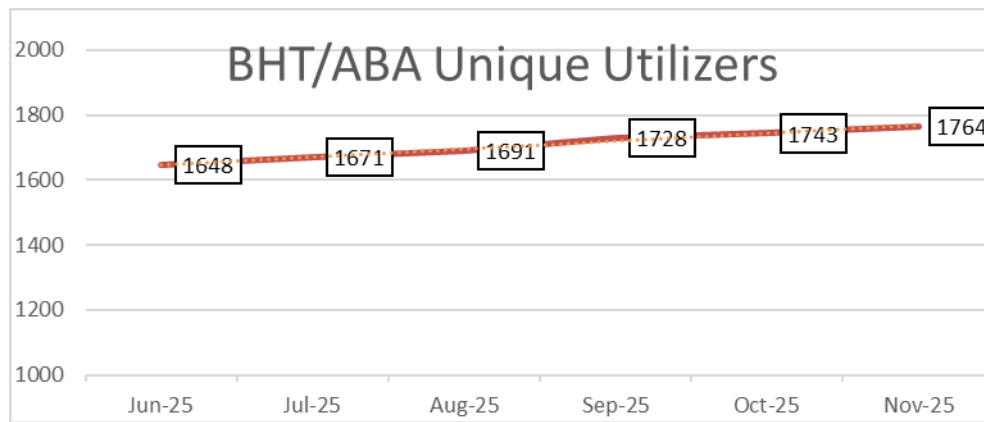
Source: 14665_BH_Cases

Behavioral Health Unique Utilizers

- Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.
- The number of unique utilizers of mental health services has increased by 0.98% compared to the previous month.



- We observed a continuing rise in unique utilizers of BHT/ABA services, reflecting a 1.2% increase compared to the previous month.



Source: PBI 14621 BHT Utilization Report

Pharmacy

- The Pharmacy Transitional Care Services (TCS) program has screened **26 Heart Failure** cases, **50 Sepsis** cases, and received **1 direct referral** for the month of January 2026.
- Pharmacy is collaborating with population health, QI, and disease management on creating clinical programs for HEDIS measures for high blood pressure, asthma, and diabetes.
- The Pharmacy Department continues to monitor members on use of opioids. We send bi-annual mailings to at risk members and their providers. Impacted members receive handouts on medication assisted treatment for opioid dependence, an opioid safety guide, and alternative pain management strategies. Their assigned PCPs receive guides to benzodiazepine and opioid tapering, formulary alternatives to opioids, and opioid dependence treatment approaches.
- We measure the use of opioid medications using Morphine Milligram Equivalents (MME). Utilization less than 120 MME decreased (-10.8%, 31-member decrease) and greater than 120 MME slightly increased from October to December (+6.4%, 6 member increase).

MME	IHSS	MCAL	Total
October			376
50	18	243	261

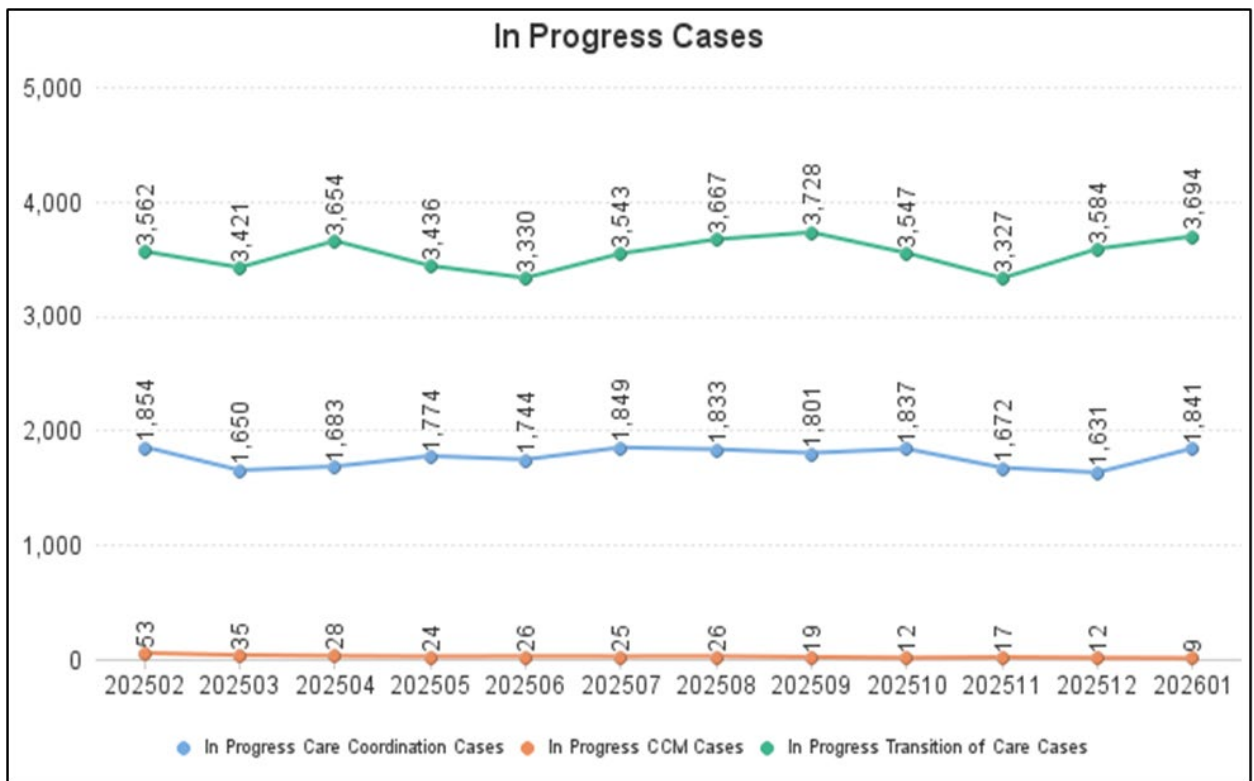
90	1	17	18
120	6	46	52
200	4	12	16
300		7	7
400		22	22
November			359
50	17	227	244
90	2	19	21
120	5	46	51
200		12	12
300	1	7	8
400		23	23
December			357
50	10	226	236
90	1	20	21
120	4	55	59
200		11	11
300		7	7
400		23	23

Case and Disease Management

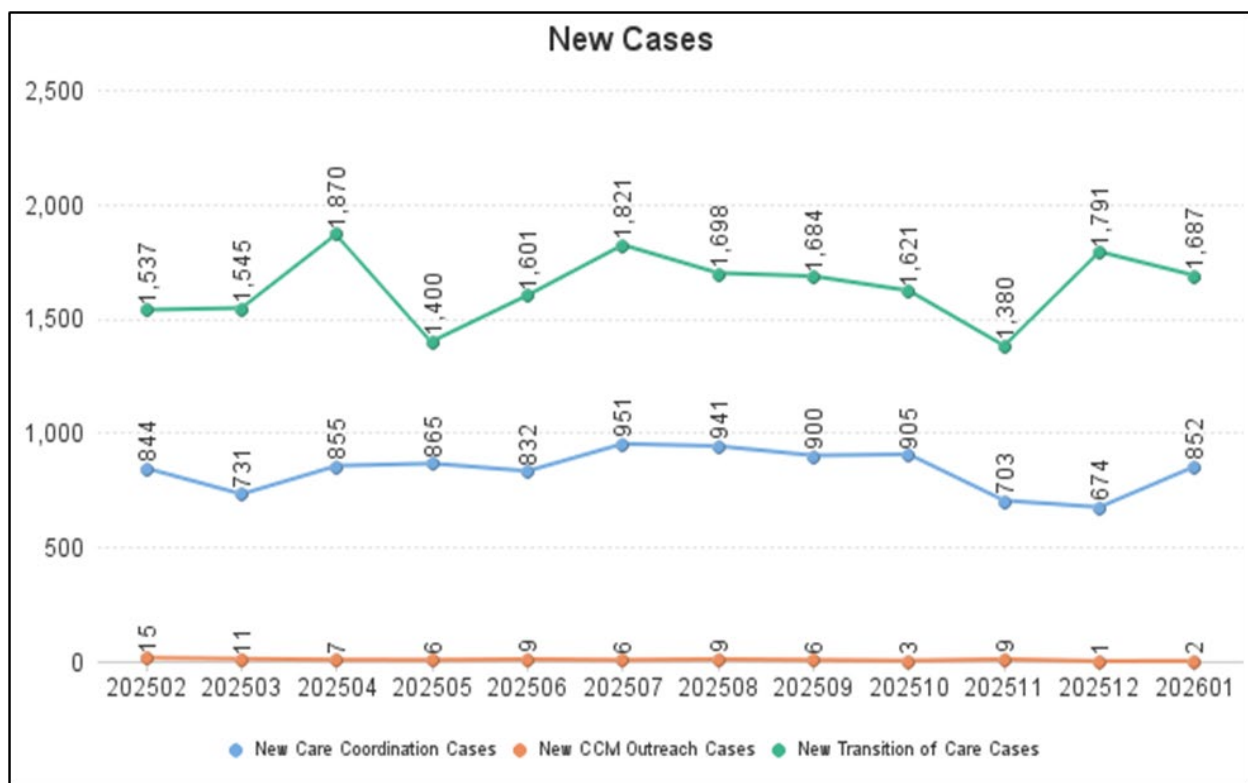
- The CM team is working hard to assist the high volume of members needing Transitional Care Services (TCS) as they transition from one level of care to another. This includes outreaching to members who are still hospitalized and following up post-discharge to help meet the members' needs.
- The CM team 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. The transportation liaison has also increased oversight of ModivCare's facility transportation services, including making onsite visits with hospitals to address transportation concerns.

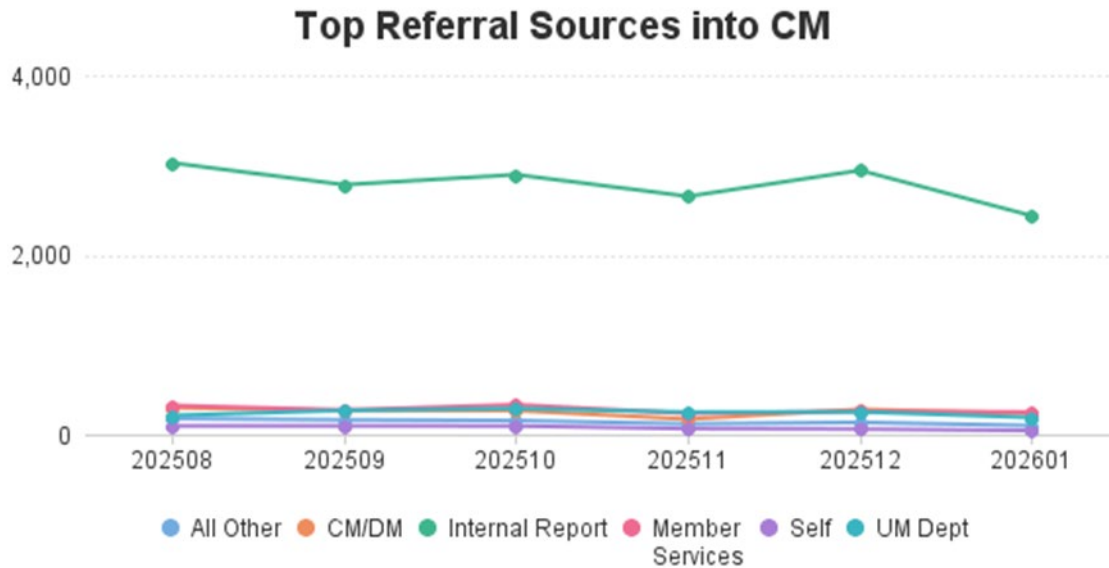
- DSNP case management is live. The Case Management (CM) team is engaging DSNP members in assessments and care plan building.



Source: #03342 TruCare Caseload



Source: #03342 TruCare Caseload



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

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

CalAIM

Enhanced Case Management

- All Populations of Focus are live:
 - Homeless children/youth and adults
 - High Utilizer children/youth and adults
 - SMI/SUD children/youth and adults
 - Children/Youth Transitioning from a Youth Correction Facility
 - Adults Transitioning from Incarceration
 - Adults Living in the Community and At Risk for Long-Term Care Institutionalization
 - Children/Youth Enrolled in CCS with Additional Needs Beyond the CCS Condition
 - Children/Youth Involved in Child Welfare
 - Children/Youth and Adults Who are Pregnant or Postpartum
- With DSNP live, the ECM team is working closely with the ECM providers to assist with Continuity of Care for these members and confirm the Alliance is meeting the new requirements associated with CICM.
- The ECM team is working closely with IT and IPD to automate creation of authorization shells, provide auto authorizations where possible, and centralize ECM referrals. This will improve referral processing and authorization determination decisions with improved turnaround times. Additionally, this will free up ECM staff to work on other areas of ECM (i.e. graduating or assisting with stepping members down to a lower level of care, clinical audits, additional support to Provider frontline staff to improve effectiveness of care plan outcomes and, further advance the growth of ECM especially in key POF areas that are underdeveloped like Birth Equity).
- Efforts to expand the ECM provider network have resumed. The screening panel reviews provider applications based on capacity to serve targeted Populations of Focus, demonstrated operational excellence in programming, and quality benchmarks.
- The Standardized ECM referral form and ECM authorization information is now visible to providers on the provider portal. Network-wide provider training started in July. All ECM providers have been trained in how to use the portal for referral submissions, checking member AAH eligibility, checking authorization status and checking ECM eligibility, however, there have been reported inconsistencies and AAH continues work to resolve.

- The ECM team continues to build rapport with the ECM providers, meeting to discuss specific cases and work with the ECM providers to assist with moving members through the ECM program by addressing care plan barriers and offering support and services ECM providers may not be aware of. This has led to more collaboration and community referrals to additional resources. Additional meetings are scheduled with ECM providers for individual case conferences as needed. Clinical Operations meetings that support ECM provider leadership and processes are launching in January. These meetings will further support the relationship between the ECM provider and AAH.
- ECM and CS teams have begun a collaborative meeting to confirm communication is occurring between Community Supports providers and ECM lead care managers. The collaboration further enhances coordination of care, ensuring non-duplicative services and members receive appropriate services to meet their needs. One new area where collaboration is happening is in preparing for Transitional Rent, ensuring smooth transitions into ECM as necessary.
- As a result of the 2025 Fall's audit of ECM providers, the ECM team continues to develop training for the ECM providers to re-educate the ECM provider network on various topics applicable to ECM. The ECM team was successful in providing monthly training sessions for all ECM providers' frontline staff to reinforce ECM requirements and expectations. Based on this success, in 2026 there will be more ECM provider staff trainings.
- In preparation for the 2026 Spring audit of the ECM providers, the ECM team is working collaboratively to refine the audit process to ensure the quality of care the ECM providers provide is consistent with DHCS expectations of the ECM program.
- 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.
- Closed-Loop Referral (CLR) requirements went live on July 1, 2025. The closed-loop referral framework is designed to ensure that members, healthcare providers, and ECM/CS providers are aware of the status of referrals from beginning to end.

	October 2025		November 2025		December 2025	
ECM Providers	Outreach	Enrolled	Outreach	Enrolled	Outreach	Enrolled
ACBH	-	13	-	13	-	13
Alameda Health System (AHS)		29251	27	233	-	221
Bay Area Community Services (BACS)	15	146	8	156	9	166
California Cardiovascular Consultants	-	147	-	148	-	147
California Children's Services (CCS)	6	45	7	48	2	52
CHCN	100	1,1137	91	1,144	107	1,197
East Bay Innovations (EBI)	124	140	19	142	15	154
Full Circle	49	170	-	159	-	155
Institute on Aging	177	223	197	237	195	253
La Familia	55	38	57	35	59	32
MedZed	30	1,023	54	1,058	34	1,126
Roots Community Health Center	-	686	1	681	-	688
Seneca Family Services	75	47	-	49	-	49
Pair Team	345	2,733	1	2,635	1	2,503
Titanium Health Care	82	1,386	11	1,417	6	1,450
Tiburcio Vasquez Health Center (Street Medicine)	-	120	-	116	-	112
BACH (Street Medicine)	-	81	-	79	-	73
Lifelong (Street Medicine)	2	431	2	447	-	435
Roots Community Health Center (Street Medicine)	Combined with Roots 'traditional' ECM program					

Source: #13360 ECM Dashboard

Community Supports (CS)

- Housing-related Community Supports guidance was shared 10/31/2025 with AC Health, with an effective date of 01/01/26, per DHCS regulations.
- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance offers the following Community Supports:
 - Housing Navigation
 - Housing Deposits
 - Tenancy Sustaining Services
 - Medical Respite
 - Medically Tailored/Supportive Meals
 - Asthma Remediation
 - (Caregiver) Respite Services
 - Personal Care & Homemaker Services
 - Environmental Accessibility Adaptations (Home Modifications)
 - Assisted Living Facility Transition
 - Community or Home Transition Services
 - Transitional Rent
- The Alliance is working to identify gaps in current service capacity and member access to Community Supports; this will inform future targeted efforts for CS network expansion.
- AAH CS staff continue to meet with CS providers to work through logistical issues as they arise, including referral management, claims payment and member throughput. AAH is also working with CS providers, in coordination with DHCS, to clarify any policy or operational questions that may inform potential refinement of processes.
- Oversight of Community Supports providers continues through the provider audit process.

Community Supports	Services Authorized in October 2025	Services Authorized in November 2025	Services Authorized in December 2025*
Housing Navigation	1,023	975	1,000
Housing Deposits	470	450	443
Housing Tenancy	1,010	1,034	1,081
Asthma Remediation	133	133	130
Meals	828	832	869
Medical Respite	60	49	55
Transition to Home	12	10	9
Nursing Facility	5	3	2
Home Modifications	6	6	8
Homemaker Services	38	35	32
Caregiver Respite	2	1	1
Total	3,587	3,528	3,630

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

Total CS Authorization Volume			
Authorization Status	November 2025	December 2025	January 2026
Approvals	591	753	759
Partial Approvals	0	0	0
Denials	48	58	68
Total	639	811	827

Source: #02569_AuthTAT_Summary

CS Turn Around Time Compliance (benchmark: 95%)			
Line of Business	November 2025	December 2025	January 2026
Medi-Cal	99%	99%	99%

Subject: Community Health Strategy (CHS) – January

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

Staffing Updates:

- Manager, Community Health Initiatives – New Hire will start February 2026

January Program Summary:

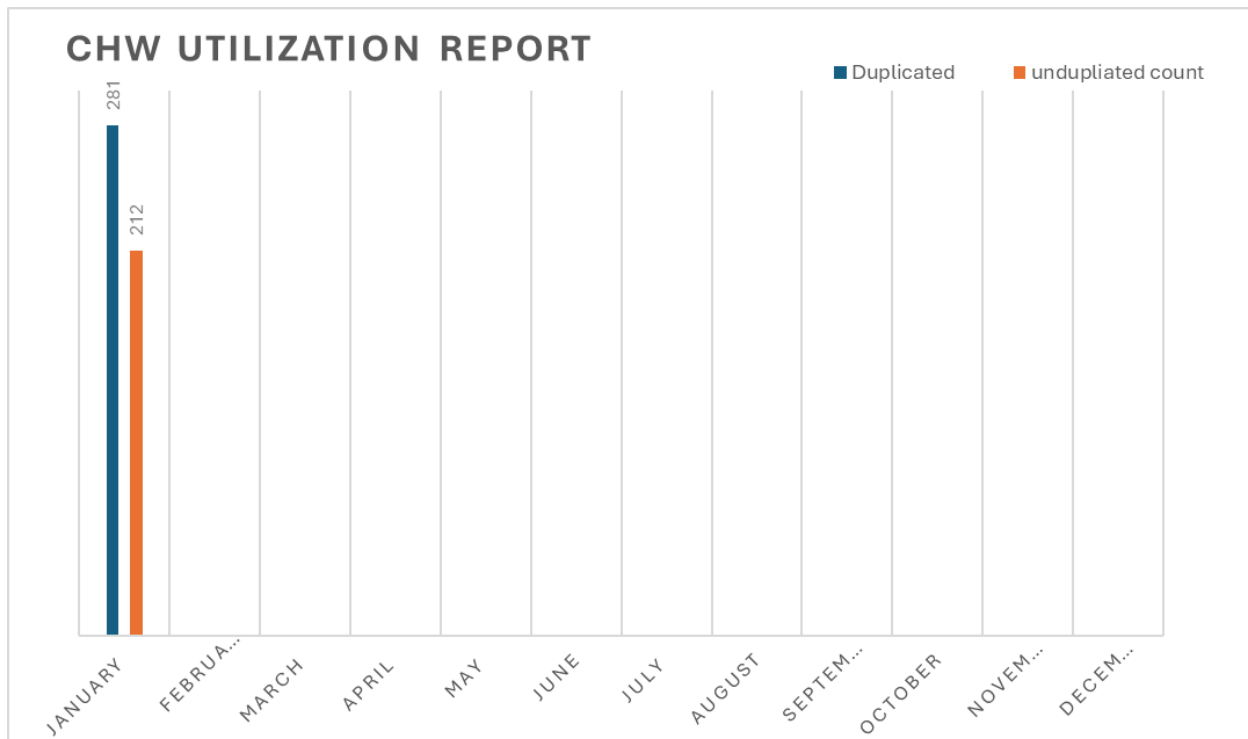
- January marked a strong start to the year, with Alameda Alliance deepening its commitment to equitable Community Health Worker (CHW) integration through strategic planning, leadership engagement, and community-facing execution. A key highlight this month was the inclusion of CHW strategy and interventions in the Quality Leadership Retreat, creating a meaningful forum to advance how CHWs can be more intentionally leveraged to close care gaps, strengthen performance across priority quality measures, and embed equity into quality improvement efforts. This engagement reinforced CHWs as a core component of quality strategy and fostered shared accountability across clinical, quality, and population health leadership.
- In parallel, the Community Health Strategy (CHS) department began contributing to Quality Improvement Trilogy documents, outlining planned CHW interventions and cross-departmental collaboration designed to deepen member impact and expand health education offerings across the Alliance membership. This work reflects continued progress toward formalizing CHW integration within enterprise quality planning and aligning equity-centered interventions with organizational improvement goals.
- CHS also supported Communications & Outreach (C&O) through direct community engagement, leading a tabling event at a school-based autism-focused convening in partnership with the Compliance Department. This collaboration ensured outreach efforts remained accessible, compliant, and responsive to family needs while expanding awareness of Alliance services. CHS further partnered with the Senior Business Analyst for Health Equity to coordinate community outreach strategies and participated in the Alameda County Black Men's Brain Health Conference, where the team engaged with community leaders on the impact of mental health in Black, Indigenous, and other communities of color. These efforts strengthened trust-based relationships and informed future CHW-supported mental health and education initiatives.
- Thanks to collaboration with Quality and Dr. Stephanie Brown, January also included exploration of new arenas to extend the reach of CHW-supported interventions, including early discussions on school-based partnerships to address topical fluoride measures and other social drivers of health-related care gaps for pediatric populations. Planning continued for upcoming initiatives, including the fatty liver disease equity project and pediatric engagement strategies launching later this year. January set a strong foundation for disciplined execution, community partnership, and sustained progress toward equitable CHW interventions in 2026.

CHW Program – Member Utilization Snapshot

Working Definitions:

Duplicated: Refers to instances where a member received CHW services more than once within the reporting period.

Unduplicated: Represents the count of unique individuals who accessed CHW services, ensuring each member is counted only once, regardless of the number of visits.



Data Considerations and Limitations

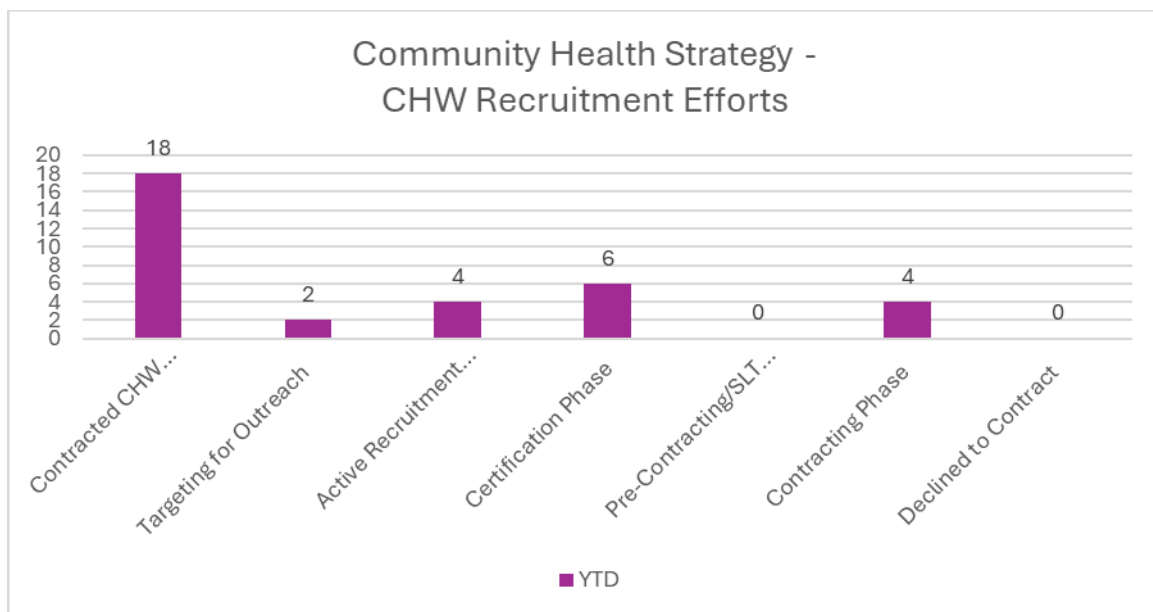
- While the current dataset is reported, several factors influence reported totals and should be considered in interpretation:
 - The following data does not include all (8) eight contracted CHW providers. This report is only representative of providers who billed January claims (Journey Health & Alameda Health Systems)
 - Documentation maturity: As providers strengthen workflows and billing accuracy, utilization reporting is expected to stabilize further.
 - Claims correction lag: Corrected claims are not always reflected uniformly across reporting systems, potentially under-representing total utilization for some providers.

CHW Program – Recruitment Efforts:

- Alameda Alliance continues to maintain a stable and active Community Health Worker (CHW) provider network while intentionally managing growth through a structured recruitment and readiness pipeline. As of January, eighteen (18) CHW provider organizations are actively contracted and delivering services to members, representing a strong and reliable core delivery network.
- In addition to currently active providers, multiple organizations are engaged across early and mid-stage recruitment milestones, reflecting continued market interest in partnering with Alameda Alliance to advance equitable, community-rooted care. As illustrated in the Recruitment Pipeline Profile (January), organizations are distributed across outreach, active recruitment, certification, and onboarding stages, demonstrating sustained engagement while maintaining appropriate pacing and quality standards.

Recruitment Pipeline Profile

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

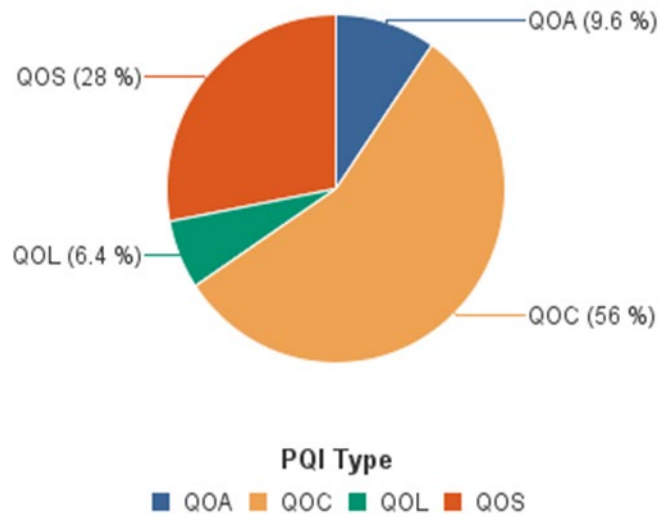


- Progression through later recruitment stages during January was moderated due to temporary capacity constraints and necessary cross-departmental prioritization, including Provider Services' focus on Dual Eligible Special Needs Plan (D-SNP) contracting activities. This coordinated approach ensured enterprise and regulatory requirements were met while preserving onboarding quality, compliance, and provider readiness.
- Recruitment throughput is expected to accelerate beginning in February 2026 with the onboarding of the new Manager of Community Health Initiatives, which will expand departmental capacity to support provider engagement, certification progression, contracting coordination, and in-person outreach. With this additional capacity, the CHS department anticipates increased movement across recruitment milestones and stronger pipeline conversion.
- Looking ahead, recruitment projections indicate growing interest from specialty and community-based organizations focused on preventive health and social drivers of health (SDOH) care gap closure. In the current political and funding environment, many traditional service providers are seeking braided funding opportunities to sustain services, positioning the CHW benefit as an increasingly attractive pathway for participation. As community development and field-based outreach efforts expand, CHS anticipates continued. Disciplined growth of the CHW provider network aligned with quality, equity, and long-term sustainability.

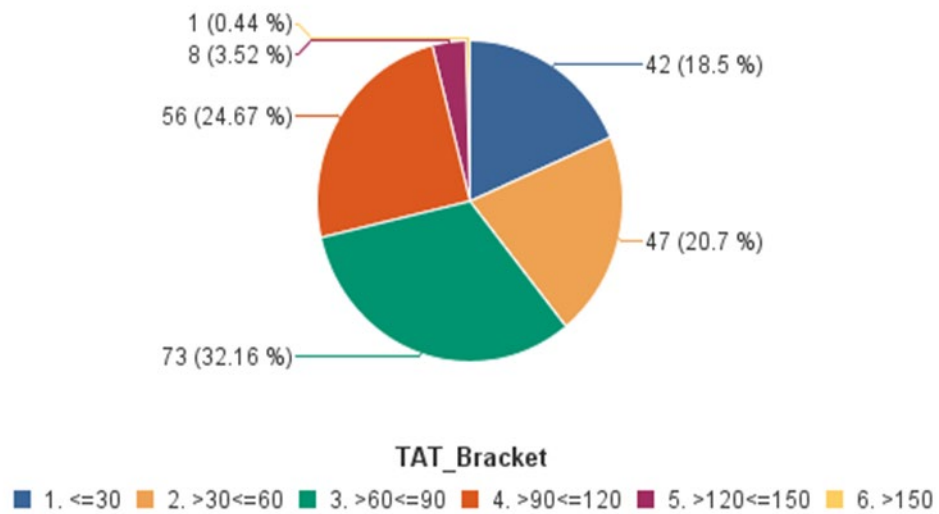
Quality

- The clinical team in QI is responsible for triaging all PQI types as they are received. This process involves assignment to an appropriate clinical reviewer for assessment, planning, intervention and evaluation. Upon initial assessment, the RN case owner makes necessary referrals when appropriate to CMDM and/or alerts QI leadership concerning issues or trends that need to be addressed prior to final MD review to prevent delays in necessary interventions and/or to prevent future similar incidents to ensure patient safety.
- Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics Services team. Quality of Care and Service issues are reviewed by the RN Clinical Reviewers. Final leveling for Quality-of-Care cases is determined by the Medical Director.
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. The TAT goal for all PQIs is 150 days from receipt to resolution. QOC cases involve nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable. Corrective Action Plans are issued after the case is closed and where applicable.
- When cases are open past TAT, the reason is typically 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.
- As of February 2, 2026, the turnaround time is 99.56% closed within 150 days which exceeded the standard of 95% case closure rate. The TAT at which PQI cases are being leveled and closed with final MD recommendations was met for the last 3 consecutive months.
- Starting on December 8, 2025, a process improvement was implemented for grievance referrals to PQIs. The process was streamlined to minimize duplicate referrals, medical record requests, provider outreach for additional information, and reporting. PQI case types of QOS, QOA, and QOL decreased with the process change as they are addressed upstream by the grievance team. Conversely, there is an expected increase of QOC case types and processed by the PQI clinical team. The QI team continues to monitor the trends from grievances and PQIs to address any system issues that may require further follow up.
- As always, the PQI process aims to support best practices in providing the highest level of care to Alliance members.

PQIs Closed by Type N= 125



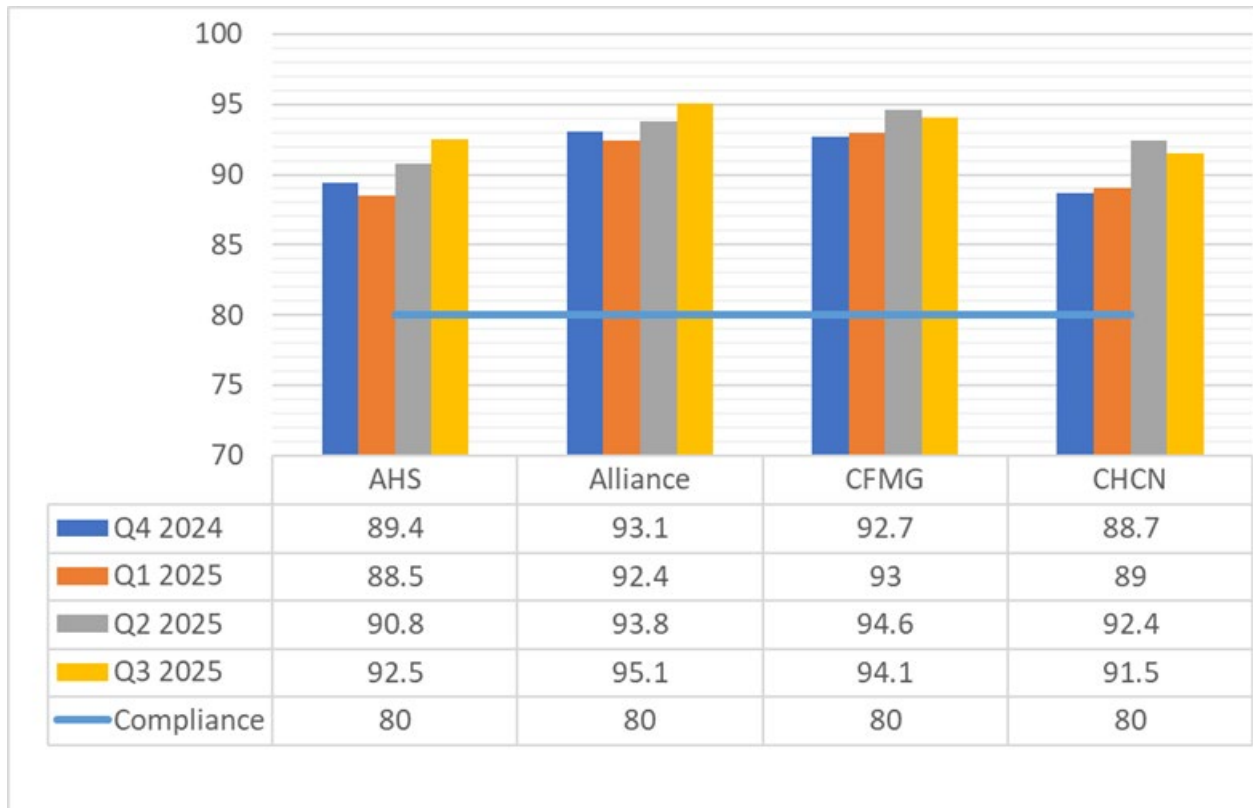
PQI Aging Report as of 02/02/2026 N= 227



CG-CAHPS Survey

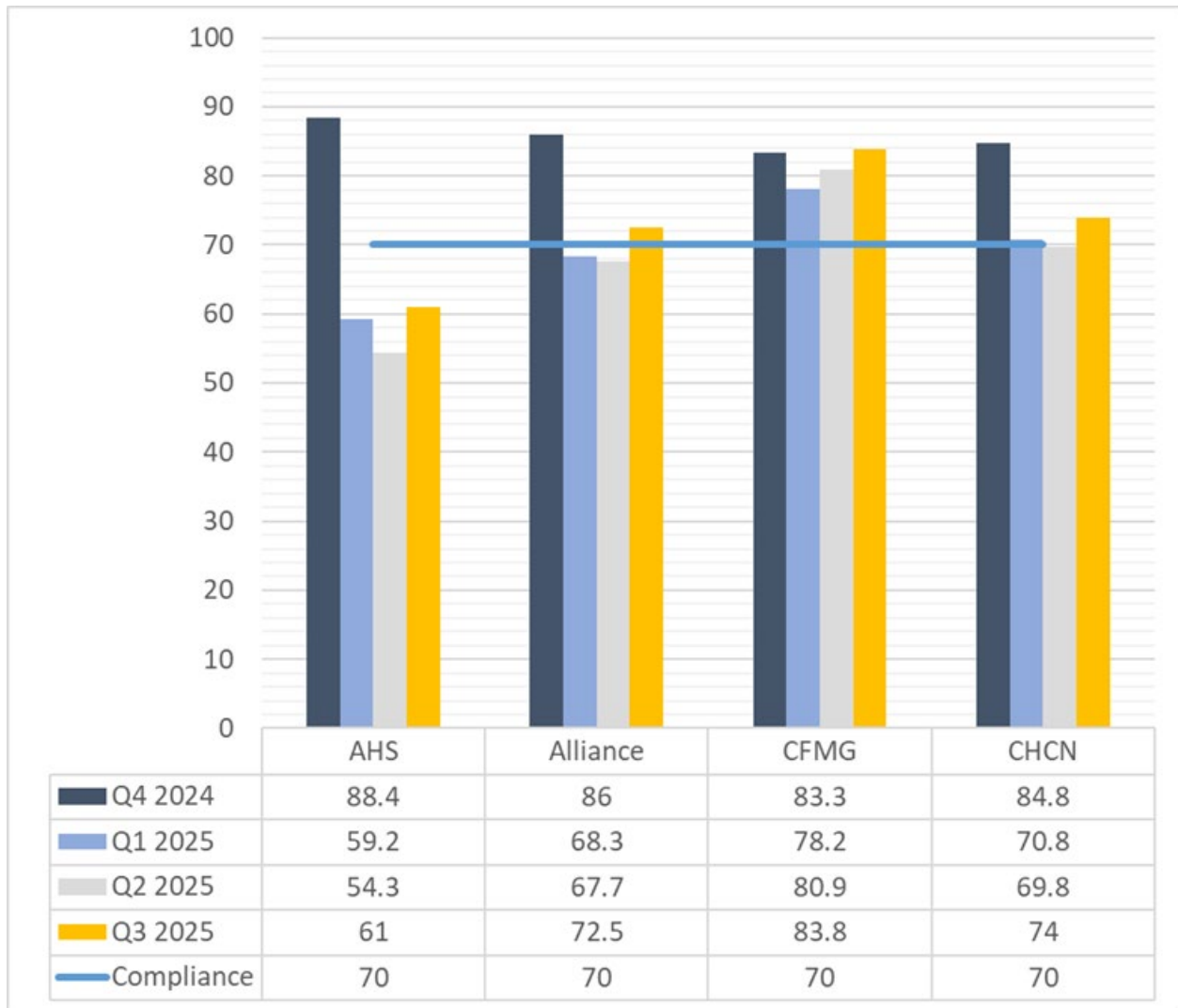
- Survey Objective: The Clinician and Group Consumer Assessment Provider and Systems (CG-CAHPS) measures member experience with health care providers and staff, as well as with in-office wait time, provider time to answer calls during business hours, and provider call return time during business hours.

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



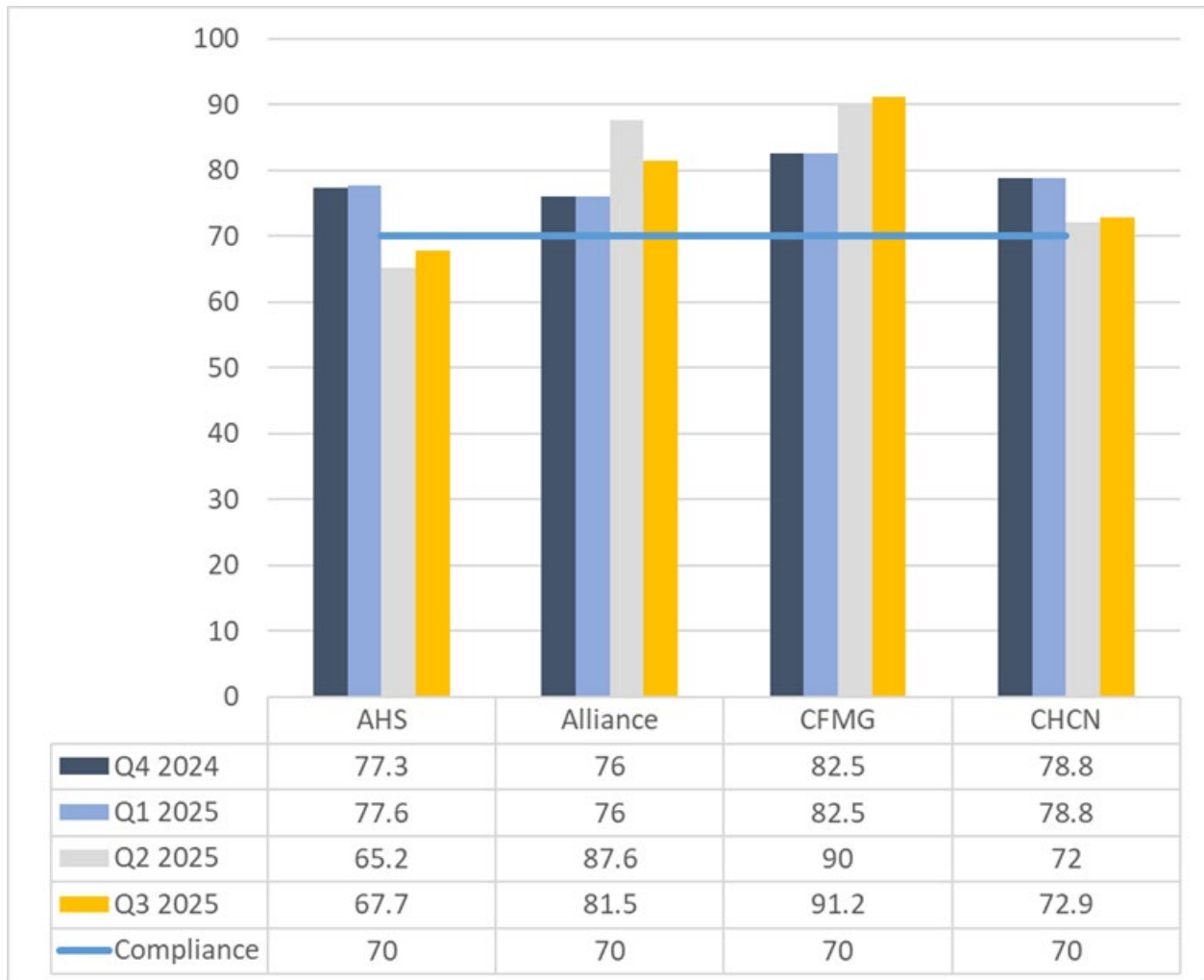
- Office wait time includes both times spent in the waiting room and the exam room before seen by the doctor:
 - Compliance rate: Less than 60 minutes
- All delegate providers continue to score above the 80% compliance threshold from Q4 2024 to Q3 2025.

PCP Call Return Time Compliance Rate by Network (%)



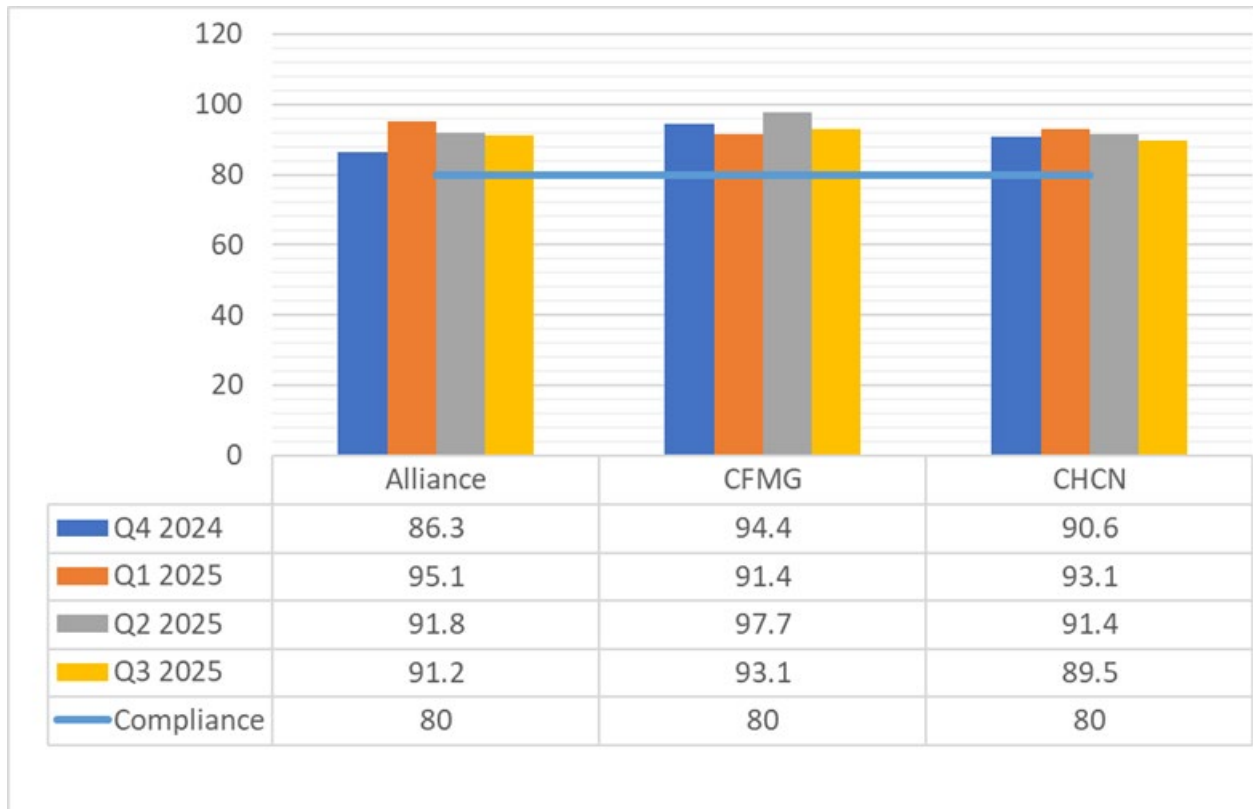
- Call return time – when a member called provider’s office during regular office hour, when did a member get a call back:
 - Compliance rate: Within 1 business day
- AHS, Alliance, and CHCN show improvement in compliance rate from Q2 2025 to Q3 2025.
- Only CFMG continues to meet the 70% threshold goal from Q4 2024 to Q3 2025.

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



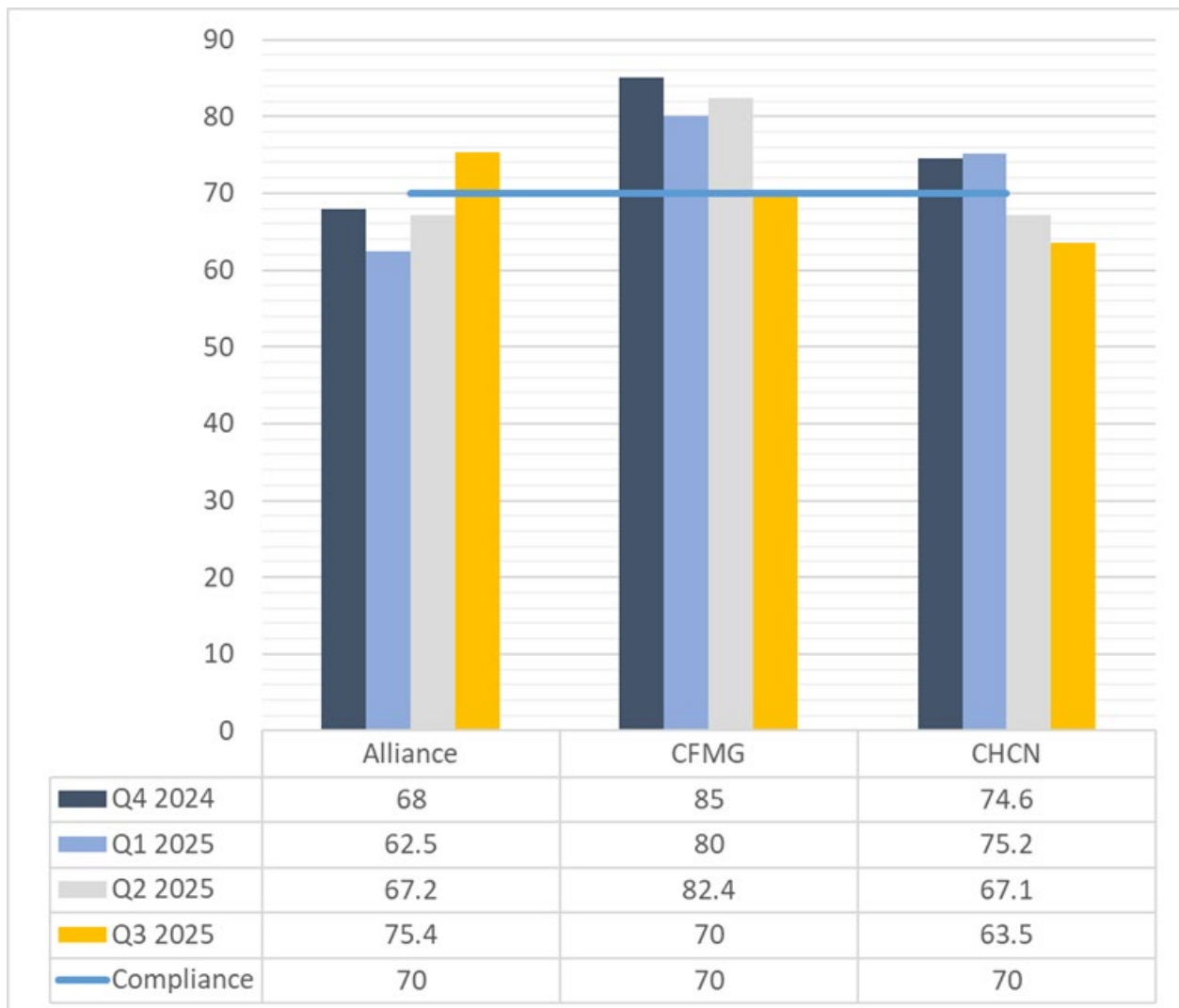
- Time to answer call – when a member called provider’s office during regular office hours, how long did a member wait to speak to a staff member:
 - o Compliance rate: 0 – 10 minutes
- AHS continues to score below the 70% threshold goal from Q2 2025 to Q3 2025. However, AHS show a 2.5% increase in compliance rate in Q3 2025. All other network providers met the 70% threshold goal from Q4 2024 to Q3 2025.

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



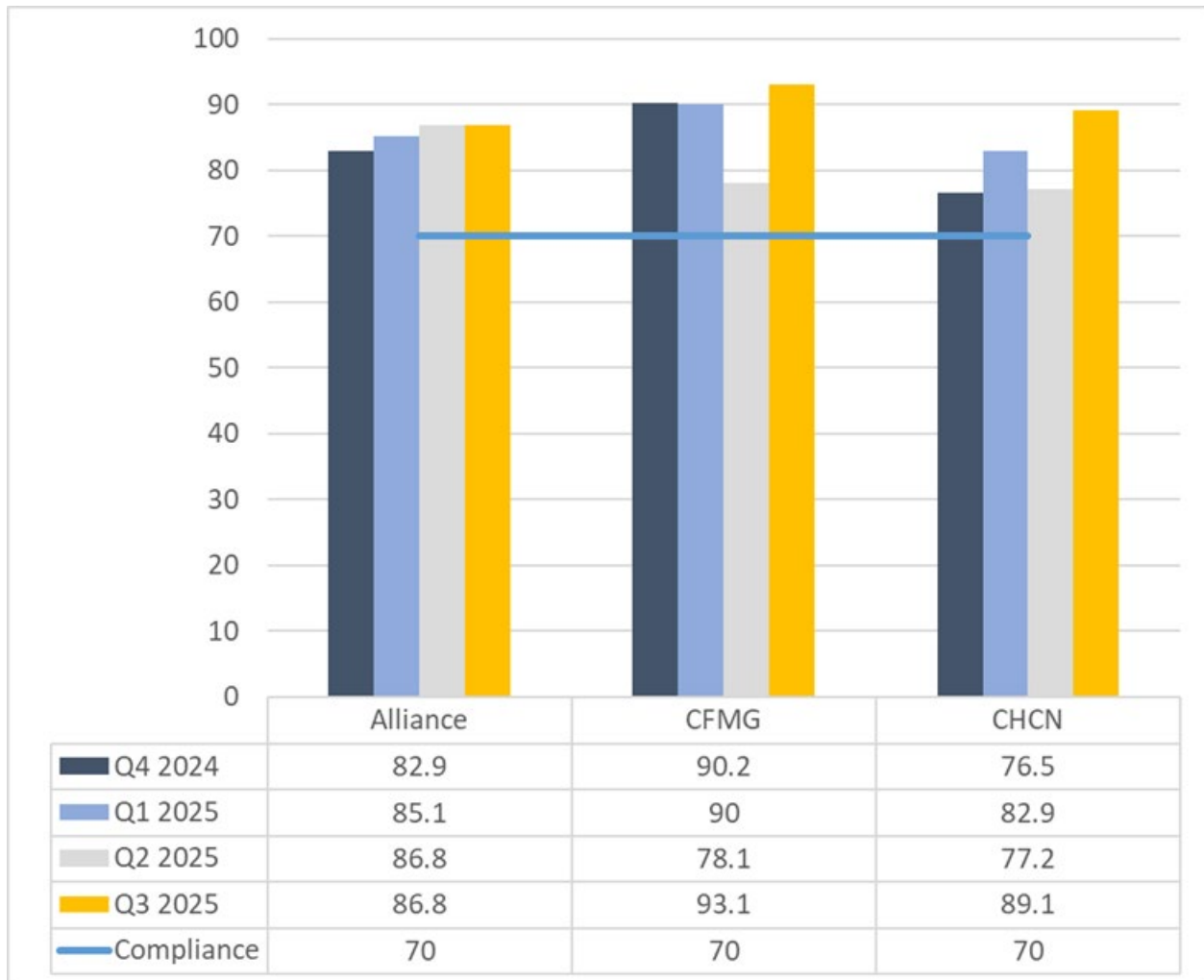
- Office wait time includes both times spent in the waiting room and the exam room before seen by the doctor:
 - Compliance rate: Less than 60 minutes
- All delegate providers continue to score above the 80% compliance threshold from Q4 2024 to Q3 2025.

BH Call Return Time Compliance Rate by Network (%)



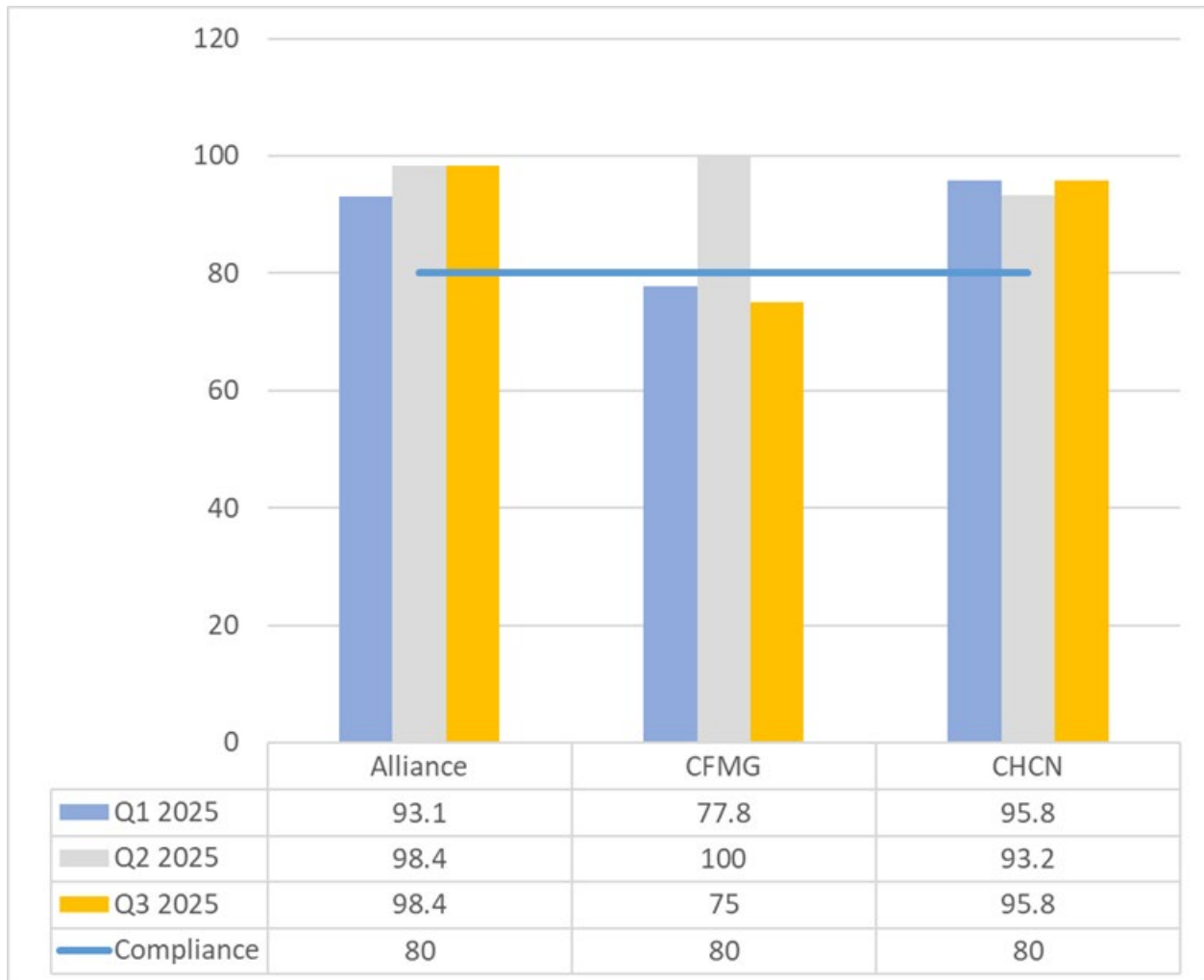
- Call return time – when a member called provider’s office during regular office hour, when did a member get a call back:
 - Compliance rate: Within 1 business day
- CFMG and CHCN show decreased in compliance rate from Q2 2025 to Q3 2025. However, CFMG continues to meet the 70% compliance threshold from Q4 2024 to Q3 2025.
- The Alliance shows an 8.2% increase in compliance rate from Q2 2025 to Q3 2025 and met the threshold goal for Call Return Time.

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



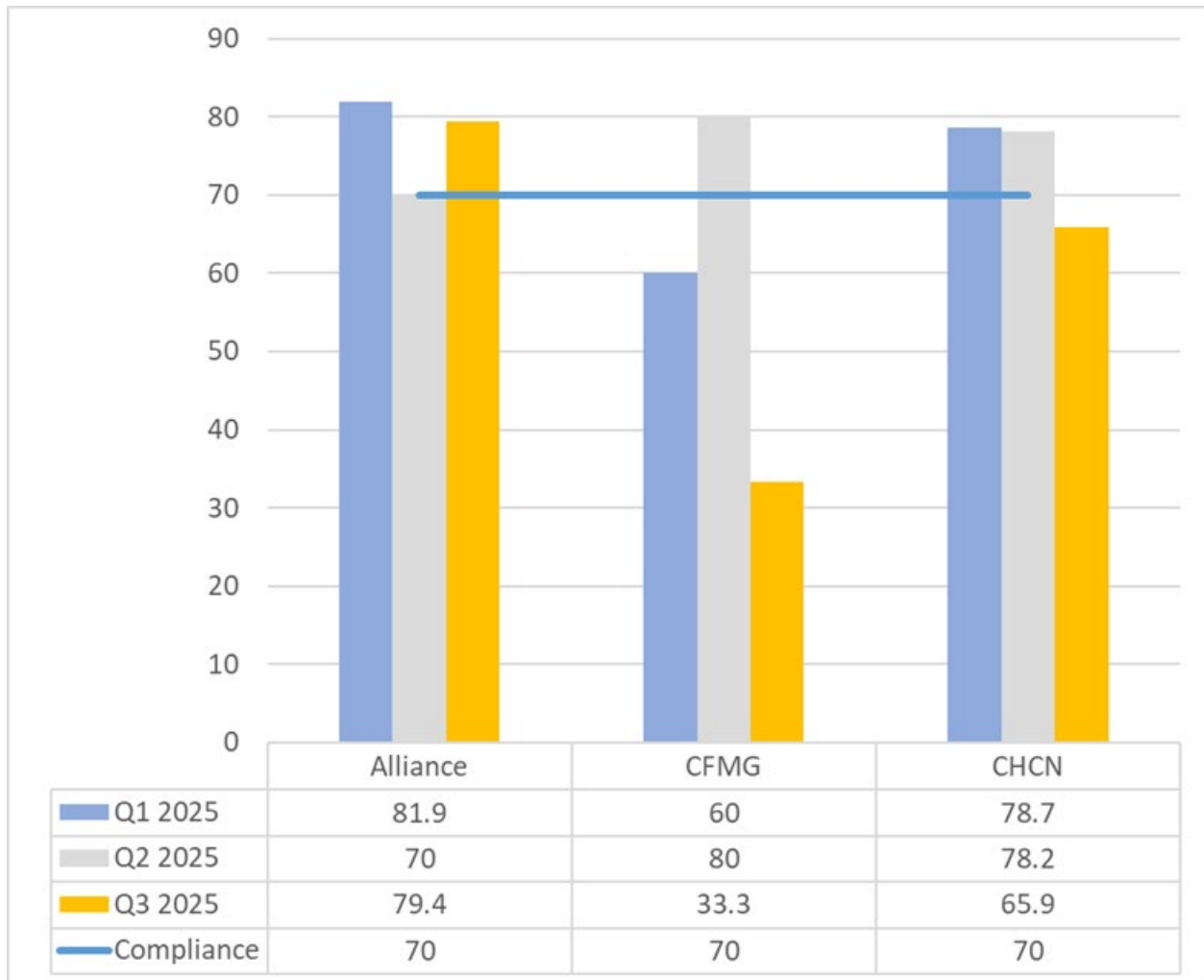
- Time to answer call – when a member called provider’s office during regular office hours, how long did a member wait to speak to a staff member:
 - Compliance rate: 0 – 10 minutes
- All delegates providers continue to score above the 70% compliance threshold from Q4 2025 to Q3 2025.

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



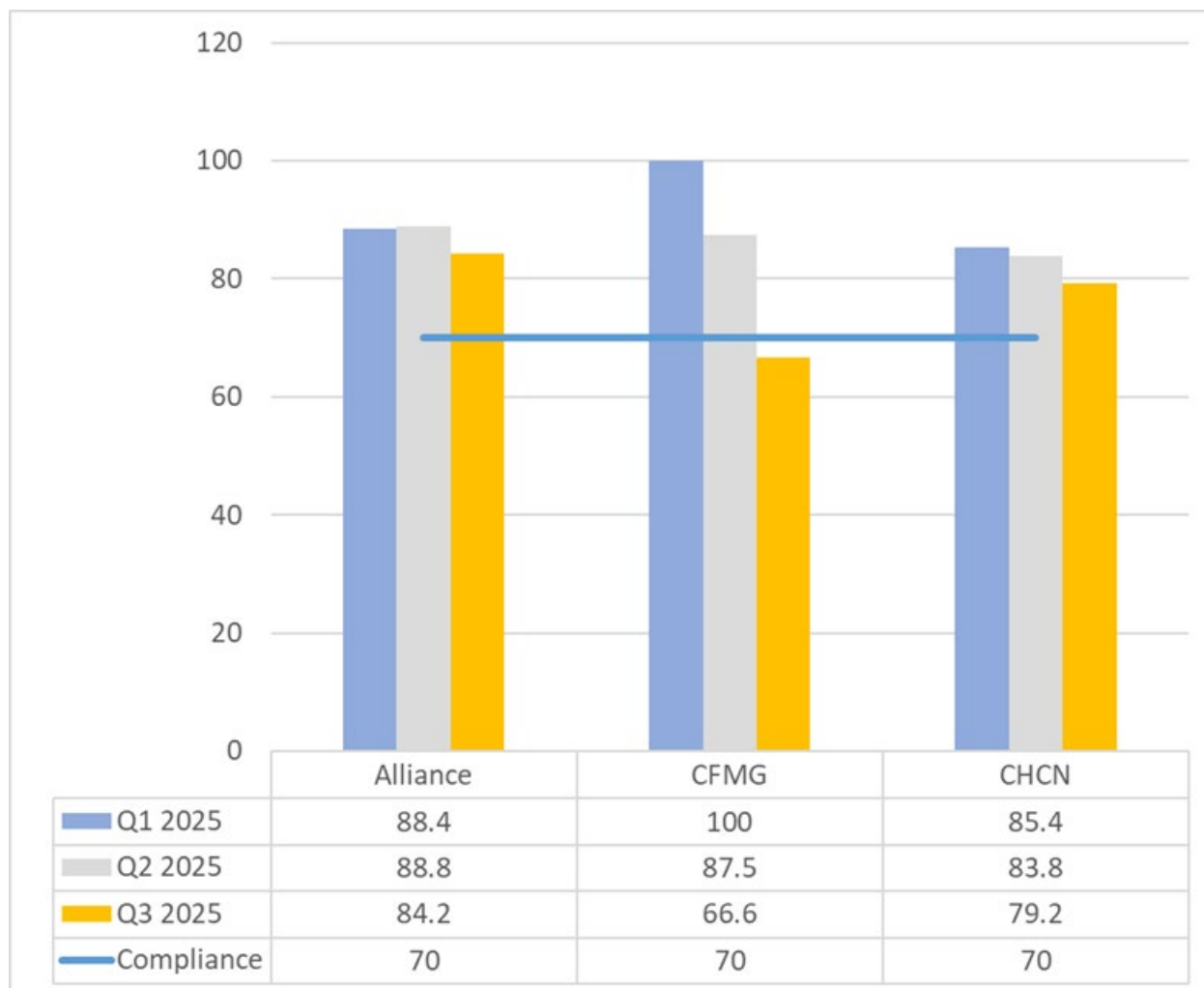
- Office wait time includes both times spent in the waiting room and the exam room before seen by the doctor:
 - Compliance rate: Less than 60 minutes
- Only CFMG did not meet the threshold goal in Q1 2025 and Q3 2025. All other network providers met the 80% threshold goal from Q1 2025 to Q3 2025.

SPEC Call Return Time Compliance Rate by Network (%)



- 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 Alliance continues to meet the 70% threshold goal from Q1 2025 to Q3 2025. CFMG and CHCN show decreased in compliance rate and did not meet the threshold goal for Call Return Time in Q3 2025.

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



- 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
- CFMG shows a 20.9% decrease in compliance rate and did not meet the threshold goal for Time to Answer Call for Q3 2025. All other network providers met the 70% threshold goal from Q1 2025 to Q3 2025.

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 providers not meeting compliance rate year over year.
- CAPs to be sent to non-compliant providers.



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Health Equity

Lao Paul Vang

To: Alameda Alliance for Health Board of Governors
From: Lao Paul Vang, Chief Health Equity Officer
Date: February 13th, 2026
Subject: Health Equity Report

Internal Collaboration

- **Ongoing 1x1 meetings and check-ins with Division Chiefs Update**
 - The CHEO meets with the Alliance division chiefs on a 1x1 basis monthly to update on Health Equity (HE) and Diversity, Equity, and Inclusion (DEI) activities.
- **NCQA Health Equity Related Issues**
 - As of August 2025, the Alliance is officially NCQA-accredited for Health Equity (HE) across both Medi-Cal and Group Care lines of business for a period of three years.
- **PHM Workgroup**
 - The Health Equity team continues to collaborate with the PHM team and participates in the weekly PHM workgroup, including reviewing new PHM strategies for the upcoming year.
- **Over/Under Utilization Workgroup**
 - The Health Equity team continues to meet with the Healthcare Service workgroup to discuss and share best practices for overcoming over- and underutilization.

External Collaboration

- **Bay Area Mongolian Community Association (BAMCA):**
 - The Alliance serves a small number of high-need, high-risk Mongolian Medi-Cal members. Although DHCS does not have disaggregated data about the Mongolian Americans in Alameda, it is estimated that a significant number of the 1500 residents living in Alameda County are enrolled in Medi-Cal.
 - The Health Equity team has reached out to this marginalized group and offered to assist them in developing a customized community health assessment to better understand the marginalized ethnic group who are invisible in all national and local data.
- **Health & Human Resource Education Center (HHREC)**
 - Initiated discussion with the local community-based organization for collaborative education outreach for our faith-based organizations.

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update**
 - Ongoing discussions regarding health equity-related issues and DEI training curriculum.
- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**
 - The DHCS CHEO and MCPs CHEOs meet to collaborate on Health Equity and DEI initiatives.
 - The meeting included updates from DHCS and CHEO.
- **Local Initiatives DEI Training Monthly Collaborative Meeting**
 - Local MCPs continue to meet to update, share, and collaborate on the DEI Training Program. The monthly collaborative allows MCPs to ask questions, update each other on curriculum information, discuss potential risks, and assist with moving the DEI Training forward. Many FQHC agencies expressed concerns about complying with the DEI training requirement because it may impact their federal funding.

Alliance Health Equity Strategic Roadmap Update

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

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

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

Rationale of the grant:

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

Goals:

- To implement the **Beloved Black Babies (BBB) Initiative** to meet the unmet SDOH, which is a culturally appropriate and racially concordant post-natal group provided by Black medical providers for Black mothers and babies to improve the WCC and other social-emotional well-being among the Black mothers.
- The CIN grant, therefore, addresses two major health disparity gaps.
 - WCC among the Black members of the Alliance has consistently not met MPL. WCC is an HEDIS measure and part of the DHCS Bold Goals.
 - Lack of culturally appropriate care is a major SDOH among the Black community.

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

- The Brown and Black communities suffer 2 to 3 times more food insecurity than the White community in Alameda County.
- Food insecurity is significantly associated with chronic diseases, and statistically, our membership data indicates that the chronic diseases, such as diabetes and hypertension, disproportionately affect our Brown and Black members.
- Access to healthy food is an established major SDOH faced by many vulnerable populations.
- Food-is-Medicine or providing access to healthy food to our patients is identified as our priority SDOH Mitigation Measure for FY 2026-2027.

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

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

D. SDOH Mitigation exploration with Direct Engagement with Providers.

- Beginning Sept 2025, Health Equity, in partnership with the QI team, began direct engagement with providers in the bimonthly quality meeting series, with the goal to explore potential partnerships for SDOH Mitigation Measures (Milestone #6), specifically food-is-medicine.
 - a) Tiburcio Vasquez: 9/11/2025
 - b) La-Clinica San Antonio Health Center: 9/12/2025
 - c) Axis: 9/24/2025
 - d) La-Clinica San Antonio Health Center: 10/21/2025 (in-person visit)

e) Bay Well Health: 1/25/2025

Health Equity Roadmap Milestone Trackers: Below are the up-to-date achievements for the six milestones.

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

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

DHCS-DMCS APL Update

- **DEI Training APL 23-025 Update**
 - We received DHCS approval for the DEI training curriculum.
 - Updated Timeline:
 - May 2025: DEI Provider Training Pilot with California Cardiovascular Consultants (CCC)
 - May – June 2025: pilot training completed.
 - July to Dec 2025: training given to subcontractors, downstream subcontractors, and network providers.
- **APL 24-018: TGI-SB 923 Update**
 - The Transgender, Gender Diverse, and Intersex (TGI) Cultural Competency Training was provided to all the Alliance staff.
 - The next step is to train our member-facing vendors, contractors, and downstream subcontractors, followed by training our providers. However, due to federal regulations and the uncertain future of TGI training, the Alliance SLT decided on 12/15/2025 to temporarily pause the TGI training/project at this time.
 - Timeline and completion rate:
 - Dec 2024: confirmation of vendor.
 - Jan-Feb 2025: Implementation of training for all Alliance staff.
 - Feb 14: 97% of the Alliance staff completed the mandatory training. The 3% of non-completion represents staff who were on vacation or medical leave. Upon returning to the office, they will have up to 30 days to complete the training.

- Feb 14, 2025: submission of documents per APL to the State, including evidence-based TGI training curriculum, updated online Providers Directory for gender-confirming services, G&A, and Policy and Procedures.
- Feb 28, 2025: Attestation was submitted to DHCS.
- June 2025 to date: HE Team is working with the TGI work group to implement phase 2 and phase 3 of the training, which is member-facing vendors, contractors, and downstream subcontractors.
- October 7, 2025: Based on the current situation involving TGI and DEI, SLT decided to pause phase 3 of the TGI training. However, the TGI working group will continue to discuss and address specific issues that may impact DSNP's launch in January 2026.
- December 12, 2025: SLT decided to pause the TGI training project until further notice by the state.
- Jan 2026: The IPD team is working to close out the TGI training, but it may be provided upon request by any of our network contracted health providers.

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

E. DEIB Committee Update

- The DEIB Committee meeting on January 9th was canceled due to no agenda items.
- The draft of the DEIB charter is still in progress and not ready for the committee's discussion.
- The committee is awaiting official votes to move the monthly meetings to quarterly.

F. VIA Committee Update

- The VIA Committee meeting on January 13th was cancelled due to no agenda items.
- The draft of the VIA charter is still in progress and not ready for the committee's discussion.

Calendar of Community Engagements

CBO/FBO/Providers		Services	Status
1.	Bay Area Mongolian Community Association BAMCA	Non-profit organization that promotes the well-being of the small and underserved community of 1500 Mongolian residents living in the Bay Area	- Initiated collaborative discussions with the president of BAMCA in Jan 2026. - Visited with the president of BAMCA in person on Feb 4, 2026. - Goal to Co-develop community health assessment for the Mongolian community in Alameda.
2.	Asian Health System	Monthly food distribution	- Participated with the C&O team to support our provider partners' monthly food distribution on Feb 4, 2026. - Approximately 300 participants received food bags and educational resources.
3.	Health & Human Resource Education Center (HHREC)	Provider of education and training in health and wellness	- Initiated discussions for a strategic partnership to augment our outreach services to our faith-based organizations and other CBOs who are serving our medical members. - Visited with the CEO and her team on Feb 9, 2026.
4.	Alameda Health System	One of the pediatricians works predominantly with Black mothers and children.	10-21-2025: BBB grant-funded Partnership project kicked off. - Successful grant application of \$20K to implement a 10-month Beloved Black Babies Initiative (BBB): a culturally appropriate program designed to improve Well-Child measures and post-partum depression.
5.	La-Clinica St Antonia Health Center	One of Alliance's contracted providers that serves our members.	10-21-2025: Visited the on-site food pantry and reviewed the food-is-medicine services. 9-12-2025: Initiated partnership meeting. - Potential collaboration: data-driven food-is-medicine targeting chronic diseases.

6.	Glad Tidings International Church of God	Established in 1978, the church serves over 1,000 members and is well known in the Hayward community.	• 12-3-2025: visited with the church bishop and the executive director of the community outreach. • 10-21-2025: Visited the church food distribution. • 7-24-2025: Initiated meeting. • <i>Potential collaboration:</i> • Promoting resources in health education, e.g., Doula services, diabetes, and other chronic diseases.
7.	California Improvement Network	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.	• Feb 5, 2026: in-person meeting in Oakland. • Oct 9, 2026: in-person meeting in LA • May 8, 2025: in-person meeting in Oakland. • July 9, 2025: Presented health equity best practices at the Affinity group virtual meeting.
8.	School-based Health Center in Madison Park Academy, Oakland	One of the eight school-based health centers operated by Native Americans.	• July 8th, 2025: Visited the school clinic. • <i>Potential collaboration:</i> promote child health. • Collaborator: QI
9.	Allen Temple Baptist Church	A predominantly African American church established in 1919. They serve approximately 3,000 members and the broader community.	• June 2025: Initiated collaborative meetings. • <i>Potential collaboration:</i> Co-design community survey with the church to identify needs and SDOHs; support health education outreach to the congregation and community at large. •
10.	Native American Health Center	Native Americans and other PCP services, WIC, and dental.	• July 6th, 2025: Table at the annual Indigenous Red Market event. • December 2024: Visited the health center.
11.	Oakland Unified School District (OUSD)	The largest school district in Alameda County, serving about 33,000 students in about 75 schools, K-12.	• April 2025: Collaborative meetings initiated. • <i>Potential collaboration:</i> Co-design Parent Survey with

			OUSD to study food insecurity and SDOHs.
12.	Black Women's Health Forum	Annual event to raise awareness about healthy living resources available to Black women in the Bay Area.	• April 8th, 2025: Table event to support and build relationships. • Collaborator: C&O
13.	Oakland Catholic Workers	Provides transitional housing and resettlement resources to Central American refugees and immigrants.	• March 2025: initiated collaborative meetings. • Resource sharing. • Collaborator: PHM
14.	True Vine Ministries Church	Serves predominantly African Americans in the West Oakland area.	• RWJF Grant application of \$250K submitted in June 2025 for a one-year grant-funded intervention to advance mental health healing through the arts. The grant application was unsuccessful.
15.	Oakland Black Cowboy Assoc., City of Oakland, Black Cowboy Parade & Heritage Festival	Local organization is celebrating its 51 st annual parade & festival in the community	• 10-4-2025: Hosted an information booth from 10-6 PM. • Bring visibility to the Alliance within the community. • Collaborator: C&O
16.	Youth ALIVE, "Free Your Mind: An Imaginative Evening Benefiting Youth ALIVE!"	Youth Alive is a community-based violence prevention, intervention, and healing organization based in Oakland since 1991, whose mission is to break the cycle of violence.	• Attended their benefit and informational on 11/13/2025, in collaboration with our Community Health Strategy Department. • Will continue building a relationship with one of our CHWs to help address one of Alameda County's CHIP Priorities: "Promoting Peaceful Families and Communities."
17.	Black Men's Brain Health Initiative: 2026 Black Men's Brain Health Conference	The fifth annual conference advocates to focus on brain health, Alzheimer's disease, mental wellness, and reducing health disparities among Black men.	• Attended the fifth annual conference focused on Black men's brain health, which aims to empower communities, especially the Black community, through education, prevention, and access to trusted health information and resources. • Continuing to partner and collaborate with our CHS department.



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Information Technology

Sasikumar Karaiyan

To: Alameda Alliance for Health Board of Governors

From: Sasi Karaiyan, Chief Information & Security Officer

Date: February 13th, 2026

Subject: Information Technology Report

Encounter Data

- In the month of January 2026, the Alliance submitted 117 encounter files to the Department of Health Care Services (DHCS) with a total of 358,365 encounters.

Enrollment

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

HEALTHsuite

- The Alliance received 373,154 claims in the month of January 2026.
- A total of 286,407 claims were finalized during the month out of which 247,802 claims auto adjudicated. This sets the auto-adjudication rate for this period to 86.5%.

TruCare

- A total of 22,200 authorizations were loaded and processed in the TruCare application.
- TruCare Application Uptime – 99.9%.

IT Security Program

- Perm Statement: The IT Security 3.0 initiative ranks among the Alliance's foremost objectives for fiscal year 2026. 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.
- Continued hardening of IT Security controls – (1) creating standard for remote desktop service server (2) follow-up penetration test completed with expected results (3) adjusted monthly simulated phishing emails to be more organizationally sensitive.
- Completed micro-segmentation vendor selection.

Intune Mobile Migration

- Intune mobile migration for company owned devices.
- Purpose: Standardize mobile device management under Microsoft Intune for improved security.
- Enrollment phase for company owned devices complete.

Intune BYOD Migration

- Intune mobile migration for BYOD devices initiative currently in progress.
- Purpose: Standardize mobile device management under Microsoft Intune for improved security.
- Enrollment phase for company owned devices complete.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of January 2026”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of January 2026”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Month	Total MC ¹	MC ¹ - Add/ Reinstatements	MC ¹ - Terminated	Total GC ²	GC ² - Add/ Reinstatements	GC ² - Terminated	Alliance Wellness
January	399,028	3,143	6,352	6,139	142	101	170

Table 1-1 Summary of Medi-Cal, Wellness and Group Care Member enrollment in the month of January 2026

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 2026

Auto-Assignments	Member Count
Auto-assignments MC	1,904
Auto-assignments Expansion	1,895
Auto-assignments GC	87
Auto-assignment Alliance Wellness	23
PCP Changes (PCP Change Tool) Total	3,758

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of January 2026”.
- There were 22,200 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 2026

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,664
Provider Portal Requests (Zipari)	6,641
EDI (CHCN)	6,629
ADT	1,347
Behavioral Health COC Update - Online	36
Behavioral initial evaluation - Online	80
Manual Entry	2,847
OCR Face sheets	1,956
Total	22,200

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)

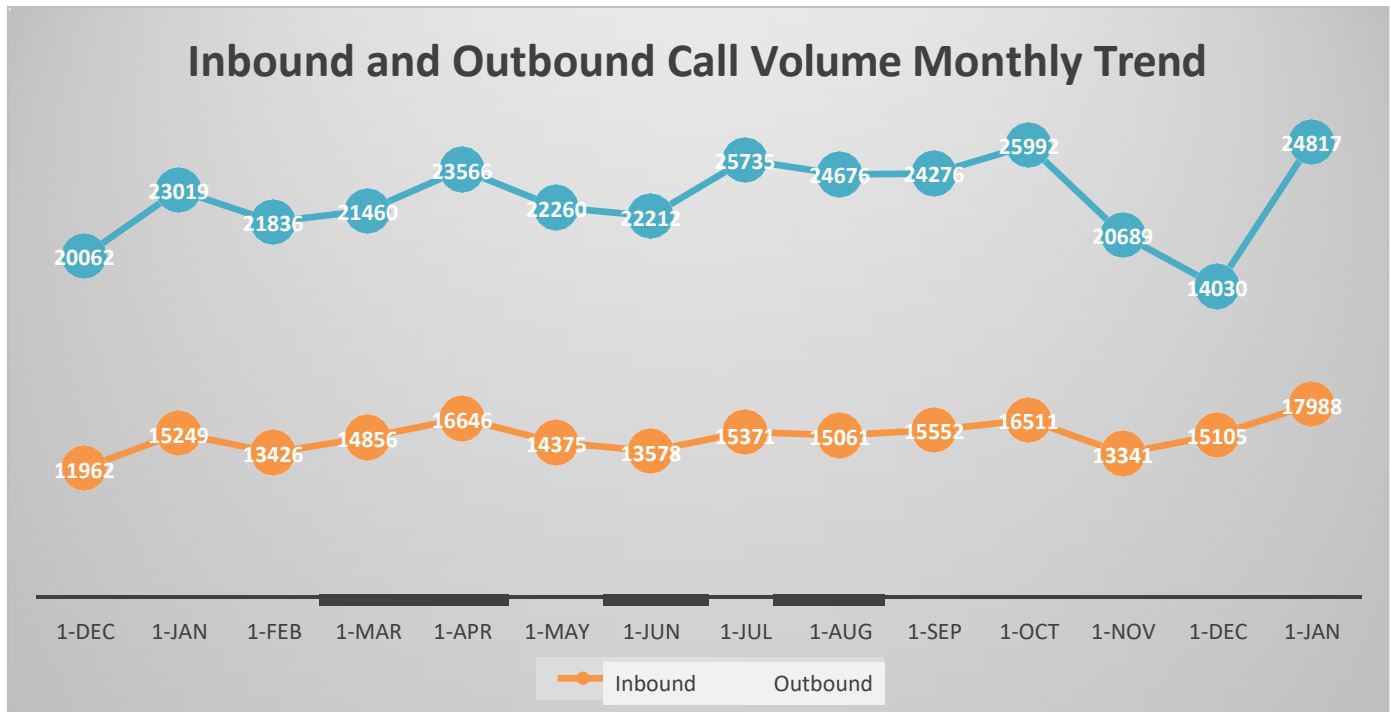
Table 3-1 Web Portal Usage for the Month of December 2025

Group	Individual User Accounts	Individual User Accounts Accessed		Total Logins	New Users
Provider	9,770	6,422		644,766	734
MCAL	136,555	3,764		8,934	1,135
IHSS	4,253	74		766	33
Total	150,578	10,260		654,466	1,992

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

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	2,080,703
Provider - Claims	Claim Status	267,656
Provider - authorizations	Auth Search	10,845
Directory Config	Provider Directory	9,451
Provider - authorizations	Auth Submit	8,109
Provider - Claims	Submit professional claims	6,025
Member My Care	Member Eligibility	4,312
Member Help Resources	Find a Doctor or Hospital	2,862
Member Help Resources	ID Card	2,482
Provider - eligibility/claim	Member Roster	2,364
Member Help Resources	Select or Change Your PCP	1,887
Provider - Home	Behavior Health Forms SSO	1,574
Member Home	MC ID Card	1,505
Provider - Home	Long Term Care Forms SSO	1,480
Member My Care	My Claims Services	1,451
Provider - Provider Directory	Provider Directory 2019	994
Member Config	Provider Directory	898
Member My Care	My Benefits	724
Member My Care	Authorization	703
Provider - Home	Forms	632
Member My Care	My Pharmacy Medication Benefits	548
Provider - reports	Reports	489
Member My Care	Member Benefits Materials	310
Member Help Resources	FAQs	294
Member Help Resources	Forms Resources	233

Call Center – Call Volume Overview:



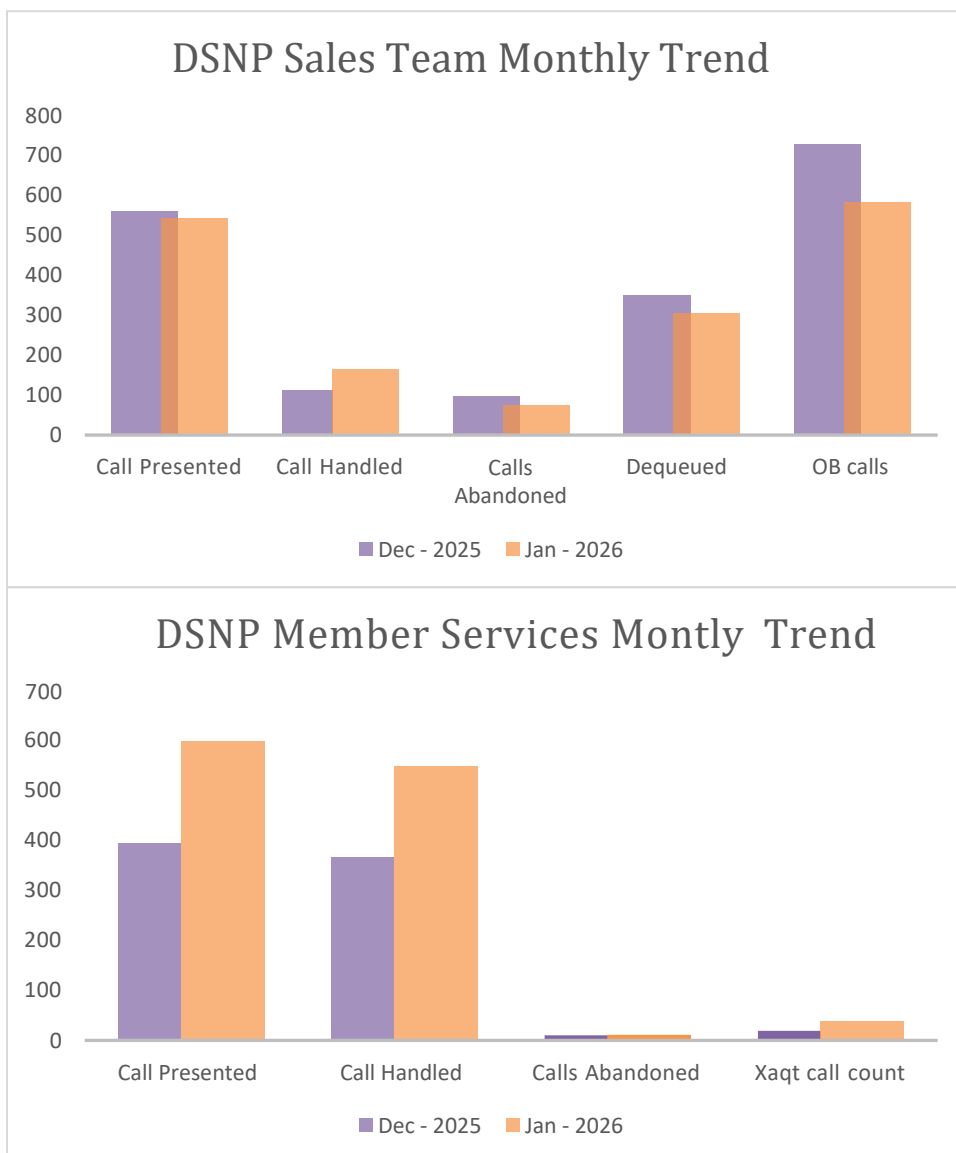
Members - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
August	13903	10487	1291
September	14280	11457	1253
October	14628	12104	705
November	11827	9662	515
December	13436	11549	594
January	15727	12696	731

Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
August	11243	8692	1926
September	11421	8473	2182
October	10884	8763	1592
November	8821	6474	1750
December	10851	7853	2251
December	13333	8809	3495

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

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

Call Center – DSNP Sales and Member Services:

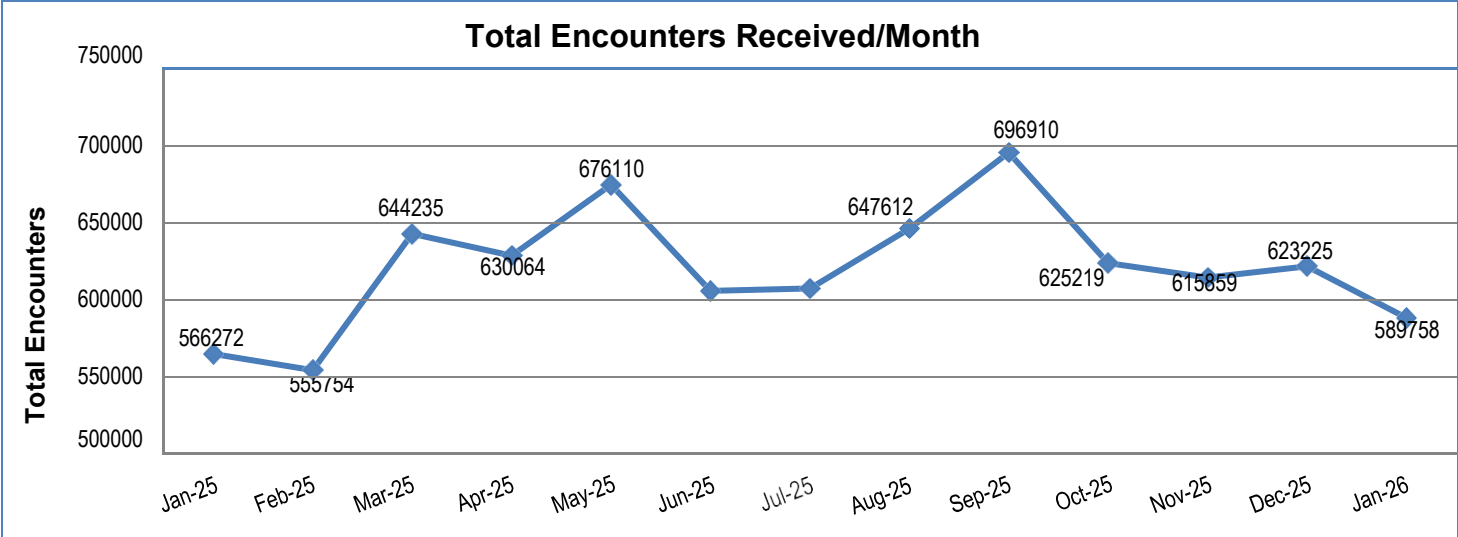


Encounter Data from Trading Partners 2026

- **AHS:** January weekly files (8,345 records) were received on time.
- **BACH:** January monthly files (0 records) were received on time.
- **BACS:** January monthly files (196 records) were received on time.
- **CHCN:** January weekly files (104,101 records) were received on time.
- **CHME:** January monthly files (8,492 records) were received on time.
- **CFMG:** January weekly files (10,692 records) were received on time.
- **Docustream:** January monthly files (1,568 records) were received on time.
- **EBI:** January monthly files (1,856 records) were received on time.
- **FULLCIR:** January monthly files (462 records) were received on time.
- **HCSA:** January monthly files (2,532 records) were received on time.
- **IOA:** January monthly files (1,697 records) were received on time.
- **LAFAM:** January monthly files (87 records) were received on time.
- **LIFE:** January monthly files (250 records) were received on time.
- **LogistiCare:** January weekly files (34,215 records) were received on time.
- **March Vision:** January monthly files (10,116 records) were received on time.
- **MED:** January monthly files (1,443 records) were received on time.
- **PAIRTEAM:** January monthly files (7,419 records) were received on time.
- **Quest Diagnostics:** January weekly files (18,001 records) were received on time.
- **SENECA:** January monthly files (360 records) were received on time.
- **SERENE:** January monthly files (0 records) were received on time.
- **TITANIUM:** January monthly files (4,746 records) were received on time.
- **TVHC:** January monthly files (26 records) were received on time.
- **Magellan:** January monthly files (561,166 records) were received on time.

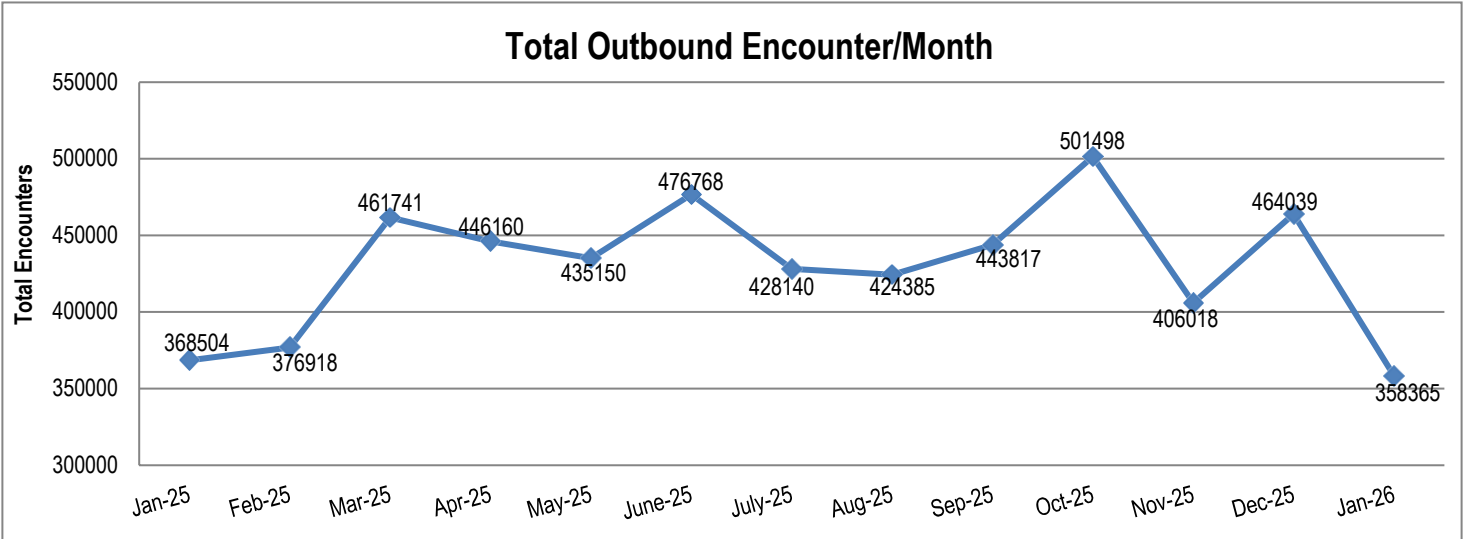
Trading Partner Encounter Inbound Submission History

Trading Partners	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Health Suite	339760	339840	347469	372126	387564	340224	355255	389082	372025	372246	349052	320327	373154
AHS	9709	8654	9273	8211	15875	7712	7880	10257	8455	9267	11333	8671	8345
BACH	426		291	131		296	172	172	180	181			
BACS	93	113	81	72	88	128	81	82	100	102	114	109	196
CHCN	117483	118972	181049	117350	151416	170810	125697	132885	170744	152102	138524	157589	104101
CHME	7781	7553	6794	8293	9045	8638	8115	8368	8228	7938	9119	7579	8492
CFMG	13536	17329	21767	15856	21443	15710	13266	13336	20280	17075	20083	16647	10692
Docustream	694	808	770	891	1068	1052	1216	707	423	830	322		1568
EBI	1440	1597	1390	2926	1457	1381	2946	1940	1800	1823	1922	1683	1856
FULLCIR	806	1534	2099	2025	1479	1441	3266	3972	5006	2176	168	1358	462
HCSA	2432	2725	2118	2384	2628	2467	2671	2453	2930	172	2481	2876	2532
IOA	3008	933	736		2068	3083	1851	635	1377	1683		3095	1697
LAFAM	112	96	85	93	101	81	85	83	74	87	247	84	87
LIFE	228	267	431	317	1274	412	388	541	245	290	330	361	250
LogistiCare	28671	32550	33754	55059	35875	15025	38834	34040	62760	15649	36206	59563	34215
March Vision	15146		6985	6704	7929	8100	6914	7877	8374	9295	9338	7336	10116
MED	758	1182	775		1581	958	2722	1246	1172	1468	1299	2894	1443
PAIRTEAM	3436		2055	16360	9244	7724	15956	14426	9446	9972	7871	10633	7419
Quest	18002	18001	22502	18003	22501	18000	18000	22500	18001	18001	22500	18004	18001
SENECA	1	69	129	108	109	160	76		188	66		123	360
SERENE	107		209				581						
TITANIUM	2487	3531	2855	3039	2970	3792	2782	3010	4102	4796	4950	4244	4746
TVHC	156		618	116	395							49	26
Total	566272	555754	644235	630064	676110	607194	608754	647612	696910	625219	615859	623225	589758



Outbound Encounter Submission

Trading Partners	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Health Suite	182192	205804	264948	210745	226401	284779	212832	228707	246133	243105	207026	228028	188845
AHS	7710	8135	7952	4510	9326	14010	7038	10166	8358	9125	11095	8218	8090
BACH	407		272	110		270	138		147	139			
BACS	128	87	59	23	51	59	60	52	82	77	86	79	96
CHCN	85439	82973	95918	115571	106733	98329	106648	92163	89837	133350	93935	101887	69962
CHME	7426	7167	6682	8156	8914	8471	7991	8232	8090	7822	8407	7470	7697
CFMG	9362	11960	15008	11394	12430	13853	9238	9252	10764	11978	11518	13611	7425
Docustream	634	559	478	551	540	385	381	192	131	247	99		338
EBI	2208	1475	1308	1493	1346	1328	1885	1745	1634	1718	1834	1600	1770
FULLCIR	1298	1251	1823	1658	1155	1236	2889	3407	2713	1748	89	1081	165
HCSA	2497	2693	2103	2332	2603	2448	2637	2430	2871	149	2462	2840	2505
IOA	2783	781	626		48	1836	1732	551	1176	1304		2911	1617
LAFAM	178	89	80	84	90	67	80	76	69	84	93	83	87
LIFE	508	63	65	116	93	202	122	142	152	111	222	175	140
LogistiCare	28502	32441	33656	54971	35829	15010	38763	33974	36968	41267	36150	59480	34166
March Vision	9586	371	4354	3870	4591	4657	3888	4183	4724	5103	4847	3696	6051
MED	546	1083	731		595	553	2471	1124	974	1103	1160	1547	1360
PAIRTEAM	6334		1489	10873	4670	4549	9364	8386	8229	7901	5824	6500	6777
Quest	16828	16855	21048	16795	16853	21031	16774	16903	16855	20951	16810	20937	16905
SENECA	112	60	116	101	98	139	63		164	19		109	319
SERENE	82		20				569						
TITANIUM	3600	3071	2551	2764	2714	3556	2577	2700	3746	4227	4361	3772	4039
TVHC	144		454	43	70							15	11
Total	368504	376918	461741	446160	435150	476768	428140	424385	443817	501498	406018	464039	358365

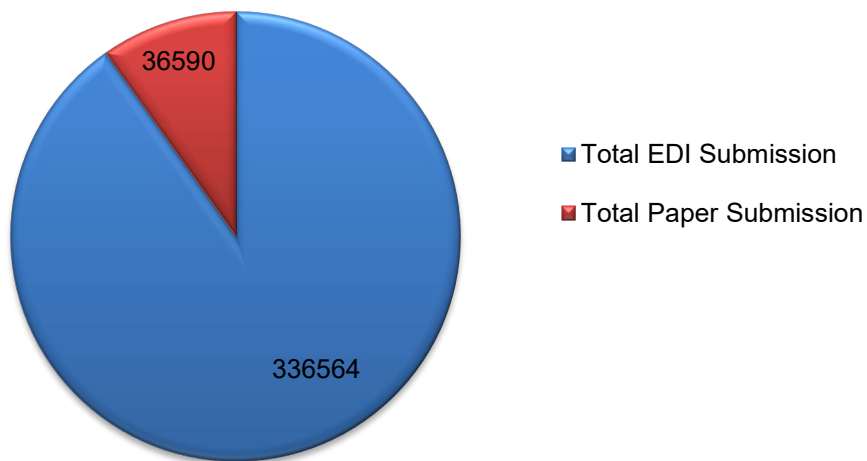


HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
26-Jan	336,564	36,590	373,154

Key: EDI – Electronic Data Interchange

EDI vs Paper Submission, January 2026

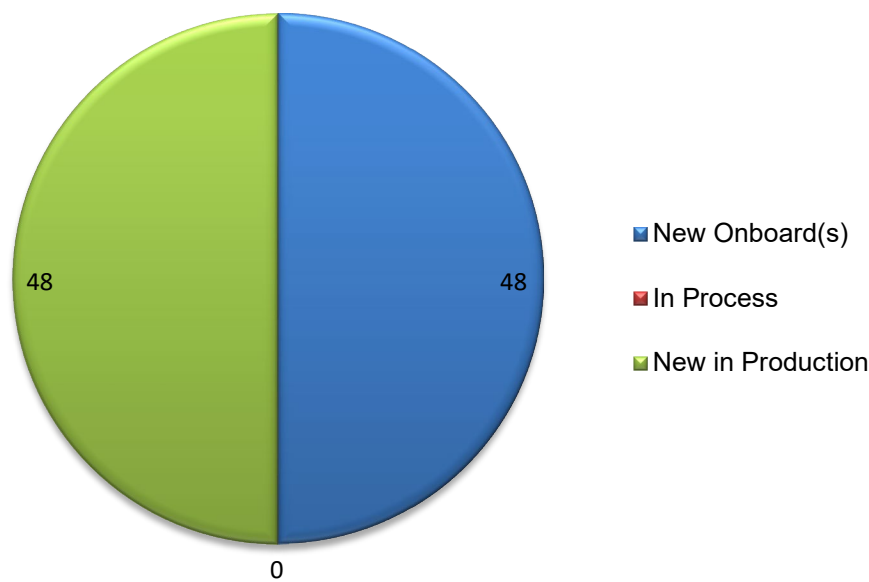


Onboarding EDI Providers – Updates

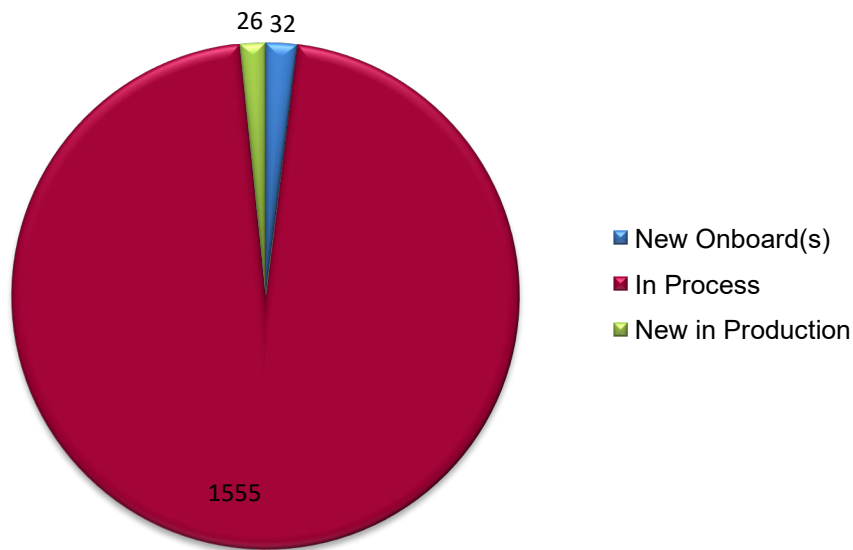
- January 2026 EDI Claims:
 - A total of 3403 new EDI submitters has been added since October 2015,
 - with 48 added in January 2026.
 - The total number of EDI submitters is 4143 providers.
- January 2026 EDI Remittances (ERA):
 - A total of 1597 new ERA receivers have been added since October 2015,
 - with 26 added in January 2026.
 - The total number of ERA receivers is 1613 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-25	58	16	42	3654	83	1286	31	1307
Mar-25	46	3	43	3697	74	1328	32	1339
Apr-25	38	14	24	3721	63	1370	26	1365
May-25	47	3	44	3765	77	1402	45	1410
Jun-25	52	25	27	3792	62	1445	19	1429
Jul-25	52	0	52	3844	60	1487	18	1447
Aug-25	35	19	16	3860	37	1502	22	1469
Sep-25	92	6	86	3946	65	1516	51	1520
Oct-25	76	11	65	4011	42	1528	30	1550
Nov-25	41	7	34	4045	26	1536	18	1568
Dec-25	50	0	50	4095	32	1549	19	1587
Jan-26	48	0	48	4143	32	1555	26	1613

837 EDI Submitters - Jan 2026



835 EDI Receivers - Jan 2026



Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

- EDSRF Submission: Below is the total number of encounter files that AAH submitted in the month of **January** 2026.

File Type	Jan-26
837 I Files	24
837 P Files	93
Total Files	117

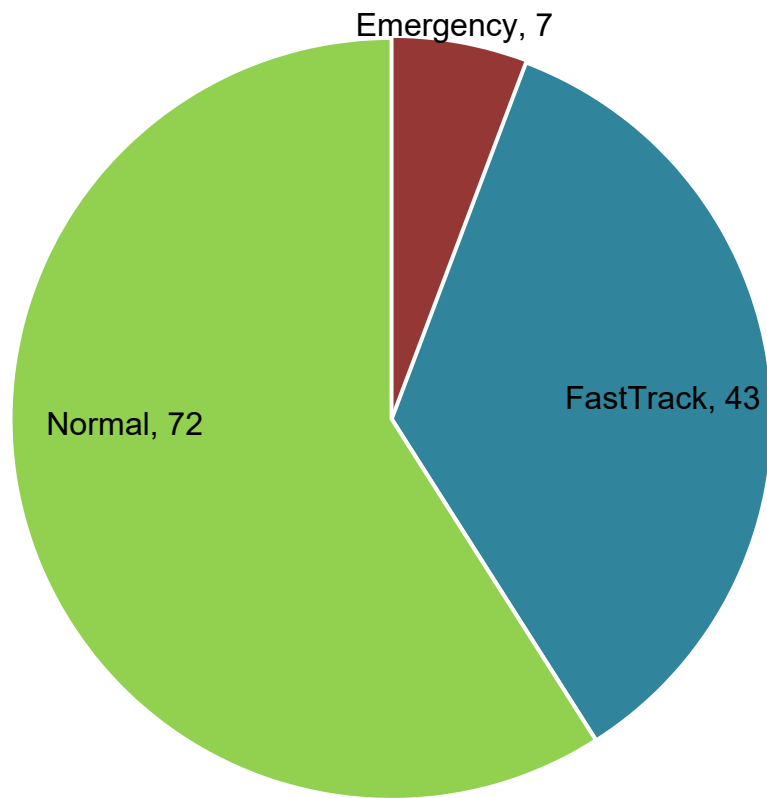
Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Jan-26	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	87%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	92%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

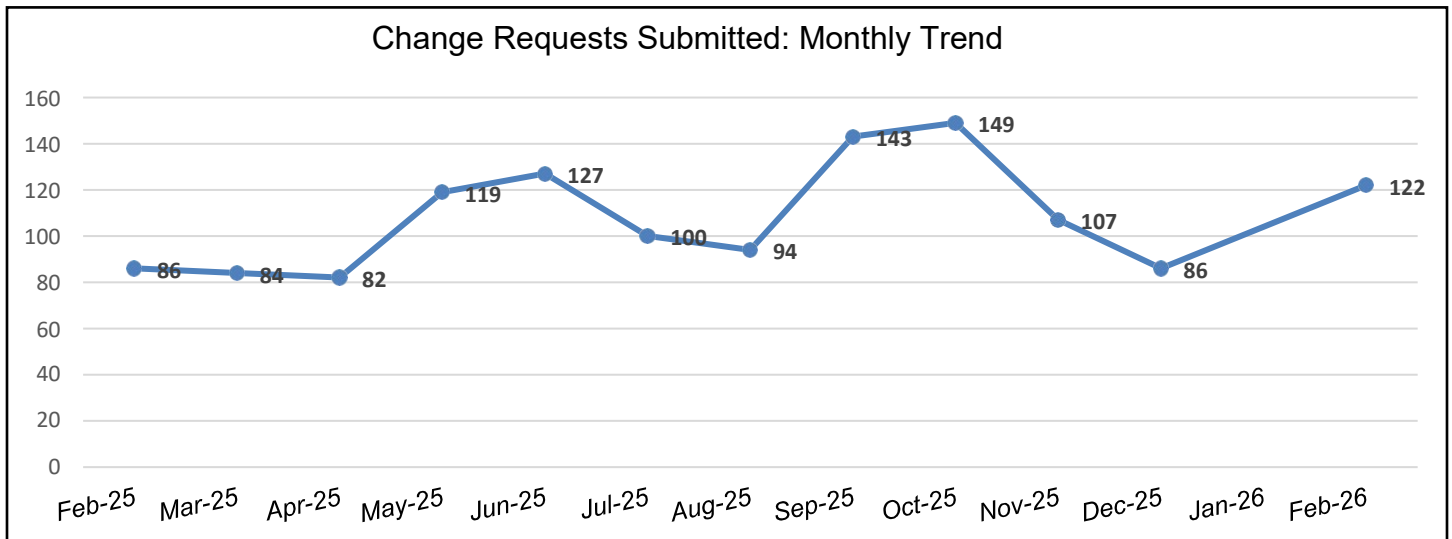
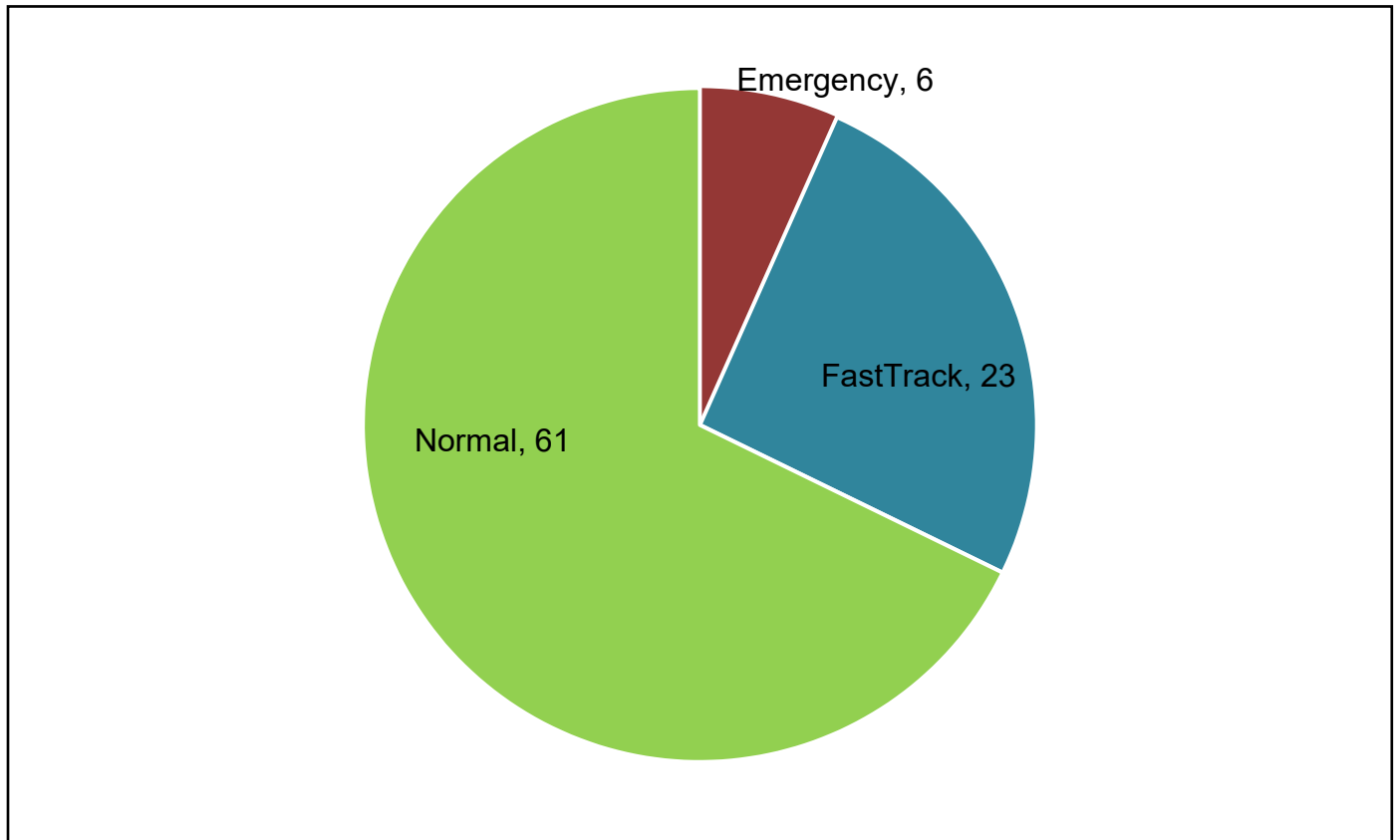
*Note, the Number of Encounters comes from: Total at bottom of this chart: **Outbound Encounter Submission**

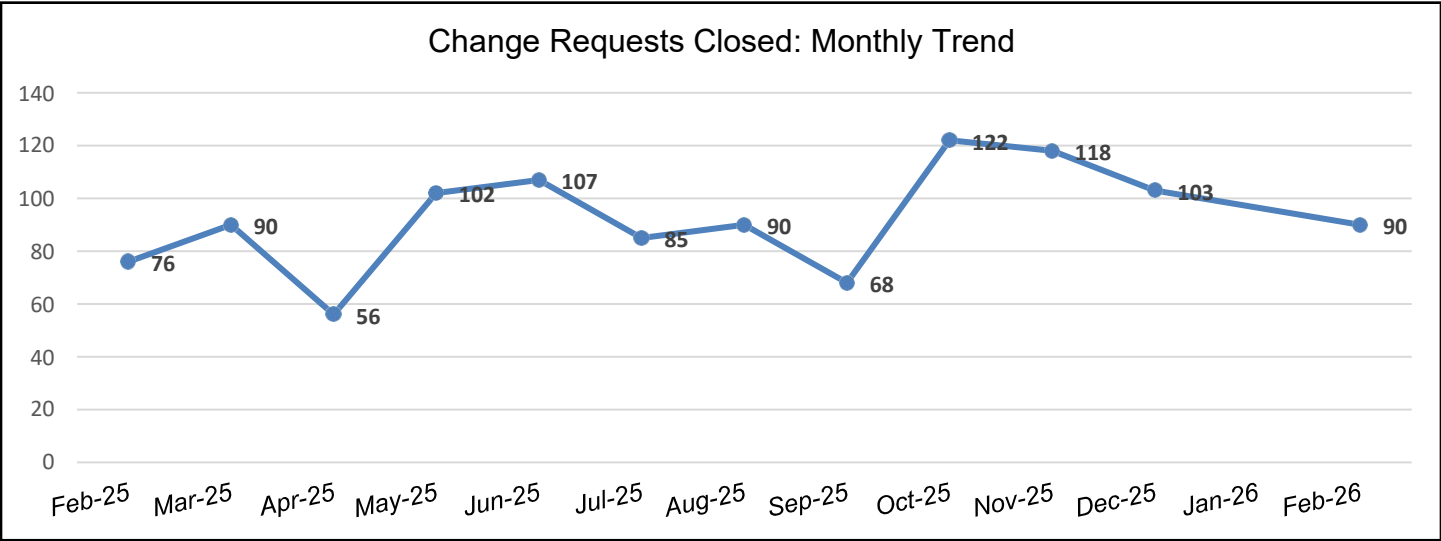
Change Management Key Performance Indicator (KPI)

- Change Request Overall Summary in the month of January 2026 KPI:
 - 122 Changes Submitted.
 - 90 Changes Completed and Closed.
 - 178 Active Change Requests in pipeline.
 - 11 Change Requests Cancelled or Rejected.
- 122 Change Requests Submitted in the month of January 2026



90 Change Requests Closed in the month of January 2026

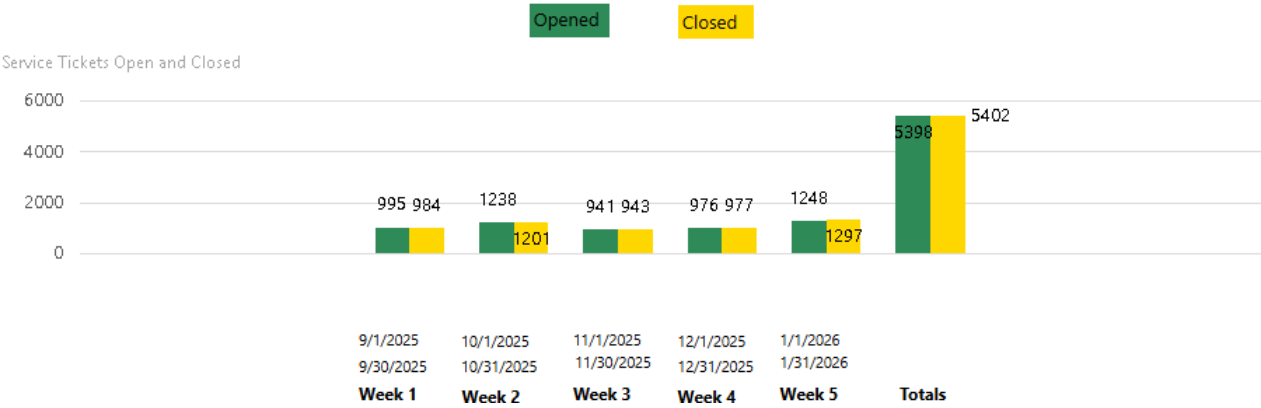




IT Stats: Service Desk

Month	Open Tickets	Closed Tickets
September	995	984
October	1238	1201
November	941	943
December	976	977
January	1248	1297

IT Service Tickets Open and Closed



- 1248 Service Desk tickets were opened in the month of January 2026, which is 21.79% higher than the previous month (976) and 16.86% higher than the previous 4-month average of 1038.
- 1297 Service Desk tickets were closed in the month of January 2026, which is 24.67% higher than the previous month (977) and 20.87% higher than the previous 4-month average of 1026.

IT Stats: Security

Security Updates

Completed			
Provided OKTA revamp plan			
Trued-up OKTA licensing count			
Supplied security verbiage provided to DR runbook			
Follow up pen test completed (report provided)			
Network Micro-Segmentation vendor selection complete			
Underway / Work-In-Progress	% Complete	ETC	Status
Pen test (original + follow up) items in process	69%	1.1.26	Delayed
Cisco Secure Workload (CSW) pricing + contract underway			
Resumed Security Risk Assessment remediations	32%	6.1.26	On-Track
Cisco Umbrella – Gen AI use-case (Debbie)	33%	2.28.26	On-track
Resources			
● JIRA workloads (Project: IT Security and Compliance)			
TrackIT workloads (WIP)			



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 13th, 2026

Subject: Performance & Analytics Report

Member Cost Analysis

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

Current reporting period: Nov 2024 – Oct 2025 dates of service

Prior reporting period: Nov 2023 – Oct 2024 dates of service

(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 12.3% of members account for 89.5% of total costs.
- In comparison, the Prior reporting period was lower 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/LTC (non duals) and ACA OE categories of aid decreased to account for 54.1% of the members, with SPD/LTCs accounting for 18.1% and ACA OE's at 36.0%.
 - The percent of members with costs $\geq$ \$30K increased from 2.6% to 3.1%.
 - Of those members with costs $\geq$ \$100K, the percentage of total members has slightly increased to 1.0%.
 - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 29.6%.
 - Demographics for member city and gender for members with costs $\geq$ \$30K follow the same distribution as the overall Alliance population.
 - However, the age distribution of the top 12.3% is more concentrated in the 45-66 year old category (33.4%) compared to the overall population (20.6%).

Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis

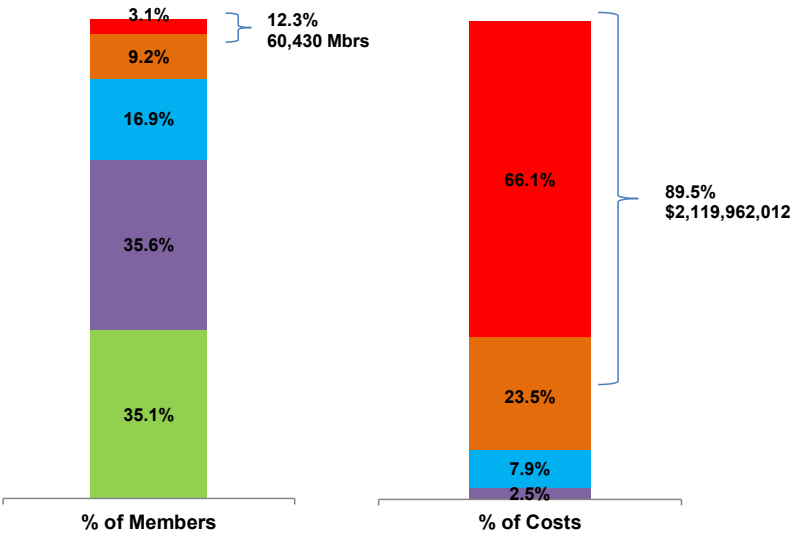
Lines of Business: MCAL, IHSS; Excludes Kaiser Members

Dates of Service: Nov 2024 - Oct 2025

Note: Data incomplete due to claims lag

Run Date: 01/28/2026

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
\$30K+	15,293	3.1%	\$ 1,563,673,764	66.1%
\$5K - \$30K	45,137	9.2%	\$ 556,288,248	23.5%
\$1K - \$5K	82,808	16.9%	\$ 188,201,537	7.9%
< \$1K	174,258	35.6%	\$ 59,208,877	2.5%
\$0	171,892	35.1%	\$ -	0.0%
Totals	489,388	100.0%	\$ 2,367,372,427	100.0%

Enrollment Status	Members	Total Costs
Still Enrolled as of Oct 2025	405,541	\$ 2,146,209,860
Dis-Enrolled During Year	83,847	\$ 221,162,566
Totals	489,388	\$ 2,367,372,427

Top 12.3% of Members = 89.5% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
\$100K+	4,988	1.0%	\$ 1,012,337,905	42.8%
\$75K to \$100K	1,785	0.4%	\$ 155,859,216	6.6%
\$50K to \$75K	2,967	0.6%	\$ 181,114,210	7.7%
\$40K to \$50K	2,189	0.4%	\$ 97,863,199	4.1%
\$30K to \$40K	3,364	0.7%	\$ 116,499,235	4.9%
SubTotal	15,293	3.1%	\$ 1,563,673,764	66.1%
\$20K to \$30K	6,428	1.3%	\$ 155,763,317	6.6%
\$10K to \$20K	17,664	3.6%	\$ 250,732,090	10.6%
\$5K to \$10K	21,045	4.3%	\$ 149,792,840	6.3%
SubTotal	45,137	9.2%	\$ 556,288,248	23.5%
Total	60,430	12.3%	\$ 2,119,962,012	89.5%

Notes:

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis

12.3% of Members = 89.5% of Costs

Lines of Business: MCAL, IHSS; Excludes Kaiser Members

Dates of Service: Nov 2024 - Oct 2025

Note: Data incomplete due to claims lag

Run Date: 01/28/2026

12.3% of Members = 89.5% of Costs

18.1% of members are SPD/LTCs and account for 24.7% of costs.

36.0% of members are ACA OE and account for 33.3% of costs.

8.0% of members disenrolled as of Oct 2025 and account for 9.5% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Members	% of Members
IHSS	IHSS	221	985	1,206	2.0%
MCAL	MCAL - ADULT	1,354	8,362	9,716	16.1%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	756	4,052	4,808	8.0%
	MCAL - ACA OE	5,051	16,698	21,749	36.0%
	MCAL - DUALS	-	-	-	0.0%
	MCAL - SPD-LTC	3,841	7,080	10,921	18.1%
	MCAL - SPD-LTC/Full Dual	2,575	4,618	7,193	11.9%
Not Eligible	Not Eligible	1,495	3,342	4,837	8.0%
Total		15,293	45,137	60,430	100.0%

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Costs	% of Costs
IHSS	IHSS	\$ 18,558,071	\$ 11,708,815	\$ 30,266,886	1.4%
MCAL	MCAL - ADULT	\$ 125,872,940	\$ 103,030,317	\$ 228,903,257	10.8%
	MCAL - BCCTP	\$ -	\$ -	\$ -	0.0%
	MCAL - CHILD	\$ 56,197,051	\$ 46,368,853	\$ 102,565,903	4.8%
	MCAL - ACA OE	\$ 499,165,788	\$ 207,000,495	\$ 706,166,283	33.3%
	MCAL - DUALS	\$ -	\$ -	\$ -	0.0%
	MCAL - SPD-LTC	\$ 432,606,687	\$ 91,409,061	\$ 524,015,747	24.7%
	MCAL - SPD-LTC/Full Dual	\$ 270,713,308	\$ 55,705,760	\$ 326,419,068	15.4%
Not Eligible	Not Eligible	\$ 160,559,921	\$ 41,064,946	\$ 201,624,868	9.5%
Total		\$ 1,563,673,764	\$ 556,288,248	\$ 2,119,962,012	100.0%

% of Total Costs By Service Type

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs
\$100K+	4%	0%	1%
\$75K to \$100K	3%	0%	1%
\$50K to \$75K	5%	0%	2%
\$40K to \$50K	6%	0%	2%
\$30K to \$40K	9%	0%	3%
\$20K to \$30K	2%	1%	5%
\$10K to \$20K	0%	0%	11%
\$5K to \$10K	1%	0%	4%
Total	4%	0%	3%

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

26.8% of members are SPD/LTCs and account for 29.5% of costs.

27.0% of members are ACA OE and account for 30.3% of costs.

8.8% of members disenrolled as of Oct 2025 and account for 10.0% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	49	1.0%
MCAL	MCAL - ADULT	302	6.1%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	91	1.8%
	MCAL - ACA OE	1,347	27.0%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,338	26.8%
	MCAL - SPD-LTC/Full Dual	1,420	28.5%
Not Eligible	Not Eligible	441	8.8%
Total		4,988	100.0%

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	\$ 9,911,081	1.0%
MCAL	MCAL - ADULT	\$ 73,186,859	7.2%
	MCAL - BCCTP	\$ -	0.0%
	MCAL - CHILD	\$ 24,710,536	2.4%
	MCAL - ACA OE	\$ 306,709,910	30.3%
	MCAL - DUALS	\$ -	0.0%
	MCAL - SPD-LTC	\$ 298,651,985	29.5%
	MCAL - SPD-LTC/Full Dual	\$ 198,322,808	19.6%
Not Eligible	Not Eligible	\$ 100,844,726	10.0%
Total		\$ 1,012,337,905	100.0%

Breakout by Service Type/Location

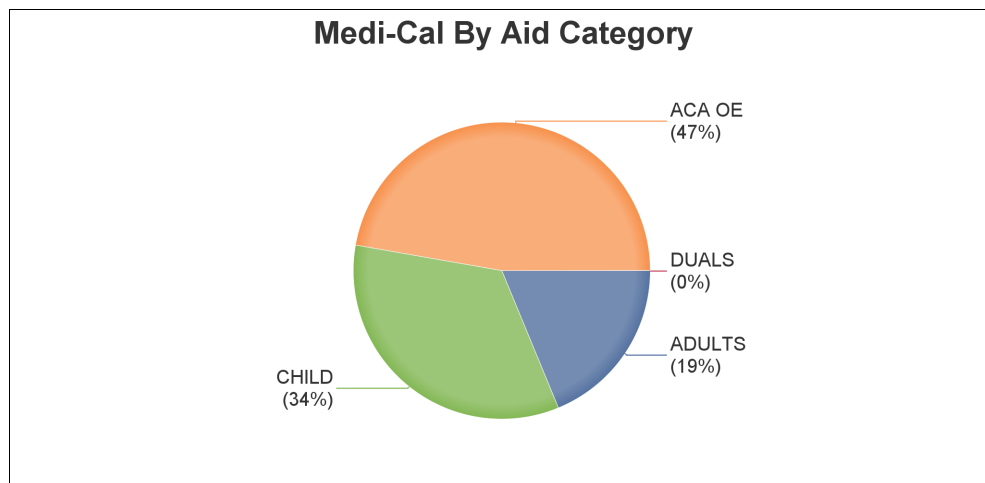
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
\$100K+	4%	0%	1%	15%	34%	1%	10%	3%	2%	35%
\$75K to \$100K	3%	0%	1%	21%	24%	3%	6%	4%	4%	38%
\$50K to \$75K	5%	0%	2%	28%	27%	5%	6%	7%	4%	23%
\$40K to \$50K	6%	0%	2%	34%	25%	8%	6%	8%	1%	19%
\$30K to \$40K	9%	0%	3%	33%	22%	12%	6%	8%	1%	18%
\$20K to \$30K	2%	1%	5%	37%	21%	7%	9%	9%	1%	18%
\$10K to \$20K	0%	0%	11%	38%	22%	6%	9%	10%	1%	15%
\$5K to \$10K	1%	0%	4%	32%	11%	11%	13%	14%	1%	19%
Total	4%	0%	3%	24%	28%	4%	9%	6%	2%	28%

Notes:

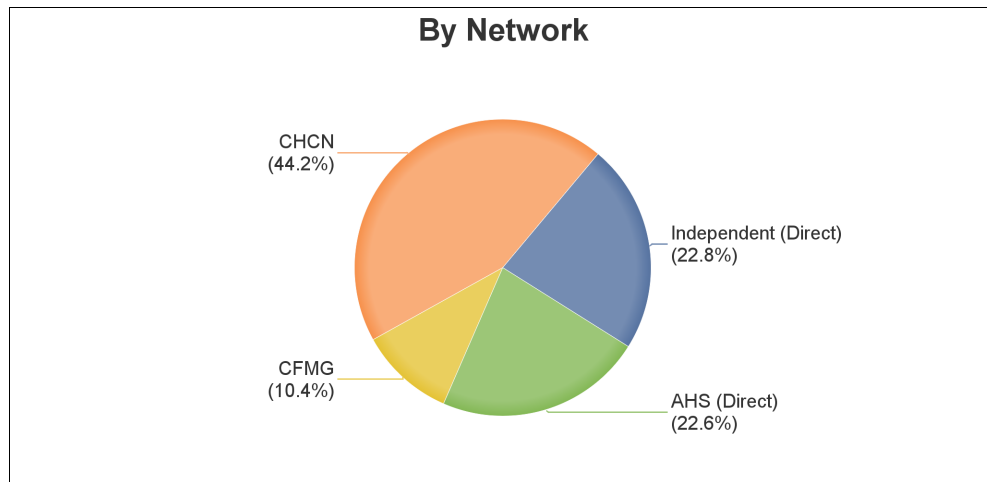
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend						
Category of Aid	Dec 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	59,414	15%	12,149	14,678	0	32,587
CHILD	107,527	27%	9,795	13,841	38,670	45,221
SPD	0	0%	0	0	0	0
ACA OE	149,473	38%	26,857	51,959	1,525	69,132
DUALS	35	0%	31	3	0	1
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,500	7%	8,597	5,530	1,520	13,853
SPD-LTC/Full Dual	49,277	12%	31,921	3,569	0	13,787
Other	0		0	0	0	0
Medi-Cal	395,226		89,350	89,580	41,715	174,581
Group Care	6,138		2,214	1,179	0	2,745
Total	401,364	100%	91,564	90,759	41,715	177,326
Other %	0.0%		0.0%	0.0%	0.0%	0.0%
Medi-Cal %	98.5%		97.6%	98.7%	100.0%	98.5%
Group Care %	1.5%		2.4%	1.3%	0.0%	1.5%
Network Distribution			22.8%	22.6%	10.4%	44.2%
			% Direct:	45%	% Delegated:	55%

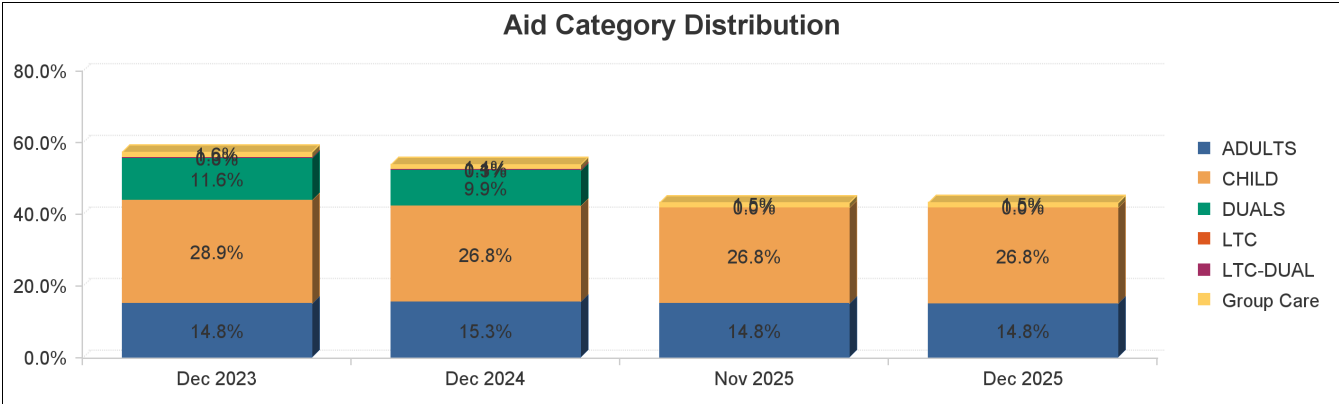


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

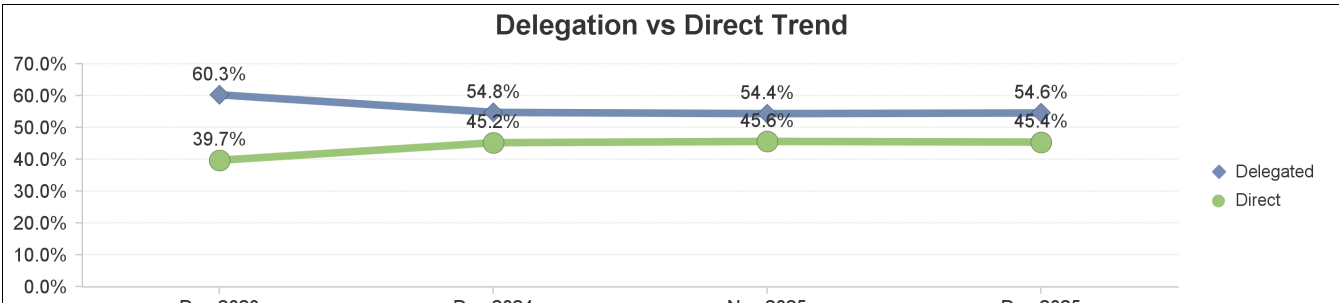


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend											
Category of Aid	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
ADULTS	52,174	62,957	59,892	59,414	14.8%	15.3%	14.8%	14.8%	17.1%	-6.0%	-0.8%
CHILD	101,634	110,547	108,001	107,527	28.9%	26.8%	26.8%	26.8%	8.1%	-2.8%	-0.4%
SPD	30,848	36,127	0	0	8.8%	8.8%	0.0%	0.0%	14.6%	0.0%	0.0%
ACA OE	119,669	154,565	150,677	149,473	34.0%	37.5%	37.3%	37.2%	22.6%	-3.4%	-0.8%
DUALS	40,976	40,812	33	35	11.6%	9.9%	0.0%	0.0%	-0.4%	-116,505.7%	5.7%
LTC	135	255	0	0	0.0%	0.1%	0.0%	0.0%	47.1%	0.0%	0.0%
LTC-DUAL	951	1,285	0	0	0.3%	0.3%	0.0%	0.0%	26.0%	0.0%	0.0%
SPD-LTC	0	0	29,590	29,500	0.0%	0.0%	7.3%	7.3%	0.0%	100.0%	-0.3%
SPD-LTC/ Full Dual	0	0	49,334	49,277	0.0%	0.0%	12.2%	12.3%	0.0%	100.0%	-0.1%
Other	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medi-Cal	346,387	406,548	397,527	395,226	98.4%	98.6%	98.5%	98.5%	14.8%	-2.9%	-0.6%
Group Care	5,622	5,790	6,092	6,138	1.6%	1.4%	1.5%	1.5%	2.9%	5.7%	0.7%
Total	352,009	412,338	403,619	401,364	100.0%	100.0%	100.0%	100.0%	14.6%	-2.7%	-0.6%



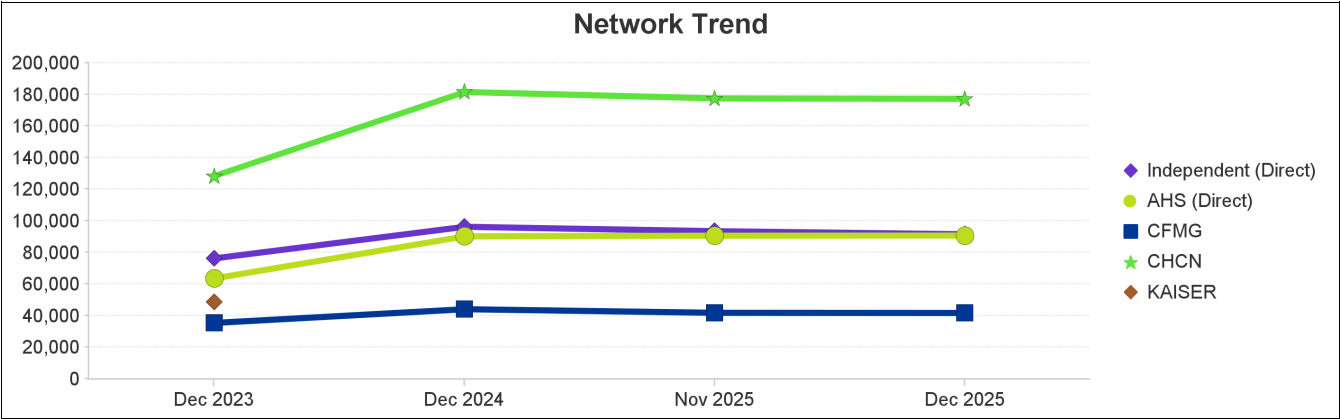
Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
Delegated	212,220	225,787	219,439	219,041	60.3%	54.8%	54.4%	54.6%	6.0%	-3.1%	-0.2%
Direct	139,789	186,551	184,180	182,323	39.7%	45.2%	45.6%	45.4%	25.1%	-2.3%	-1.0%
Total	352,009	412,338	403,619	401,364	100.0%	100.0%	100.0%	100.0%	14.6%	-2.7%	-0.6%



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

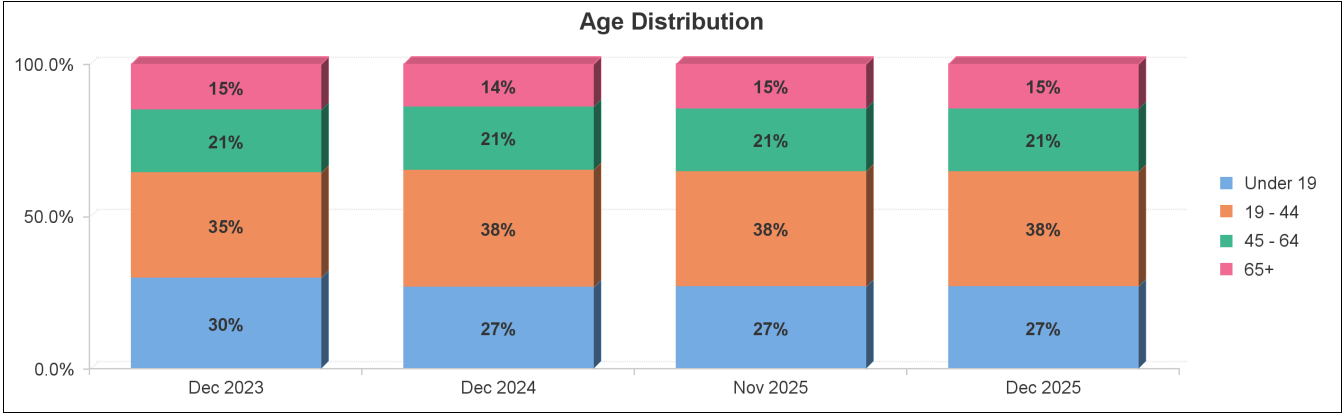
Dec 2023	Dec 2024	Nov 2025	Dec 2025
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Network Trend											
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
Independent (Direct)	76,241	96,313	93,519	91,564	21.7%	23.4%	23.2%	22.8%	20.8%	-5.2%	-2.1%
AHS (Direct)	63,548	90,238	90,661	90,759	18.1%	21.9%	22.5%	22.6%	29.6%	0.6%	0.1%
CFMG	35,401	44,111	41,820	41,715	10.1%	10.7%	10.4%	10.4%	19.7%	-5.7%	-0.3%
CHCN	128,342	181,676	177,619	177,326	36.5%	44.1%	44.0%	44.2%	29.4%	-2.5%	-0.2%
KAISER	48,477	0	0	0	13.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	352,009	412,338	403,619	401,364	100.0%	100.0%	100.0%	100.0%	14.6%	-2.7%	-0.6%

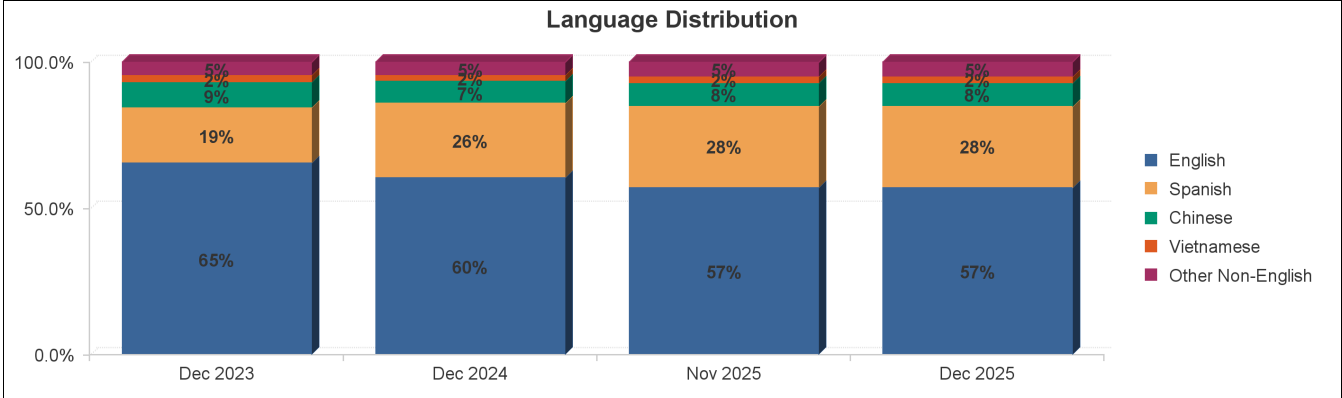


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Age Category Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
Under 19	104,062	109,506	107,820	107,339	30%	27%	27%	27%	5%	-2%	0%
19 - 44	121,694	158,707	152,698	151,400	35%	38%	38%	38%	23%	-5%	-1%
45 - 64	72,612	85,272	83,208	82,760	21%	21%	21%	21%	15%	-3%	-1%
65+	53,641	58,853	59,893	59,865	15%	14%	15%	15%	9%	2%	0%
Total	352,009	412,338	403,619	401,364	100%	100%	100%	100%	15%	-3%	-1%

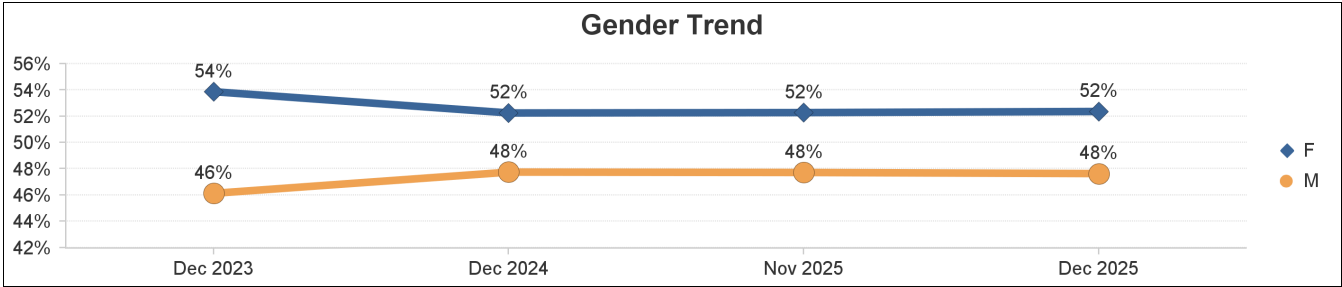


Language Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Dec 2023	Dec 2024	Nov 2025	Dec 2025	ec 2023	ec 2024	Nov 2025	ec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
English	229,835	248,451	229,585	228,253	65%	60%	57%	57%	7%	-9%	-1%
Spanish	66,602	105,234	112,007	111,394	19%	26%	28%	28%	37%	6%	-1%
Chinese	30,505	30,806	31,981	31,842	9%	7%	8%	8%	1%	3%	0%
Vietnamese	8,507	8,294	8,960	8,949	2%	2%	2%	2%	-3%	7%	0%
Other Non-English	16,560	19,553	21,086	20,926	5%	5%	5%	5%	15%	7%	-1%
Total	352,009	412,338	403,619	401,364	100%	100%	100%	100%	15%	-3%	-1%

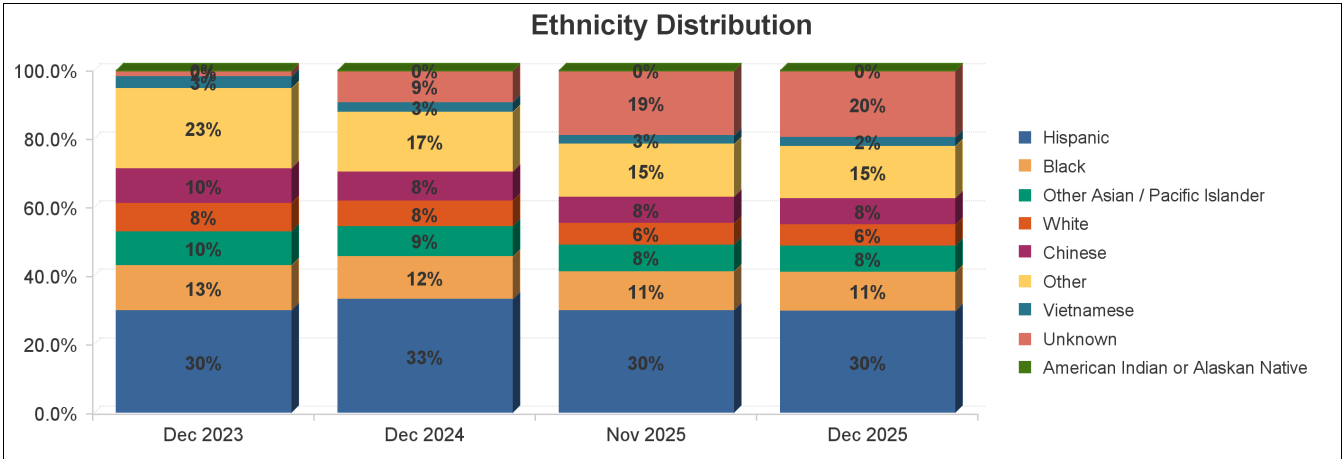


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Gender Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
F	189,639	215,451	211,017	210,175	54%	52%	52%	52%	12%	-3%	0%
M	162,370	196,887	192,602	191,189	46%	48%	48%	48%	18%	-3%	-1%
Total	352,009	412,338	403,619	401,364	100%	100%	100%	100%	15%	-3%	-1%



Ethnicity Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023	Dec 2024	Nov 2025	Dec 2025	Dec 2023 to Dec 2024	Dec 2024 to Dec 2025	Nov 2025 to Dec 2025
Hispanic	104,945	136,294	120,200	118,827	30%	33%	30%	30%	23%	-15%	-1%
Black	46,303	51,323	46,008	45,499	13%	12%	11%	11%	10%	-13%	-1%
Other Asian / Pacific Islander	34,537	36,322	31,372	30,912	10%	9%	8%	8%	5%	-18%	-1%
White	29,449	30,931	25,360	24,783	8%	8%	6%	6%	5%	-25%	-2%
Chinese	35,470	34,683	30,984	30,635	10%	8%	8%	8%	-2%	-13%	-1%
Other	82,447	71,988	62,288	61,488	23%	17%	15%	15%	-15%	-17%	-1%
Vietnamese	11,943	11,366	10,119	10,034	3%	3%	3%	2%	-5%	-13%	-1%
Unknown	6,228	38,664	76,629	78,543	2%	9%	19%	20%	84%	51%	2%
American Indian or Alaskan Native	687	767	659	643	0%	0%	0%	0%	10%	-19%	-2%
Total	352,009	412,338	403,619	401,364	100%	100%	100%	100%	15%	-3%	-1%



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

Medi-Cal By City						
City	Dec 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	157,004	40%	23,442	42,614	16,438	74,510
HAYWARD	51,512	13%	11,578	14,832	5,454	19,648
FREMONT	38,104	10%	15,804	6,733	2,082	13,485
SAN LEANDRO	24,868	6%	6,777	4,181	3,031	10,879
UNION CITY	14,213	4%	5,655	2,579	783	5,196
ALAMEDA	13,527	3%	3,380	2,548	2,038	5,561
BERKELEY	16,275	4%	3,662	2,683	1,733	8,197
LIVERMORE	12,823	3%	2,007	415	2,024	8,377
NEWARK	9,154	2%	2,713	3,869	490	2,082
CASTRO VALLEY	11,078	3%	3,244	1,779	1,710	4,345
SAN LORENZO	6,006	2%	1,257	1,418	685	2,646
PLEASANTON	7,951	2%	2,283	316	833	4,519
DUBLIN	7,653	2%	2,505	326	858	3,964
EMERYVILLE	2,992	1%	585	698	501	1,208
ALBANY	2,540	1%	539	301	536	1,164
PIEDMONT	471	0%	102	190	72	107
SUNOL	87	0%	31	9	6	41
ANTIOCH	20	0%	8	6	4	2
Other	18,948	5%	3,778	4,083	2,437	8,650
Total	395,226	100%	89,350	89,580	41,715	174,581

Group Care By City						
City	Dec 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,862	30%	336	437	0	1,089
HAYWARD	711	12%	320	195	0	196
FREMONT	681	11%	433	93	0	155
SAN LEANDRO	666	11%	270	110	0	286
UNION CITY	297	5%	179	51	0	67
ALAMEDA	310	5%	88	38	0	184
BERKELEY	163	3%	40	18	0	105
LIVERMORE	105	2%	31	1	0	73
NEWARK	147	2%	83	39	0	25
CASTRO VALLEY	222	4%	97	33	0	92
SAN LORENZO	161	3%	44	40	0	77
PLEASANTON	81	1%	31	4	0	46
DUBLIN	134	2%	52	8	0	74
EMERYVILLE	44	1%	12	8	0	24
ALBANY	22	0%	11	2	0	9
PIEDMONT	5	0%	0	2	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	29	0%	9	9	0	11
Other	497	8%	177	91	0	229
Total	6,138	100%	2,214	1,179	0	2,745

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

Total By City						
City	Dec 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	158,866	40%	23,778	43,051	16,438	75,599
HAYWARD	52,223	13%	11,898	15,027	5,454	19,844
FREMONT	38,785	10%	16,237	6,826	2,082	13,640
SAN LEANDRO	25,534	6%	7,047	4,291	3,031	11,165
UNION CITY	14,510	4%	5,834	2,630	783	5,263
ALAMEDA	13,837	3%	3,468	2,586	2,038	5,745
BERKELEY	16,438	4%	3,702	2,701	1,733	8,302
LIVERMORE	12,928	3%	2,038	416	2,024	8,450
NEWARK	9,301	2%	2,796	3,908	490	2,107
CASTRO VALLEY	11,300	3%	3,341	1,812	1,710	4,437
SAN LORENZO	6,167	2%	1,301	1,458	685	2,723
PLEASANTON	8,032	2%	2,314	320	833	4,565
DUBLIN	7,787	2%	2,557	334	858	4,038
EMERYVILLE	3,036	1%	597	706	501	1,232
ALBANY	2,562	1%	550	303	536	1,173
PIEDMONT	476	0%	102	192	72	110
SUNOL	88	0%	32	9	6	41
ANTIOCH	49	0%	17	15	4	13
Other	19,445	5%	3,955	4,174	2,437	8,879
Total	401,364	100%	91,564	90,759	41,715	177,326



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 13th, 2026

Subject: Human Resources Report

Staffing

- As of February 1st, 2026, the Alliance had 678 full time employees and 1 part time employee.
- On February 1st, 2026, the Alliance had 14 open positions in which 2 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 12 positions open to date. The Alliance is actively recruiting for the remaining 12 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by division:

Division	Open Position February 1 st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	1	1	0
Operations	8	1	7
Healthcare Analytics	1	0	1
Information Technology	1	0	1
Finance	0	0	0
Compliance	0	0	0
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	14	2	12

- Our current recruitment rate is 2%.

Employee Recognition

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

5 years:

- Claire F (Operations)
- Sylvia G (Provider Services)
- Krystal H (Utilization Management)

6 years:

- Baljeet K (Case/Disease Management)
- Mashon W (Vendor Management)

7 years:

- Jeffrey B (Pharmacy Services)
- Chidananda M (Apps Management, IT Quality & Process Improvement)
- Yan X (Utilization Management)

8 years:

- Anastacia S (Human Resources)
- Alice M (Utilization Management)

10 years:

- Jennifer K (Grievance and Appeals)
- Shruti G (Healthcare Analytics)
- Deborah A (Financial Planning & Analysis)

11 years:

- John S (IT Development)

13 years:

- Lena L (Case/Disease Management)

14 years:

- Anthony T (Financial Planning & Analysis)
- Raul C (Information Technology)

18 years:

- Beza T (IT Ops and Quality Apps Mgt)

24 years:

- Rachel C (Claims)