ALAMEDA Alliance FOR HEALTH

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Board of Governors

PACKET

JANUARY 10th, 2025

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EXECUTIVE SUMMARY APPENDIX

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

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SUPPORTING MATERIALS APPENDIX

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

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CEO Update

Matthew Woodruff

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

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

Date: **January 10th, 2025**

Subject: **CEO Report**

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

	November	YTD
Medi-Cal	($27.4M)	($85.9M)
Group Care	$255K	$99K
Medicare	($349K)	($2.8K)
Total	($27.5M)	($88.5M)

  - **Revenue was $174.2 million in November 2024 and $843.5 million Year-to-Date (YTD)**.
    - Medical expenses were $194.7 million in November and $898.8 million for the fiscal year-to-date; the medical loss ratio is 111.8% for the month and 106.6% for the fiscal year-to-date.
    - Administrative expenses were $9.0 million in November and $48.2 million for the fiscal year-to-date; the administrative loss ratio is 5.2% of net revenue for the month and 5.7% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 212% of the required DMHC minimum, representing $88.0 million in excess TNE.
  - **Total enrollment in November 2024 was 406,878**, an increase of 725 Medi-Cal members compared to October 2024.

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

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

- **Medicare Overview**
  - **D-SNP Readiness**
    - Alameda Alliance for Health (AAH) Medicare Advantage (MA) Duals Eligible Special Needs Plan (D-SNP) will begin serving members on January 1st, 2026. Currently, there are 17 different departmental workstreams and a total of 111 projects, of which 55 are active, 51 requested, and 5 on hold.
    - Teams are collaborating to complete the D-SNP application, which is scheduled for submittal to CMS on 2/12/2025.
    - For supplemental benefit vendors, AAH is moving forward with finalizing contracting with dental, vision, and hearing. AAH has selected vendors for Flex Card, OTC, and Medication Therapy Management (MTM). Selection process is still underway for risk adjustment and HRA vendor.
    - Access to HPMS has been granted to Medicare Ops, Compliance, and EDI for application preparation on 2/12. AAH has also selected a vendor for a Sales System.
    - Pharmacy PBM pre-delegation audit is nearing completion, targeting to complete by mid-January 2025 with the goal of having an executed contract prior to application deadline.
    - Continuing to collaborate with IT in updating Core Claims / Medical Management Systems and identified 321 requirements collected within Microsoft List.

- **Financial Review**
  - A special finance meeting has been called for January 22, 2025, to discuss the updated budget, rates and forecast.
  - Good news on calendar year 2024 rates. The Alliance received around a $25 million increase in rates that will be discussed at the January 22, 2025, meeting.
  - The Alliance received around a 10% increase in calendar year 2025 rates. This will be discussed in more detail at the January 22, 2025, meeting
  - Medicare decision no later than February 3, 2025.

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Demographics

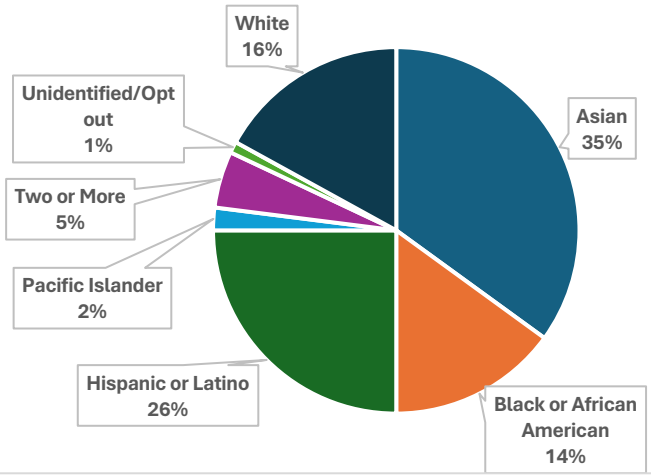
The purpose of this report is to conduct a comparative analysis of the demographic composition of Alameda Alliance for Health's workforce and the population distribution of Alameda Count. The primary focus of this comparison will be on key metrics, including race/ethnicity, gender, and age distribution.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

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

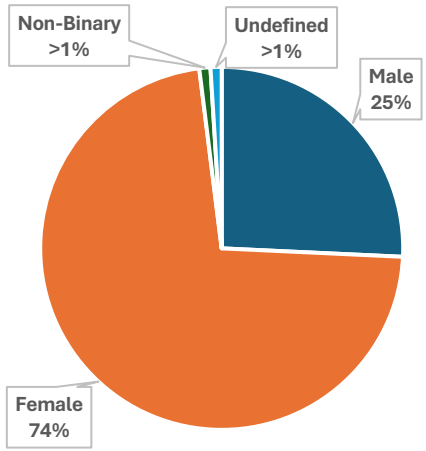
Category	**Alameda Alliance for Health** (Workforce information last updated December 2024)	**Alameda County** (Population Information last updated in April 2024)
Population/Total Employees	647	1,634,785
Race & Ethnicity		
Asian	35%	34.68%
Hispanic	26%	23.95%
White	16%	28.75%
Black/African American	14%	9.27%
Native Hawaiian/Pacific Islander	2%	0.85%
Two or More Races	5%	11.68%
Unidentified/Opt Out	1%	
Gender		
Male	25%	48.98%
Female	74%	51.02%
Non-Binary	0%	
Undefined	0%	
Age Distribution		
Under 25	1%	12.47%
25-34	21%	14.34%
35-44	35%	15.89%
45-54	25%	13.44%
55-Older	17%	27.65%

AAH Employee Demographics Data Report December 2024

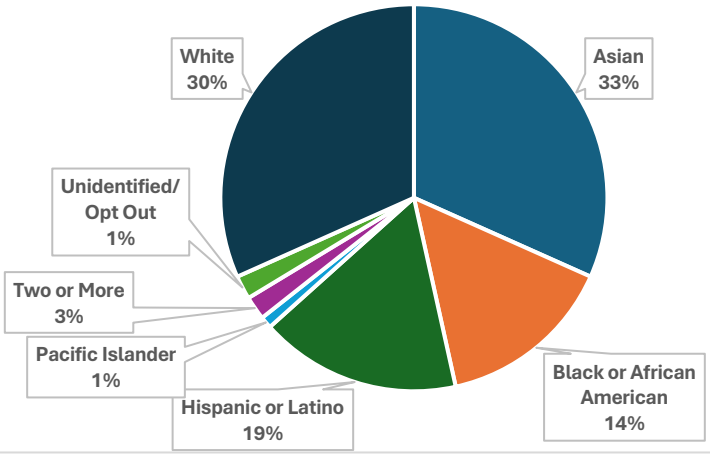
Employee Ethnicity - 647
December 2024



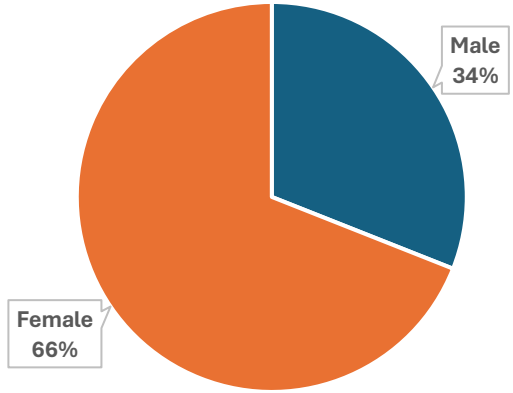
Employee Gender - 647
December 2024

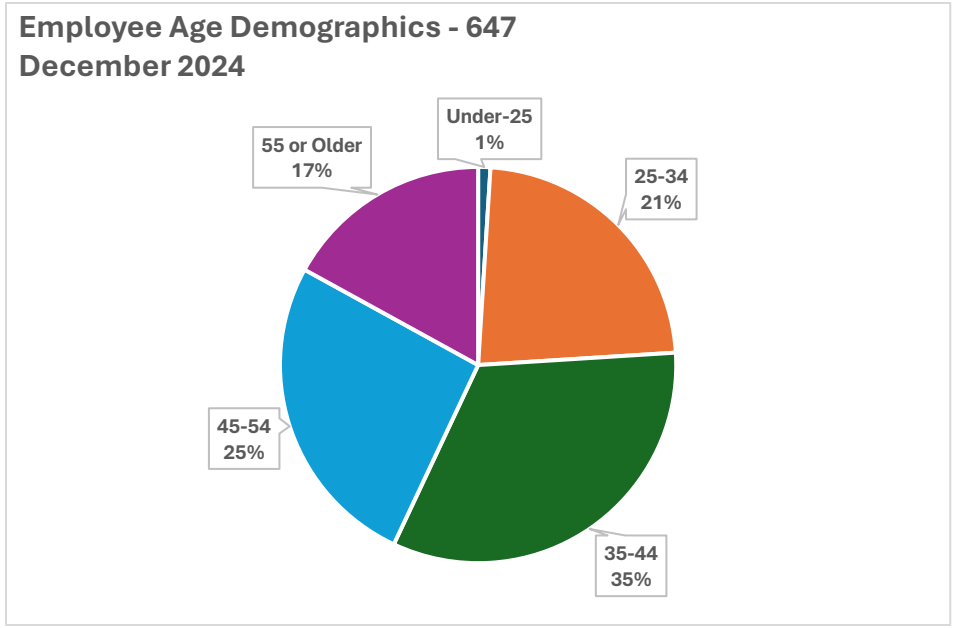


Managers Ethnicity - 128
December 2024



Managers Gender - 128
December 2024




Employee Age Demographics - 647
December 2024
Under-25
1%
25-34
21%
35-44
35%
45-54
25%
55 or Older
17%

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Legislative Tracking

2025 –2026 Legislative Tracking List

The California Legislature returned to Sacramento on January 6th to kick off the new legislative session. Last month, 29 newly elected Senators and Assemblymembers were sworn in for a total of 120 elected officials that make up the state legislature. Democrats currently have a 30-10 majority in the Senate and a 60-19 majority in the Assembly. This new session also has a record number of women serving – 59 state lawmakers are women, with 21 in the Senate and 48 in the Assembly.

Additionally, in December, legislative leaders limited the number of bills that members can introduce from 50 to 35 in the Assembly, and from 40 to 35 in the Senate – therefore, we anticipate that a smaller overall number of bills will make it through the legislative process.

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

AB 4 **(Arambula D) Covered California expansion.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be heard in committee January 2.

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

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

AB 29 **(Arambula D) Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be heard in committee January 2.

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

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

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

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

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

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

AB 40 **(Bonta D) Emergency services and care.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be heard in committee January 2.

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

Summary: Existing law provides for the licensing and regulation of health facilities by the State Department of Public Health and makes a violation of those provisions a crime. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires a health facility to provide emergency services and care upon request or when a person is in danger of loss of life or serious injury or illness and requires a health care service plan to reimburse providers for emergency services and care. Existing law defines "emergency services and care" for these purposes to mean medical screening, examination, and evaluation by a physician and surgeon, or other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility, among other things. This bill would additionally define "emergency services and care" for the above-described purposes to mean reproductive health services, including abortion. By expanding the applicability of a crime with respect to health facilities and health care service plans, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

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

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

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

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

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

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

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

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

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

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AB 55 **(Bonta D) Alternative birth centers: licensing and Medi-Cal reimbursement.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be heard in committee January 2.

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

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

AB 67 **(Bauer-Kahan D) Attorney General: Reproductive Privacy Act: enforcement.**
Current Text: Introduced: 12/4/2024 html pdf
Introduced: 12/4/2024
Status: 12/5/2024-From printer. May be heard in committee January 4.

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

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

SB 7 **(McNerney D) Artificial intelligence.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be acted upon on or after January 2.

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

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

SB 27 **(Umberg D) Community Assistance, Recovery, and Empowerment (CARE) Court Program.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be acted upon on or after January 2.

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

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

SB 32 **(Weber Pierson D) Public health: maternity ward closures.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be acted upon on or after January 2.

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

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

SB 40 **(Wiener D) Health care coverage: insulin.**
Current Text: Introduced: 12/3/2024 html pdf
Introduced: 12/3/2024
Status: 12/4/2024-From printer. May be acted upon on or after January 3.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin if it is determined to be medically necessary. This bill would generally prohibit a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2026, from imposing a copayment of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug, except as specified. On and after January 1, 2026, the bill would prohibit a health care service plan or disability insurer from imposing step therapy protocols as a prerequisite to authorizing coverage of insulin. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 41 **(Wiener D) Pharmacy benefits.**
Current Text: Introduced: 12/3/2024 html pdf

Introduced: 12/3/2024
Status: 12/4/2024-From printer. May be acted upon on or after January 3.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires a pharmacy benefit manager under contract with a health care service plan to, among other things, register with the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would additionally require a pharmacy benefit manager to apply for and obtain a license from the Department of Insurance to operate as a pharmacy benefit manager no later than January 1, 2027. The bill would establish application qualifications and requirements and would require initial license and renewal fees to be collected into the newly created Pharmacy Benefit Manager Account in the Insurance Fund to be available to the department for use, upon appropriation by the Legislature, as specified, for costs related to licensing and regulating pharmacy benefit managers. The bill would impose specified duties on pharmacy benefit managers and requirements for pharmacy benefit manager services and pharmacy benefit manager contracts, including requiring a pharmacy benefit manager to file specified reports with the department, the contents of which are not to be disclosed to the public. The bill would require the department, at specified intervals, to submit reports to the Legislature based on the reports submitted by pharmacy benefit managers and would require the department to post the reports on the department's internet website. This bill would make a violation of these provisions subject to specified civil penalties. The bill would create the Pharmacy Benefit Manager Fines and Penalties Account in the General Fund, into which fines and administrative penalties would be deposited. This bill contains other related provisions and other existing laws.

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Executive Dashboard

OPERATIONS DASHBOARD

JANUARY 2025

1/3/2025 2:21:29 PM

Financials

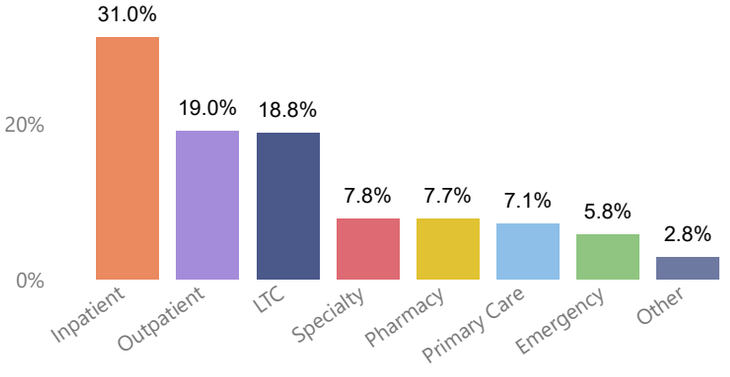
Income & Expenses

	NOVEMBER 2024	FISCAL YTD
REVENUE	$ 237.9 M	$ 1.3 B
MEDICAL EXPENSE	$ (194.7) M	$ (898.8) M
ADMIN EXPENSE	$ (9.0) M	$ (48.2) M
OTHER/TAX	$ (61.6) M	$ (400.4) M
NET INCOME	$ (27.5) M	$ (88.5) M

Medical Loss % (Fiscal YTD)

106.6%

Medical Expenses



Liquid Reserves

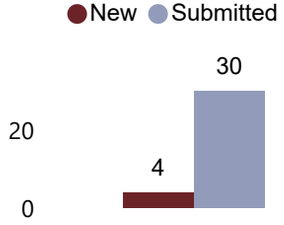
TNE %

211.6%

TNE $

$166.9M

Reinsurance Cases



Balance Sheet

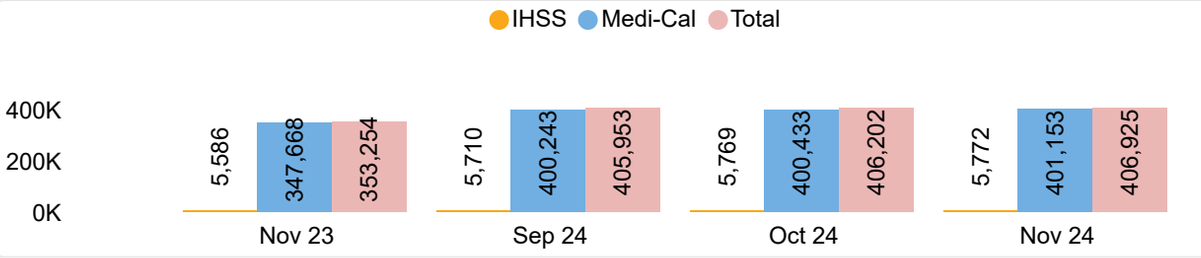
Cash Equivalents	$503.4M
Pass-Through Liabilities	$117.0M
Uncommitted Cash	$386.4M
Working Capital	$107.8M

Current Ratio

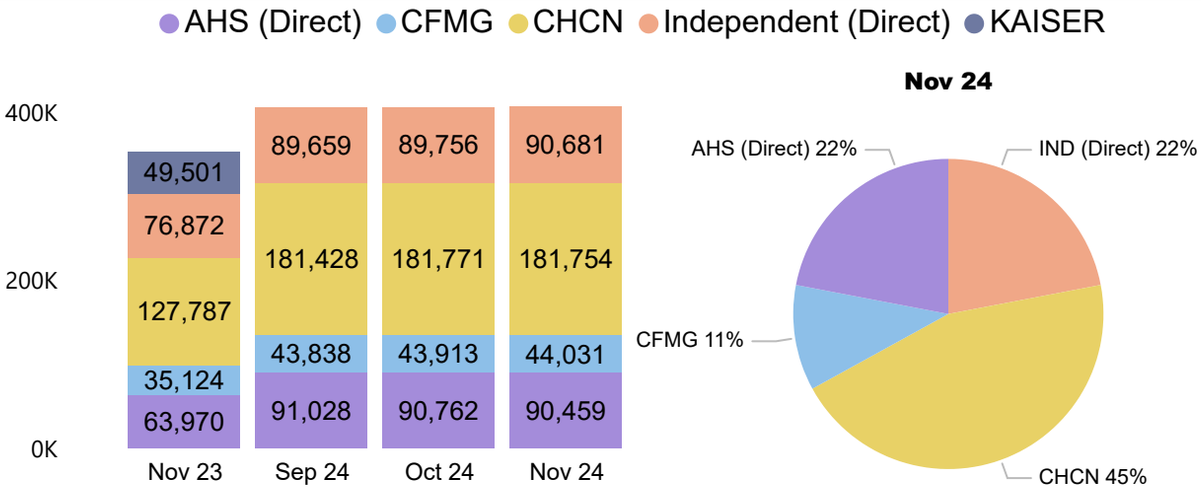
1.12

Membership

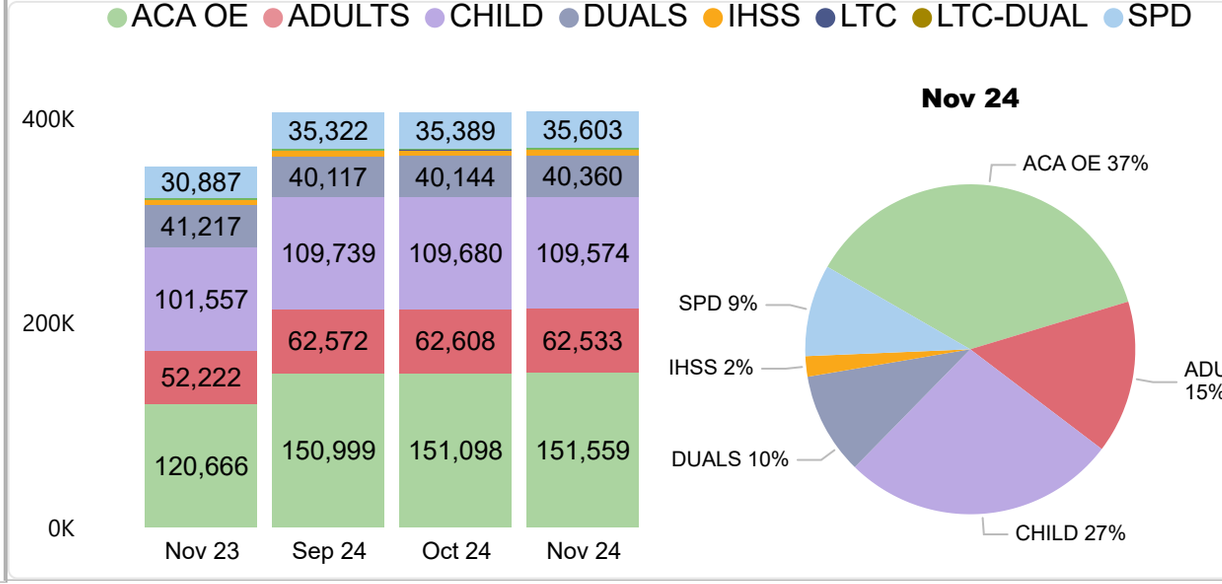
By Plan



By Network



By Category



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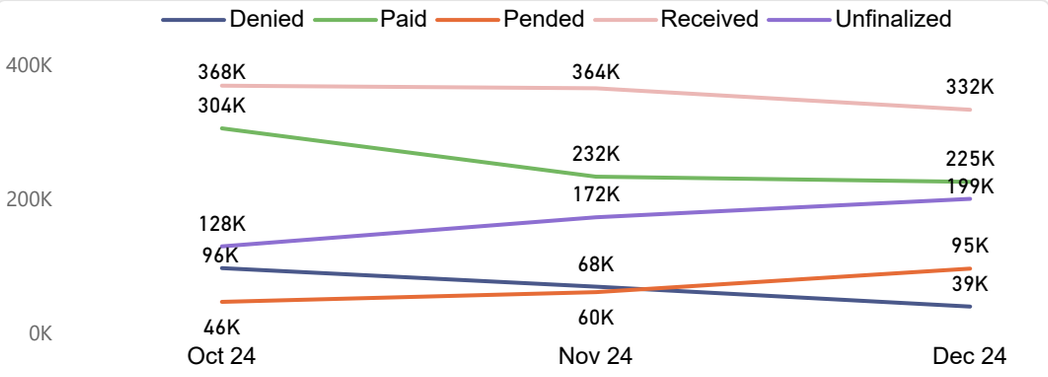
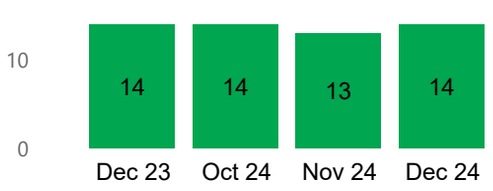
Claims

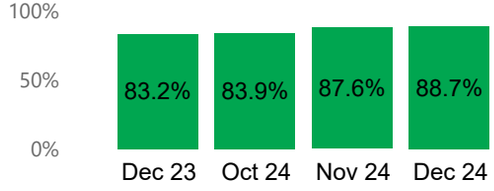
Claims Processing



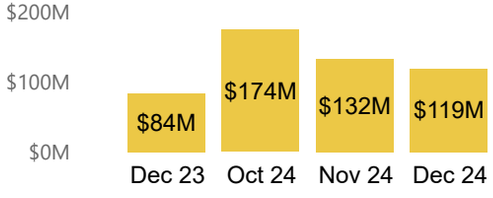
Average Payment TAT (Days)



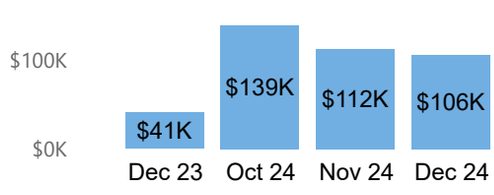
Auto Adjudication Rate (%)



Claims Paid ($)

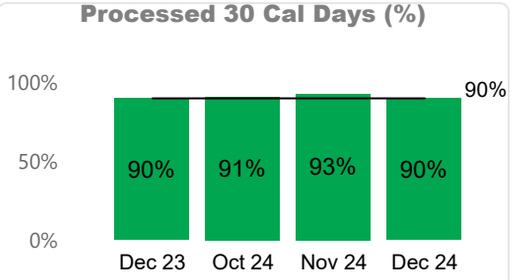


Interest Paid ($)

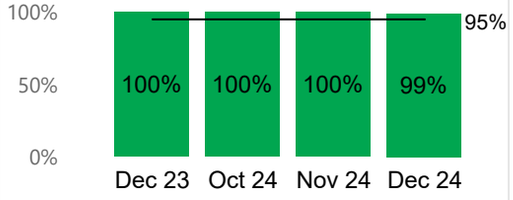


Claims Compliance

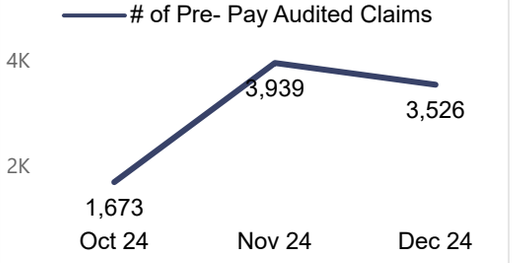
Processed 30 Cal Days (%)



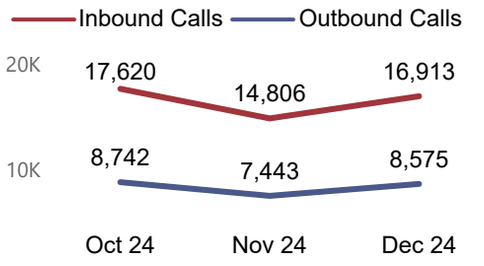
Processed 45 Work Days (%)



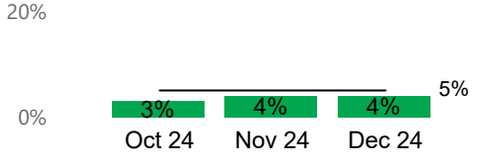
Claims Auditing



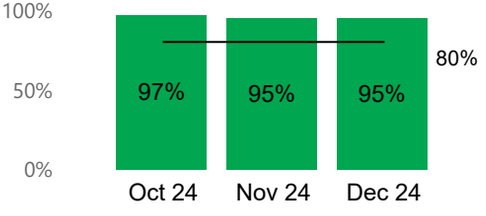
Member Services



Abandoned Call Rate (%)

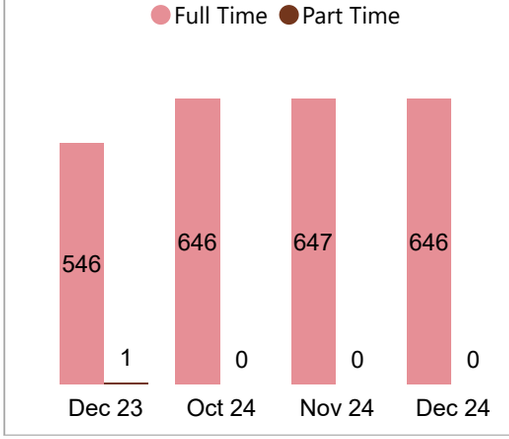


Calls Answered in 30 Seconds (%)



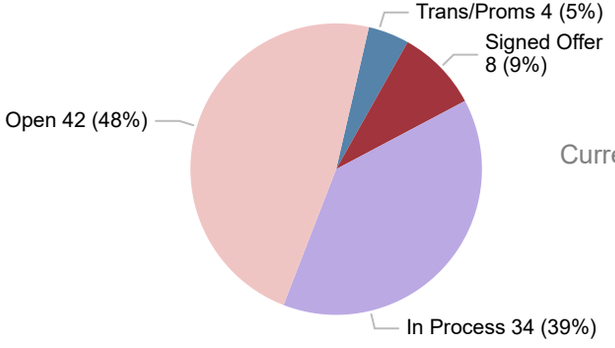
Average Call Times	Oct 24	Nov 24	Dec 24
Wait Time	00:9	00:12	00:14
Call Duration	07:08	07:13	07:33

Human Resources



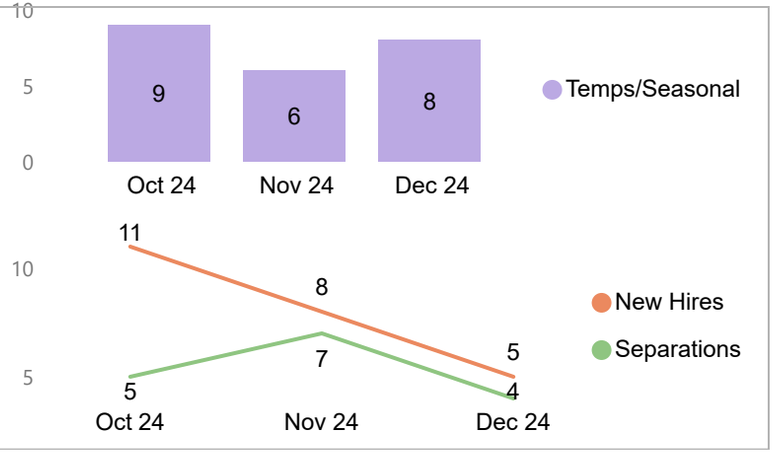
Recruiting Status

Dec 24



Current Vacancy

6%



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Provider Services

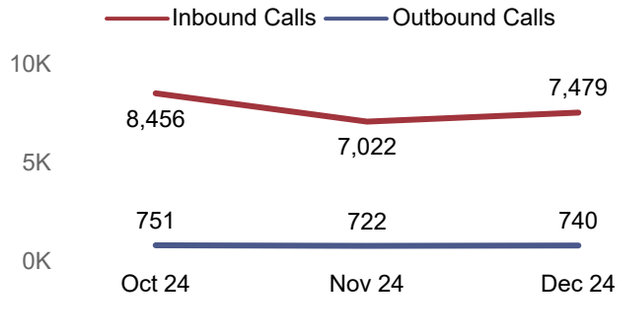
Provider Network

Hospital	17
Specialist	11,256
Primary Care Physician	789
Skilled Nursing Facility	106
Urgent Care	15
Health Centers (FQHCs and Non-FQHCs)	83
TOTAL	**12,266**

Provider Credentialing

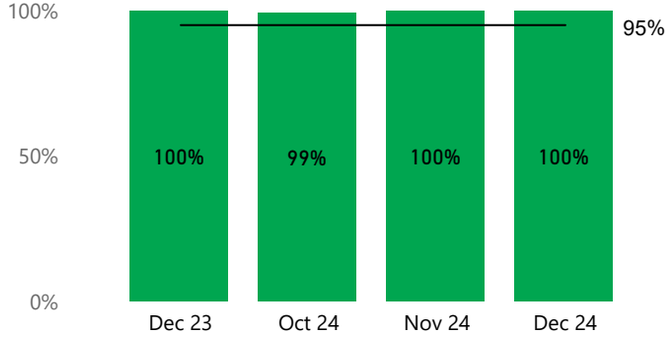
4,319

Provider Call Center



Provider Disputes & Resolutions

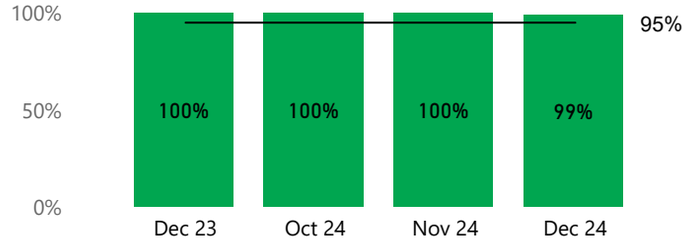
Turnaround Compliance (45 business days)



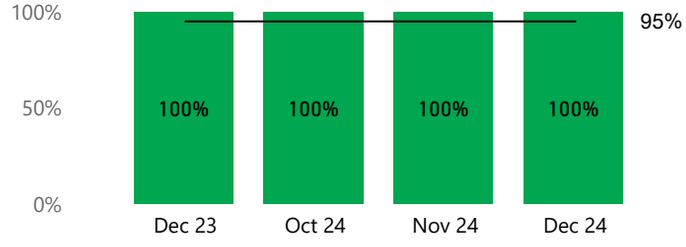
Compliance

Member Grievances

Standard (30 calendar days)

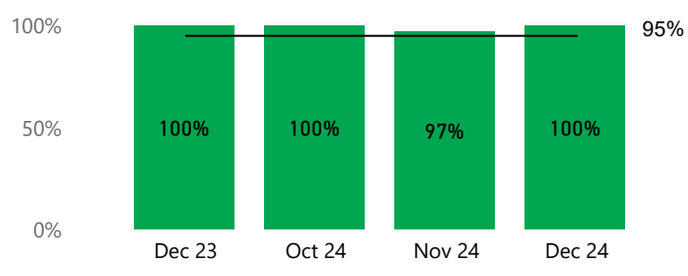


Expedited (3 calendar days)

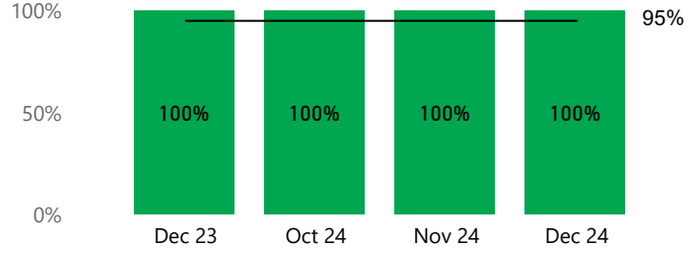


Member Appeals

Standard (30 calendar days)

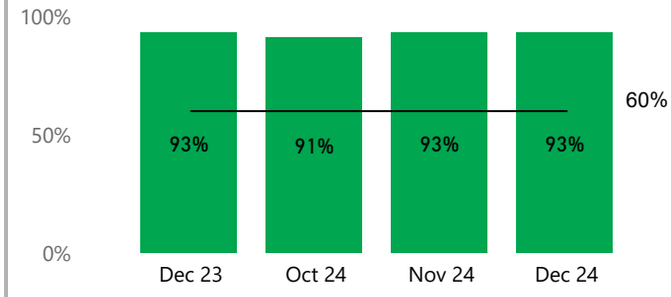


Expedited (3 calendar days)

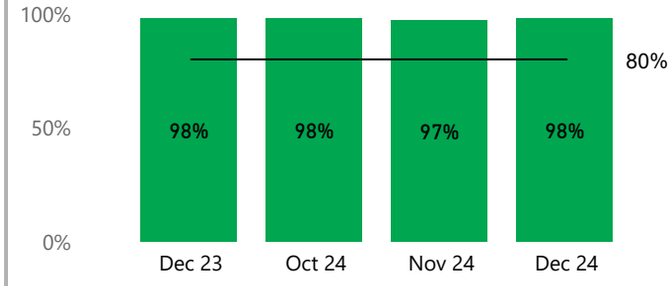


Encounter Data

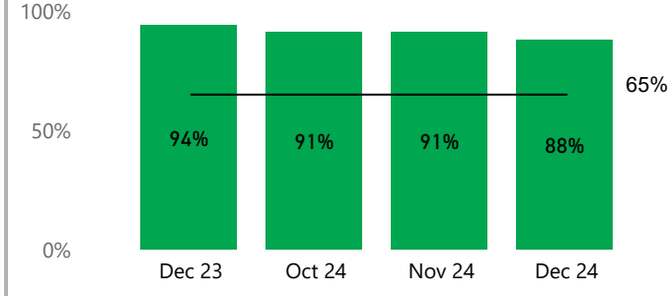
Institutional 0-90 days



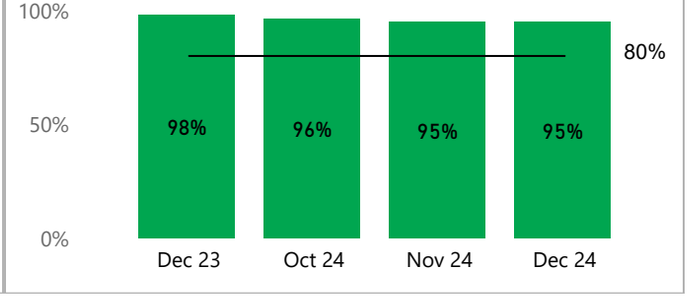
Institutional 0-180 days



Professional 0-90 days



Professional 0-180 days



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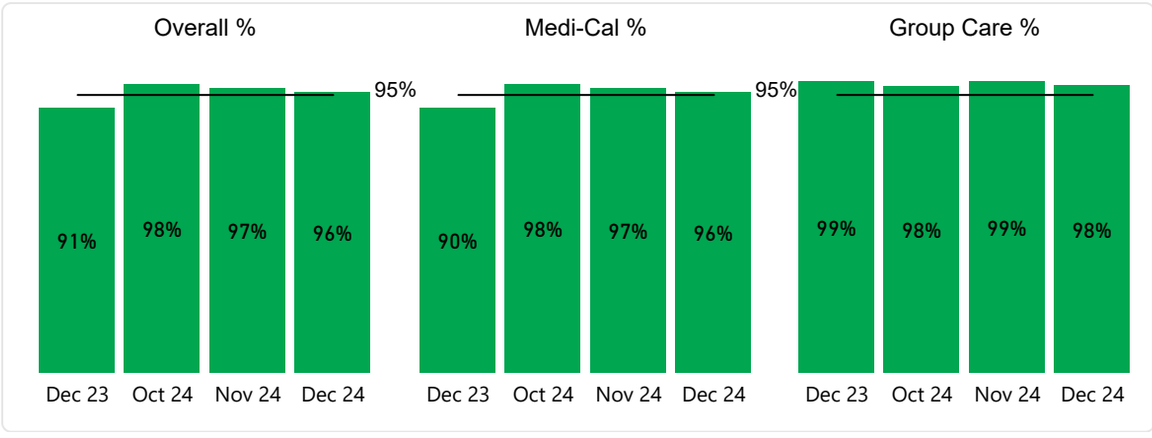
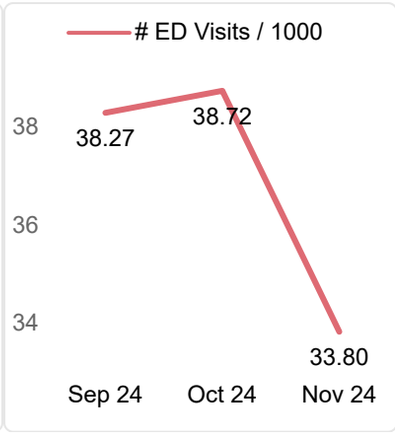
Health Care Services

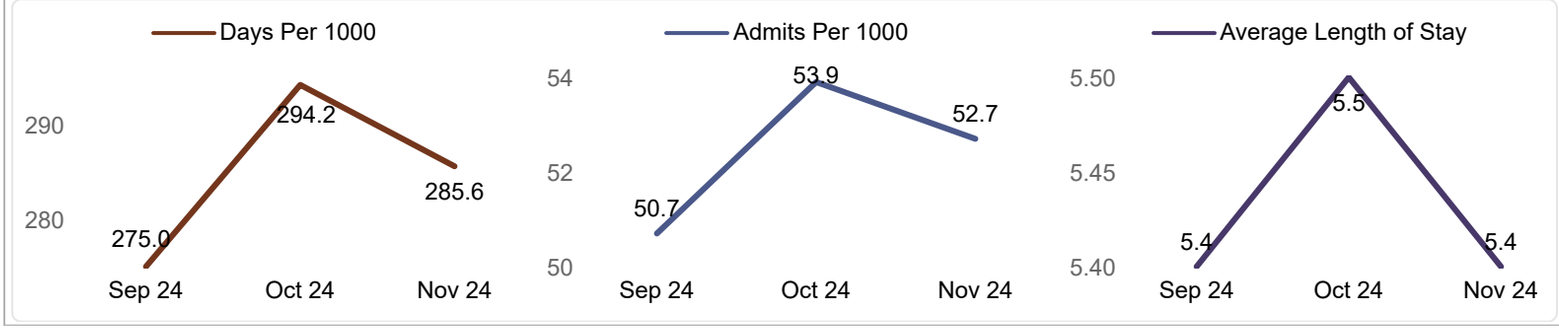
Authorization Turnaround



ED Utilization

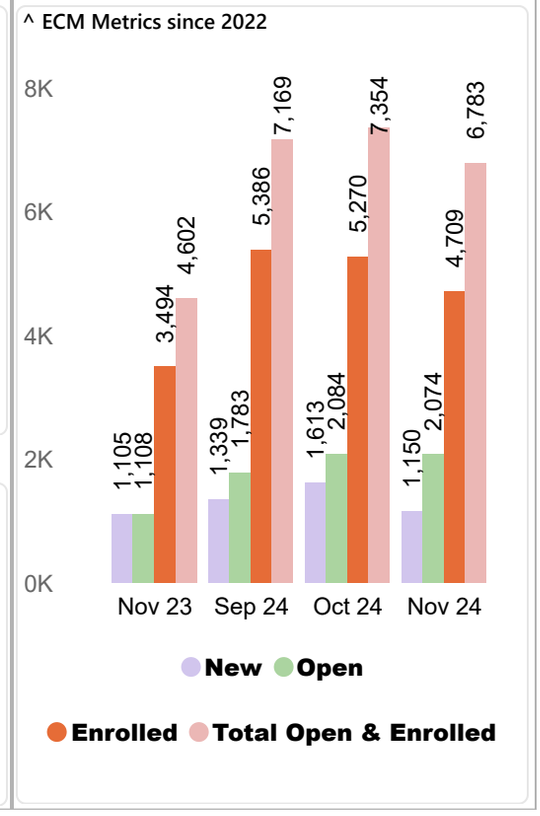


Inpatient Utilization

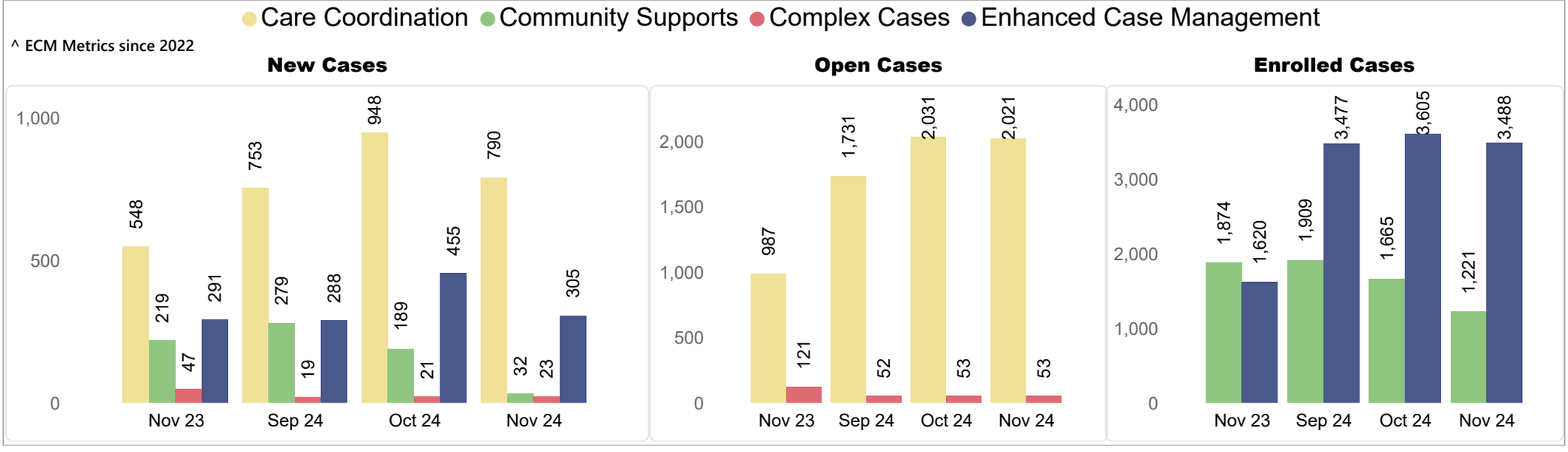


Case Management

Total Cases^



Case Management^



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Technology (Business Availability)

Applications	Dec 23	Oct 24	Nov 24	Dec 24
HEALTHsuite System	100.0%	99.9%	99.8%	100.0%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Dec 23	Oct 24	Nov 24	Dec 24
Denial Rate Excluding Partial Denials (%)	4.5%	2.8%	3.2%	2.8%
Overall Denial Rate (%)	4.7%	3.1%	3.5%	3.1%
Partial Denial Rate (%)	0.2%	0.3%	0.3%	0.3%

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

Pharmacy Authorizations

Authorizations	Dec 23	Oct 24	Nov 24	Dec 24
Approved Prior Authorizations	22	55	34	43
Closed Prior Authorizations	58	115	85	26
Denied Prior Authorizations	27	50	62	73
Total Prior Authorizations	107	220	181	142

Finance

Gil Riojas

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

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

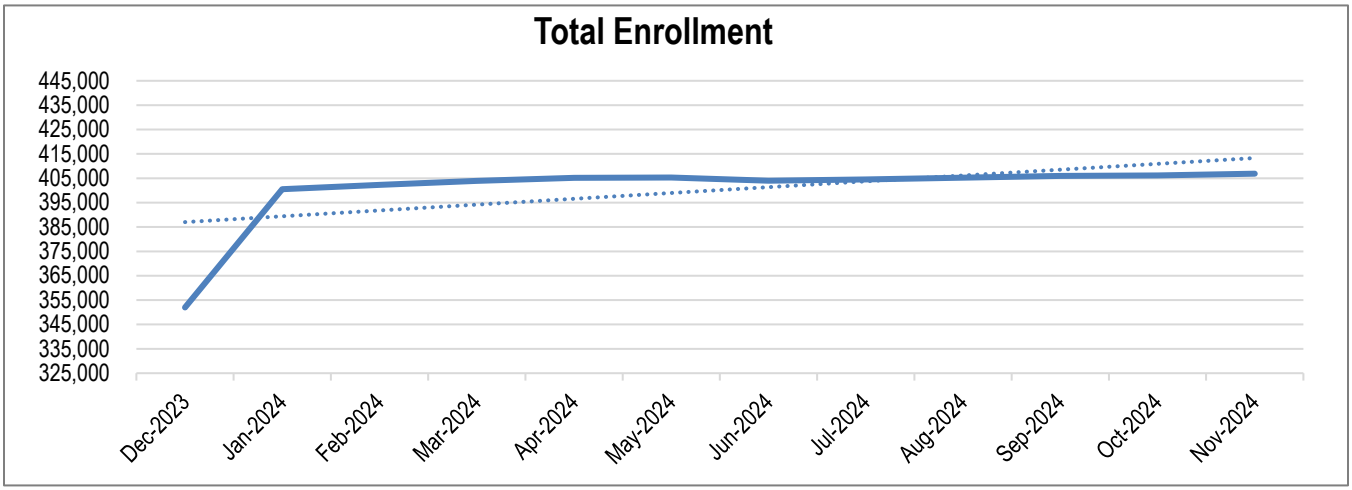
Date: **January 10th, 2025**

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

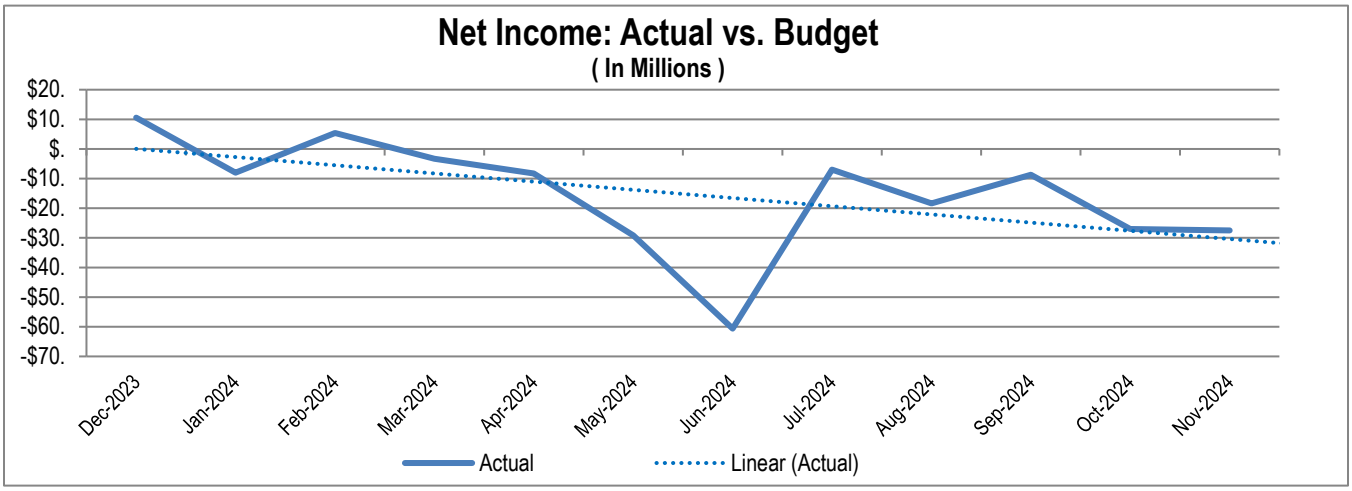
Executive Summary

For the month of November, the Alliance continued to see slight increases in enrollment, reaching 406,878 members. A Net Loss of $27.5 million was reported, and the Plan's Medical Expenses represented 111.8% of revenue. Alliance reserves decreased to 212% of required but continue to remain above minimum requirements.

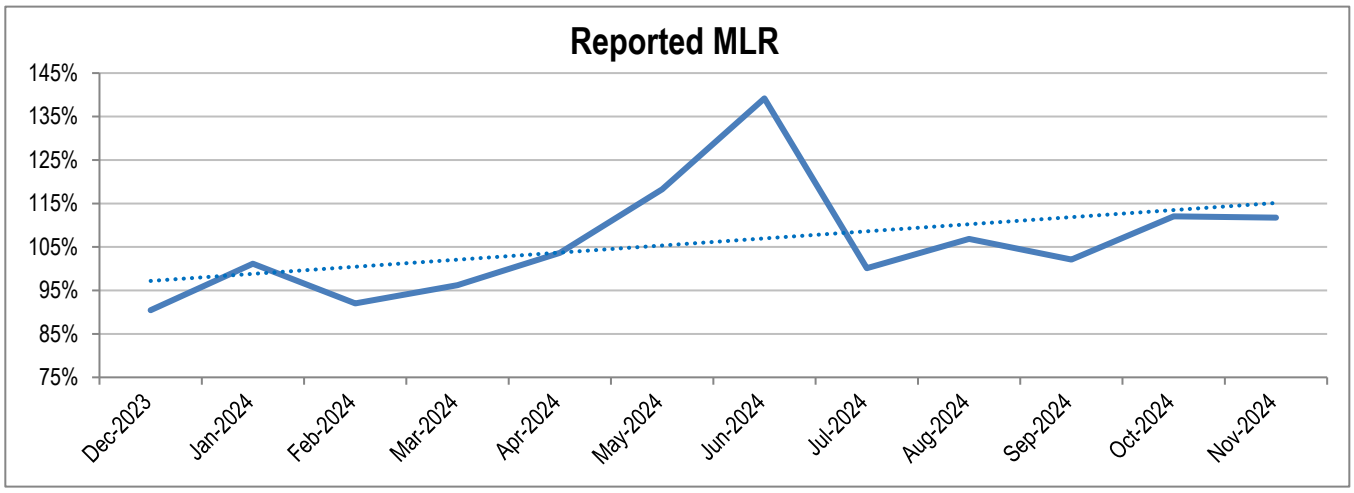
Enrollment – In November, Enrollment increased by 725 members.



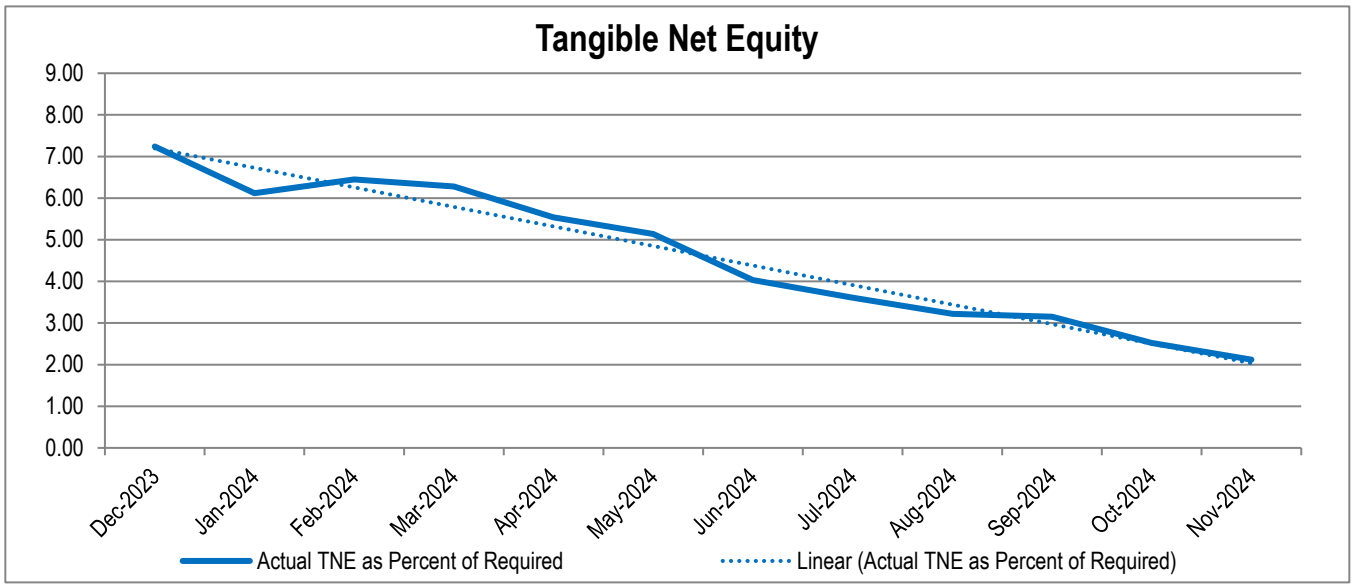
Net Income – For the month ended November 30th, 2024, actual Net Loss was $27.5 million vs. budgeted Net Loss of $10.0 million. For the fiscal YTD, actual Net Loss was $88.5 million vs. budgeted Net Loss of $71.0 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $174.2 million vs. budgeted Revenue of $173.2 million.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 111.8% for the month, and 106.6% for fiscal YTD. The major variances include unfavorable Inpatient/SNF, Ancillary FFS, Outpatient FFS, Long-Term Care, and Pharmacy expenses.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $78.9M in reserves, we reported $166.9M. Our overall TNE remains above DMHC requirements at 212%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date investments show a gain of $15.0M. Capital assets acquired so far are $530k.

To: **Alameda Alliance for Health, Finance Committee**

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

Date: **January 10th, 2025**

Subject: **Finance Report – November 2024**

Executive Summary

- For the month ended November 30th, 2024, the Alliance had enrollment of 406,878 members, a Net Loss of $27.5 million and 212% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$237,868	$1,258,879
Medical Expense	194,705	898,817
Admin. Expense	9,042	48,217
MCO Tax Expense	63,652	415,404
Other Inc. / (Exp.)	2,059	15,040
Net Income	**($27,470)**	**($88,518)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	($27,376)	($85,867)
Group Care	255	99
Medicare	(349)	(2,750)
	($27,470)	**($88,518)**

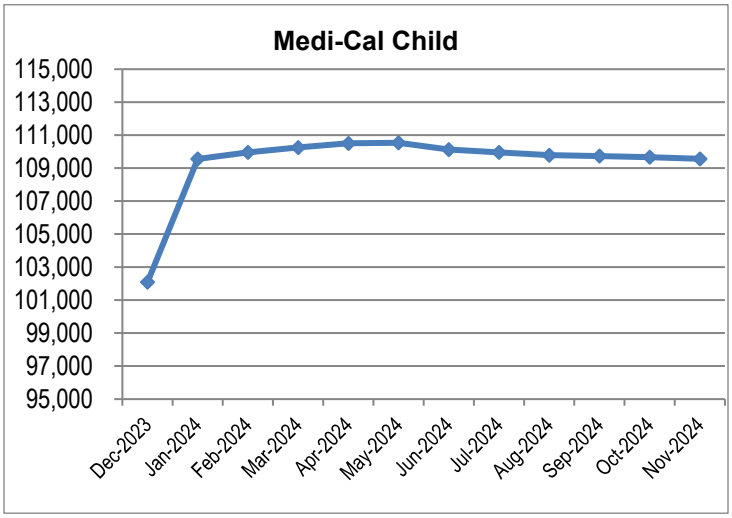
Enrollment

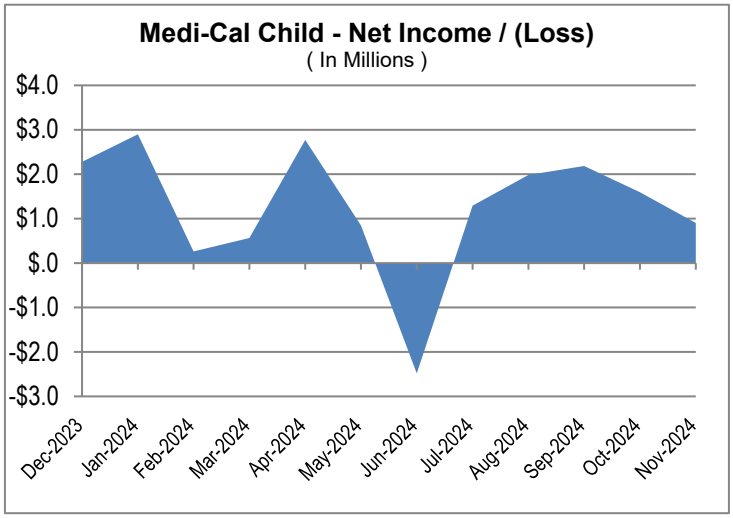
- Total enrollment increased by 725 members since October 2024.
- Total enrollment increased by 2,888 members since June 2024.

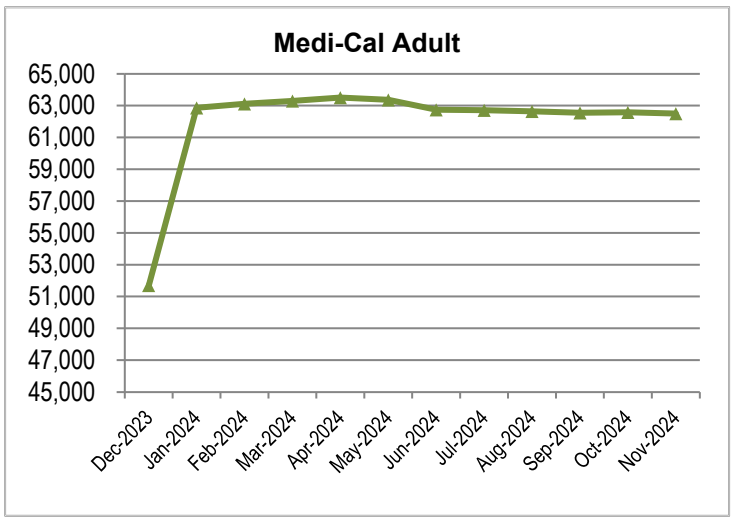
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

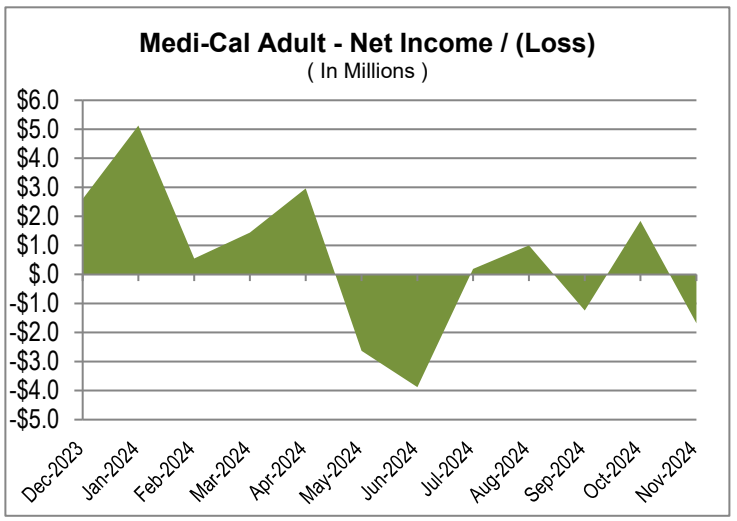
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
62,502	62,641	(139)	-0.2%	Adult	312,979	313,118	(139)	0.0%
109,561	109,772	(211)	-0.2%	Child	548,689	548,900	(211)	0.0%
35,603	35,423	180	0.5%	SPD	176,505	176,325	180	0.1%
40,357	40,144	213	0.5%	Duals	200,541	200,328	213	0.1%
151,559	151,249	310	0.2%	ACA OE	753,945	753,635	310	0.0%
255	251	4	1.6%	LTC	1,192	1,188	4	0.3%
1,269	1,266	3	0.2%	LTC Duals	6,276	6,273	3	0.0%
401,106	**400,746**	**360**	**0.1%**	**Medi-Cal Total**	**2,000,127**	**1,999,767**	**360**	**0.0%**
5,772	5,769	3	0.1%	Group Care	28,612	28,609	3	0.0%
406,878	**406,515**	**363**	**0.1%**	**Total**	**2,028,739**	**2,028,376**	**363**	**0.0%**

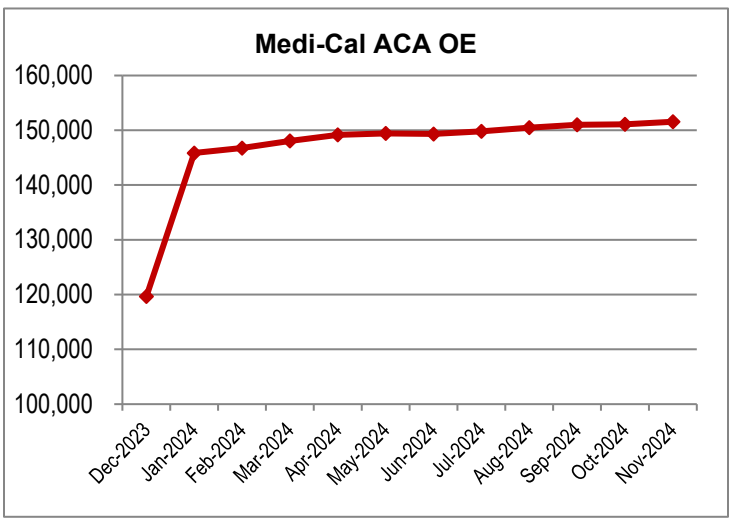
Enrollment and Profitability by Program and Category of Aid

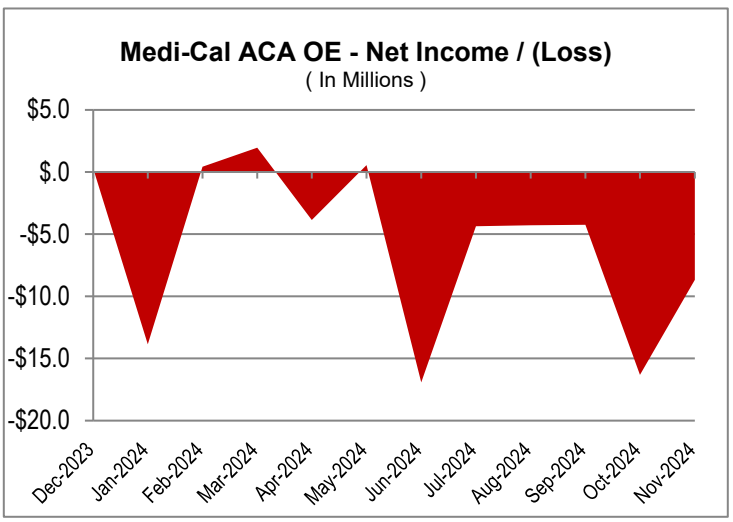












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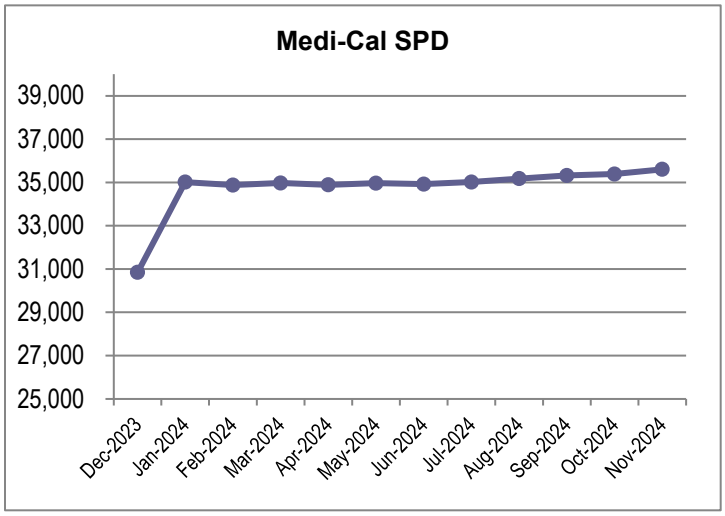

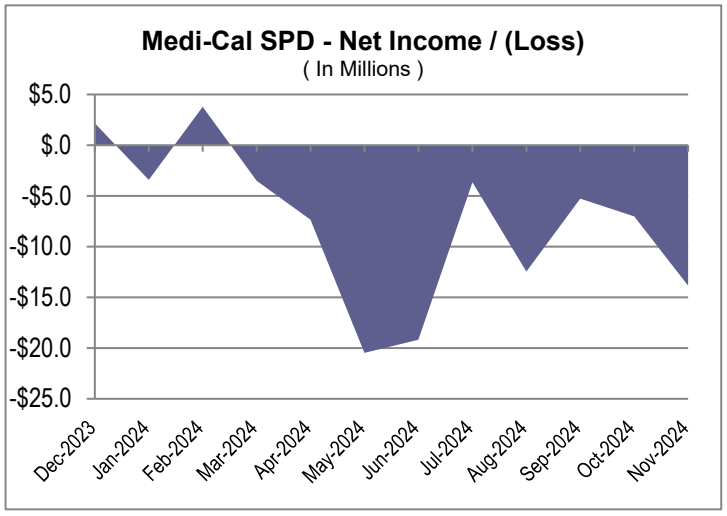

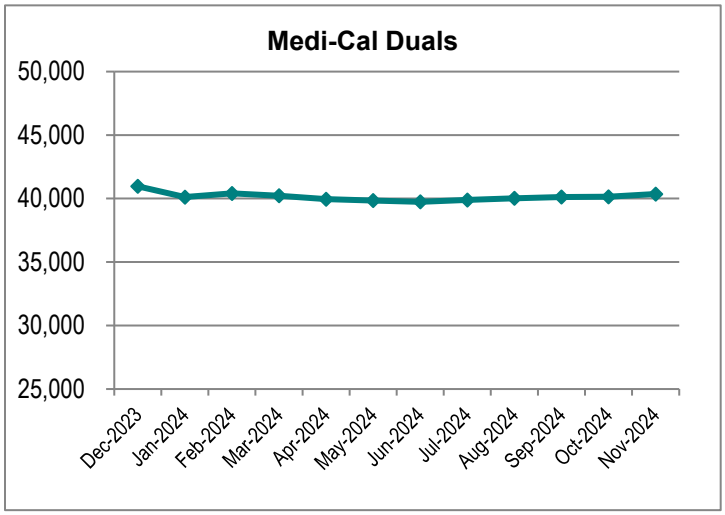

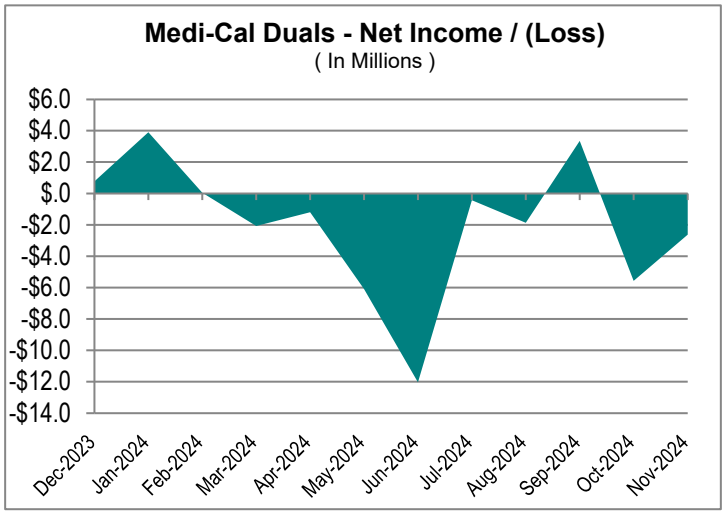

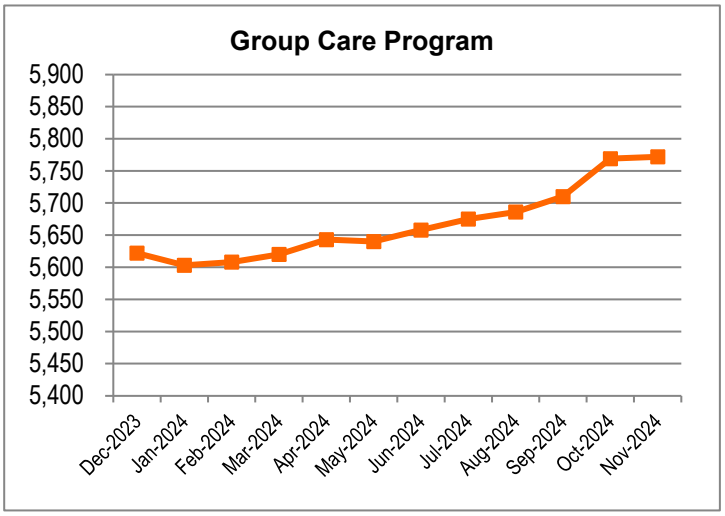

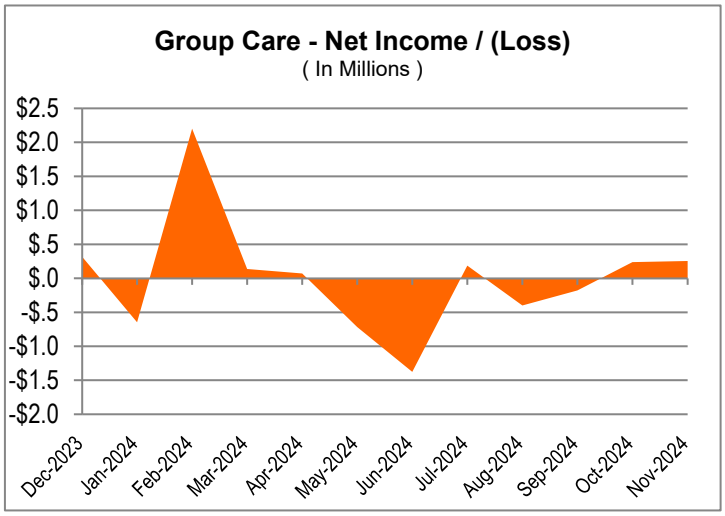

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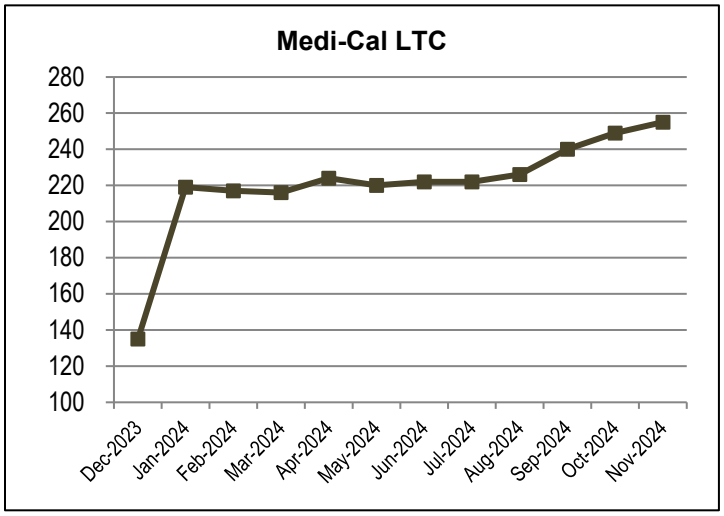
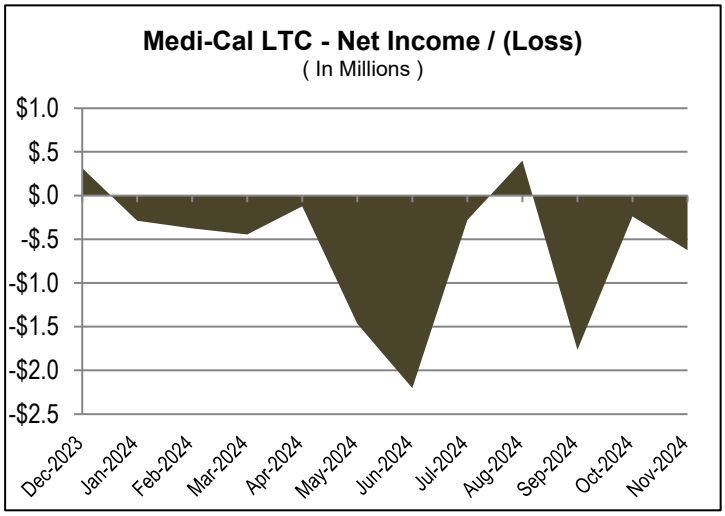
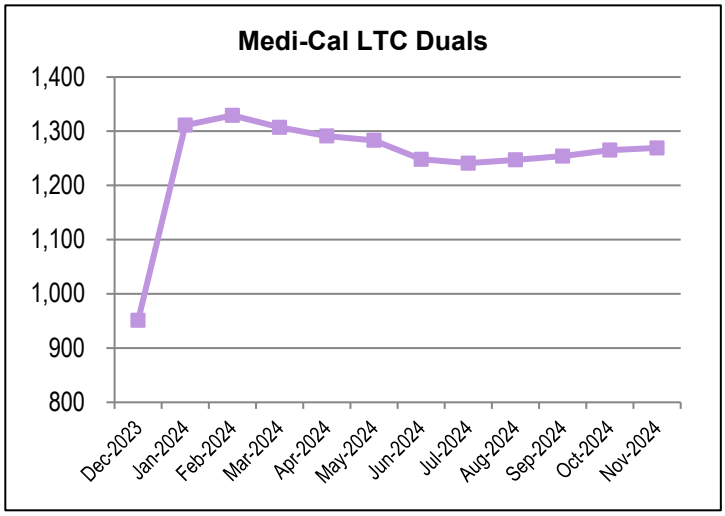
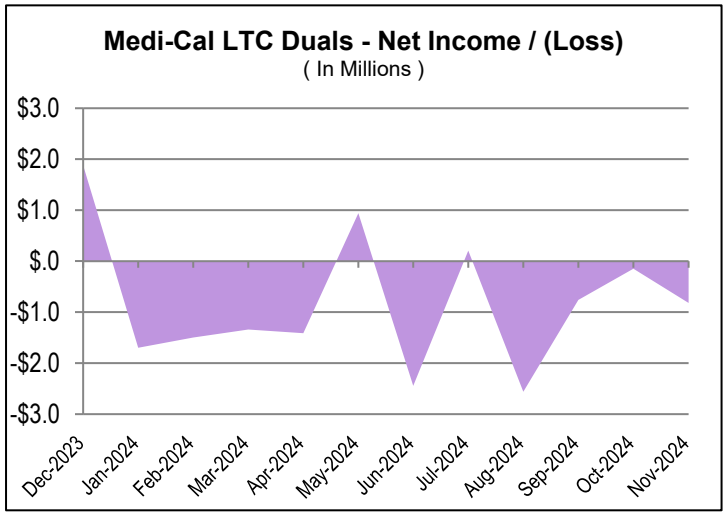
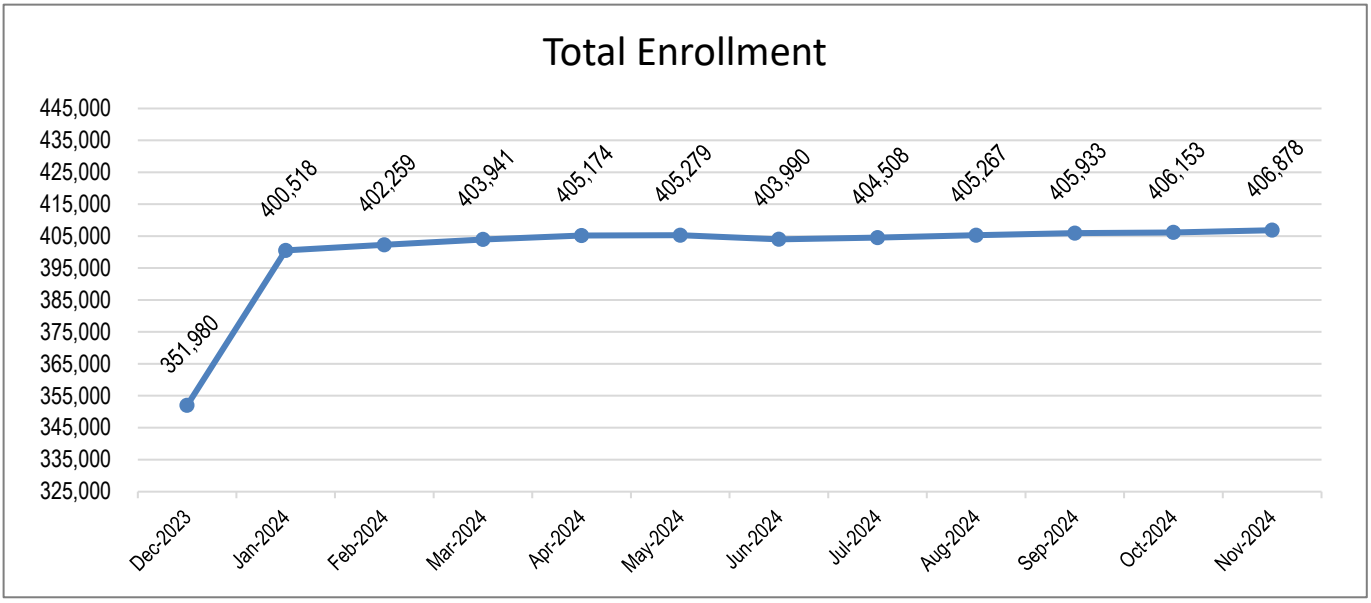
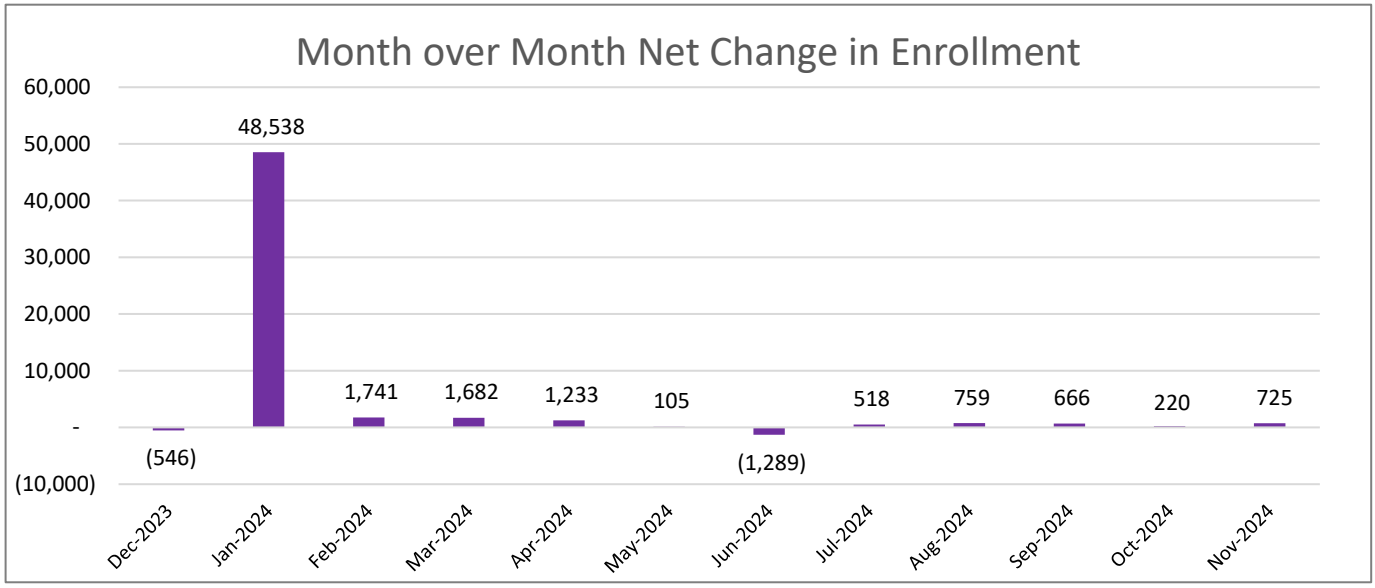








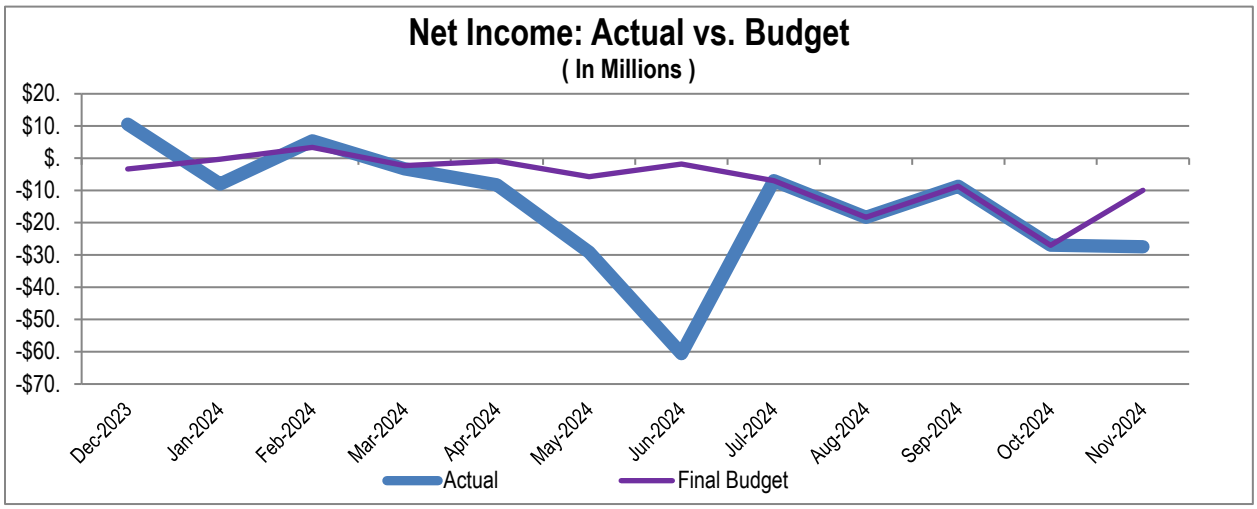




- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and ended May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the Alliance.
- In January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

Net Income

- For the month ended November 30th, 2024:
  - Actual Net Loss $27.5 million.
  - Budgeted Net Loss $10.0 million.
- For the fiscal YTD ended November 30th, 2024:
  - Actual Net Loss $88.5 million.
  - Budgeted Net Loss $71.0 million.

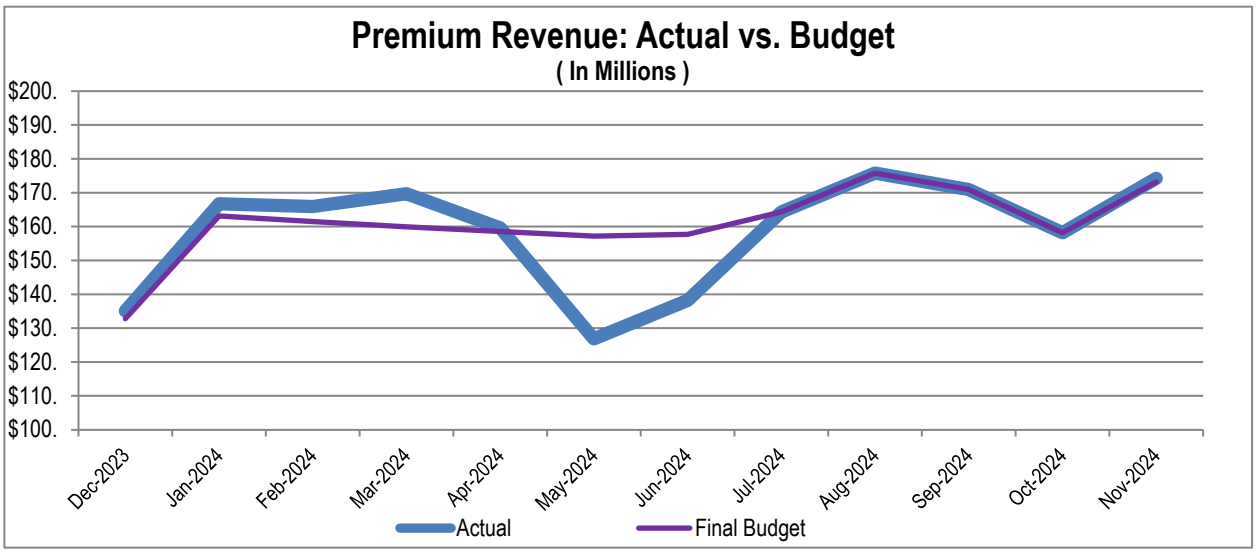


- The unfavorable variance of $17.5 million in the current month is primarily due to:
    - Favorable $1.0 million higher than anticipated Premium Revenue.
    - Favorable $1.2 million lower than anticipated Administrative Expense.
    - Unfavorable $19.8 million higher than anticipated Medical Expense.

Premium Revenue

- For the month ended November 30th, 2024:
    - Actual Revenue: $174.2 million.
    - Budgeted Revenue: $173.2 million.

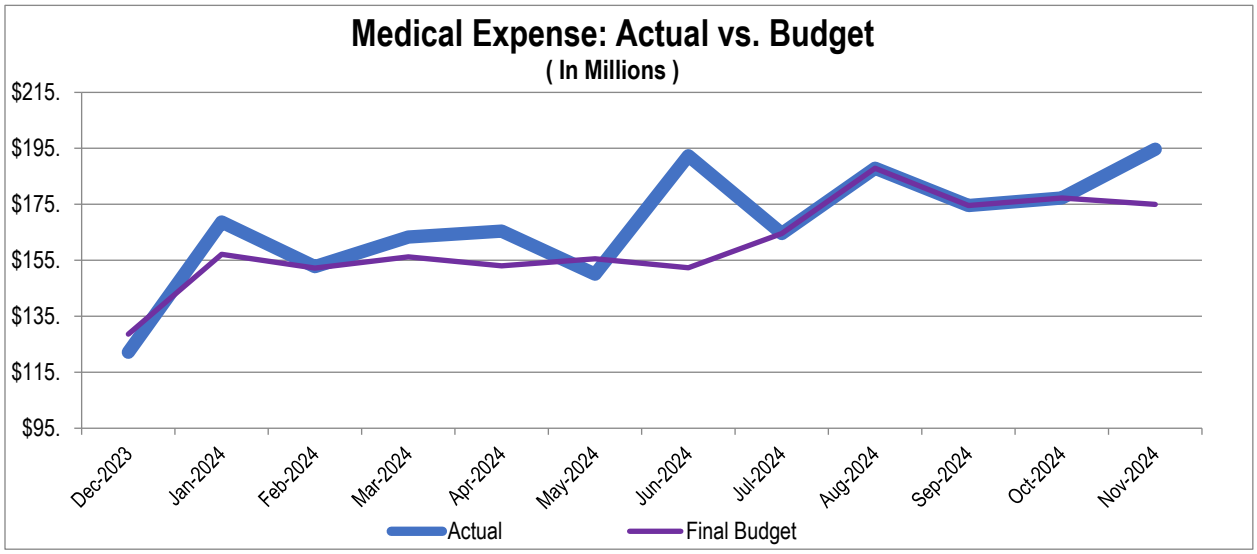
- For the fiscal YTD ended November 30th, 2024:
    - Actual Revenue: $843.5 million
    - Budgeted Revenue: $842.5 million.



- For the month ended November 30th, 2024, the favorable Premium Revenue variance of $1.1 million is primarily due to the following:
    - Favorable retroactive Medi-Cal member months for October 2023 through August 2024.
    - Favorable volume variance for the current month.
    - Partially offset by a reduction in CY2022 Prop 56 revenue via MEP (Medical Expenditure Percentage) reconciliation.

Medical Expense

- For the month ended November 30th, 2024:
    - Actual Medical Expense: $194.7 million.
    - Budgeted Medical Expense: $174.9 million.
- For the fiscal YTD ended November 30th, 2024:
    - Actual Medical Expense: $898.8 million.
    - Budgeted Medical Expense: $879.0 million.



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

- For November, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $8.5 million. Year to date, the estimate for prior years increased by $4.0 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)

Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$91,414,645	$0	$91,414,645	$89,346,770	($2,067,875)	-2.3%
Primary Care FFS	$13,636,584	$67,913	$13,704,496	$13,156,438	($480,145)	-3.6%
Specialty Care FFS	$41,162,628	$122,741	$41,285,369	$41,241,843	$79,215	0.2%
Outpatient FFS	$62,182,826	$277,046	$62,459,872	$60,764,895	($1,417,931)	-2.3%
Ancillary FFS	$95,729,894	$77,245	$95,807,138	$92,900,588	($2,829,306)	-3.0%
Pharmacy FFS	$69,574,367	$75,079	$69,649,446	$68,740,897	($833,470)	-1.2%
ER Services FFS	$51,782,597	$117,296	$51,899,893	$52,112,987	$330,389	0.6%
Inpatient Hospital & SNF FFS	$275,999,223	$2,695,345	$278,694,568	$267,777,065	($8,222,157)	-3.1%
Long Term Care FFS	$168,110,709	$563,057	$168,673,767	$166,730,694	($1,380,015)	-0.8%
Other Benefits & Services	$24,589,265	$0	$24,589,265	$25,545,610	$956,345	3.7%
Net Reinsurance	$638,482	$0	$638,482	$724,938	$86,456	11.9%
	$894,821,219	**$3,995,722**	**$898,816,941**	**$879,042,725**	**($15,778,495)**	**-1.8%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

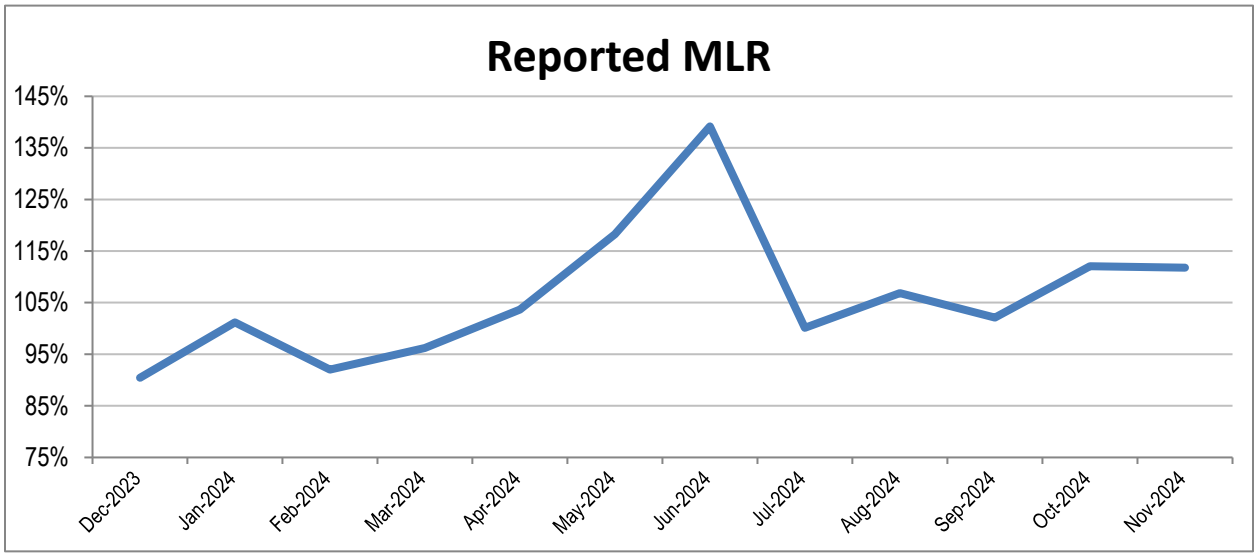
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$45.06	$0.00	$45.06	$44.05	($1.01)	-2.3%
Primary Care FFS	$6.72	$0.03	$6.76	$6.49	($0.24)	-3.6%
Specialty Care FFS	$20.29	$0.06	$20.35	$20.33	$0.04	0.2%
Outpatient FFS	$30.65	$0.14	$30.79	$29.96	($0.69)	-2.3%
Ancillary FFS	$47.19	$0.04	$47.22	$45.80	($1.39)	-3.0%
Pharmacy FFS	$34.29	$0.04	$34.33	$33.89	($0.40)	-1.2%
ER Services FFS	$25.52	$0.06	$25.58	$25.69	$0.17	0.7%
Inpatient Hospital & SNF FFS	$136.04	$1.33	$137.37	$132.02	($4.03)	-3.1%
Long Term Care FFS	$82.86	$0.28	$83.14	$82.20	($0.67)	-0.8%
Other Benefits & Services	$12.12	$0.00	$12.12	$12.59	$0.47	3.8%
Net Reinsurance	$0.31	$0.00	$0.31	$0.36	$0.04	11.9%
	$441.07	**$1.97**	**$443.04**	**$433.37**	**($7.70)**	**-1.8%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $15.8 million unfavorable to budget. On a PMPM basis, medical expense is 1.8% unfavorable to budget. For per-member-per-month expense:
    - Capitated Expense is over budget due to inclusion of Targeted Rate Increase (TRI) in capitation payments.
    - Primary Care Expense is over budget due to higher utilization and unit cost in the ACA OE and Child aid code categories.

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

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported medical expense divided by Premium revenue) was 111.8% for the month and 106.6% for the fiscal year-to-date.



Administrative Expense

- For the month ended November 30th, 2024:
  - Actual Administrative Expense: $9.0 million.
  - Budgeted Administrative Expense: $10.2 million.

- For the fiscal YTD ended November 30th, 2024:
  - Actual Administrative Expense: $48.2 million.
  - Budgeted Administrative Expense: $49.4 million.

Summary of Administrative Expense (In Dollars) **For the Month and Fiscal Year-to-Date** **Favorable/(Unfavorable)**								
Current Month					**Year-to-Date**			
Actual	**Budget**	**Variance $**	**Variance %**		**Actual**	**Budget**	**Variance $**	**Variance %**
$5,070,267	$5,423,966	$353,699	6.5%	Employee Expense	$28,101,202	$28,454,900	$353,699	1.2%
77,450	74,865	(2,585)	-3.5%	Medical Benefits Admin Expense	382,305	379,720	(2,585)	-0.7%
2,476,546	2,941,795	465,249	15.8%	Purchased & Professional Services	11,320,663	11,785,912	465,249	3.9%
1,417,485	1,787,123	369,637	20.7%	Other Admin Expense	8,412,386	8,782,024	369,637	4.2%
$9,041,748	$10,227,748	$1,186,000	11.6%	Total Administrative Expense	$48,216,556	$49,402,556	$1,186,000	2.4%

The year-to-date variances include:

- $1.0 million reversal of previously accrued holiday bonus occurred in November 2024.
- Unfavorable Favorable Employee and Temporary Services and delayed training, travel, and other employee-related expenses.
- Favorable in Purchased & Professional Services, primarily for the timing for Consulting Services and Other Purchased Services.
- Favorable Printing/Postage/Promotion and Supplies & Other Expenses.
- Favorable in Licenses, Insurance & Fees - for IT-related Licenses and Subscriptions as well as reduction in Bank Fees and the timing of Insurance Premiums.
- Favorable in Provider Interest, Supplies & Other Expenses.
- Unfavorable Medical Benefit Admin Fees as well as Building Occupancy costs.

The Administrative Loss Ratio (ALR) is 5.2% of net revenue for the month and 5.7% of net revenue year-to-date. Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $669,000.

Other Income / (Expense)

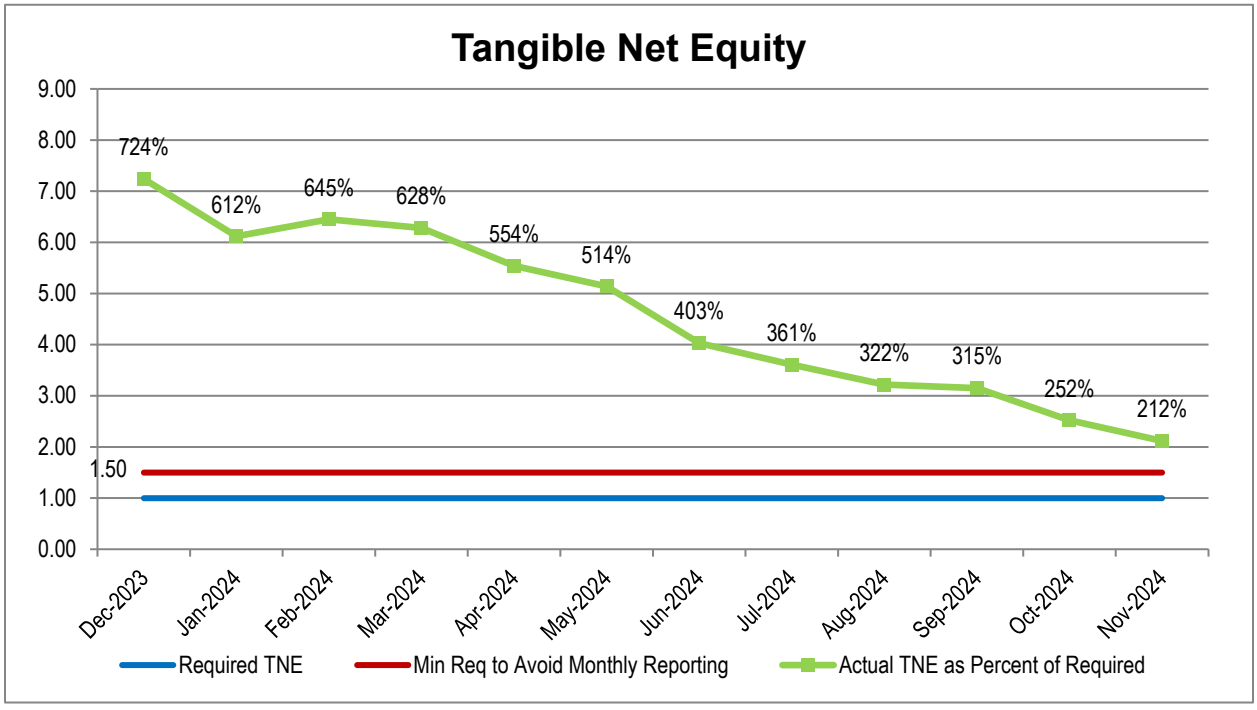
Other Income & Expense is comprised of investment income and claims interest. Fiscal year-to-date net investments show a gain of $15.0 million.

Managed Care Organization (MCO) Provider Tax

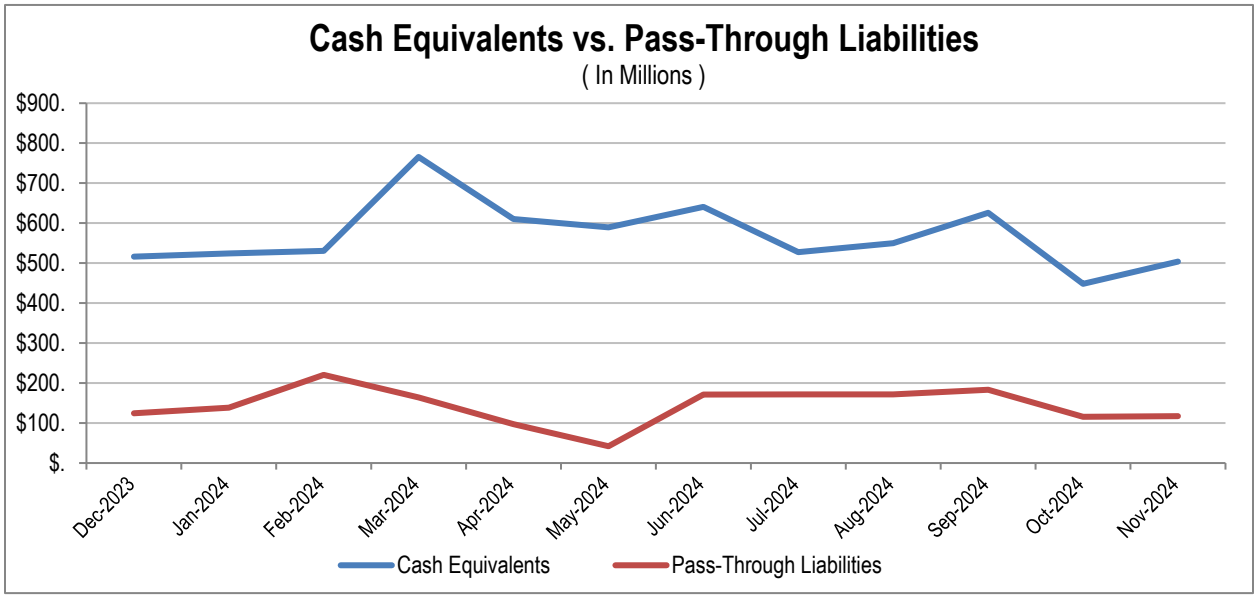
- Revenue:
  - For the month ended November 30th, 2024:
    - Actual: $63.7 million.
    - Budgeted: $63.6 million.
  - For the fiscal YTD ended November 30th, 2024:
    - Actual: $415.4 million.
    - Budgeted: $415.3 million.
- Expense:
  - For the month ended November 30th, 2024:
    - Actual: $63.7 million.
    - Budgeted: $63.6 million.
  - For the fiscal YTD ended November 30th, 2024:
    - Actual: $415.4 million.
    - Budgeted: $415.3 million.

Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
  - Required TNE $78.9 million
  - Actual TNE $166.9 million
  - Excess TNE $88.0 million
  - TNE % of Required TNE 212%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $503.4 million
    - Pass-Through Liabilities $117.0 million
    - Uncommitted Cash $386.4 million
    - Working Capital $107.8 million
    - Current Ratio 1.12 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $530,000.
- Annual capital budget: $1.7 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 NOVEMBER 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
401,106	400,746	360	0.1%	1. Medi-Cal	2,000,127	1,999,767	360	0.0%
5,772	5,769	3	0.1%	2. GroupCare	28,612	28,609	3	0.0%
406,878	**406,515**	**363**	**0.1%**	**3. TOTAL MEMBER MONTHS**	**2,028,739**	**2,028,376**	**363**	**0.0%**
				REVENUE				
$174,216,763	$173,204,149	$1,012,614	0.6%	4. Premium Revenue	$843,475,159	$842,462,545	$1,012,614	0.1%
$63,651,511	$63,594,383	$57,128	0.1%	5. MCO Tax Revenue AB119	$415,403,919	$415,346,791	$57,128	0.0%
$237,868,274	**$236,798,532**	**$1,069,742**	**0.5%**	**6. TOTAL REVENUE**	**$1,258,879,078**	**$1,257,809,336**	**$1,069,742**	**0.1%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$19,073,869	$17,005,995	($2,067,875)	(12.2%)	7. Capitated Medical Expense	$91,414,645	$89,346,770	($2,067,875)	(2.3%)
				Fee for Service Medical Expenses				
$62,101,789	$51,184,287	($10,917,502)	(21.3%)	8. Inpatient Hospital Expense	$278,694,568	$267,777,065	($10,917,502)	(4.1%)
$5,079,679	$4,531,621	($548,058)	(12.1%)	9. Primary Care Physician Expense	$13,704,496	$13,156,438	($548,058)	(4.2%)
$8,108,321	$8,064,795	($43,526)	(0.5%)	10. Specialty Care Physician Expense	$41,285,369	$41,241,843	($43,526)	(0.1%)
$21,248,937	$18,342,387	($2,906,550)	(15.8%)	11. Ancillary Medical Expense	$95,807,138	$92,900,588	($2,906,550)	(3.1%)
$13,137,113	$11,442,136	($1,694,977)	(14.8%)	12. Outpatient Medical Expense	$62,459,872	$60,764,895	($1,694,977)	(2.8%)
$9,967,647	$10,180,741	$213,093	2.1%	13. Emergency Expense	$51,899,893	$52,112,987	$213,093	0.4%
$12,967,007	$12,058,459	($908,549)	(7.5%)	14. Pharmacy Expense	$69,649,446	$68,740,897	($908,549)	(1.3%)
$34,383,314	$32,440,241	($1,943,073)	(6.0%)	15. Long Term Care Expense	$168,673,767	$166,730,694	($1,943,073)	(1.2%)
$166,993,808	$148,244,666	($18,749,142)	(12.6%)	16. Total Fee for Service Expense	$782,174,549	$763,425,407	($18,749,142)	(2.5%)
$8,284,077	$9,240,422	$956,345	10.3%	17. Other Benefits & Services	$24,589,265	$25,545,610	$956,345	3.7%
$352,844	$439,300	$86,456	19.7%	18. Reinsurance Expense	$638,482	$724,938	$86,456	11.9%
$194,704,598	**$174,930,382**	**($19,774,216)**	**(11.3%)**	**20. TOTAL MEDICAL EXPENSES**	**$898,816,941**	**$879,042,725**	**($19,774,216)**	**(2.2%)**
$43,163,676	**$61,868,150**	**($18,704,474)**	**(30.2%)**	**21. GROSS MARGIN**	**$360,062,137**	**$378,766,611**	**($18,704,474)**	**(4.9%)**
				ADMINISTRATIVE EXPENSES				
$5,070,267	$5,423,966	$353,699	6.5%	22. Personnel Expense	$28,101,202	$28,454,900	$353,699	1.2%
$77,450	$74,865	($2,585)	(3.5%)	23. Benefits Administration Expense	$382,305	$379,720	($2,585)	(0.7%)
$2,476,546	$2,941,795	$465,249	15.8%	24. Purchased & Professional Services	$11,320,663	$11,785,912	$465,249	3.9%
$1,417,485	$1,787,123	$369,637	20.7%	25. Other Administrative Expense	$8,412,386	$8,782,024	$369,637	4.2%
$9,041,748	**$10,227,748**	**$1,186,000**	**11.6%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$48,216,556**	**$49,402,556**	**$1,186,000**	**2.4%**
$63,651,511	**$63,594,383**	**($57,128)**	**(0.1%)**	**27. MCO TAX EXPENSES**	**$415,403,919**	**$415,346,791**	**($57,128)**	**(0.0%)**
($29,529,583)	**($11,953,981)**	**($17,575,602)**	**(147.0%)**	**28. NET OPERATING INCOME / (LOSS)**	**($103,558,338)**	**($85,982,736)**	**($17,575,602)**	**(20.4%)**
				OTHER INCOME / EXPENSES				
$2,059,321	**$2,000,000**	**$59,321**	**3.0%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$15,040,323**	**$14,981,002**	**$59,321**	**0.4%**
($27,470,263)	**($9,953,981)**	**($17,516,282)**	**(176.0%)**	**30. NET SURPLUS (DEFICIT)**	**($88,518,015)**	**($71,001,734)**	**($17,516,282)**	**(24.7%)**
$174,216,763	**$173,204,149**	**$1,012,614**	**0.6%**	**4. TOTAL REVENUE EXCLUDES MCO TAX RE**	**$843,475,159**	**$842,462,545**	**$1,012,614**	**0.1%**
$194,704,598	**$174,930,382**	**($19,774,216)**	**(11.3%)**	**18. TOTAL MEDICAL EXPENSES**	**$898,816,941**	**$879,042,725**	**($19,774,216)**	**(2.2%)**
111.76%	101.00%	-10.76%	-10.70%	31. Medical Loss Ratio	106.56%	104.34%	-2.22%	-2.10%
5.19%	5.91%	0.72%	12.20%	32. Administrative Expense Ratio	5.72%	5.86%	0.14%	2.40%
-11.55%	-4.20%	-7.35%	-175.00%	33. Net Surplus (Deficit) Ratio	-7.03%	-5.64%	-1.39%	-24.60%

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2024

	11/30/2024	10/31/2024	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$21,075,966	$8,277,790	$12,798,176	154.61%
CNB Short-Term Investment	482,278,187	439,944,665	42,333,522	9.62%
Interest Receivable	4,717,269	5,190,880	(473,612)	-9.12%
Premium Receivables	496,737,349	476,503,745	20,233,604	4.25%
Reinsurance Recovery Receivable	7,263,899	6,581,946	681,953	10.36%
Other Receivables	1,171,706	4,916,251	(3,744,545)	-76.17%
Prepaid Expenses	749,760	788,964	(39,204)	-4.97%
TOTAL CURRENT ASSETS	**1,013,994,135**	**942,204,241**	**71,789,894**	**7.62%**
OTHER ASSETS				
CNB Long-Term Investment	44,162,073	44,106,913	55,161	0.13%
CalPERS Net Pension Asset	(6,144,132)	(6,144,132)	0	0.00%
Deferred Outflow	14,319,532	14,319,532	0	0.00%
Restricted Asset-Bank Note	350,000	350,000	0	0.00%
GASB 87-Lease Assets (Net)	477,356	543,269	(65,913)	-12.13%
GASB 96-SBITA Assets (Net)	3,886,019	3,563,561	322,458	9.05%
TOTAL OTHER ASSETS	**57,050,848**	**56,739,142**	**311,705**	**0.55%**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.00%
Furniture And Equipment	13,071,003	13,071,003	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	38,640,099	38,640,099	0	0.00%
Less: Accumulated Depreciation	(32,960,005)	(32,900,631)	(59,373)	0.18%
PROPERTY AND EQUIPMENT (NET)	**5,680,094**	**5,739,467**	**(59,373)**	**-1.03%**
TOTAL ASSETS	**1,076,725,077**	**1,004,682,851**	**72,042,226**	**7.17%**
CURRENT LIABILITIES				
Trade Accounts Payable	8,805,061	7,057,073	1,747,988	24.77%
Incurred But Not Reported Claims	329,821,855	300,812,101	29,009,755	9.64%
Other Medical Liabilities	116,406,026	109,795,018	6,611,008	6.02%
Pass-Through Liabilities	116,963,192	115,603,841	1,359,351	1.18%
MCO Tax Liabilities	324,249,751	260,598,240	63,651,511	24.43%
GASB 87 and 96 ST Liabilities	2,923,836	2,425,565	498,270	20.54%
Payroll Liabilities	6,996,340	10,358,458	(3,362,119)	-32.46%
TOTAL CURRENT LIABILITIES	**906,166,061**	**806,650,296**	**99,515,764**	**12.34%**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	374,358	377,634	(3,276)	-0.87%
Deferred Inflow	3,327,530	3,327,530	0	0.00%
TOTAL LONG TERM LIABILITIES	**3,701,888**	**3,705,163**	**(3,276)**	**-0.09%**
TOTAL LIABILITIES	**909,867,948**	**810,355,460**	**99,512,489**	**12.28%**
NET WORTH				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	254,534,911	254,534,911	0	0.00%
Year-To-Date Net Surplus (Deficit)	(88,518,015)	(61,047,753)	(27,470,263)	45.00%
TOTAL NET WORTH	**166,857,128**	**194,327,391**	**(27,470,263)**	**-14.14%**
TOTAL LIABILITIES AND NET WORTH	**1,076,725,077**	**1,004,682,851**	**72,042,226**	**7.17%**
Cash Equivalents	503,354,153	448,222,455	55,131,698	12.30%
Pass-Through	116,963,192	115,603,841	1,359,351	1.18%
Uncommitted Cash	386,390,961	332,618,614	53,772,347	16.17%
Working Capital	107,828,074	135,553,945	(27,725,870)	-20.45%
Current Ratio	111.9%	116.8%	-4.9%	-4.2%

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **November 30, 2024**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,156,099	$9,436,688	$18,235,947	$15,648,482
GroupCare Receivable	(3,156,049)	(3,122,333)	(3,679,416)	(6,216,586)
Total	50	6,314,355	14,556,531	9,431,896
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	234,712,174	815,355,588	1,493,575,877	1,243,230,597
Premium Receivable	(17,077,555)	(120,219,288)	(330,722,958)	(123,577,243)
Total	217,634,619	695,136,300	1,162,852,919	1,119,653,354
Investment & Other Income Cash Flows				
Other Revenues	611,567	835,780	1,864,046	2,092,973
Interest Income	1,460,317	7,055,228	16,360,614	13,008,335
Interest Receivable	473,612	(356,526)	(3,190,395)	(2,801,205)
Total	2,545,496	7,534,482	15,034,265	12,300,103
Medical & Hospital Cash Flows				
Total Medical Expenses	(194,704,597)	(546,450,071)	(1,091,134,224)	(898,816,946)
Other Health Care Receivables	3,060,850	1,866,270	2,158,346	2,525,100
Capitation Payable	-	-	-	-
IBNP Payable	29,009,755	22,465,358	84,134,362	33,517,597
Other Medical Payable	7,970,358	(89,446,002)	56,321,245	(102,471,538)
Risk Share Payable	-	(2,680,192)	(2,680,192)	(2,680,192)
New Health Program Payable	-	-	-	-
Total	(154,663,634)	(614,244,637)	(951,200,463)	(967,925,979)
Administrative Cash Flows				
Total Administrative Expenses	(9,054,311)	(27,944,518)	(57,875,804)	(48,277,540)
Prepaid Expenses	39,205	(493,588)	194,809	(511,143)
Other Receivables	1,742	7,157	(64,442)	33,837
CalPERS Pension	-	-	637,208	-
Trade Accounts Payable	1,747,988	2,851,486	2,012,691	2,314,765
Payroll Liabilities	(3,362,120)	(1,369,222)	(2,870,607)	(1,102,886)
GASB Assets and Liabilities	238,450	(568,304)	(383,360)	(563,696)
Depreciation Expense	59,373	183,004	347,879	297,332
Total	(10,329,673)	(27,333,985)	(58,001,626)	(47,809,331)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(63,651,511)	(321,462,528)	(530,158,499)	(415,403,919)
MCO Tax Liabilities	63,651,511	195,993,778	279,207,500	164,466,237
Total	0	(125,468,750)	(250,950,999)	(250,937,682)
Net Cash Flows from Operating Activities	**55,186,858**	**(58,062,235)**	**(67,709,373)**	**(125,287,639)**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **November 30, 2024**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(55,161)	12,014,083	(17,413,405)	(11,169,824)
Total	(55,161)	12,014,083	(17,413,405)	(11,169,824)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	-	(528,457)	(529,610)
Purchases of Property and Equipment	-	-	(528,457)	(529,610)
Net Cash Flows from Investing Activities	**(55,161)**	**12,014,083**	**(17,941,862)**	**(11,699,434)**
Net Change in Cash	**55,131,697**	**(46,048,152)**	**(85,651,235)**	**(136,987,073)**
Rounding	-	-	-	-
Cash @ Beginning of Period	448,222,456	549,402,305	589,005,388	640,341,226
Cash @ End of Period	**$503,354,153**	**$503,354,153**	**$503,354,153**	**$503,354,153**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **November 30, 2024**

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($27,470,262)	($63,173,833)	($149,132,044)	($88,518,018)
Add back: Depreciation & Amortization	59,373	183,004	347,879	297,332
Receivables				
Premiums Receivable	(17,077,555)	(120,219,288)	(330,722,958)	(123,577,243)
Interest Receivable	473,612	(356,526)	(3,190,395)	(2,801,205)
Other Health Care Receivables	3,060,850	1,866,270	2,158,346	2,525,100
Other Receivables	1,742	7,157	(64,442)	33,837
GroupCare Receivable	(3,156,049)	(3,122,333)	(3,679,416)	(6,216,586)
Total	(16,697,400)	(121,824,720)	(335,498,865)	(130,036,097)
Prepaid Expenses	39,205	(493,588)	194,809	(511,143)
Trade Payables	1,747,988	2,851,486	2,012,691	2,314,765
Claims Payable and Shared Risk Pool				
IBNP Payable	29,009,755	22,465,358	84,134,362	33,517,597
Capitation Payable & Other Medical Payable	7,970,358	(89,446,002)	56,321,245	(102,471,538)
Risk Share Payable	-	(2,680,192.00)	(2,680,192)	(2,680,192)
Claims Payable				
Total	36,980,113	(69,660,836)	137,775,415	(71,634,133)
Other Liabilities				
CalPERS Pension	-	-	637,208.00	-
Payroll Liabilities	(3,362,120)	(1,369,222)	(2,870,606)	(1,102,886)
GASB Assets and Liabilities	238,450	(568,304)	(383,360)	(563,696)
New Health Program	-	-	-	-
MCO Tax Liabilities	63,651,511	195,993,778	279,207,500	164,466,237
Total	60,527,841	194,056,252	276,590,742	162,799,655
Rounding	-	-	-	-
Cash Flows from Operating Activities	**55,186,858**	**(58,062,235)**	**(67,709,373)**	**(125,287,639)**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **November 30, 2024**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$217,634,619	$695,136,300	$1,162,852,919	$1,119,653,354
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	50	6,314,355	14,556,531	9,431,896
Other Income	611,567	835,780	1,864,046	2,092,973
Interest Income	1,933,929	6,698,702	13,170,219	10,207,130
Less Cash Paid				
Medical Expenses	(154,663,634)	(614,244,637)	(951,200,463)	(967,925,979)
Vendor & Employee Expenses	(10,329,673)	(27,333,985)	(58,001,626)	(47,809,331)
MCO Tax Expense AB119	0	(125,468,750)	(250,950,999)	(250,937,682)
Net Cash Flows from Operating Activities	**55,186,858**	**(58,062,235)**	**(67,709,373)**	**(125,287,639)**
Cash Flows from Investing Activities:				
Long Term Investments	(55,161)	12,014,083	(17,413,405)	(11,169,824)
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	0	0	(528,457)	(529,610)
Net Cash Flows from Investing Activities	**(55,161)**	**12,014,083**	**(17,941,862)**	**(11,699,434)**
Net Change in Cash	**55,131,697**	**(46,048,152)**	**(85,651,235)**	**(136,987,073)**
Rounding	-	-	-	-
Cash @ Beginning of Period	448,222,456	549,402,305	589,005,388	640,341,226
Cash @ End of Period	**$503,354,153**	**$503,354,153**	**$503,354,153**	**$503,354,153**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($27,470,262)	($63,173,832)	($149,132,045)	($88,518,018)
Add Back: Depreciation	59,373	183,004	347,879	297,332
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(16,697,400)	(121,824,720)	(335,498,865)	(130,036,097)
Prepaid Expenses	39,205	(493,589)	194,810	(511,143)
Trade Payables	1,747,988	2,851,486	2,012,691	2,314,765
Claims Payable, IBNP and Risk Sharing	36,980,113	(69,660,836)	137,775,415	(71,634,133)
Deferred Revenue	0	0	0	0
Other Liabilities	60,527,841	194,056,252	276,590,742	162,799,655
Total	55,186,858	(58,062,235)	(67,709,373)	(125,287,639)
Rounding	-	-	-	-
Cash Flows from Operating Activities	**$55,186,858**	**($58,062,235)**	**($67,709,373)**	**($125,287,639)**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF NOVEMBER 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	109,561	62,502	35,603	151,559	40,357	255	1,269	401,106	5,772	-	406,878
Revenue	$33,682,198	$32,721,612	$49,859,641	$82,934,361	$21,296,294	$2,951,231	$11,266,838	$234,712,175	$3,156,099	$0	$237,868,274
Medical Expense	$15,030,698	$23,642,874	$56,296,108	$65,319,095	$16,892,784	$3,409,896	$11,307,398	$191,898,853	$2,784,395	$21,350	$194,704,598
Gross Margin	$18,651,500	$9,078,738	($6,436,467)	$17,615,266	$4,403,509	($458,665)	($40,559)	$42,813,322	$371,704	($21,350)	$43,163,676
Administrative Expense	$466,825	$1,100,842	$2,319,566	$2,945,434	$812,065	$164,633	$760,707	$8,570,071	$143,855	$327,822	$9,041,748
MCO Tax Expense	$17,386,235	$9,918,442	$5,649,840	$24,050,898	$6,404,252	$40,466	$201,378	$63,651,511	$0	$0	$63,651,511
Operating Income / (Expense)	$798,439	($1,940,546)	($14,405,873)	($9,381,065)	($2,812,808)	($663,764)	($1,002,644)	($29,408,261)	$227,849	($349,172)	($29,529,583)
Other Income / (Expense)	$104,140	$257,930	$553,545	$704,102	$189,210	$39,827	$183,053	$2,031,808	$27,513	$0	$2,059,321
Net Income / (Loss)	$902,579	($1,682,616)	($13,852,328)	($8,676,963)	($2,623,598)	($623,937)	($819,591)	($27,376,452)	$255,362	($349,172)	($27,470,263)
PMPM Metrics:											
Revenue PMPM	$307.43	$523.53	$1,400.43	$547.21	$527.70	$11,573.45	$8,878.52	$585.16	$546.79	$0.00	$584.62
Medical Expense PMPM	$137.19	$378.27	$1,581.22	$430.98	$418.58	$13,372.14	$8,910.48	$478.42	$482.40	$0.00	$478.53
Gross Margin PMPM	$170.24	$145.26	($180.78)	$116.23	$109.11	($1,798.69)	($31.96)	$106.74	$64.40	$0.00	$106.09
Administrative Expense PMPM	$4.26	$17.61	$65.15	$19.43	$20.12	$645.62	$599.45	$21.37	$24.92	$0.00	$22.22
MCO Tax Expense PMPM	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$0.00	$0.00	$156.44
Operating Income / (Expense) PMPM	$7.29	($31.05)	($404.63)	($61.90)	($69.70)	($2,603.00)	($790.11)	($73.32)	$39.47	$0.00	($72.58)
Other Income / (Expense) PMPM	$0.95	$4.13	$15.55	$4.65	$4.69	$156.19	$144.25	$5.07	$4.77	$0.00	$5.06
Net Income / (Loss) PMPM	$8.24	($26.92)	($389.08)	($57.25)	($65.01)	($2,446.81)	($645.86)	($68.25)	$44.24	$0.00	($67.51)
Ratio:											
Medical Loss Ratio	92.2%	103.7%	127.3%	110.9%	113.4%	117.1%	102.2%	112.2%	88.2%	0.0%	111.8%
Administrative Expense Ratio	2.9%	4.8%	5.2%	5.0%	5.5%	5.7%	6.9%	5.0%	4.6%	0.0%	5.2%
Net Income Ratio	2.7%	-5.1%	-27.8%	-10.5%	-12.3%	-21.1%	-7.3%	-11.7%	8.1%	0.0%	-11.5%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE NOVEMBER 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	548,689	312,979	176,505	753,945	200,541	1,192	6,276	2,000,127	28,612	-	2,028,739
Revenue	$189,348,096	$174,265,900	$251,899,555	$443,271,098	$117,128,555	$12,970,703	$54,346,689	$1,243,230,596	$15,648,482	$0	$1,258,879,078
Medical Expense	$65,557,998	$105,111,531	$249,446,519	$314,787,101	$79,731,208	$14,661,535	$54,440,035	$883,735,927	$15,012,089	$68,926	$898,816,941
Gross Margin	$123,790,098	$69,154,369	$2,453,036	$128,483,997	$37,397,346	($1,690,832)	($93,345)	$359,494,669	$636,394	($68,926)	$360,062,137
Administrative Expense	$2,391,888	$5,691,951	$12,170,748	$15,437,943	$4,224,168	$864,607	$4,015,820	$44,797,125	$738,444	$2,680,987	$48,216,556
MCO Tax Expense	$114,204,555	$65,243,636	$36,609,507	$156,095,446	$41,690,992	$243,318	$1,316,465	$415,403,919	$0	$0	$415,403,919
Operating Income / (Expense)	$7,193,654	($1,781,218)	($46,327,220)	($43,049,392)	($8,517,813)	($2,798,757)	($5,425,630)	($100,706,375)	($102,051)	($2,749,913)	($103,558,338)
Other Income / (Expense)	$760,539	$1,884,673	$4,042,571	$5,142,096	$1,381,813	$290,861	$1,336,846	$14,839,397	$200,925	$0	$15,040,323
Net Income / (Loss)	$7,954,193	$103,455	($42,284,649)	($37,907,296)	($7,136,000)	($2,507,897)	($4,088,784)	($85,866,978)	$98,875	($2,749,913)	($88,518,015)
PMPM Metrics:											
Revenue PMPM	$345.09	$556.80	$1,427.15	$587.94	$584.06	$10,881.46	$8,659.45	$621.58	$546.92	$0.00	$620.52
Medical Expense PMPM	$119.48	$335.84	$1,413.25	$417.52	$397.58	$12,299.95	$8,674.32	$441.84	$524.68	$0.00	$443.04
Gross Margin PMPM	$225.61	$220.96	$13.90	$170.42	$186.48	($1,418.48)	($14.87)	$179.74	$22.24	$0.00	$177.48
Administrative Expense PMPM	$4.36	$18.19	$68.95	$20.48	$21.06	$725.34	$639.87	$22.40	$25.81	$0.00	$23.77
MCO Tax Expense PMPM	$208.14	$208.46	$207.41	$207.04	$207.89	$204.13	$209.76	$207.69	$0.00	$0.00	$204.76
Operating Income / (Expense) PMPM	$13.11	($5.69)	($262.47)	($57.10)	($42.47)	($2,347.95)	($864.50)	($50.35)	($3.57)	$0.00	($51.05)
Other Income / (Expense) PMPM	$1.39	$6.02	$22.90	$6.82	$6.89	$244.01	$213.01	$7.42	$7.02	$0.00	$7.41
Net Income / (Loss) PMPM	$14.50	$0.33	($239.57)	($50.28)	($35.58)	($2,103.94)	($651.50)	($42.93)	$3.46	$0.00	($43.63)
Ratio:											
Medical Loss Ratio	87.2%	96.4%	115.9%	109.6%	105.7%	115.2%	102.7%	106.8%	95.9%	0.0%	106.6%
Administrative Expense Ratio	3.2%	5.2%	5.7%	5.4%	5.6%	6.8%	7.6%	5.4%	4.7%	0.0%	5.7%
Net Income Ratio	4.2%	0.1%	-16.8%	-8.6%	-6.1%	-19.3%	-7.5%	-6.9%	0.6%	0.0%	-7.0%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED November 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSES SUMMARY (ADMIN. DEPT. ONLY)				
$5,070,267	$5,423,966	$353,699	6.5%	Personnel Expenses	$28,101,202	$28,454,900	$353,699	1.2%
$77,450	$74,865	($2,585)	(3.5%)	Benefits Administration Expense	$382,305	$379,720	($2,585)	(0.7%)
$2,476,546	$2,941,795	$465,249	15.8%	Purchased & Professional Services	$11,320,663	$11,785,912	$465,249	3.9%
$659,854	$598,355	($61,498)	(10.3%)	Occupancy	$2,644,152	$2,582,654	($61,498)	(2.4%)
$436,324	$846,394	$410,070	48.4%	Printing Postage & Promotion	$1,967,363	$2,377,433	$410,070	17.2%
$149,188	$156,013	$6,826	4.4%	Licenses Insurance & Fees	$2,862,191	$2,869,016	$6,826	0.2%
$172,119	$186,360	$14,241	7.6%	Other Administrative Expense	$938,680	$952,920	$14,241	1.5%
$3,971,481	$4,803,783	$832,302	17.3%	Total Other Administrative Expenses (excludes Personnel Expenses)	$20,115,354	$20,947,656	$832,301	4.0%
$9,041,748	$10,227,748	$1,186,000	11.6%	Total Administrative Expenses	$48,216,556	$49,402,556	$1,186,000	2.4%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED November 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,780,664	3,101,566	(679,098)	(21.9%)	Salaries & Wages	18,831,363	18,152,266	(679,098)	(3.7%)
291,980	519,802	227,823	43.8%	Paid Time Off	1,652,878	1,880,701	227,823	12.1%
5,950	7,755	1,805	23.3%	Compensated Incentives	11,739	13,544	1,805	13.3%
0	400,000	400,000	100.0%	Severence	0	400,000	400,000	100.0%
60,244	86,386	26,142	30.3%	Payroll Taxes	307,199	333,342	26,142	7.8%
42,512	25,460	(17,052)	(67.0%)	Overtime	357,131	340,079	(17,052)	(5.0%)
287,994	425,572	137,578	32.3%	CalPERS ER Match	1,570,027	1,707,605	137,578	8.1%
1,014,300	694,629	(319,672)	(46.0%)	Employee Benefits	4,846,496	4,526,825	(319,672)	(7.1%)
(1,380)	0	1,380	0.0%	Personal Floating Holiday	2,513	3,894	1,380	35.4%
17,823	56,250	38,427	68.3%	Language Pay	103,832	142,259	38,427	27.0%
(1,260)	0	1,260	0.0%	Med Ins Opted Out Stipend	14,750	16,010	1,260	7.9%
(648,810)	(248,810)	400,000	(160.8%)	Holiday Bonus	(400,000)	0	400,000	1,333,333,4…
121,928	0	(121,928)	0.0%	Sick Leave	392,656	270,728	(121,928)	(45.0%)
3,535	56,772	53,237	93.8%	Compensated Employee Relations	3,619	56,856	53,237	93.6%
20,280	25,150	4,870	19.4%	Work from Home Stipend	99,250	104,120	4,870	4.7%
759	11,733	10,974	93.5%	Mileage, Parking & LocalTravel	5,750	16,725	10,974	65.6%
2,527	38,958	36,430	93.5%	Travel & Lodging	14,844	51,274	36,430	71.0%
48,936	101,365	52,429	51.7%	Temporary Help Services	161,580	214,010	52,429	24.5%
15,959	100,737	84,778	84.2%	Staff Development/Training	59,217	143,995	84,778	58.9%
6,328	20,641	14,313	69.3%	Staff Recruitment/Advertisement	66,356	80,669	14,313	17.7%
5,070,267	**5,423,966**	**353,699**	**6.5%**	**Personnel Expense**	**28,101,202**	**28,454,900**	**353,699**	**1.2%**
24,843	22,018	(2,825)	(12.8%)	Pharmacy Administrative Fees	119,976	117,150	(2,825)	(2.4%)
52,607	52,847	240	0.5%	Telemedicine Admin. Fees	262,330	262,570	240	0.1%
77,450	**74,865**	**(2,585)**	**(3.5%)**	**Benefits Administration Expense**	**382,305**	**379,720**	**(2,585)**	**(0.7%)**
498,557	864,314	365,756	42.3%	Consultant Fees - Non Medical	2,977,681	3,343,438	365,756	10.9%
843,857	552,142	(291,715)	(52.8%)	Computer Support Services	2,912,527	2,620,812	(291,715)	(11.1%)
12,500	15,000	2,500	16.7%	Audit Fees	80,658	83,158	2,500	3.0%
16,350	17	(16,333)	(97,980.4%)	Consultant Fees - Medical	995	(15,338)	(16,333)	106.5%
235,717	280,157	44,440	15.9%	Other Purchased Services	1,253,169	1,297,610	44,440	3.4%
0	1,688	1,688	100.0%	Maint.&Repair-Office Equipment	0	1,688	1,688	100.0%
111,801	70,067	(41,734)	(59.6%)	Legal Fees	443,086	401,352	(41,734)	(10.4%)
0	0	0	0.0%	Member Health Education	320	320	0	0.0%
27,179	26,000	(1,179)	(4.5%)	Translation Services	114,242	113,064	(1,179)	(1.0%)
193,627	177,300	(16,327)	(9.2%)	Medical Refund Recovery Fees	1,308,998	1,292,671	(16,327)	(1.3%)
467,416	724,809	257,392	35.5%	Software - IT Licenses & Subsc	1,814,273	2,071,665	257,392	12.4%
22,313	181,602	159,289	87.7%	Hardware (Non-Capital)	179,371	338,659	159,289	47.0%
47,229	48,700	1,471	3.0%	Provider Credentialing	235,342	236,813	1,471	0.6%
2,476,546	**2,941,795**	**465,249**	**15.8%**	**Purchased & Professional Services**	**11,320,663**	**11,785,912**	**465,249**	**3.9%**
59,373	91,579	32,206	35.2%	Depreciation	297,332	329,538	32,206	9.8%
136,785	76,371	(60,414)	(79.1%)	Lease Building	386,186	325,772	(60,414)	(18.5%)
4,858	10,570	5,712	54.0%	Lease Rented Office Equipment	22,823	28,535	5,712	20.0%
29,853	19,188	(10,665)	(55.6%)	Utilities	92,926	82,261	(10,665)	(13.0%)
93,395	91,065	(2,330)	(2.6%)	Telephone	441,060	438,730	(2,330)	(0.5%)
23,266	60,447	37,181	61.5%	Building Maintenance	167,721	204,902	37,181	18.1%
312,323	249,136	(63,188)	(25.4%)	GASB96 SBITA Amort. Expense	1,236,104	1,172,916	(63,188)	(5.4%)
659,854	**598,355**	**(61,498)**	**(10.3%)**	**Occupancy**	**2,644,152**	**2,582,654**	**(61,498)**	**(2.4%)**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED November 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
71,498	108,767	37,270	34.3%	Postage	348,269	385,538	37,270	9.7%
5,518	5,300	(218)	(4.1%)	Design & Layout	31,698	31,480	(218)	(0.7%)
140,691	111,590	(29,101)	(26.1%)	Printing Services	530,091	500,990	(29,101)	(5.8%)
8,998	6,910	(2,088)	(30.2%)	Mailing Services	43,382	41,293	(2,088)	(5.1%)
4,727	12,860	8,133	63.2%	Courier/Delivery Service	27,324	35,457	8,133	22.9%
0	0	0	0.0%	Pre-Printed Materials & Public	29	29	0	0.0%
0	0	0	0.0%	Promotional Products	43,118	43,118	0	0.0%
0	300	300	100.0%	Promotional Services	0	300	300	100.0%
204,893	600,667	395,774	65.9%	Community Relations	943,453	1,339,227	395,774	29.6%
436,324	**846,394**	**410,070**	**48.4%**	**Printing Postage & Promotion**	**1,967,363**	**2,377,433**	**410,070**	**17.2%**
0	0	0	0.0%	Regulatory Penalties	285,000	285,000	0	0.0%
24,198	31,600	7,402	23.4%	Bank Fees	157,179	164,581	7,402	4.5%
0	6,253	6,253	100.0%	Insurance Premium	976,663	982,916	6,253	0.6%
45,809	56,823	11,014	19.4%	License,Permits, & Fee - NonIT	1,008,682	1,019,696	11,014	1.1%
79,181	61,338	(17,843)	(29.1%)	Subscriptions and Dues - NonIT	434,667	416,824	(17,843)	(4.3%)
149,188	**156,013**	**6,826**	**4.4%**	**License Insurance & Fees**	**2,862,191**	**2,869,016**	**6,826**	**0.2%**
14,637	13,783	(854)	(6.2%)	Office and Other Supplies	47,011	46,158	(854)	(1.9%)
0	2,000	2,000	100.0%	Furniture & Equipment	0	2,000	2,000	100.0%
34,529	29,942	(4,588)	(15.3%)	Ergonomic Supplies	158,744	154,156	(4,588)	(3.0%)
7,094	15,785	8,691	55.1%	Meals and Entertainment	58,557	67,248	8,691	12.9%
0	0	0	0.0%	Miscellaneous	5,300	5,300	0	0.0%
0	4,850	4,850	100.0%	Member Incentive	0	4,850	4,850	100.0%
115,859	120,000	4,141	3.5%	Provider Interest (All Depts)	669,067	673,208	4,141	0.6%
172,119	**186,360**	**14,241**	**7.6%**	**Other Administrative Expense**	**938,680**	**952,920**	**14,241**	**1.5%**
3,971,481	**4,803,783**	**832,302**	**17.3%**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**20,115,354**	**20,947,656**	**832,301**	**4.0%**
9,041,748	**10,227,748**	**1,186,000**	**11.6%**	**TOTAL ADMINISTRATIVE EXPENSES**	**48,216,556**	**49,402,556**	**1,186,000**	**2.4%**

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

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

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 11/30/24	**$ 38,640,099**
Fixed Assets @ Cost - 6/30/24	**$ 38,110,489**
Fixed Assets Acquired YTD	**$ 529,610**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2025

TANGIBLE NET EQUITY (TNE)	**QTR. END Jun-24**	**Jul-24**	**Aug-24**	**QTR. END Sep-24**	**Oct-24**	**Nov-24**
Current Month Net Income / (Loss)	($60,614,028)	($6,989,303)	($18,354,879)	($8,719,232)	($26,984,338)	($27,470,263)
YTD Net Income / (Loss)	($68,581,898)	($6,989,303)	($25,344,182)	($34,063,414)	($61,047,752)	($88,518,015)
Actual TNE						
Net Assets	$255,375,144	$248,385,841	$230,030,961	$221,311,730	$194,327,391	$166,857,128
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$255,375,144**	**$248,385,841**	**$230,030,961**	**$221,311,730**	**$194,327,391**	**$166,857,128**
Increase/(Decrease) in Actual TNE	($60,614,028)	($6,989,303)	($18,354,879)	($8,719,232)	($26,984,338)	($27,470,263)
Required TNE[(1)]	**$63,328,179**	**$68,750,939**	**$71,470,183**	**$70,224,330**	**$77,225,115**	**$78,852,430**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$94,992,268	$103,126,409	$107,205,274	$105,336,495	$115,837,673	$118,278,645
TNE Excess / (Deficiency)	$192,046,965	$179,634,902	$158,560,778	$151,087,400	$117,102,276	$88,004,698
Actual TNE as a Multiple of Required	**4.03**	**3.61**	**3.22**	**3.15**	**2.52**	**2.12**

Note 1: Required TNE reflects quarterly DMHC calculations for quarter-end months (underlined) and monthly DMHC calculations (not underlined). Quarterly and Monthly Required TNE calculations differ slightly in calculation methodology.

LIQUID TANGIBLE NET EQUITY						
Net Assets	$255,375,144	$248,385,841	$230,030,961	$221,311,730	$194,327,391	$166,857,128
Fixed Assets at Net Book Value	(5,447,816)	(5,662,370)	(5,863,098)	(5,803,725)	(5,739,467)	(5,680,094)
Net Lease Assets/Liabilities/Interest	(501,485)	(319,957)	(496,877)	(1,004,186)	(1,303,630)	(1,065,182)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$249,075,843**	**$242,053,514**	**$223,320,986**	**$214,153,819**	**$186,934,294**	**$159,761,852**
Liquid TNE as Multiple of Required	**3.93**	**3.52**	**3.12**	**3.05**	**2.42**	**2.03**

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,951	109,784	109,731	109,662	109,561								548,689
Adult	62,708	62,641	62,550	62,578	62,502								312,979
SPD	35,018	35,177	35,319	35,388	35,603								176,505
ACA OE	149,801	150,482	151,005	151,098	151,559								753,945
Duals	39,892	40,024	40,124	40,144	40,357								200,541
MCAL LTC	222	226	240	249	255								1,192
MCAL LTC Duals	1,241	1,247	1,254	1,265	1,269								6,276
Medi-Cal Program	398,833	399,581	400,223	400,384	401,106								2,000,127
Group Care Program	5,675	5,686	5,710	5,769	5,772								28,612
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**								**2,028,739**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(173)	(167)	(53)	(69)	(101)								(563)
Adult	(38)	(67)	(91)	28	(76)								(244)
SPD	98	159	142	69	215								683
ACA OE	477	681	523	93	461								2,235
Duals	144	132	100	20	213								609
MCAL LTC	0	4	14	9	6								33
MCAL LTC Duals	(7)	6	7	11	4								21
Medi-Cal Program	501	748	642	161	722								2,774
Group Care Program	17	11	24	59	3								114
Total	**518**	**759**	**666**	**220**	**725**								**2,888**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%	27.4%	27.4%	27.3%								27.4%
Adult % of Medi-Cal	15.7%	15.7%	15.6%	15.6%	15.6%								15.6%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%	8.9%								8.8%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%	37.8%								37.7%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%	10.1%								10.0%
Medi-Cal Program % of Total	98.6%	98.6%	98.6%	98.6%	98.6%								98.6%
Group Care Program % of Total	1.4%	1.4%	1.4%	1.4%	1.4%								1.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**								**100.0%**

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	87,980	88,518	89,634	89,724	90,655								446,511
Alameda Health System	91,091	91,170	91,024	90,756	90,451								454,492
	179,071	179,688	180,658	180,480	181,106								901,003
Delegated:													
CFMG	44,087	43,956	43,837	43,910	44,029								219,819
CHCN	181,350	181,623	181,438	181,763	181,743								907,917
Delegated Subtotal	225,437	225,579	225,275	225,673	225,772								1,127,736
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**								**2,028,739**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617	970	(178)	626								2,202
Delegated:													
CFMG	96	(131)	(119)	73	119								38
CHCN	255	273	(185)	325	(20)								648
Delegated Subtotal	351	142	(304)	398	99								686
Total	**518**	**759**	**666**	**220**	**725**								**2,888**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%	44.5%	44.4%	44.5%								44.4%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%								10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.7%								44.8%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.5%								55.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**								**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2025							**FINAL BUDGET**						
	Budget Jul-24	**Budget Aug-24**	**Budget Sep-24**	**Budget Oct-24**	**Budget Nov-24**	**Budget Dec-24**	**Budget Jan-25**	**Budget Feb-25**	**Budget Mar-25**	**Budget Apr-25**	**Budget May-25**	**Budget Jun-25**	**YTD Member Months**
Enrollment by Plan & Aid Category:													
Medi-Cal Program by Category of Aid:													
Child	109,951	109,784	109,731	109,662	109,772	109,882	110,102	110,212	110,322	110,432	110,542	110,653	1,321,045
Adult	62,708	62,641	62,550	62,578	62,641	62,704	62,767	62,830	62,893	62,956	63,019	63,082	753,369
SPD	35,018	35,177	35,319	35,388	35,423	35,458	0	0	0	0	0	0	211,783
ACA OE	149,801	150,482	151,005	151,098	151,249	151,400	151,551	151,703	151,855	152,007	152,159	152,311	1,816,621
Duals	39,892	40,024	40,124	40,144	40,144	40,144	0	0	0	0	0	0	240,472
MCAL LTC	222	226	240	249	251	254	0	0	0	0	0	0	1,442
MCAL LTC Duals	1,241	1,247	1,254	1,265	1,266	1,267	0	0	0	0	0	0	7,540
Medi-Cal Program	398,833	399,581	400,223	400,384	400,746	401,109	324,420	324,745	325,070	325,395	325,720	326,046	4,352,272
Group Care Program	5,675	5,686	5,710	5,769	5,769	5,769	5,769	5,769	5,769	5,769	5,769	5,769	68,992
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,515**	**406,878**	**330,189**	**330,514**	**330,839**	**331,164**	**331,489**	**331,815**	**4,421,264**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(167)	(53)	(69)	110	110	220	110	110	110	110	111	(505)
Adult	(624)	(67)	(91)	28	63	63	63	63	63	63	63	63	(250)
SPD	(225)	159	142	69	35	35	0	0	0	0	0	0	215
ACA OE	(1,260)	681	523	93	151	151	151	152	152	152	152	152	1,250
Duals	(43)	132	100	20	0	0	0	0	0	0	0	0	209
MCAL LTC	(9)	4	14	9	2	3	0	0	0	0	0	0	23
MCAL LTC Duals	4	6	7	11	1	1	0	0	0	0	0	0	30
Medi-Cal Program	(3,364)	748	642	161	362	363	434	325	325	325	325	326	972
Group Care Program	(15)	11	24	59	0	0	0	0	0	0	0	0	79
Total	**(3,379)**	**759**	**666**	**220**	**362**	**363**	**434**	**325**	**325**	**325**	**325**	**326**	**1,051**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	27.6%	27.5%	27.4%	27.4%	27.4%	27.4%	33.9%	33.9%	33.9%	33.9%	33.9%	33.9%	30.4%
Adult % (Medi-Cal)	15.7%	15.7%	15.6%	15.6%	15.6%	15.6%	19.3%	19.3%	19.3%	19.3%	19.3%	19.3%	17.3%
SPD % (Medi-Cal)	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.9%
ACA OE % (Medi-Cal)	37.6%	37.7%	37.7%	37.7%	37.7%	37.7%	46.7%	46.7%	46.7%	46.7%	46.7%	46.7%	41.7%
Duals % (Medi-Cal)	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.5%
MCAL LTC % (Medi-Cal)	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MCAL LTC Duals % (Medi-Cal)	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Medi-Cal Program % of Total	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.3%	98.3%	98.3%	98.3%	98.3%	98.3%	98.4%
Group Care Program % of Total	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.7%	1.7%	1.7%	1.7%	1.7%	1.7%	1.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2025							**FINAL BUDGET**						
	Budget Jul-24	**Budget Aug-24**	**Budget Sep-24**	**Budget Oct-24**	**Budget Nov-24**	**Budget Dec-24**	**Budget Jan-25**	**Budget Feb-25**	**Budget Mar-25**	**Budget Apr-25**	**Budget May-25**	**Budget Jun-25**	**YTD Member Months**
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	87,980	88,518	89,634	89,724	89,786	89,849	90,244	90,630	91,016	91,401	91,786	92,171	1,082,739
Alameda Health System	91,091	91,170	91,024	90,756	90,843	90,930	90,951	90,960	90,968	90,976	90,984	90,992	1,091,645
	179,071	179,688	180,658	180,480	180,629	180,779	181,195	181,590	181,984	182,377	182,770	183,163	2,174,384
Delegated:													
CFMG	44,087	43,956	43,837	43,910	43,953	43,996	44,035	44,033	44,030	44,027	44,024	44,021	527,909
CHCN	181,350	181,623	181,438	181,763	181,933	182,103	182,121	182,092	182,064	182,036	182,007	181,978	2,182,508
Delegated Subtotal	225,437	225,579	225,275	225,673	225,886	226,099	226,156	226,125	226,094	226,063	226,031	225,999	2,710,417
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,515**	**406,878**	**407,351**	**407,715**	**408,078**	**408,440**	**408,801**	**409,162**	**4,884,801**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	305	538	1,116	90	62	63	395	386	386	385	385	385	4,496
Alameda Health System	(1,244)	79	(146)	(268)	87	87	21	9	8	8	8	8	(1,343)
	(939)	617	970	(178)	149	150	416	395	394	393	393	393	3,153
Delegated:													
CFMG	(441)	(131)	(119)	73	43	43	39	(2)	(3)	(3)	(3)	(3)	(507)
CHCN	(1,721)	273	(185)	325	170	170	18	(29)	(28)	(28)	(29)	(29)	(1,093)
Delegated Subtotal	(2,162)	142	(304)	398	213	213	57	(31)	(31)	(31)	(32)	(32)	(1,600)
Total	**(3,101)**	**759**	**666**	**220**	**362**	**363**	**473**	**364**	**363**	**362**	**361**	**361**	**1,553**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	21.7%	21.8%	22.1%	22.1%	22.1%	22.1%	22.2%	22.2%	22.3%	22.4%	22.5%	22.5%	22.2%
Alameda Health System	22.5%	22.5%	22.4%	22.3%	22.3%	22.3%	22.3%	22.3%	22.3%	22.3%	22.3%	22.2%	22.3%
	44.3%	44.3%	44.5%	44.4%	44.4%	44.4%	44.5%	44.5%	44.6%	44.7%	44.7%	44.8%	44.5%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.8%	44.8%	44.7%	44.7%	44.6%	44.6%	44.5%	44.5%	44.7%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.6%	55.6%	55.5%	55.5%	55.4%	55.3%	55.3%	55.2%	55.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

	Variance Jul-24	Variance Aug-24	Variance Sep-24	Variance Oct-24	Variance Nov-24	Variance Dec-24	Variance Jan-25	Variance Feb-25	Variance Mar-25	Variance Apr-25	Variance May-25	Variance Jun-25	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	(211)								(211)
Adult	0	0	0	0	(139)								(139)
SPD	0	0	0	0	180								180
ACA OE	0	0	0	0	310								310
Duals	0	0	0	0	213								213
MCAL LTC	0	0	0	0	4								4
MCAL LTC Duals	0	0	0	0	3								3
Medi-Cal Program	0	0	0	0	360								360
Group Care Program	0	0	0	0	3								3
Total	**0**	**0**	**0**	**0**	**363**								**363**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	869								869
Alameda Health System	0	0	0	0	(392)								(392)
	0	0	0	0	477								477
Delegated:													
CFMG	0	0	0	0	76								76
CHCN	0	0	0	0	(190)								(190)
Delegated Subtotal	0	0	0	0	(114)								(114)
Total	**0**	**0**	**0**	**0**	**363**								**363**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
$4,617,780	$1,713,478	($2,904,302)	(169.5%)	PCP Capitation	$19,293,389	$16,389,087	($2,904,302)	(17.7%)
6,158,415	6,529,667	371,252	5.7%	PCP Capitation FQHC	30,776,705	31,147,956	371,252	1.2%
387,030	447,053	60,023	13.4%	Specialty Capitation	1,893,594	1,953,617	60,023	3.1%
5,408,578	5,958,090	549,512	9.2%	Specialty Capitation FQHC	27,011,995	27,561,507	549,512	2.0%
753,426	712,388	(41,038)	(5.8%)	Laboratory Capitation	3,751,711	3,710,673	(41,038)	(1.1%)
340,074	339,952	(122)	0.0%	Vision Capitation	1,696,957	1,696,835	(122)	0.0%
112,611	130,066	17,455	13.4%	CFMG Capitation	551,055	568,510	17,455	3.1%
266,494	289,578	23,084	8.0%	ANC IPA Admin Capitation FQHC	1,332,024	1,355,108	23,084	1.7%
0	0	0	0.0%	Kaiser Capitation	(995)	(995)	0	0.0%
9,318	0	(9,318)	0.0%	Maternity Supplemental Expense	37,270	27,953	(9,318)	(33.3%)
1,020,145	885,723	(134,422)	(15.2%)	DME Capitation	5,070,941	4,936,519	(134,422)	(2.7%)
19,073,869	**17,005,995**	**(2,067,875)**	**(12.2%)**	**7. TOTAL CAPITATED EXPENSES**	**91,414,645**	**89,346,770**	**(2,067,875)**	**(2.3%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
11,121,563	0	(11,121,563)	0.0%	IBNR Inpatient Services	7,818,400	(3,303,163)	(11,121,563)	336.7%
333,647	0	(333,647)	0.0%	IBNR Settlement (IP)	234,553	(99,094)	(333,647)	336.7%
889,725	0	(889,725)	0.0%	IBNR Claims Fluctuation (IP)	625,471	(264,254)	(889,725)	336.7%
46,034,047	51,184,287	5,150,240	10.1%	Inpatient Hospitalization FFS	246,912,130	252,062,369	5,150,240	2.0%
2,547,588	0	(2,547,588)	0.0%	IP OB - Mom & NB	15,087,751	12,540,164	(2,547,588)	(20.3%)
59,351	0	(59,351)	0.0%	IP Behavioral Health	1,129,658	1,070,307	(59,351)	(5.5%)
1,115,868	0	(1,115,868)	0.0%	Inpatient Facility Rehab FFS	6,886,605	5,770,736	(1,115,868)	(19.3%)
62,101,789	**51,184,287**	**(10,917,502)**	**(21.3%)**	**8. Inpatient Hospital Expense**	**278,694,568**	**267,777,065**	**(10,917,502)**	**(4.1%)**
458,097	0	(458,097)	0.0%	IBNR PCP	164,658	(293,439)	(458,097)	156.1%
13,744	0	(13,744)	0.0%	IBNR Settlement (PCP)	4,943	(8,801)	(13,744)	156.2%
36,647	0	(36,647)	0.0%	IBNR Claims Fluctuation (PCP)	81,438	44,791	(36,647)	(81.8%)
3,821,446	2,851,254	(970,192)	(34.0%)	PCP FFS	18,889,205	17,919,013	(970,192)	(5.4%)
330,147	802,716	472,569	58.9%	PCP FQHC FFS	1,968,569	2,441,138	472,569	19.4%
0	0	0	0.0%	Physician Extended Hrs. Incent	12,000	12,000	0	0.0%
(502,528)	877,651	1,380,179	157.3%	Prop 56 Physician Pmt	(5,123,131)	(3,742,952)	1,380,179	(36.9%)
66,817	0	(66,817)	0.0%	Prop 56 Hyde	131,740	64,923	(66,817)	(102.9%)
73,621	0	(73,621)	0.0%	Prop 56 Trauma Screening	183,754	110,133	(73,621)	(66.8%)
80,123	0	(80,123)	0.0%	Prop 56 Developmentl Screening	176,163	96,040	(80,123)	(83.4%)
701,565	0	(701,565)	0.0%	Prop 56 Family Planning	(66,101)	(767,666)	(701,565)	91.4%
0	0	0	0.0%	Prop 56 VBP	(2,718,741)	(2,718,741)	0	0.0%
5,079,679	**4,531,621**	**(548,058)**	**(12.1%)**	**9. Primary Care Physician Expense**	**13,704,496**	**13,156,438**	**(548,058)**	**(4.2%)**
730,209	0	(730,209)	0.0%	IBNR Specialist	(16,967)	(747,176)	(730,209)	97.7%
21,907	0	(21,907)	0.0%	IBNR Settlement (SCP)	(507)	(22,414)	(21,907)	97.7%
58,417	0	(58,417)	0.0%	IBNR Claims Fluctuation (SCP)	(1,358)	(59,775)	(58,417)	97.7%
380,396	0	(380,396)	0.0%	Psychiatrist FFS	1,939,467	1,559,071	(380,396)	(24.4%)
3,343,209	7,939,942	4,596,733	57.9%	Specialty Care FFS	18,597,635	23,194,367	4,596,733	19.8%
211,666	0	(211,666)	0.0%	Specialty Anesthesiology	1,272,671	1,061,004	(211,666)	(19.9%)
1,378,113	0	(1,378,113)	0.0%	Specialty Imaging FFS	8,221,150	6,843,037	(1,378,113)	(20.1%)
33,056	0	(33,056)	0.0%	Obstetrics FFS	214,263	181,208	(33,056)	(18.2%)
381,307	0	(381,307)	0.0%	Specialty IP Surgery FFS	2,060,806	1,679,499	(381,307)	(22.7%)
854,146	0	(854,146)	0.0%	Specialty OP Surgery FFS	5,207,598	4,353,452	(854,146)	(19.6%)
597,919	0	(597,919)	0.0%	Speciality IP Physician	3,141,752	2,543,833	(597,919)	(23.5%)
117,977	124,854	6,876	5.5%	Specialist FQHC FFS	648,860	655,737	6,876	1.0%
8,108,321	**8,064,795**	**(43,526)**	**(0.5%)**	**10. Specialty Care Physician Expense**	**41,285,369**	**41,241,843**	**(43,526)**	**(0.1%)**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,600,554	0	(1,600,554)	0.0%	IBNR Ancillary (ANC)	2,504,745	904,191	(1,600,554)	(177.0%)
48,017	0	(48,017)	0.0%	IBNR Settlement (ANC)	162,205	114,188	(48,017)	(42.1%)
128,042	0	(128,042)	0.0%	IBNR Claims Fluctuation (ANC)	364,290	236,248	(128,042)	(54.2%)
110,855	0	(110,855)	0.0%	IBNR Transportation FFS	318,711	207,856	(110,855)	(53.3%)
2,260,468	0	(2,260,468)	0.0%	Behavioral Health Therapy FFS	10,451,033	8,190,565	(2,260,468)	(27.6%)
1,731,400	0	(1,731,400)	0.0%	Psychologist & Other MH Prof	8,965,650	7,234,250	(1,731,400)	(23.9%)
430,384	0	(430,384)	0.0%	Other Medical Professional	2,296,219	1,865,835	(430,384)	(23.1%)
67,873	0	(67,873)	0.0%	Hearing Devices	742,430	674,558	(67,873)	(10.1%)
18,458	0	(18,458)	0.0%	ANC Imaging	246,606	228,147	(18,458)	(8.1%)
71,294	0	(71,294)	0.0%	Vision FFS	351,591	280,298	(71,294)	(25.4%)
6	0	(6)	0.0%	Family Planning	16	10	(6)	(64.6%)
1,552,472	0	(1,552,472)	0.0%	Laboratory FFS	8,145,928	6,593,456	(1,552,472)	(23.5%)
124,599	0	(124,599)	0.0%	ANC Therapist	768,861	644,262	(124,599)	(19.3%)
1,054,915	0	(1,054,915)	0.0%	Transp/Ambulance FFS	7,016,942	5,962,027	(1,054,915)	(17.7%)
3,458,066	0	(3,458,066)	0.0%	Non-ER Transportation FFS	11,984,549	8,526,483	(3,458,066)	(40.6%)
2,408,667	0	(2,408,667)	0.0%	Hospice FFS	11,659,628	9,250,960	(2,408,667)	(26.0%)
1,586,487	0	(1,586,487)	0.0%	Home Health Services	8,675,241	7,088,754	(1,586,487)	(22.4%)
0	13,764,086	13,764,086	100.0%	Other Medical FFS	128	13,764,214	13,764,086	100.0%
268,308	0	(268,308)	0.0%	Medical Refunds through HMS	558,501	290,192	(268,308)	(92.5%)
35,240	0	(35,240)	0.0%	DME & Medical Supplies FFS	223,073	187,833	(35,240)	(18.8%)
1,810,355	1,819,939	9,584	0.5%	ECM Base/Outreach FFS ANC	5,008,989	5,018,573	9,584	0.2%
99,233	93,757	(5,476)	(5.8%)	CS Housing Deposits FFS ANC	590,426	584,949	(5,476)	(0.9%)
544,147	766,230	222,083	29.0%	CS Housing Tenancy FFS ANC	3,757,353	3,979,436	222,083	5.6%
531,122	430,645	(100,478)	(23.3%)	CS Housing Navi Servic FFS ANC	2,439,195	2,338,717	(100,478)	(4.3%)
726,619	688,135	(38,484)	(5.6%)	CS Medical Respite FFS ANC	3,250,276	3,211,792	(38,484)	(1.2%)
138,909	159,340	20,431	12.8%	CS Med. Tailored Meals FFS ANC	1,016,778	1,037,209	20,431	2.0%
9,883	20,194	10,311	51.1%	CS Asthma Remediation FFS ANC	37,342	47,653	10,311	21.6%
0	9,864	9,864	100.0%	MOT Wrap Around (Non Med MOT)	0	9,864	9,864	100.0%
0	9,975	9,975	100.0%	CS Home Modifications FFS ANC	24,053	34,027	9,975	29.3%
107,113	527,789	420,676	79.7%	CS P.Care & Hmker Svcs FFS ANC	1,607,431	2,028,107	420,676	20.7%
0	19,965	19,965	100.0%	CS Cgiver Respite Svcs FFS ANC	42,347	62,311	19,965	32.0%
308,055	0	(308,055)	0.0%	CommunityBased Adult Svc(CBAS)	2,511,429	2,203,374	(308,055)	(14.0%)
17,394	25,000	7,606	30.4%	CS LTC Diversion FFS ANC	85,172	92,778	7,606	8.2%
0	7,470	7,470	100.0%	CS LTC Transition FFS ANC	0	7,470	7,470	100.0%
21,248,937	**18,342,387**	**(2,906,550)**	**(15.8%)**	**11. Ancillary Medical Expense**	**95,807,138**	**92,900,588**	**(2,906,550)**	**(3.1%)**
1,039,382	0	(1,039,382)	0.0%	IBNR Outpatient	1,271,011	231,629	(1,039,382)	(448.7%)
31,182	0	(31,182)	0.0%	IBNR Settlement (OP)	38,131	6,949	(31,182)	(448.7%)
83,150	0	(83,150)	0.0%	IBNR Claims Fluctuation (OP)	101,677	18,527	(83,150)	(448.8%)
2,110,640	11,442,136	9,331,496	81.6%	Outpatient FFS	12,598,750	21,930,246	9,331,496	42.6%
2,341,356	0	(2,341,356)	0.0%	OP Ambul Surgery FFS	13,935,315	11,593,959	(2,341,356)	(20.2%)
2,677,317	0	(2,677,317)	0.0%	Imaging Services FFS	12,807,720	10,130,403	(2,677,317)	(26.4%)
1,020,699	0	(1,020,699)	0.0%	Behavioral Health FFS	1,118,160	97,460	(1,020,699)	(1,047.3%)
677,152	0	(677,152)	0.0%	Outpatient Facility Lab FFS	3,540,576	2,863,424	(677,152)	(23.6%)
196,338	0	(196,338)	0.0%	Outpatient Facility Cardio FFS	1,040,791	844,453	(196,338)	(23.3%)
104,882	0	(104,882)	0.0%	OP Facility PT/OT/ST FFS	505,290	400,408	(104,882)	(26.2%)
2,855,014	0	(2,855,014)	0.0%	OP Facility Dialysis Ctr FFS	15,502,451	12,647,437	(2,855,014)	(22.6%)
13,137,113	**11,442,136**	**(1,694,977)**	**(14.8%)**	**12. Outpatient Medical Expense**	**62,459,872**	**60,764,895**	**(1,694,977)**	**(2.8%)**
1,500,319	0	(1,500,319)	0.0%	IBNR Emergency	1,334,516	(165,803)	(1,500,319)	904.9%
45,009	0	(45,009)	0.0%	IBNR Settlement (ER)	40,035	(4,974)	(45,009)	904.8%
120,027	0	(120,027)	0.0%	IBNR Claims Fluctuation (ER)	106,761	(13,266)	(120,027)	904.8%
7,245,900	10,180,741	2,934,841	28.8%	ER Facility	44,481,797	47,416,638	2,934,841	6.2%

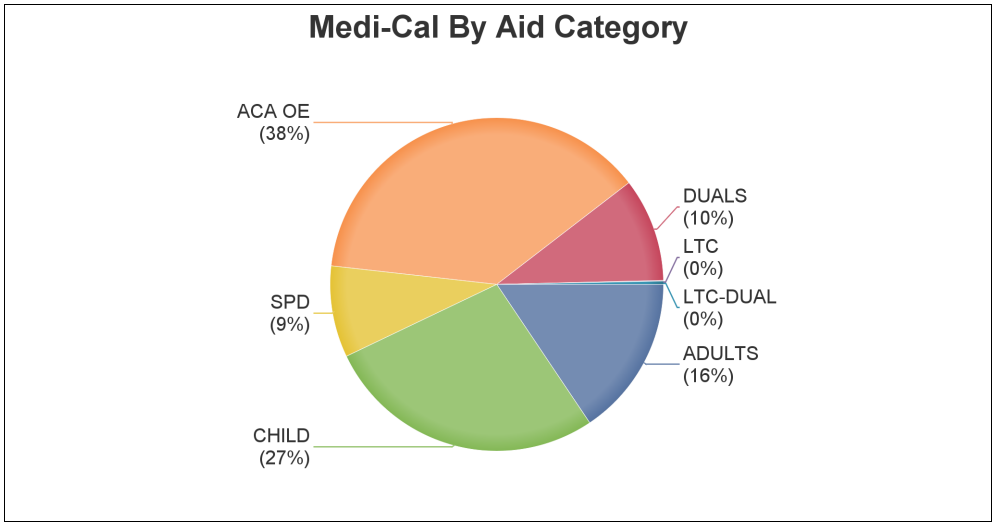
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2024

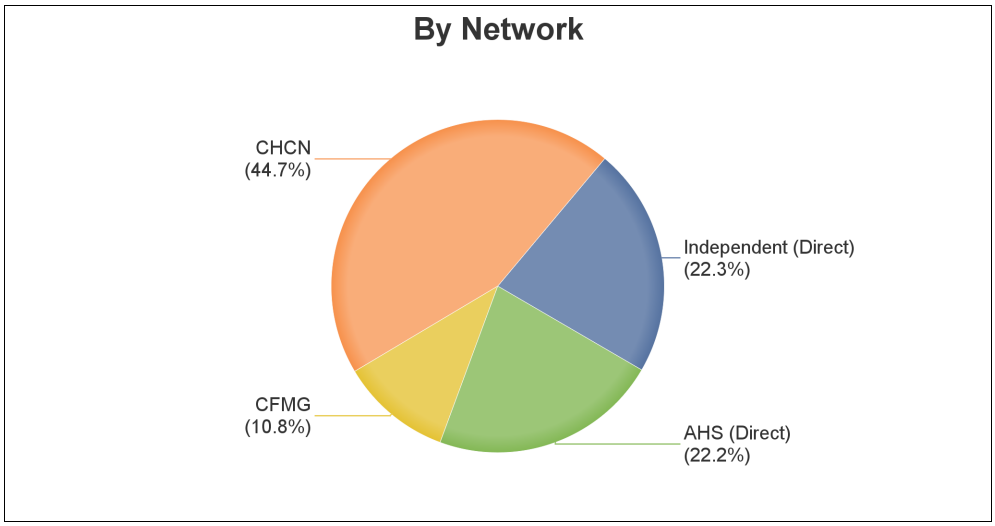
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,056,393	0	(1,056,393)	0.0%	Specialty ER Physician FFS	5,936,785	4,880,392	(1,056,393)	(21.6%)
9,967,647	**10,180,741**	**213,093**	**2.1%**	**13. Emergency Expense**	**51,899,893**	**52,112,987**	**213,093**	**0.4%**
1,435,718	0	(1,435,718)	0.0%	IBNR Pharmacy (OP)	3,427,491	1,991,773	(1,435,718)	(72.1%)
43,072	0	(43,072)	0.0%	IBNR Settlement Rx (OP)	102,827	59,755	(43,072)	(72.1%)
114,859	0	(114,859)	0.0%	IBNR Claims Fluctuation Rx(OP)	274,201	159,342	(114,859)	(72.1%)
709,276	454,372	(254,903)	(56.1%)	Pharmacy FFS (OP)	3,749,210	3,494,307	(254,903)	(7.3%)
110,335	11,553,120	11,442,785	99.0%	Pharmacy Non PBM FFS Other-ANC	654,227	12,097,012	11,442,785	94.6%
8,565,577	0	(8,565,577)	0.0%	Pharmacy Non PBM FFS OP-FAC	47,892,133	39,326,556	(8,565,577)	(21.8%)
181,560	0	(181,560)	0.0%	Pharmacy Non PBM FFS PCP	1,167,123	985,563	(181,560)	(18.4%)
1,828,785	0	(1,828,785)	0.0%	Pharmacy Non PBM FFS SCP	12,446,512	10,617,727	(1,828,785)	(17.2%)
21,191	0	(21,191)	0.0%	Pharmacy Non PBM FFS FQHC	103,766	82,575	(21,191)	(25.7%)
10,634	0	(10,634)	0.0%	Pharmacy Non PBM FFS HH	102,263	91,629	(10,634)	(11.6%)
0	0	0	0.0%	RX Refunds HMS	(306)	(306)	0	0.0%
(54,000)	50,966	104,966	206.0%	Medical Expenses Pharm Rebate	(270,000)	(165,034)	104,966	(63.6%)
12,967,007	**12,058,459**	**(908,549)**	**(7.5%)**	**14. Pharmacy Expense**	**69,649,446**	**68,740,897**	**(908,549)**	**(1.3%)**
6,411,200	0	(6,411,200)	0.0%	IBNR LTC	2,654,264	(3,756,936)	(6,411,200)	170.6%
192,337	0	(192,337)	0.0%	IBNR Settlement (LTC)	79,628	(112,709)	(192,337)	170.6%
512,896	0	(512,896)	0.0%	IBNR Claims Fluctuation (LTC)	212,341	(300,555)	(512,896)	170.6%
1,250,714	0	(1,250,714)	0.0%	LTC - ICF/DD	8,006,440	6,755,726	(1,250,714)	(18.5%)
19,797,230	0	(19,797,230)	0.0%	LTC Custodial Care	119,480,519	99,683,289	(19,797,230)	(19.9%)
6,218,936	32,440,241	26,221,304	80.8%	LTC SNF	38,240,575	64,461,879	26,221,304	40.7%
34,383,314	**32,440,241**	**(1,943,073)**	**(6.0%)**	**15. Long Term Care Expense**	**168,673,767**	**166,730,694**	**(1,943,073)**	**(1.2%)**
166,993,808	**148,244,666**	**(18,749,142)**	**(12.6%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**782,174,549**	**763,425,407**	**(18,749,142)**	**(2.5%)**
0	(1,389,434)	(1,389,434)	100.0%	Clinical Vacancy #102	0	(1,389,434)	(1,389,434)	100.0%
85,965	414,449	328,484	79.3%	Quality Analytics #123	675,331	1,003,815	328,484	32.7%
299,777	410,178	110,401	26.9%	LongTerm Services and Support #139	1,136,602	1,247,003	110,401	8.9%
874,269	1,130,287	256,018	22.7%	Utilization Management #140	4,940,738	5,196,756	256,018	4.9%
646,366	894,903	248,536	27.8%	Case & Disease Management #185	3,391,518	3,640,054	248,536	6.8%
5,181,846	5,471,904	290,058	5.3%	Medical Management #230	6,622,838	6,912,896	290,058	4.2%
753,897	1,375,977	622,080	45.2%	Quality Improvement #235	5,332,456	5,954,536	622,080	10.4%
286,869	443,639	156,771	35.3%	HCS Behavioral Health #238	1,585,709	1,742,480	156,771	9.0%
102,831	392,776	289,944	73.8%	Pharmacy Services #245	575,150	865,095	289,944	33.5%
52,257	95,744	43,487	45.4%	Regulatory Readiness #268	328,922	372,409	43,487	11.7%
8,284,077	**9,240,422**	**956,345**	**10.3%**	**17. Other Benefits & Services**	**24,589,265**	**25,545,610**	**956,345**	**3.7%**
(1,409,000)	(1,317,900)	91,100	(6.9%)	Reinsurance Recoveries	(8,120,986)	(8,029,886)	91,100	(1.1%)
1,761,844	1,757,200	(4,644)	(0.3%)	Reinsurance Premium	8,759,469	8,754,824	(4,644)	(0.1%)
352,844	**439,300**	**86,456**	**19.7%**	**18. Reinsurance Expense**	**638,482**	**724,938**	**86,456**	**11.9%**
194,704,598	**174,930,382**	**(19,774,216)**	**(11.3%)**	**20. TOTAL MEDICAL EXPENSES**	**898,816,941**	**879,042,725**	**(19,774,216)**	**(2.2%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

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

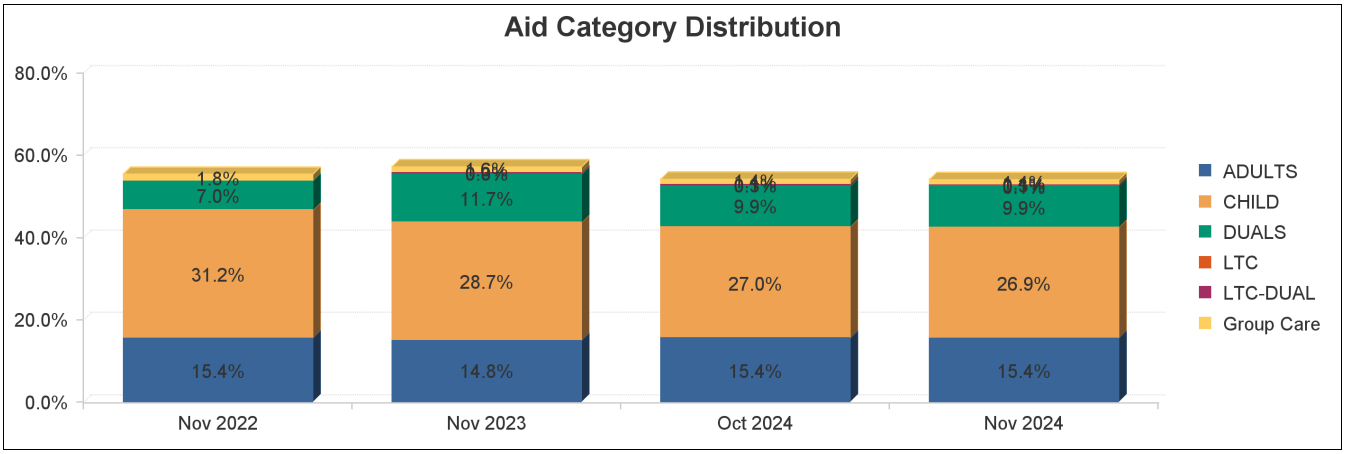




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

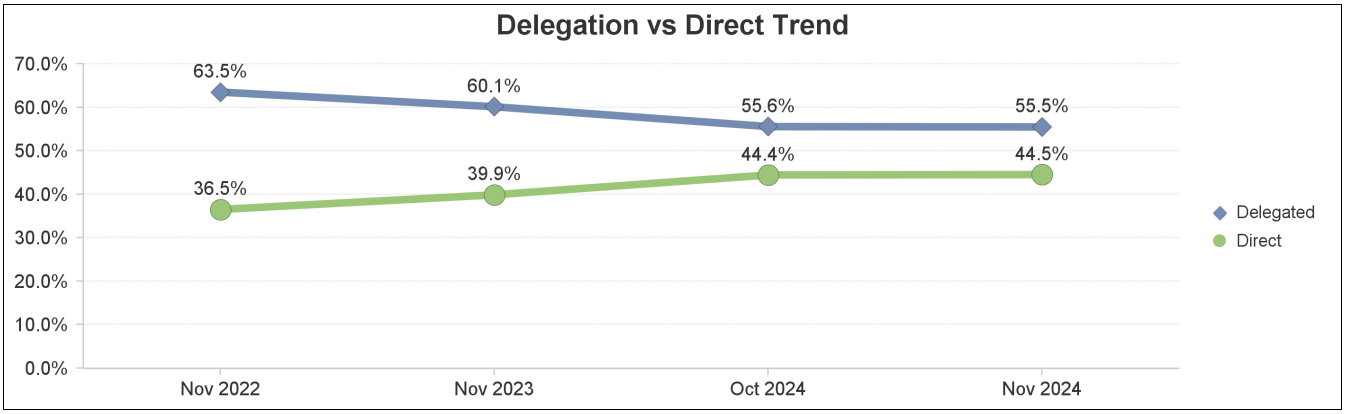
Category of Aid Trend

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



Delegation vs Direct Trend

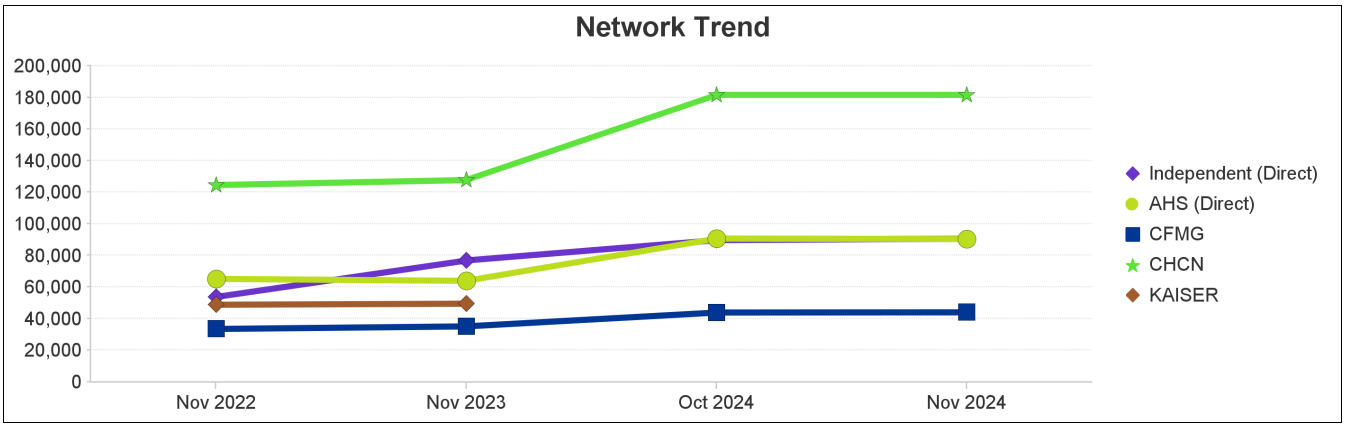
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Delegated	206,973	212,412	225,684	**225,785**	63.5%	60.1%	55.6%	55.5%	2.6%	6.3%	0.0%
Direct	118,952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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Network Trend

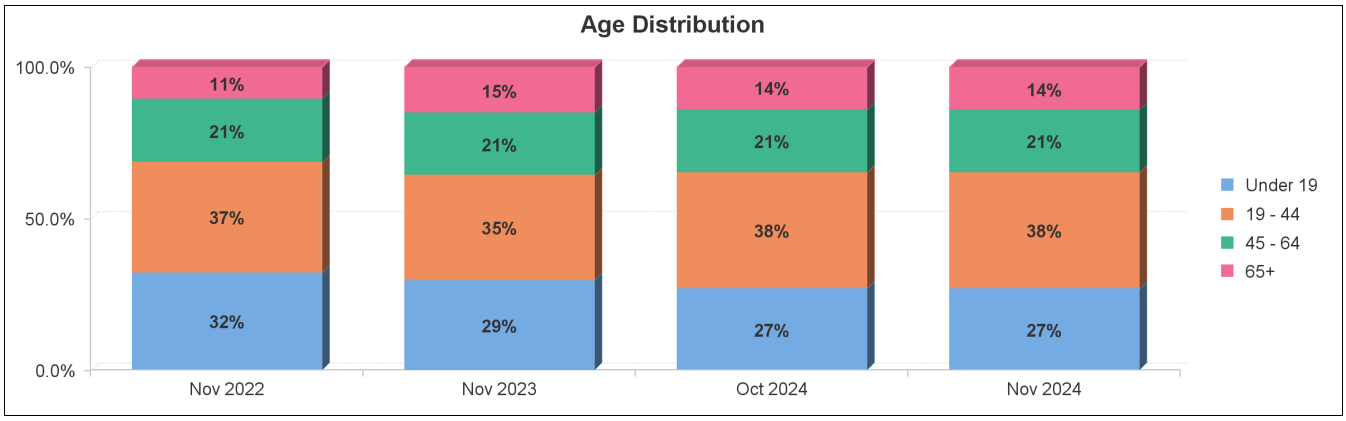
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Independent (Direct)	53,736	76,872	89,756	**90,681**	16.5%	21.8%	22.1%	22.3%	43.1%	18.0%	1.0%
AHS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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

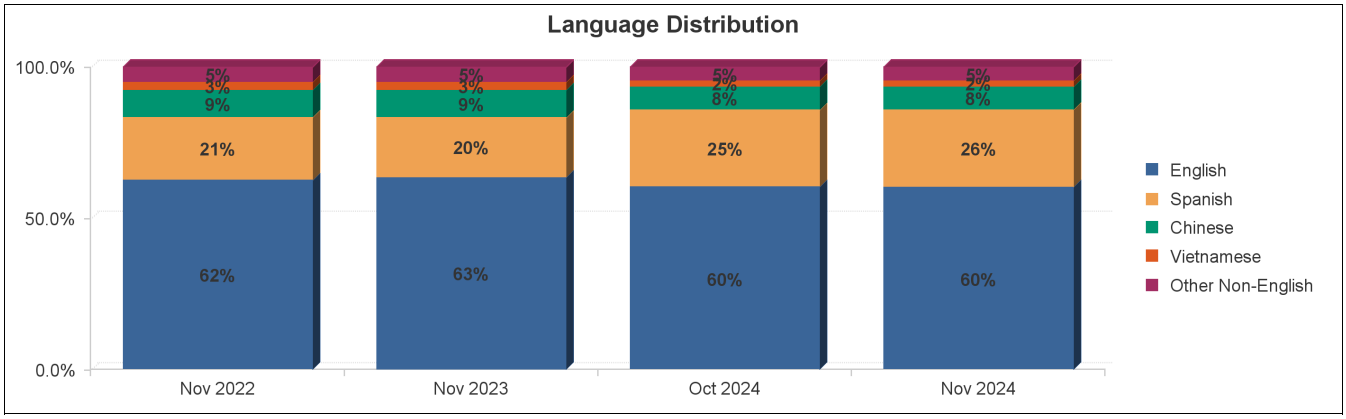
Age Category Trend

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



Language Trend

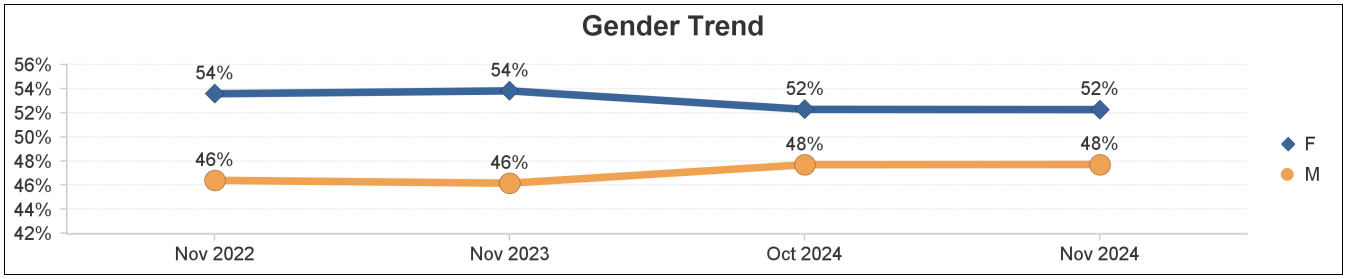
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Nov 2022	Nov 2023	Oct 2024	Nov 2024	ov 2022	ov 2023	Oct 2024	ov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
English	203,441	223,617	244,693	**244,547**	62%	63%	60%	60%	10%	9%	0%
Spanish	67,653	69,914	103,228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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

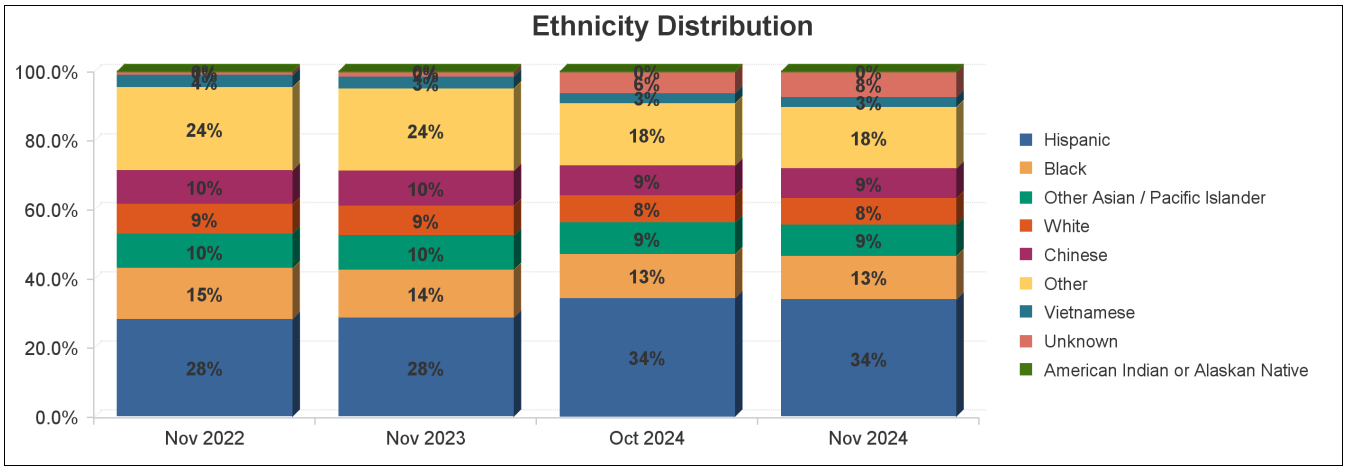
Gender Trend

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



Ethnicity Trend

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



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

Medi-Cal By City

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

Group Care By City

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

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

Total By City

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

ALAMEDA Alliance FOR HEALTH

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

Operations

Ruth Watson

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

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

Date: **January 10th, 2025**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:

    - The Member Services Department received a 20% increase in calls in December 2024, totaling 16,913 compared to 13,510 in December 2023.
    - The abandonment rate for December 2024 was 4%, compared to 4% in December 2023.
    - The Department's service level was 95% in December 2024, compared to 91% in December 2023. The average speed to answer (ASA) was 00:14 seconds compared to 00:23 seconds in December 2023. 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 07:33 minutes for December 2024 compared to 06:42 minutes for December 2023.
    - 100%) of calls were answered within 10 minutes for December 2024 and 99% of calls were answered within 10 minutes for December 2023.
    - Outbound calls totaled 8,575 in December 2024 compared to 4,504 in December 2023.
    - The top five call reasons for December 2024 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Benefits 4). Grievances/Appeals, 5). Provider Network. The top five call reasons for December 2023 were: 1). Eligibility/Enrollment, 2). Change of PCP 3). Benefits, 4). Grievance and Appeals, 5). Provider Network.
    - December utilization for the member automated eligibility IVR system totaled 1,057 in December 2024 compared to 1,146 in December 2023.
    - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests and in-person) while honoring the organization's policies. The Department responded to 1,054 web-based requests in December 2024 compared to 916 in December 2023. The top three web reason requests for December 2024 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information. In December 2024, 43 members were assisted in-person compared to 25 in December 2023.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health Unit received a total of 1,102 calls in December 2024 compared to 771 in December 2023.

- The abandonment rate was 8% in December 2024 compared to 5% in December 2023.
- The service level was 76% in December 2024 and 92% in December 2023.
- The average speed to answer (ASA) in December 2024 was 01:11 minutes compared to 00:32 seconds in December 2023.
- Calls answered in 10 minutes were 99% in December 2024 compared to 99% in December 2023.
- The Average Talk Time (ATT) was 08:50 minutes in December 2024 compared to 10:36 minutes in December 2023. 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.
- 118 screenings were completed in December 2024 compared to 131 in December 2023.
- 30 referrals were made to the County (ACCESS) in December 2024 compared to 35 in December 2023.
- 851 outbound calls were completed in December 2024 compared to 738 in December 2023.
- 62 outreach campaigns were completed in December 2024 compared to 183 in December 2023.
- 18 members were referred to Center Point for SUD services in December 2024 compared to 12 in December 2023.

Claims

- 12-Month Trend Summary:

  - The Claims Department received 332,108 claims in December 2024 compared to 215,246 in December 2023.
  - The Auto Adjudication rate was 88.7% in December 2024 compared to 83.2% in December 2023.
  - Claims compliance for the 30-day turn-around time was 90.2% in December 2024 compared to 90% in December 2023. The 45-day turn-around time was 99.3% in December 2024 compared to 99.9% in December 2023.

- Monthly Analysis:

  - In the month of December, we received a total of 332,108 claims in the HEALTHsuite system. This represents a decrease of .09% from November and is higher, by 116,862 claims, than the number of claims received in December 2023.
  - Drivers of the higher volume of received claims includes:
    - The increased membership since January 2024.
    - Members who delayed care during the pandemic are now catching up and utilizing services.
    - Certain provider types that bill more frequently, e.g., LTC facilities that bill weekly or bi-weekly.

        - Providers with dual eligible members who are submitting paper claims even though we receive the same claim in our COBA file.
    - We received 89.6% of claims via EDI and 10.4% of claims via paper.
    - During the month of December, 99.3% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 88.7% for the month of December.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services department's call volume in December 2024 was seven thousand four hundred seventy-nine (7,479) calls compared to six thousand two hundred forty-seven (6,247) calls in December 2023.
    - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
    - The Provider Services department completed four hundred two (402) calls/visits during December 2024.
    - The Provider Services department answered five thousand five hundred thirty-six (5,536) calls for December 2024 and made seven hundred forty (740) outbound calls.

Credentialing

- 12-Month Trend Summary:

    - At the Peer Review and Credentialing (PRCC) meeting held on December 17th, 2024, there were 190 initial network providers approved; 4 primary care providers, 15 specialists, 23 ancillary providers, 16 midlevel providers, and 77 behavioral health providers. Additionally, 30 providers were re-credentialed at this meeting; 5 primary care providers, 17 specialists, 1 ancillary provider, and 7 midlevel providers.

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

Provider Dispute Resolution

- 12-Month Trend Summary:

    - In December 2024, the Provider Dispute Resolution (PDR) team received 3,173 PDRs versus 1,642 in December 2023.
    - The PDR team resolved 2,185 cases in December 2024 compared to 1,040 cases in December 2023.

- In December 2024, the PDR team upheld 69% of cases versus 68% in December 2023.
- The PDR team resolved 99.9% of cases in December 2024 within 45 working days compared to 99.8% in December 2023; the regulatory requirement is 95% within 45 working days.

- Monthly Analysis:

  - AAH received 3,173 PDRs in December 2024.
  - In the month of December, 2,185 PDRs were resolved. Out of the 2,185 PDRs, 1,508 were upheld and 677 were overturned.
  - 2,182 out of 2,185 cases were resolved within 45 working days, resulting in a 99.9% compliance rate.
  - The average turnaround time for resolving PDRs in December was 42 days.
  - There were 3,961 PDRs pending resolution as of 12/31/2024, with no cases older than 45 working days.
  - The overturn rate for PDRs was 31%, which did not meet our internal goal of 25% or less.
    - The primary reason which caused the Department to miss their goal of 25% or less was:
    - Member OHC corrections – 143 cases that were denied incorrectly.
  - The full breakdown of all 677 overturned PDRs is as follows:

Category	# of Cases	% of Cases	Comments
System Related Issues	**67**	**10%**	
General configuration issues	24	4%	Non-covered code, modifier, etc.
Financial responsibility	28	4%	Mental Health denied to delegate
Claims Editing System (CES)	15	2%	
OHC Issues	**143**	**21%**	OHC Member TPL data, incorrect primary EOB not matching, incorrect manual entry
Authorization Issues	**209**	**31%**	
Processor error	42	6%	Claim denied in error; authorization was on file
UM/retro auth review	76	12%	Auth updated after claim was processed and sent for medical review.
PTPN	41	6%	
Mismatch auth provider name	27	4%	Same billing NPI, but the provider's name did not match claim billed.
CFMG Authorization	23	3%	Authorization on file, CFMG auth provided with Dispute.
Additional Documentation	**25**	**3%**	
Duplicate claim	22	3%	Documentation received confirmed claim was not a duplicate

Timely filing	3	0%	Documentation received confirmed claim was submitted on time
Incorrect Rates	**106**	**16%**	
Contract	24	4%	Incorrect rates in system
Letter of Agreement (LOA)	9	1%	Underpaid; LOA on file
Incorrect PTPN Rates	17	3%	Incorrect rates in system
Incorrect LTC rate	55	8%	
Share of Cost (SOC)	1	0%	Underpaid; SOC already met Overpaid; SOC not billed
Processor Errors	**127**	**19%**	
Duplicate claim	22	3%	Claim was a duplicate; processor paid it in error
Incorrect rate	54	8%	Claim manually priced incorrectly
Misc errors	51	8%	
PDR Overturn Totals	**677**	**100%**	

Community Relations and Outreach

The 2024 Year-in-Review Report (January 2024 through December 2024):

1. **Alliance Member Connect Newsletter:**
   - In 2024, the Alliance published the Spring/Summer 2024 and Fall/Winter 2024 Alliance Member Connect Newsletter in our threshold languages: English, Spanish, Chinese, Vietnamese, and Tagalog.
   - An average of more than 206,000 printed copies of each publication were disseminated to member households to reach more than 404,000 members, and community outreach events and digital copies of the publications are made available on the Alliance website.
   - Please see attached **Addendum A**.

2. **Provider Pulse Newsletter:**
   - In 2024, the Alliance published a Fall 2024 Provider Pulse Newsletter.
   - The newsletter was published on the Alliance website and emailed to more than 300 Alliance providers in December 2024.
   - Please see attached **Addendum B**.

3. **Multi-Media Print, Radio, and TV Ads:**
   - In 2024, the Alliance published 17 print, billboard, bus, BART, DMV, and public service announcement (PSA) ethnic Radio ads for more than 1.2 million impressions. These efforts support access to care and services in our community.
   - Please see attached **Addendum C**.

4. **Outreach:**
   - 12-Month Trend Summary:

    - The C&O Department reached 11,950 people (53% identified as Alliance members) during outreach activities.
    - The C&O Department spent a total of $2,987.55 in donations, fees, and/or sponsorships.
    - The C&O Department reached members in more than 39 cities/unincorporated areas throughout Alameda County, Bay Area, and the United States.
- Quarterly Analysis:
    - In Q2 2025, the C&O Department completed 335 member orientations by phone, 2 community, and 12 member education events, and 149 website inquiries.
    - Among the 1608 people reached, 36% identified as Alliance members.
    - In Q2 2025, the C&O Department reached members in 19 cities / unincorporated areas throughout Alameda County, Bay Area, and the United States.
- Please see attached **Addendum D**.

5. Social Media and Website Engagement

- In 2024, the Alliance public website received 203,000 unique visits and 200,000 new user visits. The top 10 website page visits were:
    i. Homepage
    ii. Providers
    iii. Find a Doctor
    iv. Medi-Cal Benefits and Covered Services
    v. Careers
    vi. Contact Us
    vii. Members
    viii. Check In for Check-Ups
    ix. Medi-Cal
    x. Get a New ID Card
- The Alliance Glassdoor Page:
    - Increased from 3.0 to 3.5 out of 5-star overall rating
    - Received nine (9) crowdsourced Glassdoor Reviews
- The Alliance Facebook Page:
    - Completed 276 compared to 173 original posts in 2023
    - Increased page likes to 633 compared to 628 in 2023
- The Alliance Instagram Page:
    - Completed 295 compared to 208 original posts in 2023
    - Increased 595 Followers compared to 483 in 2023
- The Alliance X (formerly known as Twitter) Page:
    - Completed 395 compared to 322 tweets in 2023
    - Increased followers to 359 compared to 358 in 2023
- The Alliance LinkedIn Page:
    - Completed 232 compared to 164 posts in 2023
    - Increased followers 6.1k compared to 4.7k followers in 2023

- The Alliance Yelp Page:
    - Appeared in Yelp searches 1,200
    - Received four (4) crowdsourced reviews
- The Alliance Google Page:
    - 54,127 business profile interactions.
    - 21,239 calls made from the business profile
    - Received seventeen (17) reviews
- Please see attached **Addendum E**.

Housing and Community Services Program Report – December Activities

Overview

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

Project Status Updates:

- Alameda County Health (AC Health) Pre 10/1/2024 Extension Authorization Clean Up Project – completed
- Denial Process Workflow in TruCare – in progress
- Developing Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis for the housing bundle – ongoing
- Development of Standard Operating Procedures (SOPs) for housing-related Community Supports (CS) – drafts completed and pending approval
- Housing CS automation planning for referrals – in progress
- ROI project for housing-related CS – ongoing

Interdepartmental Collaborations:

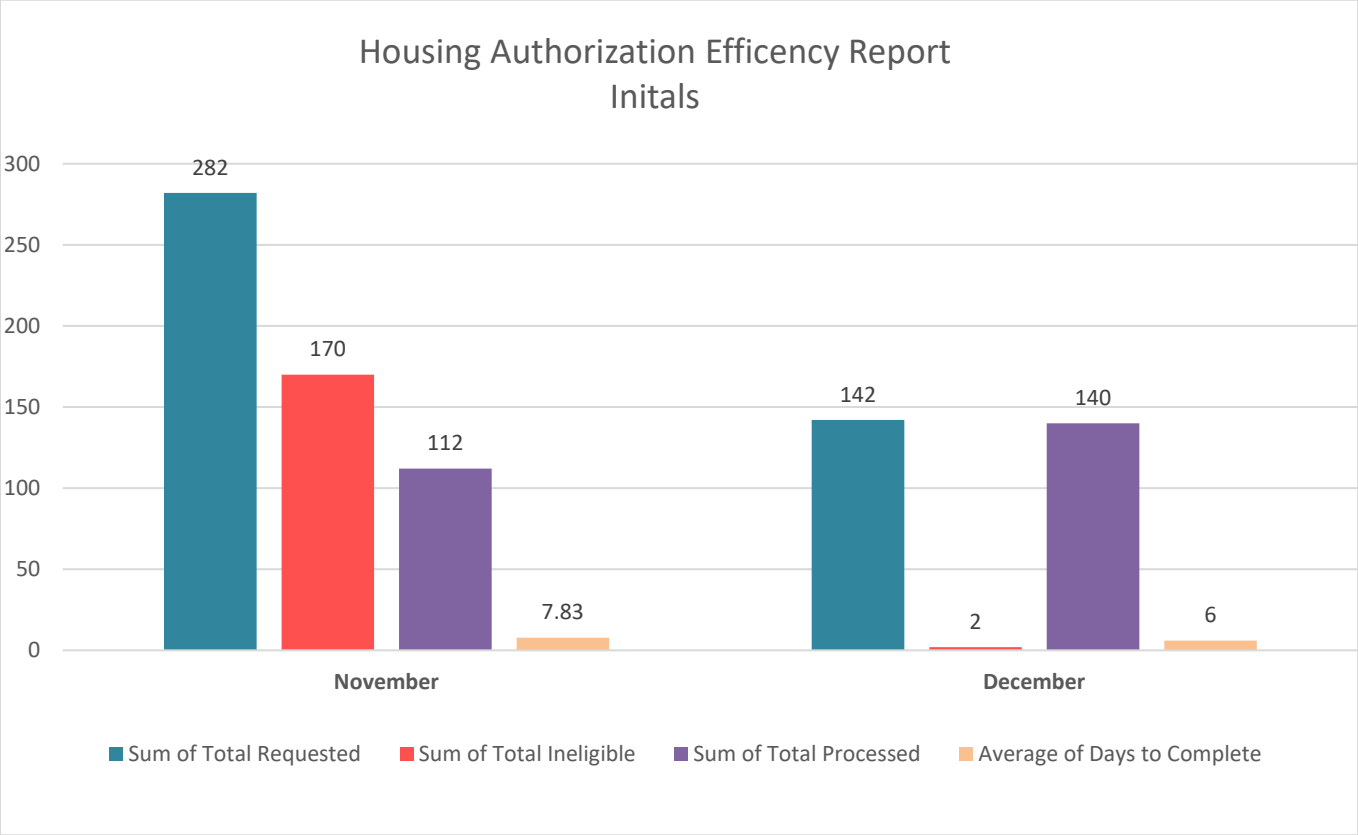
- Health Care Services and Housing Operations
    - Community Supports Goal Document – in progress
    - Operational Efficiency Workgroup and Transition support – ongoing
    - TruCare Steering Committee Workgroup – ongoing

Community Networks and Partnership Development:

- Continued participation with various stakeholders throughout Alameda County, including the Continuum of Care (CoC), Racial Equity Committee, Outreach Access and Coordination Committee, Healthcare for the Homeless Oakland Regional Housing Meeting, Homeless Management Information System (HMIS) Committee, and Corporation for Supportive Housing Advisory Council.
    - Corporation for Supportive Housing Advisory Council – Housing Deposits standardization workflow
    - DHCS Transitional Rent Workgroup participation – next meeting scheduled for 01/16/2025

- National Association of Housing and Redevelopment Officials – AAH Housing Manager is the President of the Local Chapter; the regional conference, highlighting Housing CS is scheduled to take place 01/27 – 01/28/2025

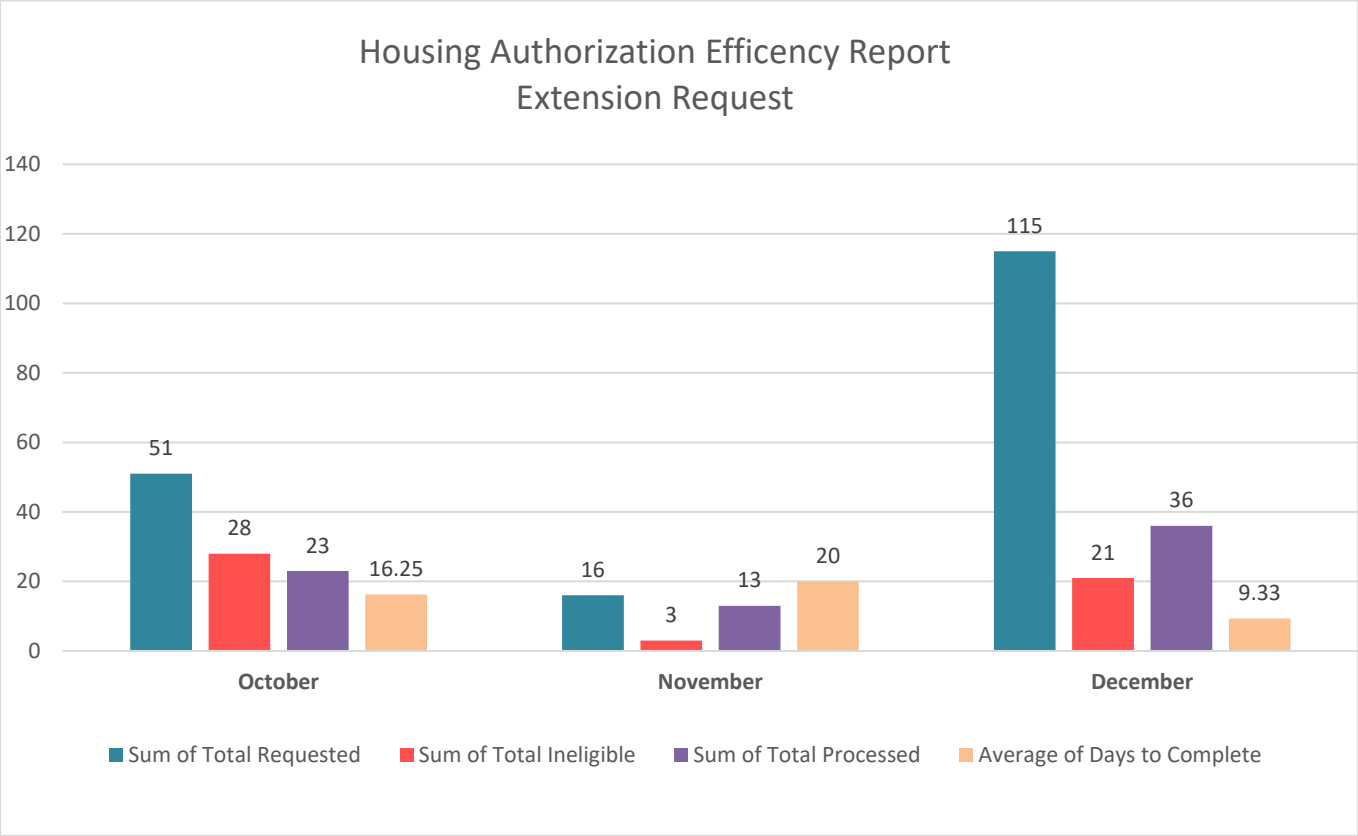
Housing Authorization Efficiency Project Report:



The Housing Authorization Efficiency Project Report is a point-in-time report focusing on Initial Authorization completion for the Housing & Community Supports Department. The following provides an overview of the initial authorization efficiency report comparisons from November 1st, 2024 – December 31st, 2024:

- November 2024:
  - HCSD received 6 batches of initial housing authorizations requests which included 282 individual requests
    - 170 authorizations were determined to be ineligible due to member not meeting the criteria for the service
  - The team completed 112 authorizations, with an average completion time of 8 days per batch
- December 2024:
  - HCSD received 4 batches of initial housing authorizations requests which included 142 individual requests
    - 2 authorizations were determined to be ineligible due to member not meeting the criteria for the service

- The team completed 140 authorizations, with an improved average completion time of 6 days per batch



- October 2024:
  - HCSD received 4 batches of extension requests which included 51 individual requests
    - 28 extensions were determined to be ineligible due to member not meeting the criteria for the service
    - The team completed 23 authorizations, with an average completion time of 16 days per batch (completion goal is 30 calendar days)

- November 2024:
  - HCSD received 2 batches of extension requests which included 16 individual requests
    - 3 authorization extension requests were determined to be ineligible due to member not meeting the criteria for the service
    - The team completed 13 authorization extensions with an average completion time of 20 days per batch

- December 2024:
  - HCSD received a total of 4 batches of authorization extension requests which included 115 individual requests
    - 21 authorization extensions were determined to be ineligible due to members not meeting the criteria for the service

- The team completed 36 authorizations, with an average completion time of 9 days per batch

- 58 pending extension requests were submitted to HCSD by AC Health on 12/22/2024 but contained discrepancies. HCSD is awaiting corrections from AC Health to complete the batch
    - These requests are not included in the December data; HCSD will report on the completion of these extension requests on the next board report

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

Project Status Updates:

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

Interdepartmental Collaboration:

- Quality Team – CHW utilization projects
    - CHW utilization to support member follow-up for Mental Health (FUM) measures – active project
    - CHW integration to improve A1C for Alameda Alliance members; go–live targeted for January 2025
    - Expansion of Faith based CHW Organizations in Hayward location to close care gaps – in progress
- Population Health Management – integration of CHW services for Perinatal Depression
    - 2 organizations, Zocalo Health and Our Roots, have been identified as new CHW providers specializing in perinatal depression and mental wellness for under-resourced and BIPOC women and other birthing communities impacted by poverty
        - Scope of Services discussion scheduled for January 2025

Community Health Worker Utilization:

Total Number of unique members utilizing services	294
Total Number of CHW Services billed through December 2024	1,008

Observation from granular data shows the following areas of focus for the next three months:

- Provider education on billing CHW services and accountability for timely claims submission
- Increasing staff capacity to:

- Partner with internal Alameda Alliance Subject Matter Experts (SMEs) to promote CHW utilization through scope of work projects
- Increase targeted community outreach efforts to diversify the CHW portfolio

Incentives & Reporting Board Report – December 2024 Activities

Current Incentive and Grant Programs

CalAIM Incentive Payment Program (IPP) – three-year DHCS program to provide funding for the support of ECM and Community Supports (CS) in 1) Delivery System Infrastructure, 2) ECM Provider Capacity Building, 3) CS Provider Capacity Building and CS Take-Up, and 4) Quality and Emerging CalAIM Priorities:

- For Program Year 1 (1/1/2022 - 12/31/2022):
  - Alameda Alliance earned 100% of the allocated funds ($14.8M) and distributed funding to 10 providers and organizations to support ECM and CS programs
- For Program Year 2 (1/1/2023 - 12/31/2023):
  - Alameda Alliance earned $4.56M, which was 60% of the allocated funds for the Submission 3 report ($15.1M); the Plan distributed funding to 12 providers and organizations to support ECM and CS programs
  - Alameda Alliance earned 71.81% of the allocated points for the Submission 4 report, reflecting the lookback period of 7/1/2023 - 12/31/2023
- For Program Year 3 (1/1/2024 - 6/30/2024):
  - Alameda Alliance earned 86.59% of the allocated points for the Submission 5 report, reflecting the lookback period of 1/1/2024 - 06/30/2024

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

- Partner meetings continued with the Local Education Agencies (LEAs) regarding project plan activities and to prepare for the last SBHIP submission, the Project Outcome Report, which was due to DHCS on December 31st
- The Alliance submitted the Project Outcome Report, the final SBHIP report for the entire measurement period of January 1st, 2022, to December 31st, 2024, to DHCS on December 19th
- To date, $8.6M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $7.7M has been paid to LEA and SBHIP partners

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

- Total eligible dollars available to the Alliance under this program was $44M
- The Alliance earned a total of $38M based on submission of deliverables and achievement of DHCS-defined metrics
  - $19.7M has been awarded to our HHIP partners to date
- A HHIP funding opportunity was released in June 2024 to SBHIP LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)

    - The Alliance received applications from 10 LEAs totaling $1.3M in requests; all submitted applications were approved and work on the funded programs continues
- In a separate HHIP-funded initiative, the Alliance awarded $11.2M in funding to 10 community partners through a program that supports the HHIP goals of reducing and preventing homelessness
    - MOUs are in place, or underway, for projects related to capacity building, innovation, diversity and health equity, and housing stability

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

- Program launched on June 1st, 2024, and 11 informational sessions were conducted to share program details with interested practices
- The application period closed on September 6th; the Alliance received a total of 15 applications totaling $6M in funding requests
- A multi-disciplinary team evaluated the applications and made funding recommendations to a group of senior leaders (CEO, COO, CFO, CMO); funding decisions were approved on October 25th, 2024, and partners were notified
- $2M in funding will be awarded to 13 provider partners, pending finalization of MOUs and related program deliverables for the following:
    - 18 providers in total, 8 of which are bi-lingual

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

- Of the 14 practices that submitted program applications, Alameda Health System was the only Alliance-associated applicant selected by DHCS to participate
- The original funding was $700 million over 5 years; however, due to state budget constraints, the funding was reduced to $140 million over 3 years

Recruiting and Staffing

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

Incentive and Grant Program Descriptions

CalAIM Incentive Payment Program (IPP) – The CalAIM ECM and CS programs will require significant new investments in care management capabilities, ECM and CS infrastructure, information technology (IT) and data exchange, and workforce capacity across MCPs, city and county agencies, providers, and other community-based organizations. CalAIM incentive payments are intended to:

- Build appropriate and sustainable ECM and Community Supports capacity
- Drive MCP investment in necessary delivery system infrastructure
- Incentivize MCP take-up of Community Supports
- Bridge current silos across physical and behavioral health care service delivery

- Reduce health disparities and promote health equity
- Achieve improvements in quality performance

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

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

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

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

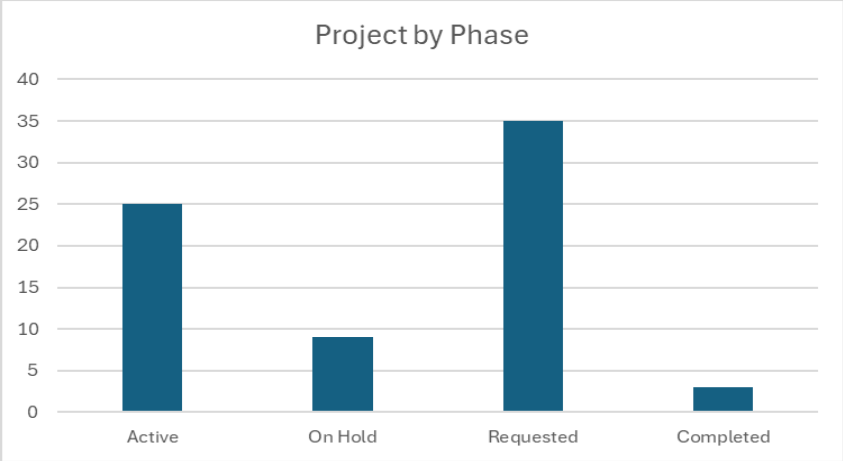
The Provider Recruitment Initiative (PRI) – program launched on June 1st, 2024, and is designed to provide grants to support the Alameda County Safety Net and community-based organizations to hire and retain healthcare professionals who serve the Alameda County Medi-Cal population. The PRI aims to grow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

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

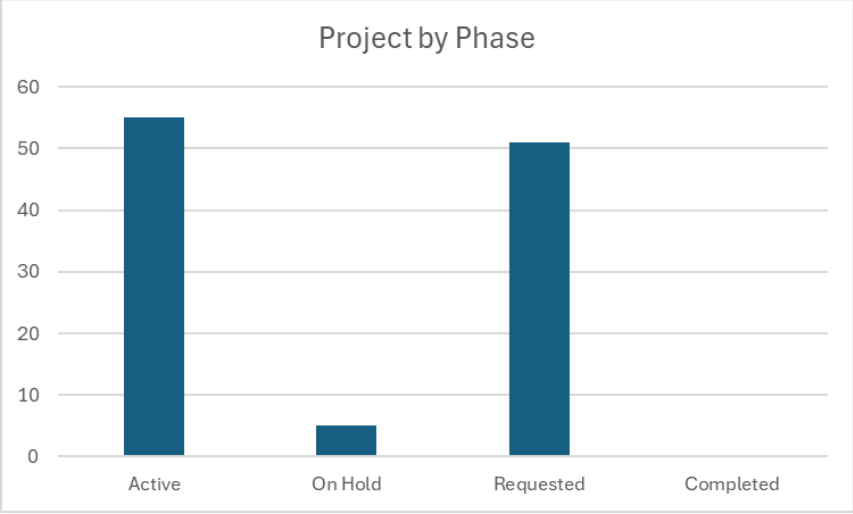
INTEGRATED PLANNING DIVISION BOARD REPORT – DECEMBER 2024 ACTIVITIES

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

- 3 Completed Projects (Last month)



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



- D-SNP Key Initiatives and Dates
  - DMHC Material Modification Submission – MA Service Area Expansion – March 2024
  - DMHC Material Modification Submission – D-SNP Product – August 2024
  - CMS Notice of Intent to Apply – November 2024
  - CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025
  - CMS Formulary & Bid Submission (Benefit Determination) – June 2025
  - CMS SMAC Submission – July 7th, 2025
  - Rebate Allocation with CMS and Health Plan – July / August 2025

    - Annual Enrollment Period (AEP) – October thru December 2025
    - IT System Readiness – December 15th, 2025
    - Open Enrollment Period (OEP) Begins – January 1st, 2026
- D-SNP Activities – November 2024
    - Provider Services & Contracting
        - Provider contracting started July 22nd, 2024. Following the changes to the sequestration language in the Medicare amendment, 564 Provider Amendments were sent with 143 signed. 800 Letter of Intent (LOIs) were sent and 68 have been signed
        - Continued development of business process future state workflows and requirements for the Provider Portal and Provider Repository
    - Product
        - The 3-month deeming period for D-SNP members losing Medi-Cal eligibility before disenrollment was approved by SLT. The decision supports minimal membership gains beyond 3 months, financial impact, and alignment with California market norms
        - Continued review of the D-SNP Branding recommendations for D-SNP and the refreshed Alliance brands
        - Continued the D-SNP Medicare Organizational Structure Exercise and 18 documents reviewed / approved out of 21 total number of departments
        - Received Business Requirement Document (BRD) Enrollment, Disenrollment and Eligibility approvals
    - Vendor Management
        - Engagement with the following vendors to support Supplemental Benefit Offering(s)
            - Dental – in Pre-Del / Contracting
            - Vision – in Pre-Del / Contracting
            - Hearing – in Pre-Del / Contracting
            - Flex Card – in Pre-Del / Contracting
            - OTC – in Pre-Del / Contracting
            - MTM – in Pre-Del / Contracting
            - HRA – scoring in process
    - Quality
        - Model of Care
            - All MOC files have been reviewed/approved by the business, compiled, and sent for proof reading/editing
            - MOC 2 & 3 have been sent to senior leadership (Ruth & Dr. Carey) for approval
            - MOC 1 & 4 are being reviewed by ED of Medicare
            - MOC Submission is due February 12th by 8pm EST

MOC Element	Total Factors	# Draft Complete	# In Progress	# Not Started
MOC 1	8	8	0	0
MOC 2	32	32	0	0
MOC 3	12	12	0	0
MOC 4	21	21	0	0
Totals	**73**	**73**	**0**	**0**
		100%	**0%**	**0%**

        - Quality Program
            - Quality Committee Structure has been reviewed with the business
            - Quality Policies are being organized for review and gap analysis
            - Future state PQI is being drafted, requirements will be pulled from the future state flow
    - Health Care Services (HCS) and Behavioral Health (BH)
        - Redlining UM and CM Program Descriptions for D-SNP elements
        - Developing Prior Authorization Form
        - Updating existing HRA with D-SNP Requirements
        - Future State (D-SNP) Inpatient and OP UM Business BRD – System Requirements Documentation started in collaboration with vendor
        - Future State D-SNP CM Global Workflow in draft – Outlining process flows for new D-SNP components to include Face-to-Face visit, Palliative Care Program, and Dementia Care Program
        - Defining structure for California Integrated Care Management (CICM) to include new requirements outlined in the CY2024 Program Guide
        - Completing inventory of existing CM and UM artifacts including assessments and notes to identify needs
        - BH UM Future State (D-SNP) Business Process Documentation in progress – Defining program model and IT needs as this will be a new process for D-SNP
        - BH CM – Continuing to document proposed - CM program structure. Beginning initial discussion of CBO integrations for BH CM Programs
    - Finance
        - Received Business Requirement Document (BRD) approvals for each of the following
            - Financial Planning & Decisions
            - Medicare Finance Program
            - Financial Reconciliation
    - Compliance
        - DMHC Material Modification – D-SNP Product (Filing #20244060)
            - Initial AAH responses submitted to DMHC on 9/9/24

        - DMHC Comment Table received 11/21/24; responses submitted 12/18/24
        - Entered Policies into Policy Tech for review and editing
- Enrollment and Eligibility
    - Received Enrollment and Disenrollment Business Requirements Document (BRD) Approval
- Pharmacy
    - Pre-delegation audit is nearing completion, targeting to complete by mid-January 2025. Additional auditing for appeals will be conducted in January.
    - PBM contracting negotiations are on track to be completed by the end of January 2025
    - MTM vendor selection is complete, and the selected vendor has been notified. Contracting negotiations have been initiated and the MTM vendor has been provided an MSA and SOW for review and approval.
    - 19 P&Ps in development with Rebellis: 10 in review, 9 ready for committee review
- Operations (Claims / Member Services / Mailroom / IVR)
    - Continue development of Claims, Member Services, Mailroom, and IVR business process and requirements
- IT
    - TruCare: Core Module demos, System Requirement Documents are completed. Business Hierarchy Profile (BHP) configuration is completed and tested
    - HEALTHsuite: Workstream Leads identified and working sessions are in progress. HEALTHsuite confirmed as source of letter triggers. Staging Region upgrade complete and copy down from Production in progress. RAM provided with 4 options for Plan Structure. Leadership engaged to decide on the best option for AAH
    - QualitySuite: Requirement development supporting G&A, PDR, PQI & Part D are in process. Grievances requirements completed and uploaded to MS List
- Policies / SOPs / KPIs
    - Continued policy review within all workstreams
    - Continued development of KPI strategy and tracking documents for all workstreams
- Program Decisions Reviewed
    - Grievance & Appeals
        - AAH will delegate Part D appeals to PerformRx (PBM) and AAH will own Part D grievances
    - Health Care Services
        - Use of ADT to auto generate referrals for Observation Status Admissions
    - Pharmacy
        - Members who enroll in Part C D-SNP Plan will automatically be enrolled in Part D
        - AAH will delegate Part D appeals to PerformRx (PBM) and AAH will own Part D grievances

        - Product
            - 3 month deeming period for D-SNP members losing Medi-Cal eligibility before disenrollment
        - Provider Services & Contracting
            - Approval to use a consultant to support provider contracting efforts
        - Sales
            - Selection of NationsBenefits CRM to support Sales and Online Enrollment
        - Vendor Management
            - D-SNP First Tier, Downstream, and Related Entities (FDR) Pre-Delegation Process will be managed by Vendor Management

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

- DHCS continues holding a series of meetings with Cohort participants; these include Onboarding Sessions for the LEAs as well as Technical Office Hours each Thursday of the month
    - The meetings held have been heavily focused on the LEA process
- The Alliance will utilize Carelon as the Third-Party Administrator (TPA)
- The Claims submission date has been extended from April 1st, 2024, to July 1st, 2024
    - It may not be true that all MCPs or LEAs have systems set up, however, LEAs may submit claims for up to 180 days from the date of service
    - Claims may be submitted retroactively back to July 1st, 2024, as long as it is submitted by end of the year
- MCPs have expressed concern over the initial TPA model and DHCS is considering two options, requesting MCP feedback.
- DHCS Health Plan Work Group (HPWG were to meet every week, Fridays between August and September 10-11am, however, most meetings have been cancelled in the month of October
    - An email was to be shared each Monday with recaps and agendas for subsequent meetings, however, this has not been taking place.
- High Level Timeline provided by Carelon for Claims Processing without solid Go Live Date
    - Interim ASO Model proposed
    - MOU & BAAs between Plans and Carelon not yet finalized.
        - Third MOU draft republished for MCPs to review and provide feedback. Due back to LHPC on 10/7
        - MOU still pending finalization
    - Program Design and Documentation not yet finalized
    - Invoice Template introduced
        - TPA / ASO Interim draft timeline published
    - Request from MCPs to review timeline activities and provide feedback by 1/10/25
    - AAH feels this timeline is too tight and will request an extension

Recruiting and Staffing

- Integrated Planning Open position(s):
    - Business Analyst – Integrated Planning – Position pending
    - Backfill Business Analyst – Integrated Planning – Position pending

ALAMEDA Alliance FOR HEALTH

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

Integrated Planning

Ruth Watson

Integrated Planning

Supporting Documents Project Descriptions

Key projects currently in-flight:

- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs.
  - Enhanced Care Management (ECM) – ECM will target eight (8) specific populations of vulnerable and high-risk children and adults
    - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022
    - Two (2) additional PoF became effective on January 1st, 2023
    - One (1) PoF became effective on July 1st, 2023
    - Two (2) PoF became effective on January 1st, 2024
  - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays
    - As of January 1st, 2024, AAH will offer twelve (12) of the fourteen (14) DHCS-designated CS services
      - January 1st, 2022 – Six (6) Community Supports were implemented
      - July 1st, 2023 – Three (3) additional CS services went live
      - January 1st, 2024
        - Two (2) CS services that support the LTC PoFs that were effective January 2023 are being piloted in 7/1-12/31/2023 and went live in January
        - One (1) additional CS service is also targeted for implementation in July 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 in order 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

- Community Health Worker Services Benefit – Community Health Worker (CHW) services became a billable Medi-Cal benefit effective July 1st, 2022. CHW services are covered as preventive services on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law for individuals who need such services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being.
- 2024 Single Plan Model
    - 2024 Managed Care Plan Contract Operational Readiness – new MCP contract developed as part of Procurement RFP; all MCPs must adhere to new contract effective January 1st, 2024
        - Business Continuity Plan required as part of Operational Readiness
        - MOUs with third parties required as part of Operational Readiness
    - MCP Member Transition
        - Anthem members will transition to AAH effective January 1st, 2024
        - Members currently delegated to Kaiser will transition to Kaiser as part of their direct contract with DHCS effective January 1st, 2024
- CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed and a multi-payer, school-linked, statewide fee schedule for outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site. CYBHI requires commercial health plans and the Medi-Cal delivery system, as applicable, to reimburse, at or above the published rates, these school-linked providers, regardless of network provider status, for services furnished to students pursuant to the fee schedule. Effective January 1st, 2024, the Alliance is partnering with the Alameda County Office of Education (ACOE) and several Local Education Agencies (LEAs) who were selected to participate in the CYBHI Fee Schedule Cohort 1.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	December 2024
Incoming Calls (R/V)	16,913
Abandoned Rate (R/V)	4%
Answered Calls (R/V)	16,258
Average Speed to Answer (ASA)	00:14
Calls Answered in 30 Seconds (R/V)	95%
Average Talk Time (ATT)	07:33
Calls Answered in 10 minutes	100%
Outbound Calls	8,575

Top 5 Call Reasons (Medi-Cal and Group Care) December 2024
Change of PCP
Eligibility/Enrollment
Benefits
Grievances/Appeals
Provider Network Info

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) December 2024
Change PCP
ID Card Requests
Update Contact Info

MSBH	December 2024
Incoming Calls (R/V)	1102
Abandoned Rate (R/V)	8%
Answered Calls (R/V)	1009
Average Speed to Answer (ASA)	01:11
Calls Answered in 30 Seconds (R/V)	76%
Average Talk Time (ATT)	08:50
Calls Answered in 10 minutes	99%
Outbound Calls	851
Screenings Completed	118
ACBH Referrals	30
SUD referrals to Center Point	18

Claims Department
November 2024 Final and December 2024 Final

METRICS

Claims Compliance	Nov-24	Dec-24
90% of clean claims processed within 30 calendar days	93.2%	90.2%
95% of all claims processed within 45 working days	99.8%	99.3%
Claims Volume (Received)	**Nov-24**	**Dec-24**
Paper claims	33,722	34,446
EDI claims	330,408	297,662
Claim Volume Total	**364,130**	**332,108**
Percentage of Claims Volume by Submission Method	**Nov-24**	**Dec-24**
% Paper	9.26%	10.37%
% EDI	90.74%	89.63%
Claims Processed	**Nov-24**	**Dec-24**
HEALTHsuite Paid (original claims)	232,293	224,568
HEALTHsuite Denied (original claims)	68,269	38,592
HEALTHsuite Original Claims Sub-Total	**300,562**	**263,160**
HEALTHsuite Adjustments	20,454	56,589
HEALTHsuite Total	**321,016**	**319,749**
Claims Expense	**Nov-24**	**Dec-24**
Medical Claims Paid	$132,414,360	$119,016,631
Interest Paid	$112,351	$105,882
Auto Adjudication	**Nov-24**	**Dec-24**
Claims Auto Adjudicated	263,359	260,398
% Auto Adjudicated	87.6%	88.7%
Average Days from Receipt to Payment	**Nov-24**	**Dec-24**
HEALTHsuite	13	14
Pended Claim Age	**Nov-24**	**Dec-24**
0-30 calendar days	44,280	64,568
HEALTHsuite		
31-61 calendar days	15,812	29,816
HEALTHsuite		
Over 62 calendar days	7	778
HEALTHsuite		
Overall Denial Rate	**Nov-24**	**Dec-24**
Claims denied in HEALTHsuite	68,269	38,592
% Denied	21.3%	12.1%

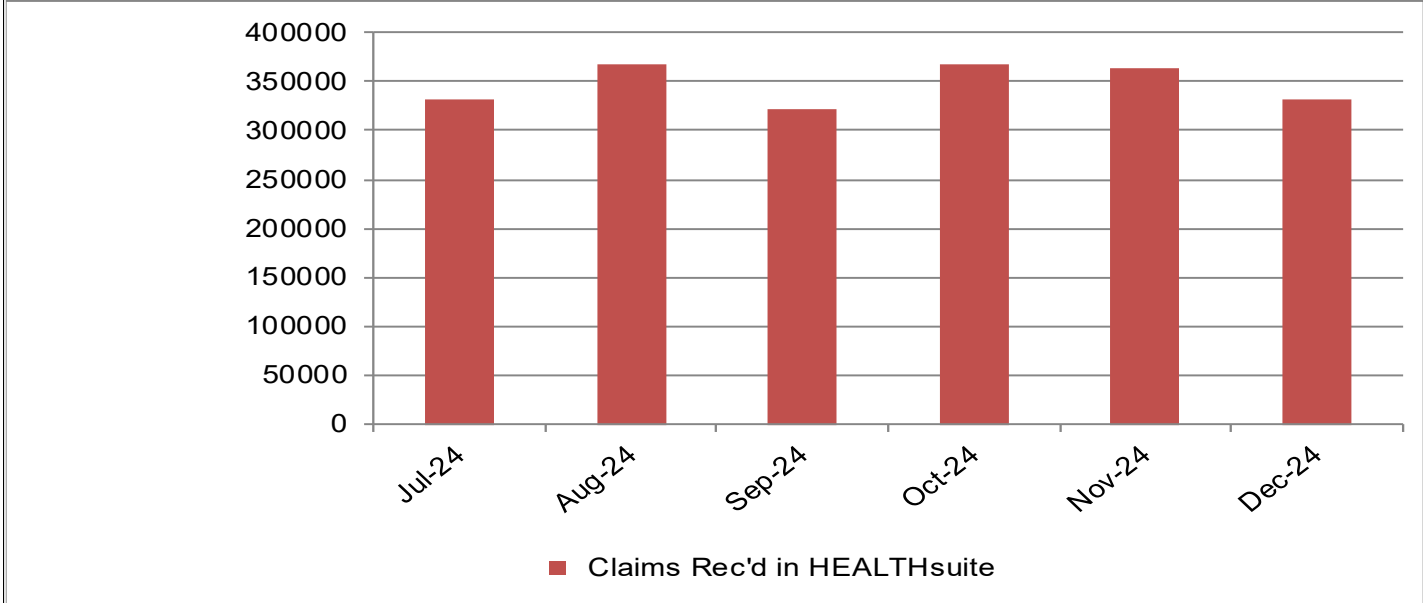
Claims Department
November 2024 Final and December 2024 Final

Dec-24

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	27%
No Benefits Found For Dates of Service	14%
Non-Covered Benefit For This Plan	10%
Duplicate Claims	9%
Must Submit Paper Claim With Copy of Primary Payor EOB	8%
% Total of all denials	**68%**

Claims Received By Month

Run Date	8/1/2024	9/1/2024	10/1/2024	11/1/2024	12/1/2024	1/1/2025
Claims Received Through	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**
aims Rec'd in HEALTHsuite	332,150	368,235	322,196	367,989	364,130	332,108



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing December 2024 to December 2023 as follows: 30 Days - 90.2% (2024) vs 90.0% (2023) 45 Days - 99.3% (2024) vs 99.9% (2023) 90 Days - 99.9% (2024) vs 99.9% (2023)	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 332,108 claims in December 2024 vs 215,246 in December 2023	N/A	N/A
EDI - the volume of EDI submissions was 89.63% which exceeded our normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 319,749 in December 2024 (20 working days) vs 215,111 in December 2023 (21 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in December 2024 was $119,016,631 (4 check runs) vs $83,516,690 in December 2023 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in December 2024 was $105,882 vs $40,964 in December 2023	N/A	< $496,000 per fiscal year or $30,000 per month
Auto Adjudication - the AAH rate in December 2024 was 88.7% vs 83.2% in December 2023	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in December 2024 was 14 days vs 14 days in December 2023	N/A	<= 25 days
Pended Claim Age - comparing December 2024 to December 2023 as follows: 0-30 calendar days - 64,568 (2024) vs 31,758 (2023) 31-61 calendar days - 29,816 (2024) vs 7,971 (2023) Over 62 calendar days - 778 (2024) vs 5 (2023)	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 December 2024 to December 2023	N/A	N/A

Provider Relations Dashboard December 2024

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10695	9359	9033	8064	7469	6825	8593	8233	7634	8456	7022	7479
Abandoned Calls	4806	4325	3272	2275	1519	1207	1787	1663	1529	1554	1803	1943
Answered Calls (PR)	5889	5034	5761	5789	5950	5618	6806	6570	6105	6902	5219	5536
Recordings/Voicemails	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (R/V)	413	2551	1970	1595	1093	896	1247	1211	985	1055	1392	1423
Abandoned Calls (R/V)												
Answered Calls (R/V)	413	2551	1970	1595	1093	896	1247	1211	985	1055	1392	1423
Outbound Calls	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Outbound Calls	1140	1358	1298	831	1018	829	1066	893	889	751	722	740
N/A												
Outbound Calls	1140	1358	1298	831	1018	829	1066	893	889	751	722	740
Totals	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Incoming, R/V, Outbound Calls	11835	13268	12301	10490	9580	8550	10906	10337	9508	10262	9136	9642
Abandoned Calls	4806	4325	3272	2275	1519	1207	1787	1663	1529	1554	1803	1943
Total Answered Incoming, R/V, Outbound Calls	7442	8993	9029	8215	8061	7343	9119	8674	7979	8708	7333	7699

Provider Relations Dashboard December 2024

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.5%	5.6%	5.5%	6.1%	6.4%	6.4%	6.0%	6.0%	6.4%	5.8%	6.0%	6.8%
Benefits	4.3%	3.6%	2.4%	3.0%	2.5%	2.8%	2.8%	2.9%	2.9%	2.9%	3.5%	3.5%
Claims Inquiry	38.5%	41.7%	45.4%	40.1%	43.3%	42.1%	43.8%	44.0%	44.9%	45.6%	43.0%	43.9%
Change of PCP	3.3%	3.9%	2.6%	3.6%	2.6%	2.9%	2.9%	2.9%	2.9%	3.1%	2.8%	3.0%
Check Tracer	1.1%	1.1%	1.2%	1.0%	1.3%	1.2%	0.9%	0.9%	1.0%	1.0%	0.9%	0.8%
Complaint/Grievance (includes PDR's)	4.4%	4.3%	6.1%	5.8%	7.9%	7.5%	7.6%	8.0%	7.5%	7.1%	6.1%	6.5%
Contracts/Credentialing	1.1%	1.0%	1.5%	1.4%	0.7%	0.7%	0.6%	0.9%	1.0%	0.7%	0.8%	1.0%
Demographic Change	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Eligibility - Call from Provider	23.0%	20.5%	17.5%	20.9%	18.2%	17.7%	17.8%	18.1%	17.8%	15.4%	18.1%	17.9%
Exempt Grievance/ G&A	0.6%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Intrepreter Services Request	0.5%	0.6%	0.7%	1.1%	0.6%	0.7%	0.4%	0.4%	0.7%	0.6%	0.8%	0.8%
Provider Portal Assistance	3.7%	3.8%	3.2%	3.2%	3.6%	3.6%	3.5%	3.2%	2.9%	4.5%	5.5%	3.2%
Pharmacy	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%
Prop 56	0.2%	0.4%	0.3%	0.3%	0.4%	0.4%	0.2%	0.2%	0.4%	0.5%	0.5%	0.3%
Provider Network Info	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Transportation Services	0.2%	0.2%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%
Transferred Call	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%
All Other Calls	13.4%	13.1%	13.1%	13.1%	12.3%	13.5%	12.9%	12.4%	11.4%	12.2%	11.9%	12.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	13	56	38	40	28	60	66	65	77	70	32	10
Contracting/Credentialing	9	21	50	26	19	49	63	99	53	44	26	7
Drop-ins	27	49	29	30	54	73	77	174	119	168	141	200
JOM's	3	2	2	2	2	1	2	3	2	1	1	3
New Provider Orientation	104	103	140	101	113	219	82	125	N/A	334	100	182
Quarterly Visits	0	0	0	0	82	89	125	94	65	1	45	0
UM Issues	0	0	0	0	0	1	7	7	4	2	5	0
Total Field Visits	156	231	259	199	298	492	422	567	320	620	350	402

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS - DECEMBER 2024						
Practitioners		BH/ABA 2,516	AHP 634	PCP 392	SPEC 764	PCP/SPEC 13
AAH/AHS/CHCN Breakdown			AAH 3,078	AHS 307	CHCN 595	COMBINATION OF GROUPS 339
Facilities	**429**					

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	103	10	Y	Y	Y
Recred Files in Process	133	18	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**236**				
				*** 25 business days = 35 calendar days**	

December 2024 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	4
SPEC	15
ANCILLARY	23
MIDLEVEL/AHP	16
BH/ABA	77
Sub-total	**135**
Recredentialing	
PCP	5
SPEC	17
ANCILLARY	1
MIDLEVEL/AHP	7
Sub-total	**30**
TOTAL	**165**

December 2024 Facility Approvals	
Initial Credentialing	**3**
Recredentialing	**21**
Sub-total	**24**
Facility Files in Process	**49**

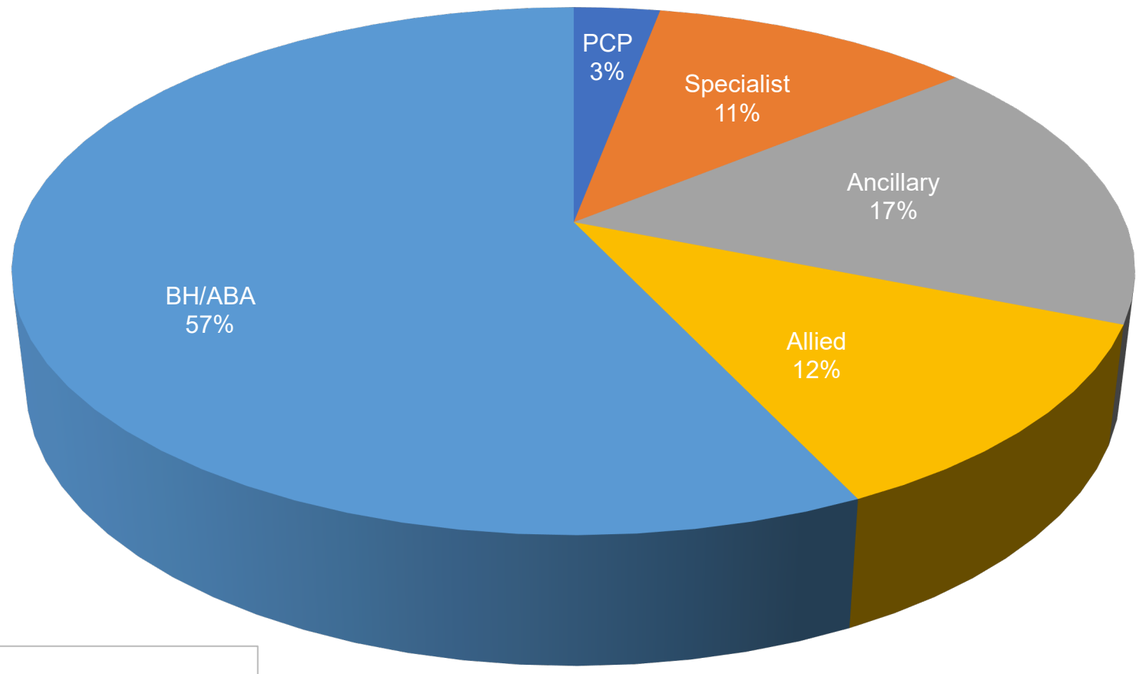
December 2024 Employee Metrics (5 FTEs)	**Goal**		**Met (Y/N)**
File Processing	Timely processing within 3 days of receipt		Y
Credentialing Accuracy	<3% error rate		Y
DHCS, DMHC, CMS, NCQA Compliant	98%		Y
MBC Monitoring	Timely processing within 3 days of receipt		Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Agudah	Victoria	BH/ABA-Telehealth	INITIAL	12/19/2024
Andrews	Taylor	BH/ABA	INITIAL	12/19/2024
Arcilla	Gilbert Nolly	BH/ABA	INITIAL	12/19/2024
Armenta	Guillermo	BH/ABA-Telehealth	INITIAL	12/19/2024
Asidanya	Chinwe	BH/ABA-Telehealth	INITIAL	12/19/2024
Asulin	Shiran	BH/ABA-Telehealth	INITIAL	12/19/2024
Avila	Arturo	Allied Health	INITIAL	12/19/2024
Ayres	Rachel	BH/ABA-Telehealth	INITIAL	12/19/2024
Baird	Melissa	BH/ABA-Telehealth	INITIAL	12/19/2024
Bardos	Rachel	BH/ABA-Telehealth	INITIAL	12/19/2024
Barrientos	Alexandria	BH/ABA-Telehealth	INITIAL	12/19/2024
Bowen	Lyndsay	Ancillary	INITIAL	12/19/2024
Bowerman	Christopher	Allied Health	INITIAL	12/19/2024
Brown	Anais	Ancillary	INITIAL	12/19/2024
Butler	Angel	BH/ABA-Telehealth	INITIAL	12/19/2024
Calderon	Daniel	BH/ABA	INITIAL	12/19/2024
Campbell	Shelitha	Allied Health	INITIAL	12/19/2024
Cannon	Clarissa	BH/ABA	INITIAL	12/19/2024
Cao	Marian	BH/ABA-Telehealth	INITIAL	12/19/2024
Chauhan	Nirali	Ancillary	INITIAL	12/19/2024
Choi	Joanna	Primary Care Physician	INITIAL	12/19/2024
Chung Chavez	Yung Fang Irene	BH/ABA-Telehealth	INITIAL	12/19/2024
Covarrubius-Gamino	Maria	BH/ABA	INITIAL	12/19/2024
Dean	Michelle	BH/ABA-Telehealth	INITIAL	12/19/2024
Del Toro	Jose	BH/ABA	INITIAL	12/19/2024
Delius	Sylvia	Specialist	INITIAL	12/19/2024
Dickerson	JaNece	BH/ABA-Telehealth	INITIAL	12/19/2024
DiLaura	Angela	Allied Health	INITIAL	12/19/2024
Dufour	David	Ancillary	INITIAL	12/19/2024
Dunnigan	Keriann	Ancillary	INITIAL	12/19/2024
Dupre	Rebecca	Ancillary	INITIAL	12/19/2024
E	Lina	Allied Health	INITIAL	12/19/2024
Ehrlich	Marcus	BH/ABA	INITIAL	12/19/2024
England	Jason	Allied Health	INITIAL	12/19/2024
Finkeldey	Megan	BH/ABA-Telehealth	INITIAL	12/19/2024
Flegal	Kristi	BH/ABA	INITIAL	12/19/2024
Francois	Berthlyne	Ancillary	INITIAL	12/19/2024
Galindo	Jamie	BH/ABA-Telehealth	INITIAL	12/19/2024
Garg	Sunakshi	Specialist	INITIAL	12/19/2024
Gaully	Aniefiok	BH/ABA	INITIAL	12/19/2024
Gibson	Britney	BH/ABA-Telehealth	INITIAL	12/19/2024
Gibson	Victoria	BH/ABA-Telehealth	INITIAL	12/19/2024
Gonzalez	Claudia	BH/ABA-Telehealth	INITIAL	12/19/2024
Guy	Elana	BH/ABA	INITIAL	12/19/2024
Haase	Sarah	BH/ABA-Telehealth	INITIAL	12/19/2024
Hakim	Tiffany	BH/ABA-Telehealth	INITIAL	12/19/2024
Havey	John	BH/ABA	INITIAL	12/19/2024
Hernandez	Juana	BH/ABA-Telehealth	INITIAL	12/19/2024
Hill	Erica	BH/ABA	INITIAL	12/19/2024
Hilton	Dorian	BH/ABA	INITIAL	12/19/2024
Hoang	Robert	Specialist	INITIAL	12/19/2024
Hunter	Lauryn	BH/ABA-Telehealth	INITIAL	12/19/2024
Ingram	Madeline	Ancillary	INITIAL	12/19/2024
Ivy-Louthaman	Leslie	BH/ABA-Telehealth	INITIAL	12/19/2024
Johnson	Marisa	Specialist	INITIAL	12/19/2024
Jose	Sharon	BH/ABA	INITIAL	12/19/2024
Joseph	Jeby	BH/ABA-Telehealth	INITIAL	12/19/2024

Kaufman	Jessica	BH/ABA-Telehealth	INITIAL	12/19/2024
Kenney	Nicole	Ancillary	INITIAL	12/19/2024
Khan	Rashida	BH/ABA	INITIAL	12/19/2024
Kim	Yeji	Specialist	INITIAL	12/19/2024
Kumari	Radhika	Specialist	INITIAL	12/19/2024
Lampignano	Sofia	BH/ABA-Telehealth	INITIAL	12/19/2024
Lane	Michaela	Ancillary	INITIAL	12/19/2024
Langford	Jessica	BH/ABA-Telehealth	INITIAL	12/19/2024
Le	Tiffany	BH/ABA-Telehealth	INITIAL	12/19/2024
Lefevre	Danielle	BH/ABA	INITIAL	12/19/2024
Long	Kristin	BH/ABA	INITIAL	12/19/2024
Magoon	Samantha	BH/ABA-Telehealth	INITIAL	12/19/2024
Malagon	Stephanie	BH/ABA	INITIAL	12/19/2024
Maldonado	Cristal	BH/ABA	INITIAL	12/19/2024
Mann	Pryscilla Lyhn	BH/ABA	INITIAL	12/19/2024
Mason	Katherine	BH/ABA	INITIAL	12/19/2024
Matthews	Pamela	BH/ABA	INITIAL	12/19/2024
Maxwell	Torbertha	Allied Health	INITIAL	12/19/2024
McClure	Kyla	BH/ABA-Telehealth	INITIAL	12/19/2024
McCosker	Madeline	Specialist	INITIAL	12/19/2024
McLawhorn	Donald	BH/ABA-Telehealth	INITIAL	12/19/2024
Michel	Emily	Ancillary	INITIAL	12/19/2024
Molina	Ma Luz Isabel	BH/ABA-Telehealth	INITIAL	12/19/2024
Moore	Gregg	BH/ABA-Telehealth	INITIAL	12/19/2024
Morrison	Chet	Specialist	INITIAL	12/19/2024
Nahebzada	Farishta	Allied Health	INITIAL	12/19/2024
Naranjo	Percy	BH/ABA	INITIAL	12/19/2024
Nguyen	Minhthy	Specialist	INITIAL	12/19/2024
Nunis	Ludecea	BH/ABA	INITIAL	12/19/2024
Nunn	Lolita	BH/ABA-Telehealth	INITIAL	12/19/2024
Olson	Bridget	Ancillary	INITIAL	12/19/2024
Oskouie	Suzanne	Specialist	INITIAL	12/19/2024
Paar	Stacy	Specialist	INITIAL	12/19/2024
Pandes	Mariam	BH/ABA	INITIAL	12/19/2024
Parra	Miriam	Allied Health	INITIAL	12/19/2024
Penny	Clare	BH/ABA-Telehealth	INITIAL	12/19/2024
Perez	Diego	BH/ABA-Telehealth	INITIAL	12/19/2024
Perumal	Cariann	Allied Health	INITIAL	12/19/2024
Petti	Mae	BH/ABA	INITIAL	12/19/2024
Pim	Maryna	BH/ABA-Telehealth	INITIAL	12/19/2024
Plewak	Betty	BH/ABA-Telehealth	INITIAL	12/19/2024
Polidoro	Nicole	Ancillary	INITIAL	12/19/2024
Powell	Ferris	Allied Health	INITIAL	12/19/2024
Powlis	Keita	LCSW SP_CHW	INITIAL	12/19/2024
Raheja	Sonia	BH/ABA-Telehealth	INITIAL	12/19/2024
Raiola	Beth	BH/ABA-Telehealth	INITIAL	12/19/2024
Ramirez	Jacqueline	BH/ABA	INITIAL	12/19/2024
Ramirez	Sandy	Primary Care Physician	INITIAL	12/19/2024
Regan	Maureen	Primary Care Physician	INITIAL	12/19/2024
Reyes	Jacqueline	BH/ABA	INITIAL	12/19/2024
Rodden	Erin	Allied Health	INITIAL	12/19/2024
Rogers	John	BH/ABA-Telehealth	INITIAL	12/19/2024
Rudy	Aaron	BH/ABA	INITIAL	12/19/2024
Sarkar	Ronojoy	BH/ABA-Telehealth	INITIAL	12/19/2024
Schmidt	Allison	Ancillary	INITIAL	12/19/2024
Silva	Carolina	AHP SP_CHW	INITIAL	12/19/2024
Silva	Marissa	Ancillary	INITIAL	12/19/2024
Smith	Emma	Specialist	INITIAL	12/19/2024

Smith	Kathleen	LCSW SP_CHW	INITIAL	12/19/2024
Sonstelie	Marit	Allied Health	INITIAL	12/19/2024
Soto	David	Specialist	INITIAL	12/19/2024
Soto Gonzalez	Pamela	BH/ABA-Telehealth	INITIAL	12/19/2024
Spencer	Marcia	BH/ABA-Telehealth	INITIAL	12/19/2024
Stone	Melinda	BH/ABA-Telehealth	INITIAL	12/19/2024
Sun	Manying	Allied Health	INITIAL	12/19/2024
Sung	Irene	Specialist	INITIAL	12/19/2024
Tafuri	Sydney	BH/ABA-Telehealth	INITIAL	12/19/2024
Tehrani	Fedra	BH/ABA	INITIAL	12/19/2024
Tsai	Jennifer	Primary Care Physician	INITIAL	12/19/2024
Urcia	Charlie Ann	Specialist	INITIAL	12/19/2024
Vanderaa	Victoria	Ancillary	INITIAL	12/19/2024
Vellanki	Hetalben	Allied Health	INITIAL	12/19/2024
Wassel	Andrea	Ancillary	INITIAL	12/19/2024
Wilkinson	Sandra	Allied Health	INITIAL	12/19/2024
Williams	Vashaun	BH/ABA-Telehealth	INITIAL	12/19/2024
Woodcock	Ashley	AHP SP_CHW	INITIAL	12/19/2024
Wyatt	Amber	Ancillary	INITIAL	12/19/2024
Zyss	Joshua	PCP SP_CHW	INITIAL	12/19/2024
Abudayeh	Nabil	Primary Care Physician and Specialist	RE-CRED	12/19/2024
Aoki	Maki	Primary Care Physician	RE-CRED	12/19/2024
Austin	Kristina	Specialist	RE-CRED	12/19/2024
Bhargava	Monica	Specialist	RE-CRED	12/19/2024
Blaauw	Erica	Allied Health	RE-CRED	12/19/2024
Bui	Nhat	Allied Health	RE-CRED	12/19/2024
Cartwright	Wade	Specialist	RE-CRED	12/19/2024
Chan	Eliza	Ancillary	RE-CRED	12/19/2024
Chen	Sophia	Specialist	RE-CRED	12/19/2024
Chiu	Cynthia	Specialist	RE-CRED	12/19/2024
Eile	Susan	Specialist	RE-CRED	12/19/2024
Ferguson	Jennifer	Allied Health	RE-CRED	12/19/2024
Gupta	Sachin	Specialist	RE-CRED	12/19/2024
Helmand	Huma	Allied Health	RE-CRED	12/19/2024
Jones	Anthony	Specialist	RE-CRED	12/19/2024
Kilaru	Prasad	Specialist	RE-CRED	12/19/2024
Korah	Mariam	Specialist	RE-CRED	12/19/2024
Lash	Bhrett	Primary Care Physician	RE-CRED	12/19/2024
Melkumyan	Dalila	Allied Health	RE-CRED	12/19/2024
Mulder	Hannah	Allied Health	RE-CRED	12/19/2024
Naderi	Tahereh	Primary Care Physician	RE-CRED	12/19/2024
Neuwelt	Clark	Specialist	RE-CRED	12/19/2024
Pasricha	Malini	Specialist	RE-CRED	12/19/2024
Samiaei	Nadieh	Allied Health	RE-CRED	12/19/2024
Sethi	Saurabh	Specialist	RE-CRED	12/19/2024
Shihabi	Nader	Specialist	RE-CRED	12/19/2024
Stine	Shelene	Primary Care Physician	RE-CRED	12/19/2024
Wong	Bryan	Specialist	RE-CRED	12/19/2024
Woo	Renee	Specialist	RE-CRED	12/19/2024
Yan	Qingwei	Specialist	RE-CRED	12/19/2024

DECEMBER PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	4
SPECIALIST	15
ANCILLARY	23
ALLIED	16
BH/ABA	77
TOTAL	135

Provider Dispute Resolution
November 2024 and December 2024

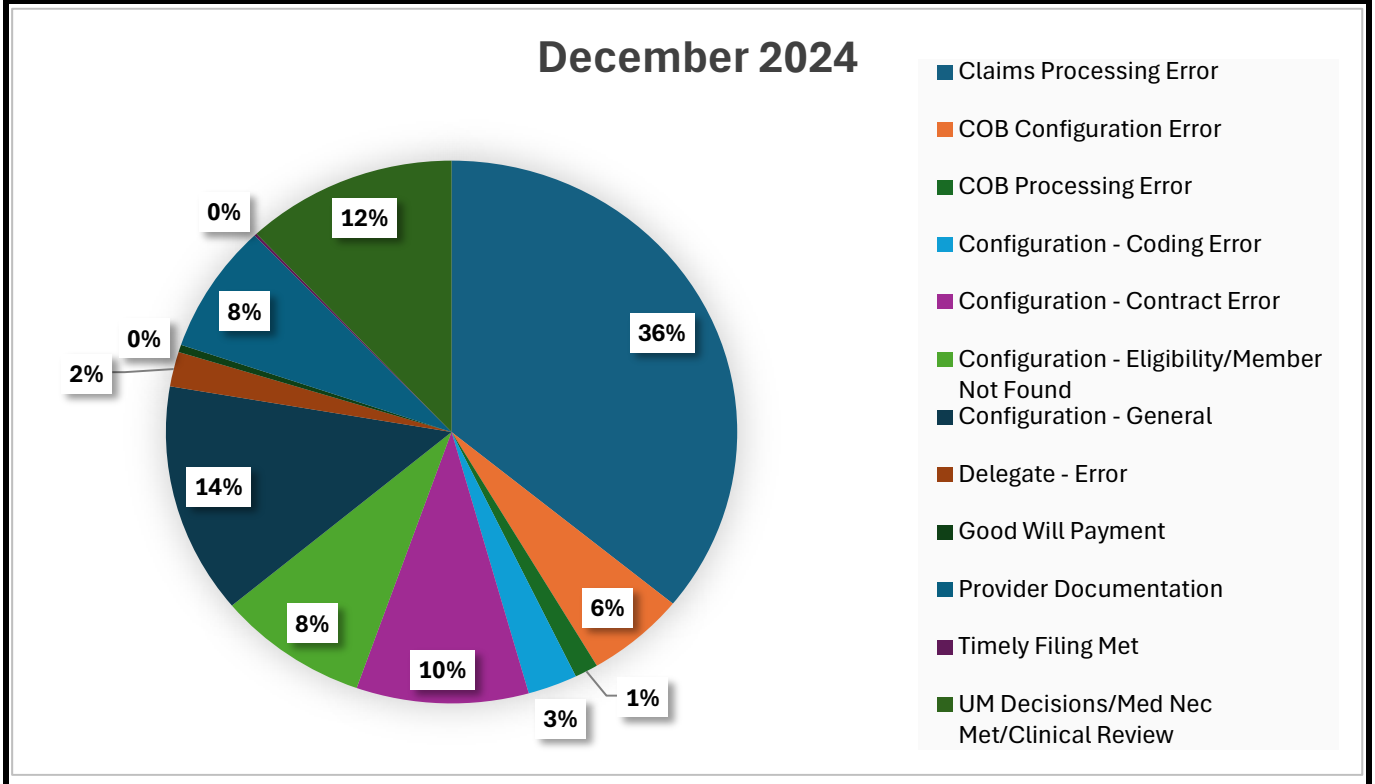
METRICS

PDR Compliance	Nov-24	Dec-25
# of PDRs Resolved	1,935	2,185
# Resolved Within 45 Working Days	1,932	2,182
% of PDRs Resolved Within 45 Working Days	99.8%	99.9%
PDRs Received	**Nov-24**	**Dec-25**
# of PDRs Received	2,568	3,173
PDR Volume Total	**2,568**	**3,173**
PDRs Resolved	**Nov-24**	**Dec-25**
# of PDRs Upheld	1323	1508
% of PDRs Upheld	68%	69%
# of PDRs Overturned	612	677
% of PDRs Overturned	32%	31%
Total # of PDRs Resolved	**1,935**	**2,185**
Average Turnaround Time	**Nov-24**	**Dec-25**
Average # of Days to Resolve PDRs	42	42
Oldest Resolved PDR in Days	118	167
Unresolved PDR Age	**Nov-24**	**Dec-25**
0-45 Working Days	4,368	3,961
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**4,368**	**3,961**

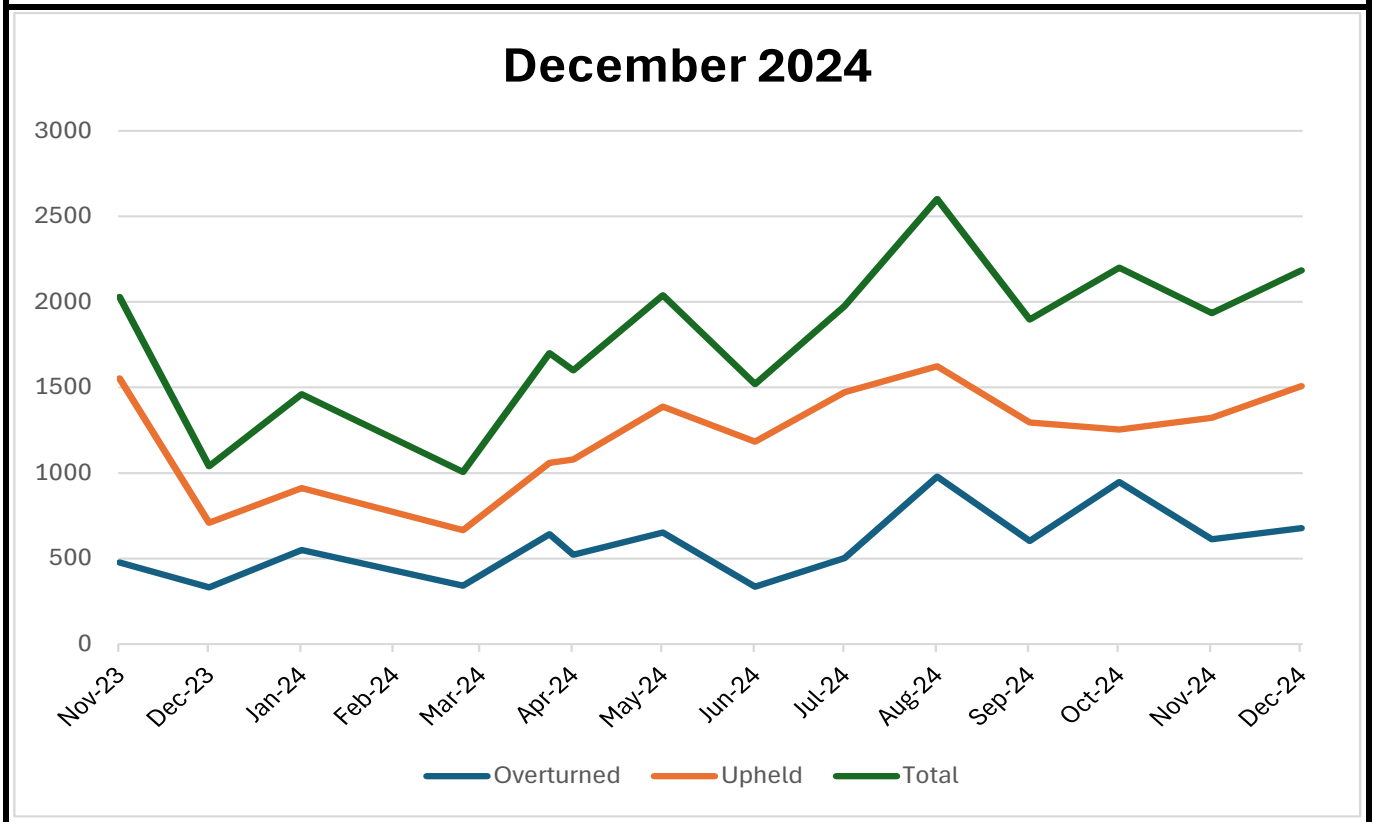
Provider Dispute Resolution
November 2024 and December 2024

Dec-24

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Resolved - 2,185 in December 2024 vs 1,040 in December 2023	N/A	N/A
# of PDRs Received - 3,173 in December 2024 vs 1,642 in December 2023	N/A	N/A
# of PDRs Resolved within 45 working days - 2,182 in December 2024 vs 1,040 in December 2023	N/A	N/A
% of PDRs Resolved within 45 working days - 99.8% in December 2024 vs 100% in December 2023	95%	95%
Average # of Days to Resolve PDRs - 42 days in December 2024 vs 41 days in December 2023	N/A	30
Oldest Resolved PDR in Days - 167 days in December 2024 vs 45 days December 2023	N/A	N/A
# of PDRs Upheld - 1,508 in December 2024 vs 709 in December 2023	N/A	N/A
% of PDRs Upheld - 69% in December 2024 vs 68% in December 2023	N/A	> 75%
# of PDRs Overturned - 677 in December 2024 vs 331 in December 2023	N/A	N/A
% of PDRs Overturned - 31% in December 2024 vs 32% in December 2023	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 37% (2024) vs 29% (2023) Configuration errors 35% (2024) vs 42% (2023) COB 7% (2024) vs 18% (2023) Clinical Review/UM Decisions/Medical Necessity Met -12% (2024) vs 9% (2023)	N/A	N/A

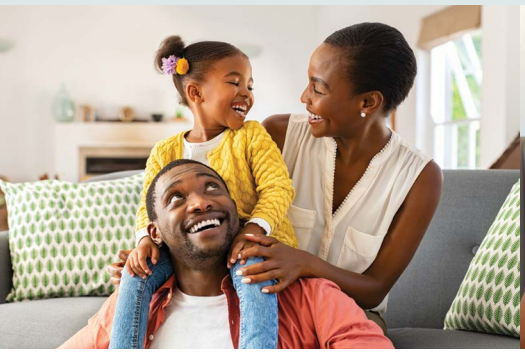
MEMBER CONNECT

Spring/Summer 2024

ALAMEDA Alliance FOR HEALTH

we are ALAMEDA COUNTY

Helping People in Our Community Since 1996



PROVIDER SPOTLIGHT: EMPOWERING MENTAL HEALTH CARE IN LOCAL COMMUNITIES

– SUNGILA BLACK CALF'S STORY

Sungila Black Calf, LCSW (licensed clinical social worker), is a proud supporter of the Native American community in the Bay Area. Sungila is a behavioral health clinician at the Native American Health Center (NAHC) in Oakland. Sungila provides mental health care services to people at different stages of their lives.

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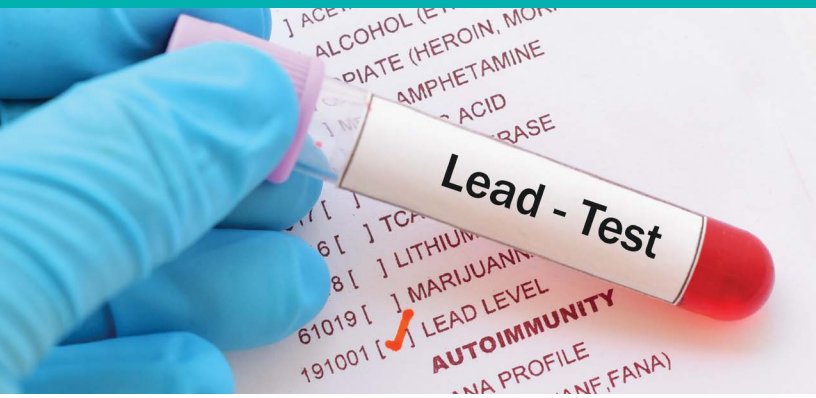
LEAD POISONING: A HIDDEN DANGER



Do you know where lead poison lurks? Though not as common today, lead is still around. Children have the highest risk of lead poisoning. That's because kids touch lots of objects then put their hands in their mouths. Lead can cause illness, growth delays, and even death.

Lead was commonly found in house paint. It can still be found in homes built before 1978. Lead paint chips and dust can be dangerous. Lead can also be found in old toys and some toys made in other countries. It can get into the soil near homes and highways and is found in older pipes and faucets. Even some children's art supplies may contain lead.

Children should be tested for lead when they are 12 and 24 months old. The doctor may decide if there is a need for more or fewer screenings. If you think your child could have been exposed to lead, ask the doctor for a simple blood test. Lead poisoning can be treated if caught early enough.

If you need help finding a doctor, please call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

Are you worried about lead in your home?

Call the Alameda County Healthy Homes project for a home visit at no cost at **1.510.567.8280**.

Article adapted from the American Academy of Pediatrics (AAP): **Lead Exposure: Steps to Protect Your Family – HealthyChildren.org**

PROVIDER SPOTLIGHT: EMPOWERING MENTAL HEALTH CARE IN LOCAL COMMUNITIES – SUNGILA BLACK CALF'S STORY

(CONTINUED FROM PAGE 1)

Do you want to learn more about Sungila? Please visit our website to watch a short video at **www.alamedaalliance.org**.

You can also connect with us on Facebook, Instagram, or X (formerly known as Twitter) to access the video.

Born to a Diné mother and Sicangu Lakota father, Sungila was born in Pine Ridge, South Dakota. Her clans are Honághááhnii (Walks About) and Nakai dine'é (Mexican Clan). She grew up in Arizona living on the Navajo Reservation and in surrounding communities.

The Native American community, history, and social justice movements in the Bay Area drew Sungila to Oakland, California, where she attended Mills College and earned a Bachelor of Arts in ethnic studies and sociology.

Sungila first began working at NAHC in 2011 as an Intake Worker after college. The community embraced her and she was inspired to continue her education. She added to her achievements by earning her Master of Social Welfare, with a focus in Community Mental Health from University of California, Berkeley, School of Social Welfare in 2017. After a few years as a clinician, Sungila happily returned to NAHC in 2022.

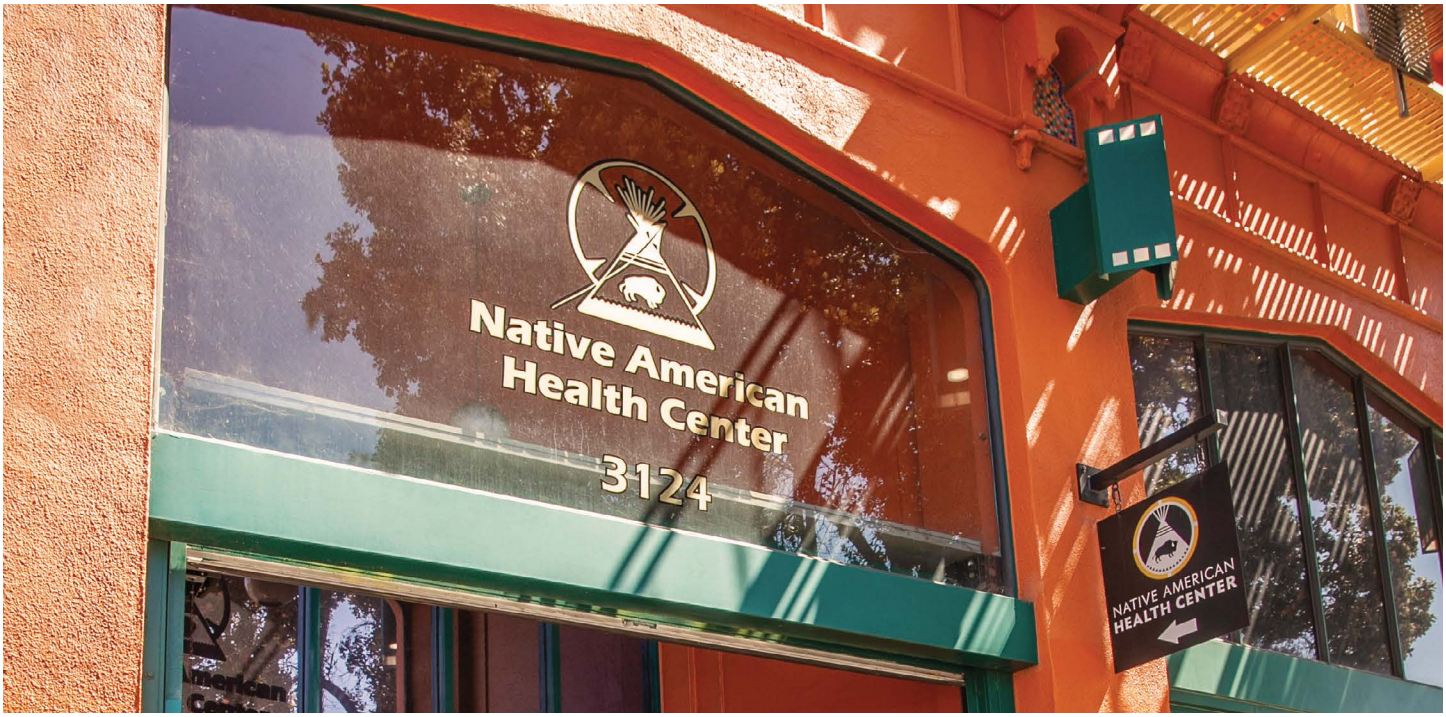
For Sungila, working with the Alliance is a way for NAHC patients to access services that are culturally relevant. Sungila is grateful that community members can receive the behavioral health and other medical care they need from NAHC. She encourages patients to learn about the benefits and services available to them. Talking with members about their medical needs and offering referrals are two (2) of the many ways that Sungila provides support.

The Alliance is honored to have Sungila as a provider. Her passion for behavioral health care and providing services and support are important to the Alliance, our members, provider partners, and the community.

We look forward to continuing our partnership with Sungila and NAHC.

PROVIDER SPOTLIGHT: EMPOWERING MENTAL HEALTH CARE IN LOCAL COMMUNITIES – SUNGILA BLACK CALF'S STORY

(CONTINUED FROM PAGE 4)



Alliance members can choose Native American Health Center as their clinic by calling:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567** • Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

NATIVE AMERICAN HEALTH CENTER CLINICS

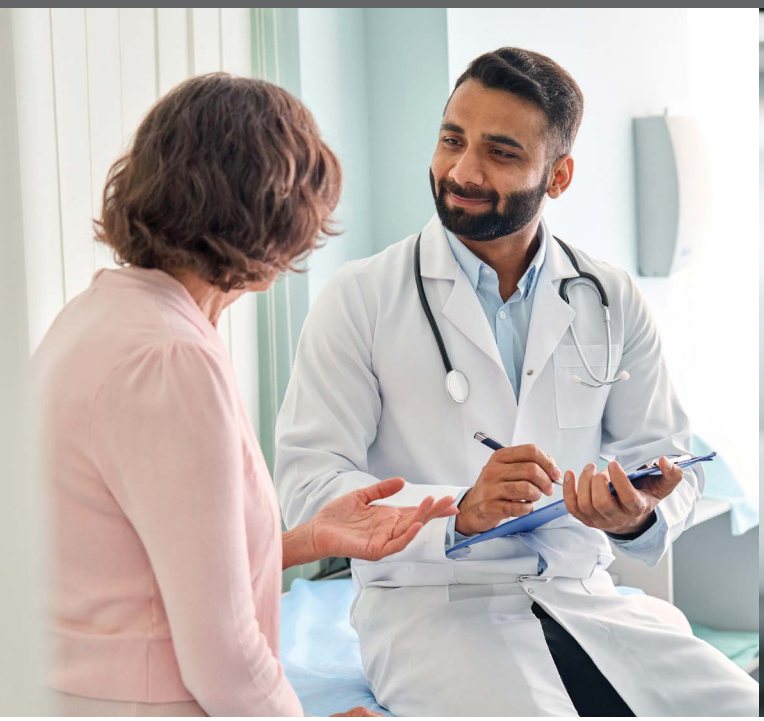
7 Generations
2920 International Blvd.
Oakland, CA 94601
Monday – Friday, 8:30 am – 5 pm
Phone Number: **1.510.485.5901**

7 Directions
2950 International Blvd.
Oakland, CA 94601
Monday – Friday, 8:30 am – 5 pm
[and second (2nd) and fourth (4th) Saturdays of each month]
Phone Numbers:
Medical: **1.510.535.4410**
Dental: **1.510.535.4450**

American Indian Human Services
3124 International Blvd.
Oakland, CA 94601
Monday – Friday, 8:30 am – 5 pm
Phone Number: **1.510.535.4400**

Native American Health Center offers services throughout the Bay Area. For more information and locations, please visit **nativehealth.org**.

THE ALLIANCE IS ONE (1) OF THE HIGHEST-RATED MEDI-CAL HEALTH PLANS IN THE STATE



The Alliance is a top-rated California Medi-Cal managed care plan for 2023.

The Alliance is a local health plan that serves more than 400,000 Alameda County residents. In 2023, the Alliance was rated a top health plan in the state of California. The Alliance is the only Medi-Cal health plan in Alameda County to receive a rating of four (4) out of five (5) in the National Committee for Quality Assurance's (NCQA) 2023 Medicaid Health Plan Ratings. No other Medi-Cal (California's Medicaid benefits program) health plan in the state earned a rating higher than four (4) out of five (5) stars.

NCQA's Health Plan Ratings are scored on a one (1)- to five (5)- star scale and use three (3) quality measures. This includes patient experience – such as encounters with doctors, plan services, and customer service. Additionally, plans are rated on clinical measures. This refers to the number of members who received preventive services. The third is the number of members who received care for certain health conditions.

"We know that patient experience and access to preventive services are associated with better health outcomes," said Matthew Woodruff, Alliance CEO. "That is why we are proud to have achieved a four (4) out of five (5) stars in NCQA's 2023 Medicaid Health Plan Ratings. This achievement could not be reached without the dedication and hard work of our provider partners, care teams, and customer service department."

The Alliance would like to thank its member engagement and programs, community providers, and customer service efforts for this success.

THE ALLIANCE IS ONE (1) OF THE HIGHEST-RATED MEDI-CAL HEALTH PLANS IN THE STATE

(CONTINUED FROM PAGE 6)

ALLIANCE LANGUAGE ASSISTANCE SERVICES

The Alliance works hard to help make sure that all of our members can talk to their providers and with us about their health care. We provide over-the-phone, in-person, and video remote interpreter services. We also provide translations and alternative formats of written member information, all at no cost to you and your Authorized Representative.

Alliance members can request:

- A trained and qualified American Sign Language (ASL) interpreter.
- A trained and qualified foreign language interpreter.
- Alliance-written information in formats such as braille, large print, audio CD, or data CD.
- Alliance-written information in a language that members can understand.

Over-the-phone interpreter services are available to you, 24 hours a day, 7 days a week for your health care visits. For American Sign Language (ASL), or highly sensitive or complex health care visits, your doctor can request an in-person interpreter at no cost to you. You should not have to use family or friends. If you would like an interpreter, let your doctor's office know which language you need when you call to make an appointment.

To learn more about interpreter services, please call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
(for after hours, select your language then option "1")
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY):
711/1.800.735.2929

CANCER SCREENING TESTS FOR YOUR HEALTH

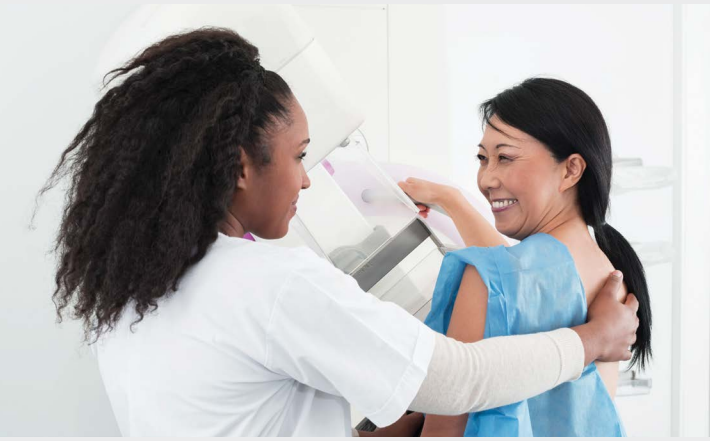
Being healthy includes understanding your risk of getting cancer. One way to learn about your risk is to have regular cancer screening tests. Screening means checking your body for cancer before you have symptoms. Getting screening tests regularly may find breast, cervical, and colorectal (colon) cancers early, when treatment is likely to work best.

Here are some important screening tests to know about:

MAMMOGRAM

Doctors use mammograms to check for breast cancer. Mammograms use low-dose X-rays to create pictures of the inside of your breasts. Women, and those with breasts, ages 50 to 74 should get a mammogram every other year.

Some people may be at a higher risk of developing breast cancer. Talk with your doctor about your risk level, when to start, and how often to get screened.



PAP AND HPV TESTS

Cervical cancer screening is for those between the ages of 21 and 65. Cervical cancer occurs in the cervix, the lower part of the uterus (womb).

Cervical cancer screenings include:

- The Pap test (or Pap smear) looks for cell changes on the cervix that might become cervical cancer if they are not treated.
- The human papillomavirus (HPV) test looks for the virus that can cause cells to change.

Talk to your doctor about which testing option is right for you. Some tests are only needed every three (3)- to five (5) years depending on your age.

CANCER SCREENING TESTS FOR YOUR HEALTH
(CONTINUED FROM PAGE 8)

COLORECTAL (COLON) CANCER SCREENING TESTS

This screening looks for signs of cancer in your colon and other parts of your digestive system. There are different screening options based on your risk level and preference. Some tests involve going to a doctor's office, and some can be done from the comfort of your home by sending a stool sample to a lab.

45

All adults should begin screening at age 45.

Call your doctor today to schedule a visit or to ask more questions about the screening process.

If you need help finding a doctor, please call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

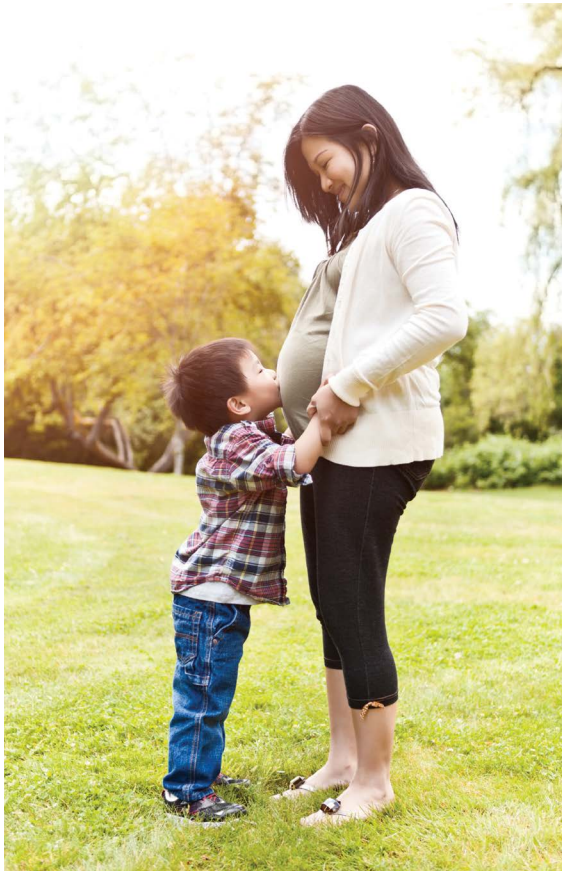
DOULA SERVICES

Alameda Alliance for Health (Alliance) provides doula services to its members. Doulas are birth workers who are trained in labor and childbirth support. They provide physical, emotional, and non-medical support for pregnant and postpartum people. This includes the time before, during, and after childbirth.

BENEFITS

Studies have shown that persons who work with a doula:

- Have better birth outcomes
- Are less likely to have a low-birthweight baby
- Reduce the risk of a birth problem (complication)
- Are more likely to breastfeed



SERVICES

If you are pregnant, or were pregnant in the last year, you can receive doula services. This includes members who may have had an abortion, a miscarriage, or stillbirth.

Services offered by doulas include:

- Birth planning
- Emotional, physical, and non-medical support
- Health education
- Help to access care
- Lactation support (breastfeeding help)
- Link to community-based resources

PLEASE NOTE: Services can be provided online or in person.

Connect with a doula today to learn more about prenatal and postpartum visits.

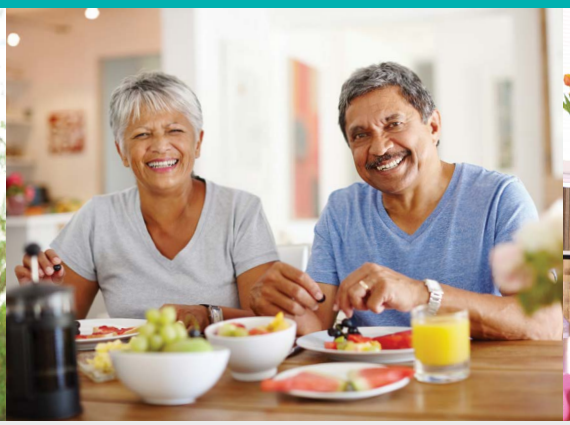
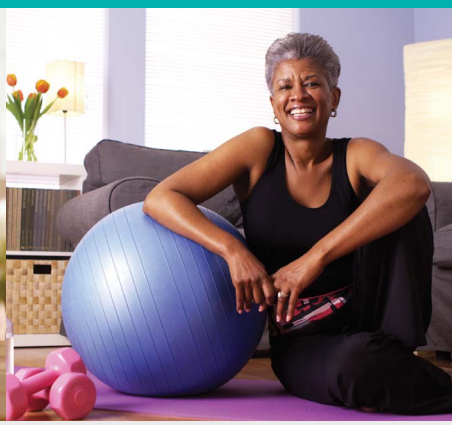
To connect with a doula, members can:

- Search the Alliance Provider Directory at **www.alamedaalliance.org/help/find-a-doctor** and contact a doula directly.
- Call:

  Alliance Member Services Department
  Monday – Friday, 8 am – 5 pm
  Phone Number: **1.510.747.4567**
  Toll-Free: **1.877.932.2738**
  People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

Source:
1. www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-024.pdf
2. www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/

PREVENT TYPE 2 DIABETES

More than one (1) out of three (3) American adults are at risk for getting diabetes. Having diabetes means your blood sugar (glucose) level is too high. Having high blood sugar levels raises your risk for type 2 diabetes, heart disease, and stroke.

You can prevent type 2 diabetes through:

- **Weight loss.** Start making small changes to your eating and exercise habits. Even a small amount of weight loss can delay or prevent type 2 diabetes.
- **Eating healthy.** Choose vegetables, fruits, whole grains, and lean proteins. Limit processed foods high in sugar, fat, and salt.
- **Getting active.** Aim for 30 minutes of physical activity most days of the week. Limit the amount of time you spend sitting.
- **Quitting smoking.** Smoking can increase your risk for diabetes. If you already smoke, try to quit. You can work with your doctor to create a quit plan or call Kick It California (formerly California Smokers' Helpline) toll-free at **1.800.300.8086**.

Ask your doctor about what other changes you can make to prevent or delay diabetes.

The Alliance has partnered with HabitNu and Yumlish to offer the Diabetes Prevention Program (DPP). DPP is a year-long lifestyle change program that can help you adopt healthy habits, lose weight, and reduce your risk of type 2 diabetes.

Take a one (1)-minute quiz and see if this program is right for you.

To learn more about the DPP program please contact:

Alliance Member Services Department Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**
www.alamedaalliance.org/live-healthy/dpp

Source:
medlineplus.gov/howtopreventdiabetes.html
www.cdc.gov/diabetes/basics/diabetes.html

PROTECT KIDS FROM SMOKING'S HARM

You've heard it before, smoking is harmful. But did you know the smoke from cigarettes and vapes harms the health of the smoker and the people around them? Tobacco smoke hurts babies, kids, pregnant people, and even your pets. Smoke hurts babies and kids more than adults because their bodies are small and still growing. It also harms a baby's development before they are born.

You can keep yourself and your family safe from tobacco and vape smoke by:

- **Keeping your home and car smoke-free** (including vape smoke). Do not allow anyone to smoke in or near your home.
- **Reducing your own tobacco use or quitting smoking.** Talk to your doctor about making a plan and medicines that can help you quit.
- **Talking to kids about tobacco use early to help them understand the harm.** Teach your children to stay away from secondhand smoke.

HELP TO QUIT SMOKING

Looking for help to stop smoking? ***Kick It California*** can help you quit.

Call them toll-free at **1.800.300.8086** (interpreter offered). Visit their website at kickitca.org (English, Spanish, Chinese, Korean, Vietnamese).

Find more resources on the "Quit Smoking" page at **www.alamedaalliance.org/live-healthy-library**. You can also send us a Wellness Programs & Materials Request Form found on page **20**, or call Alliance Health Programs at **1.510.747.4577**.

Article adapted from the American Academy of Pediatrics (AAP):
Protecting Kids From Tobacco's Harms: AAP Policy Explained – HealthyChildren.org

WHAT IS HEPATITIS

Hepatitis means inflammation (swelling) of the liver. The liver helps to process nutrients, filter to clean the blood, and fight infections. When the liver is swollen or damaged, it does not work as well as it can.

WHAT CAUSES HEPATITIS?

Heavy alcohol use, toxins, and some medications and medical conditions can cause hepatitis. However, hepatitis is often caused by a virus. In the United States, some of the most common hepatitis viruses are hepatitis B (or hep B) and hepatitis C (or hep C).

WHAT IS HEPATITIS B AND HEPATITIS C?

Hepatitis B (hep B) and hepatitis C (hep C) are liver infections that affect millions of people across the world. They are caused by the hep B virus (HBV) or hep C virus (HCV). The Centers of Disease Control and Prevention (CDC) recommends adults 18 years of age and older to be screened for hep B and hep C at least once. These infections can lead to serious health issues if left untreated.

HOW DOES HEPATITIS B AND HEPATITIS C SPREAD?

- Blood transfusions
- Childbirth
- Healthcare exposures
- Organ transplants
- Sexual contact
- Sharing drug-injection equipment like needles
- Sharing personal items (razors, toothbrushes)
- Unregulated tattoos or piercings

COMMON SYMPTOMS

People with hep B show no symptoms. It is why hep B has been called the "silent killer."

People with hep C rarely show symptoms and can take from two (2) weeks to six (6) months to show up. Hep C symptoms may include yellow skin or eyes, low appetite, throwing up, stomach pain, fever, dark-colored urine, light-colored stool, joint pain, and feeling tired.

WHAT IS HEPATITIS
(CONTINUED FROM PAGE 13)

HOW DO I KNOW IF I HAVE HEPATITIS B OR C?

Getting tested is the only way to know if you have hep B or hep C.
A blood antibody test can tell if you have ever been infected with the virus.

I HAVE HEP B OR HEP C. NOW WHAT?

Your doctor will decide on the treatment that's right for you. They may prescribe an antiviral medication (pill) to fight the infection.

The following medications are recommended for the treatment of hep B:

1. Baraclude (entecavir)
2. Vemlidy (tenofovir alafenamide fumarate)
3. Viread (tenofovir disoproxil fumarate)

The following medications are recommended for the treatment of hep C:

1. Mavyret (glecaprevir/pibrentasvir)
2. Sofosbuvir/Velpatasvir (generic Epclusa)
3. Ledipasvir/Sofosbuvir (generic Harvoni)

HOW DOES ANTIVIRAL TREATMENT HELP?

Antiviral treatment can reduce the amount of HBV or HCV in your body. It also lowers the risk of liver problems, such as cirrhosis (liver scarring), liver failure, and liver cancer. Hep C can be cured in 8 to 12 weeks.

WHEN TO CONTACT YOUR HEALTHCARE PROVIDER

If you are showing any symptoms or think you may have hep B or hep C, please contact your doctor. If you ever experience any side effects from any medication or treatment including medication from hep B or hep C contact your doctor.

If you ever need any help with coordinating your care, please call the Alameda Alliance for Health (Alliance) Case and Disease Management (CMDM) Department toll-free at **1.877.251.9612** or email **DeptCMDM@alamedaalliance.org**.

Source:
www.cdc.gov/hepatitis
hepB.com

IMPORTANT PHONE NUMBERS

Service	Contact Number
Emergency	**911**
Poison Control	**1.800.222.1222**
Alameda County Social Services Medi-Cal Center	**1.800.698.1118** or **1.510.777.2300**
Medi-Cal Plan Enrollment/Changes	**1.800.430.4263**

ALAMEDA ALLIANCE FOR HEALTH (ALLIANCE)

Main Line	**1.510.747.4500**
Member Services Department Monday – Friday, 8 am – 5 pm	**1.510.747.4567**
Toll-Free	**1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY)	**711/1.800.735.2929**

CARE SERVICES

Behavioral Health Care Services	
Alameda Alliance for Health	**1.855.856.0577**
Alameda County Behavioral Health Care Services (ACCESS)	**1.800.491.9099**
Dental Care Services	
Medi-Cal Members: Medi-Cal Dental	**1.800.322.6384**
Group Care Members: Please call Public Authority for In-Home Supportive Services (IHSS)	**1.510.577.3552**
Vision Care Services	
Medi-Cal Members: MARCH Vision Care	**1.844.336.2724**
Group Care Members: Please call Public Authority for In-Home Supportive Services (IHSS)	**1.510.577.3552**
Nurse Advice Line	
Medi-Cal Members	**1.888.433.1876**
Group Care Members	**1.855.383.7873**

KEEP IN TOUCH WITH US AND JOIN THE CONVERSATION!

facebook.com/alamedaallianceforhealth

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@alamedaallianceforhealth

@alameda-alliance-for-health

@alamedaalliance

NOTICE OF NONDISCRIMINATION

Alameda Alliance for Health (Alliance) complies with all applicable state and federal civil rights laws and does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

LANGUAGE ASSISTANCE SERVICES

English Tagline
ATTENTION: If you need help in your language call **1.877.932.2738** (TTY: **1.800.735.2929**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1.877.932.2738** (TTY: **1.800.735.2929**). These services are at no cost.

الشعار بالعربية (Arabic)
يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ **1.877.932.2738** (TTY: **1.800.735.2929**). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ **1.877.932.2738** (TTY: **1.800.735.2929**). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1.877.932.2738** (TTY: **1.800.735.2929**): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1.877.932.2738** (TTY: **1.800.735.2929**): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)
ចំណាំ៖ បើអ្នក តម្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ **1.877.932.2738** (TTY: **1.800.735.2929**)។ ជំនួយ និងសេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជូនអ្នក សរសេរ សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **1.877.932.2738** (TTY: **1.800.735.2929**)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Simplified Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 **1.877.932.2738** (TTY: **1.800.735.2929**)。我们另外还提供针对残疾人士的帮助和服务，例如盲文和大字体阅读，提供您方便取用。请致电 **1.877.932.2738** (TTY: **1.800.735.2929**)。这些服务都是免费的。

简体中文标语 (Traditional Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 **1.877.932.2738** (TTY: **1.800.735.2929**)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 **1.877.932.2738** (TTY: **1.800.735.2929**)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)
توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با **1.877.932.2738** (TTY: **1.800.735.2929**) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **1.877.932.2738** (TTY: **1.800.735.2929**) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **1.877.932.2738** (TTY: **1.800.735.2929**) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **1.877.932.2738** (TTY: **1.800.735.2929**) पर कॉल करें। ये सेवाएं निःशुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1.877.932.2738** (TTY: **1.800.735.2929**). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1.877.932.2738** (TTY: **1.800.735.2929**). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)
注意日本語での対応が必要な場合は **1.877.932.2738** (TTY: **1.800.735.2929**)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。**1.877.932.2738** (TTY: **1.800.735.2929**)へお電話ください。これらのサービスは無料で提供しています。

NOTICE OF NONDISCRIMINATION

(CONTINUED FROM PAGE 16)

한국어 태그라인 **(Korean)**
유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1.877.932.2738** (TTY: **1.800.735.2929**) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1.877.932.2738 (TTY: **1.800.735.2929**) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)
ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ **1.877.932.2738** (TTY: **1.800.735.2929**). ຍັງມີຄວາມຊ່ວຍເຫຼືອ ແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ **1.877.932.2738** (TTY: **1.800.735.2929**). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux **1.877.932.2738** (TTY: **1.800.735.2929**). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx **1.877.932.2738** (TTY: **1.800.735.2929**). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)
ਧਿਆਨ ਦਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **1.877.932.2738** (TTY: **1.800.735.2929**). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ **1.877.932.2738** (TTY: **1.800.735.2929**). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский слоган (Russian)
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1.877.932.2738** (линия TTY: **1.800.735.2929**). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1.877.932.2738** (линия TTY: **1.800.735.2929**). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al **1.877.932.2738** (TTY: **1.800.735.2929**). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1.877.932.2738** (TTY: **1.800.735.2929**). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1.877.932.2738** (TTY: **1.800.735.2929**). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1.877.932.2738** (TTY: **1.800.735.2929**). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1.877.932.2738** (TTY: **1.800.735.2929**) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1.877.932.2738** (TTY: **1.800.735.2929**) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1.877.932.2738** (TTY: **1.800.735.2929**). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер **1.877.932.2738** (TTY: **1.800.735.2929**). Ці послуги безкоштовні.

Khẩu Hiệu Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1.877.932.2738** (TTY: **1.800.735.2929**). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **1.877.932.2738** (TTY: **1.800.735.2929**). Các dịch vụ này đều miễn phí.

ADDRESS AND PHONE NUMBER CHANGES

If you move or get a new phone number, please let us know by calling the Alliance Member Services Department at **1.510.747.4567**.

PROGRAM AND MATERIALS AT NO COST

Would you like to get more resources or learn more about classes and programs? Just fill out the **Alliance Wellness Programs & Materials Request Form** on page **20**, check the programs or materials that you want, and send it to us. Programs and materials are at no cost to you as our Alliance member. To learn more, please call the Alliance Member Services Department at **1.510.747.4567** or visit **www.alamedaalliance.org/live-healthy**.

LANGUAGE SERVICES AT NO COST

We offer our Alliance members interpreters for health care visits and health plan calls. We provide documents in their language or other formats such as Braille, audio, or large print. For help with your language needs, please call the Alliance Member Services Department at **1.510.747.4567**.

QUALITY IMPROVEMENT PROGRAM

The Alliance Quality Improvement (QI) program helps improve care for our members. We look to see if you are getting regular exams, screenings, and tests that you need. We also find out if you are happy with the care you get from our providers and the services we provide to you. Each year, we set goals to improve the care our members receive. The goals address care and service. We look yearly to see if we meet our goals.

To learn more about our QI program goals, progress, and results, please visit **www.alamedaalliance.org/members**.

If you would like a paper copy of the QI program, please call the Alliance Member Services Department at **1.510.747.4567**.

Alameda Alliance for Health

Wellness Programs & Materials

Member Request Form – Alameda Alliance for Health (Alliance) provides health education at no cost. We want you to take charge of your health by having the best information possible. Please select the topics that you want us to send you. You can also request the handouts in other formats. Many handouts can be found at **www.alamedaalliance.org**.

CLASSES & PROGRAM REFERRALS

- ☐ Asthma
- ☐ Breastfeeding Support
- ☐ CPR/First Aid
- ☐ Diabetes
- ☐ Diabetes Prevention Program *(prediabetes)*
- ☐ Healthy Eating, Exercise, and Weight
- ☐ Heart Health
- ☐ Parenting
- ☐ Pregnancy and Childbirth
- ☐ Quit Smoking
  (please have Kick It California call me)

MEDICAL ID

Choose one: ☐ Bracelet ☐ Necklace

- ☐ Asthma
  - ☐ Child ☐ Adult
- ☐ Diabetes
  - ☐ Child ☐ Adult

WRITTEN MATERIALS

- ☐ Advance Directive *(medical power of attorney)*
- ☐ Alcohol and Other Substance Use
- ☐ Asthma
- ☐ Back Pain
- ☐ Birth Control
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Diabetes
- ☐ Domestic Violence
- ☐ Healthy Eating, Exercise, and Weight
  - ☐ Child ☐ Adult
- ☐ Heart Health
- ☐ Parenting
- ☐ Pregnancy
- ☐ Preventive Care
- ☐ Quit Smoking
- ☐ Safety
  - ☐ Child ☐ Adult
- ☐ Sexual Health
- ☐ Stress and Depression
  - ☐ Child ☐ Adult

Name (self): _____

Alliance Member ID Number: _____

Child's Name (if applies): _____

Child's Member ID Number: _____

Age of Child: _____

Address: _____

City: _____ Zip Code: _____

Written Language: _____

Spoken Language: _____

The requested materials will be mailed to you. How may the Alliance contact you?
Please check all that apply:

- ☐ Phone: _____
- ☐ Email: _____
- ☐ Text: _____

ALAMEDA Alliance FOR HEALTH

To order, please complete this form on the member portal at www.alamedaalliance.org or mail this form to:

Alliance Health Programs • 1240 South Loop Road, Alameda, CA 94502

Phone Number: **1.510.747.4577** • **Toll-Free: 1.855.891.9169**

People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

HE_MBRS_WELLNESS REQ FORM 10/2023
HED W-1 08/2023

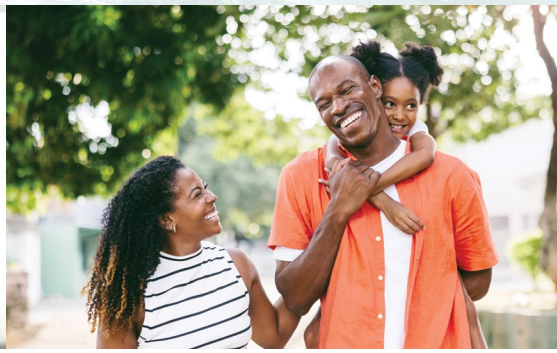
MEMBER CONNECT

Fall/Winter 2024

ALAMEDA Alliance FOR HEALTH

we are ALAMEDA COUNTY

Helping People in Our Community Since 1996



THE ALLIANCE ANNOUNCES NEW CHIEF MEDICAL OFFICER, DR. DONNA WHITE CAREY

Dr. Donna White Carey has been a partner with the Alameda Alliance for Health (Alliance) for many years. As an experienced healthcare leader and serving as the interim Chief Medical Officer (CMO) since February 2024, Dr. Carey was selected for the permanent CMO position at Alliance. The Alliance is the number one local health plan in Alameda and serves one (1) out of every four (4) Alameda County residents.

In her role as CMO, Dr. Carey will be responsible for creating programs to improve the quality of care and health outcomes for Alliance members. She will lead all areas of clinical operations, including case and disease management, utilization management, pharmacy, quality improvement, health education, and behavioral health.

(Continued on page 2)

www.alamedaalliance.org

PO Box 3789
San Leandro, California 94578

Alliance FOR HEALTH ALAMEDA

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US POSTAGE
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Alliance for Health

THE ALLIANCE ANNOUNCES NEW CHIEF MEDICAL OFFICER (CMO) DR. DONNA WHITE CAREY

(CONTINUED FROM PAGE 1)

"Dr. Carey is a dedicated healthcare leader who cares deeply about addressing inequities that shape health care outcomes," said Matthew Woodruff, Alliance Chief Executive Officer. "Her background as a physician coupled with her passion to achieve health equity will help us fulfill our mission and reinforce the work that we do every day to serve our community."

"I am thrilled for the opportunity to lead and support the Alliance's Health Care Services Department as we find meaningful ways to improve the health and well-being of our members and the communities we serve," said Dr. Carey, Alliance CMO.

Dr. Carey brings over two decades of experience in clinical medicine and hospital administrative roles. She served as the first African American Chief of the Division of Pediatrics and later became the inaugural Chair of the Department of Pediatrics at Alameda Health System. Dr. Carey is a past President of Sinkler Miller Medical Association and has served on numerous Boards, including her current service on the Board of Samuel Merritt University's Ethnic Health Institute.

Additionally, Dr. Carey is a leader in the faith community who spearheaded her church's – True Vine Ministries – COVID-19 response efforts during the pandemic, organizing vaccination clinics that served over 7,000 people and forming contact tracing and health education teams in collaboration with the Alameda County Public Health Department and Lifelong Medical Clinics.

TABLE OF CONTENTS

ALLIANCE 2024-2025 HOLIDAY CALENDAR

The Alliance office will be closed in observance of the following holidays:

2025

New Year's Day
Wednesday, January 1st

Martin Luther King Jr. Day
Monday, January 20th

Presidents' Day
Monday, February 17th

Cesar Chavez Day
Monday, March 31st

Memorial Day
Monday, May 26th

Juneteenth Holiday
Thursday, June 19th

Independence Day
Friday, July 4th

Labor Day
Monday, September 1st

Veterans Day
Tuesday, November 11th

Thanksgiving Day
Thursday, November 27th

Day After Thanksgiving
Friday, November 28th

Floating Holiday (Christmas Eve)
Wednesday, December 24th

Christmas Day
Thursday, December 25th

STAY HEALTHY – LET'S CHECK IN FOR CHECK-UPS

We're here to help you make every step in life a healthy one.
These are the doctor-recommended well-child check-up visits from 0 to 30 months of age. After this, everyone should have a wellness check-up visit every year.

WELL-CHILD AND YEARLY VISITS ARE NO COST FOR ALLIANCE MEMBERS.

Please call or talk to your doctor today to schedule your visits. If you are an Alliance member and you need help finding a doctor, an interpreter, or a ride to any of your visits, please go to our website for more information **www.alamedaalliance.org** or scan the QR code.

STAY HEALTHY – GET YOUR FLU SHOT TODAY

We are here to help you stay healthy, and protect yourself, your family, and our community from the flu and COVID-19.

We are sharing this important reminder to get your flu shot. It will help you stay healthy, safe, and strong during this flu season. By getting the flu shot and COVID-19 vaccine and boosters you are doing your part to protect yourself, your family, and others.

The flu shot and COVID-19 vaccines are available to all eligible Alliance members at no cost. Call your doctor's office to find a location near you to receive your flu shot and see if the updated COVID-19 vaccine booster is right for you. You can get a flu vaccine and COVID-19 vaccine or booster during the same visit.

To learn more please visit **www.alamedaalliance.org**.

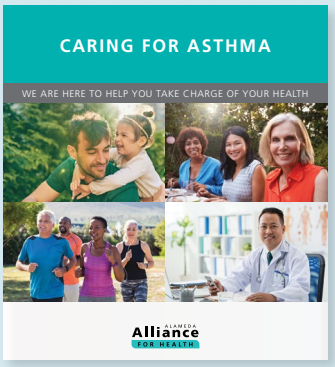
For more help, you can also call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone: **1.510.747.4567**
Toll-free: **1.877.932.2738**
People with speaking and hearing impairments (CRS/TTY): **711/1.800.735.2929**

Source: The Centers for Disease Control and Prevention – Frequently Asked Influenza (Flu) Questions: 2023-2024 Season.

HEALTH EDUCATION FOR ALLIANCE MEMBERS AT NO COST

Looking for clear health guides and programs for healthy living and to help you manage health concerns? Alliance health education offerings include tips and tools you can use in your daily life. Our care books are clear, colorful, and easy to read. You can request them in English, Spanish, Chinese, Vietnamese, and Tagalog.



We offer these topics and more:

- Asthma
- Diabetes
- Eat Well Be Active (adults)
- Live Healthy 5-2-1-0 (children)
- Heart Health
- Preventive Care
- Pregnancy

Check out our Live Healthy Website at **www.alamedaalliance.org/live-healthy** for a full list of health topics that you can access from your computer or phone.

You can also find:

- Community resource guides for older adults, LGBTQIA+, families
- Health handouts, tools, and links
- Listings of classes and programs that you can join at no cost and more

If you would like paper copies of handouts or program listings, you can call Alliance Health Programs at **1.510.747.4577** or mail us an Alliance Wellness Program & Materials Request Form found on page **24**.

ARE YOU LOOKING FOR MORE SUPPORT DURING YOUR PREGNANCY OR AFTER HAVING A BABY?

At the Alliance, we are here to support you and your family. If you are pregnant or were pregnant in the past 12 months, you may be eligible for the following services:

BIRTHWISE WELLBEING

Becoming a new parent can be hard. It is normal to feel depressed, anxious, and overwhelmed after having a baby. You are not alone.

Our ***BirthWise Wellbeing Program*** is designed to help you:

- Connect you with a doula (birth helper), at no cost to you
- Decide what type of help would be best for you
- Find a mental health provider
- Learn about self-care and emotional wellbeing

To learn how we can help you, please call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone: **1.510.747.4567**
Toll-free: **1.877.932.2738**
People with speaking and hearing impairments (CRS/TTY): **711/1.800.735.2929**

It's important to remember that mental health challenges are common during this time, and it is okay to seek help.

WHO ARE DOULAS?

Doulas are people who are trained in labor and childbirth support. You may also hear Doulas be called "birth workers." They provide physical, emotional, and non-medical support for pregnant and postpartum people. This includes the time before, during, and after childbirth.

Services offered by doulas

Doula services include:

- Birth planning
- Emotional, physical, and non-medical support
- Health education
- Help to access care
- Lactation support (breastfeeding help)
- Link to community-based resources

How do I find a doula?

- Search the online Alliance Provider Directory by visiting our website at **www.alamedaalliance.org/help/find-a-doctor** and call a doula to ask about their services
- Call us:

  Alliance Member Services Department
  Monday – Friday, 8 am – 5 pm
  Phone: **1.510.747.4567**
  Toll-free: **1.877.932.2738**
  People with speaking and hearing impairments (CRS/TTY): **711/1.800.735.2929**

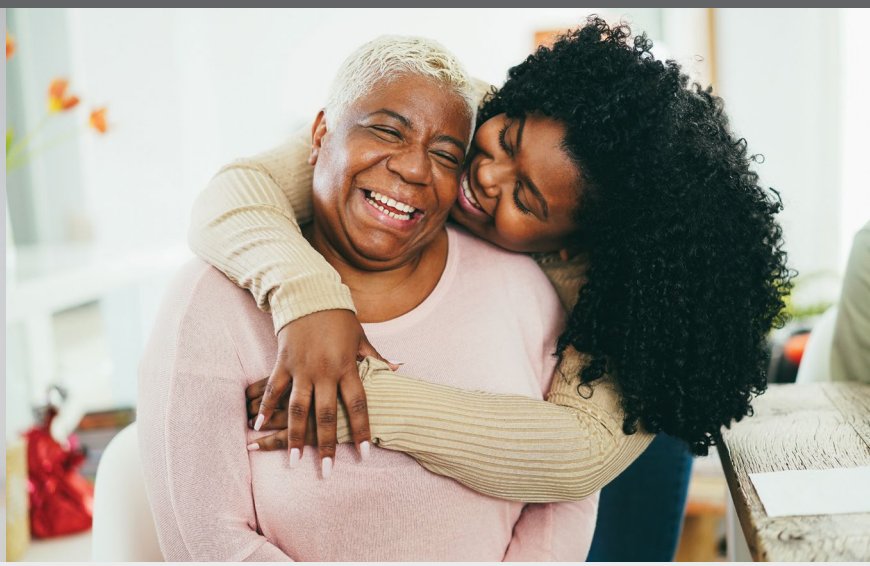
Need additional support? To find a behavioral health provider (or therapist), please contact:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone: **1.510.747.4567**
Toll-free: **1.877.932.2738**
People with speaking and hearing impairments (CRS/TTY): **711/1.800.735.2929**

You can also visit our website at **www.alamedaalliance.org/help/find-a-behavioral-health-care-provider**.

To talk to someone any time, you can also dial **9-8-8**, or call or text the National Maternal Mental Health Hotline toll-free at **1.833.TLC.MAMA (1.833.852.6262)**. It's confidential and at no cost to you. To learn more, please visit **www.MCHB.HRSA.gov/national-maternal-mental-health-hotline**.

PRIVACY CORNER



As a member of the Alliance, you have the right to assign a friend, family member, or another person you choose to help coordinate your care. This person will become your authorized representative (AOR).

An authorized representative **CAN**:

- Change your doctor/medical group
- File a grievance or appeal for you
- Order a new copy of your Alliance member ID card
- Speak to the Alliance on your behalf to coordinate medical care

An authorized representative **CANNOT**:

- Access your medical records without your signed permission
- Change medical care decisions you make for yourself
- Make medical care decisions for you

To assign an authorized representative you must complete and return the Alliance Appointment of Authorized Representative (AOR) Form. This form can be accessed through the Alliance Member Portal, our website, or by contacting the Alliance Member Services Department to request a mailed copy. All fields must be completed.

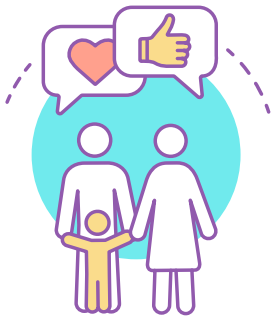
You can return the completed form by mail, fax, or email to:

Alameda Alliance for Health
ATTN: Member Services Department
1240 South Loop Road
Alameda, CA 94502
Fax: **1.877.747.4504**
Email: **memberservices@alamedaalliance.org**

You can also view and download the form on the Alliance website at **www.alamedaalliance.org/members/member-forms**.

ARE YOU WORRIED ABOUT YOUR CHILD'S DEVELOPMENT?

If you're worried about your child's development, acting quickly is important. Below are some steps to help you through the process.



ASSESS: Watch and note your child's behaviors. Try to compare them to typical developmental milestones. Milestones are big changes or stages in development.

Examples of milestones include:

- Physical – Rolling, sitting without support, crawling, standing and walking.
- Communication - Listening, understanding, imitating speech or talking.
- Social and emotional – Playing, feeling secure with familiar adults.
- Self-help – Self-feeding and dressing.

You can use the no-cost Milestone Tracker app by the Centers for Disease Control or checklists online at **www.cdc.gov/Milestones**.

ASK: If you have a concern about your child's behavior, ***talk to your child's doctor***. Your child's doctor can run some tests and provide advice.

For children under three (3) years old, parents can call the Regional Center of the East Bay. They offer evaluations and supportive services at no cost. If your child is three (3) or older, you can ask your local school district for a developmental evaluation or your pediatrician.

ADVOCATE: Be proactive in seeking services and support for your child.

Here are some ways that you can support:

- Follow up with your child's doctor and ask for a developmental screening.
- Involve yourself in the testing and treatment process.
- Look for a second opinion if needed.
- Look for local or online support groups for parents of children with developmental delays.
- Stay informed about developmental milestones and interventions (treatments).

THE ALLIANCE WELCOMES TWO (2) NEW BOARD OF GOVERNOR MEMBERS, **TOSAN O. BOYO AND WENDY PETERSON**

The Board governs the Alliance with 19 member seats representing specific stakeholder groups. These groups include Long-Term Services and the Alameda County Hospital.

Mr. Boyo will hold the Alameda County Hospital seat and Ms. Peterson will fill the Long-Term Services and Supports Seat of the Alliance Board of Governors.

With nearly thirty years of advocating for services for older adults, Mrs. Peterson will provide a much-needed aging policy lens to our Board of Governors," said Matthew Woodruff, Alliance CEO. "Her depth of knowledge will be a huge asset to the Alliance and our aging members."

Mr. Woodruff continued, "As a long-time healthcare leader dedicated to eliminating health disparities, Mr. Boyo will provide a valuable perspective to our Board of Governors. I am confident that they both will help the Alliance move our mission and vision forward to achieve optimal health and well-being for our members and the larger community throughout every stage of life."

Mr. Boyo is President of Sutter Health's East Bay Market and oversees six (6) hospitals, 15 ambulatory centers, and four (4) surgery centers with 10,000 staff and physicians that provide care to 500,000 patients across Alameda, Contra Costa, and Solano Counties.

Mr. Boyo previously served as the Chief Operating Officer of San Francisco General Hospital (SFGH) – the city's only Level 1 Trauma Center, Psychiatric Emergency Center, and largest Primary Care Center. During the pandemic, he served as the Chief of Operations for the city's COVID-19 Command Center. Before his roles at SFGH, Mr. Boyo led the Ambulatory Network of San Mateo Medical Center. Mr. Boyo is a board-certified fellow in healthcare management and was the first graduate of Montclair's Master of Public Health program.

Last fall, the Alameda County Board of Supervisors adopted an ordinance adding four (4) additional seats to the Alliance Board of Governors, including a subject-matter expert seat to represent Long-Term Services and Supports that Ms. Peterson fills.

Mrs. Peterson is the Director of the Senior Services Coalition of Alameda County, representing providers of health and supportive services for older adults throughout the county. The Coalition and its members advance policy change and collaborative initiatives to improve the lives of older adults and their families. Together, members of the Coalition serve more than over 90,000 older adults. Mrs. Peterson serves on the leadership team for the Alameda County Council for Age-Friendly Communities and helped develop the 2016 and 2020 Countywide Area Plan and advanced the Board resolution designating Alameda County as an Age-Friendly County. She also serves on various organizational boards that serve older adults in Alameda County.

PROVIDER SPOTLIGHT: FOCUSED ON PREVENTIVE CARE AND LISTENING – **DR. WAHEED IBRAHIMI'S STORY**

Dr. Waheed Ibrahimi is an internal medicine doctor, trained in Arizona. He has worked in hospitals, clinics, and urgent care places for the last 15 years.

Now, Dr. Ibrahimi has his own practice. It is an exciting journey. He enjoys helping his patients, being in health care, and caring for the local community.

Dr. Waheed enjoys working with the Alliance. When requesting lab tests or providing care, he knows he is working with a trusted partner.

When his patients visit, Dr. Waheed checks the vitamins they are taking and recommends lifestyle changes. He talks to them about supplements and other types of medicine that can help treat stress, anxiety, and sleep issues.

It is important to Dr. Waheed to never overlook potential health issues. Although patients may seem and look healthy, there could be underlying health concerns. He enjoys listening to his patients and takes his time with them during their appointments.

The Alliance and Dr. Waheed are partners in health and work together to support his patients. For example, if Dr. Waheed's patients can't get to their visit, transportation services are available through the Alliance. Members can also access language services through the Alliance to ensure clear communication during medical visits.

Do you want to learn more about Dr. Ibrahimi? Please visit our website to watch a short video at **www.alamedaalliance.org**. You can also connect with us on Facebook, Instagram, YouTube, or X to view the video.

Alliance members can select Dr. Ibrahimi as their primary care provider (PCP) by calling:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

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TALK TO A DOCTOR IN MINUTES WITH TELADOC®

Now you can talk to a doctor whenever you need it and wherever you are, using your phone, smartphone app, or computer with our free service – Teladoc.

Alliance members can use Teladoc to talk to a doctor anytime, day or night. You can get care when you need it from the comfort of your own home. You can talk to a doctor in the language you want to use.

The Alliance works with our benefit partner Teladoc to give you access to care when your primary care doctor is not available. You should always call your regular doctor first. You can also call the Alliance Advice Nurse Line toll-free at **1.888.433.1876** with your health questions.

Teladoc is for non-emergency medical issues. You should **NOT** use it if you are experiencing a medical emergency. For medical emergencies, please dial **9-1-1**.

WHAT IS TELADOC?

Teladoc is a network of California board-certified doctors who can help with a wide variety of health concerns. Teladoc is one way you can get care for some health issues that are not life-threatening, like a sprained ankle or sore throat. Teladoc doctors can diagnose and treat minor illnesses, allergies, and skin conditions — all by phone or video chat.

HOW DO I USE TELADOC?

Using Teladoc is easy. Set up an account with Teladoc before you use it the first time. All you need is your Alliance member ID number.

You can set up your account and schedule a phone or video medical chat by:

- Downloading the Teladoc app to your smartphone
- Calling Teladoc toll-free at **1.800.TELADOC (1.800.835.2362)**

We can help you set up your account, please call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

The wait time for a medical chat is usually less than one hour before you get a callback. You do not need to get a pre-approval or pay to use this service. Teladoc services for Alliance members are not available outside of California at this time.

WHAT SERVICES ARE COVERED?

You can use Teladoc for:

- Cold and flu symptoms
- Minor illnesses
- Minor injuries
- Other non-emergency illnesses
- Outpatient mental health
- Pink eye
- Rashes
- Respiratory infections
- Seasonal sickness and allergies
- Sinus problems
- Skin conditions and treatments
- And more

GET THE CARE YOU NEED EVEN AFTER HOURS WITH URGENT CARE

For conditions that need attention quickly but are not life-threatening, urgent care may be your best choice. Many urgent care clinics are open late, on weekends, and holidays. Appointments are offered within 96 hours.

Urgent care is for services you need to prevent serious damage to your health from a sudden illness, injury, or complication of a condition you already have. Most urgent care appointments are given within 48 hours. If your urgent care visit requires a pre-approval (prior authorization), you will get an appointment within 96 hours of your request.

Call your doctor's office, clinic, or our advice nurse line to find out what level of care is best for you. Doctors expect to get phone calls at night or on weekends. They set up their practices to receive your calls at times when they are not open. Your doctor can help you decide if you need to go to the emergency room or urgent care clinic. They can give you advice about what to do at home that can get you or your child through the night or weekend.

To find an urgent care clinic in the Alliance network, please search our online Alliance Provider Directory at **bit.ly/47wzqG6**.

Urgent care needs could be:

- Cold
- Ear pain
- Fever
- Maternity services
- Sprained muscle
- Sore throat

For urgent care, call your doctor.

If you cannot reach your doctor, please call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

You can also call our Advice Nurse Line toll-free at **1.888.433.1876**. For medical emergencies, dial **9-1-1**.

If you need urgent care out of the area, go to the nearest urgent care facility. You must get urgent care services from an in-network provider when you are inside the Alliance's service area. The Alliance does not cover urgent care services outside the United States.

If you get medicines as part of your covered urgent care visit, the Alliance will cover them as part of your covered visit.

If you need mental health urgent care, dial **9-8-8**, or call the Alameda County Behavioral Health Care Services toll-free at **1.800.309.2131** or text "**Safe**" or "**Seguro**" to ***20121***. You can also call the Alliance Member Services Department at any time.

MEMBER RIGHTS AND RESPONSIBILITIES

We are a part of your health care family and we each have a role to play.

Alliance members have these rights:

1. To be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain the confidentiality of your medical information.
2. To be provided with information about the plan and its services, including covered services, practitioners, and member rights and responsibilities.
3. To receive fully translated written member information in your preferred language, including all grievance and appeals notices.
4. To make recommendations about the Alliance's member rights and responsibilities policy.
5. To be able to choose a primary care provider within the Alliance's network.
6. To have timely access to network providers.
7. To participate in decision-making with providers regarding your own health care, including the right to refuse treatment.
8. To voice grievances, either verbally or in writing, about the organization or the care you got.
9. To know the medical reason for the Alliance's decision to deny, delay, terminate, or change a request for medical care.
10. To get care coordination.
11. To ask for an appeal of decisions to deny, defer, or limit services or benefits.
12. To get no-cost interpreting services for your language.
13. To get free legal help at your local legal aid office or other groups.
14. To formulate advance directives.
15. To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with the Alliance and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible.
16. To disenroll (drop) from the Alliance and change to another health plan in the county upon request.
17. To access minor consent services.
18. To get no-cost written member information in other formats (such as braille, large-size print, audio, and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions (W&I) Code Section 14182 (b)(12).
19. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
20. To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
21. To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) §164.524 and 164.526.
22. Freedom to exercise these rights without adversely affecting how you are treated by the Alliance, your providers, or the state.
23. To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency services outside the Alliance's network pursuant to federal law.
24. To access the Advice Nurse Line, anytime, 24 hours a day, 7 days a week. Advice Nurse Line Toll-Free: **1.888.433.1876.**
25. To access your medical records. You have the right to share the records of any telehealth services provided with your primary care doctor. These records will be shared with your primary care doctor, unless you object.

Alliance members have these responsibilities:

1. To treat all the Alliance staff and health care staff with respect and courtesy.
2. To give your doctors and the Alliance correct information.
3. To work with your doctor. Learn about your health, and help to set goals for your health.
   Follow care plans and advice for care that you have agreed to with your doctors.
4. To always present your Alliance member identification (ID) card to receive services.
5. To ask questions about any medical condition, and make sure you understand your doctor's reasons and instructions.
6. To help the Alliance maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
7. To make and keep medical appointments and inform your doctor at least **24 hours** in advance when you need to cancel an appointment.
8. To use the emergency room only in the case of an emergency or as directed by your doctor.

NOTICE OF NONDISCRIMINATION AND LANGUAGE ASSISTANCE SERVICES

Alameda Alliance for Health (Alliance) complies with all applicable state and federal civil rights laws and does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

LANGUAGE ASSISTANCE SERVICES

English Tagline
ATTENTION: If you need help in your language call **1.877.932.2738** (TTY: **1.800.735.2929**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1.877.932.2738** (TTY: **1.800.735.2929**). These services are at no cost.

الشعار بالعربية (Arabic)
يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ **1.877.932.2738** (TTY: **1.800.735.2929**). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ **1.877.932.2738** (TTY: **1.800.735.2929**). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1.877.932.2738** (TTY: **1.800.735.2929**): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1.877.932.2738** (TTY: **1.800.735.2929**): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)
ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ **1.877.932.2738** (TTY: **1.800.735.2929**)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរធំ សំរាប់ជនពិការភ្នែក ឬអ្នកសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **1.877.932.2738** (TTY: **1.800.735.2929**)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Simplified Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 **1.877.932.2738** (TTY: **1.800.735.2929**)。我们另外还提供针对残疾人士的帮助和服务，例如盲文和大字体阅读，提供您方便取用。请致电 **1.877.932.2738** (TTY: **1.800.735.2929**)。这些服务都是免费的。

简体中文标语 (Traditional Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 **1.877.932.2738** (TTY: **1.800.735.2929**)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 **1.877.932.2738** (TTY: **1.800.735.2929**)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)
توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با **1.877.932.2738** (TTY: **1.800.735.2929**) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **1.877.932.2738** (TTY: **1.800.735.2929**) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)
ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **1.877.932.2738** (TTY: **1.800.735.2929**) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **1.877.932.2738** (TTY: **1.800.735.2929**) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1.877.932.2738** (TTY: **1.800.735.2929**). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1.877.932.2738** (TTY: **1.800.735.2929**). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)
注意日本語での対応が必要な場合は **1.877.932.2738** (TTY: **1.800.735.2929**)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。**1.877.932.2738** (TTY: **1.800.735.2929**)へお電話ください。これらのサービスは無料で提供しています。

NOTICE OF NONDISCRIMINATION AND LANGUAGE ASSISTANCE SERVICES

(CONTINUED FROM PAGE 19)

한국어 태그라인 **(Korean)**
유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1.877.932.2738** (TTY: **1.800.735.2929**) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1.877.932.2738 (TTY: **1.800.735.2929**) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)
ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ **1.877.932.2738** (TTY: **1.800.735.2929**). ຍັງມີຄວາມຊ່ວຍເຫຼືອ ແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ **1.877.932.2738** (TTY: **1.800.735.2929**). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux **1.877.932.2738** (TTY: **1.800.735.2929**). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx **1.877.932.2738** (TTY: **1.800.735.2929**). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **1.877.932.2738** (TTY: **1.800.735.2929**). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ **1.877.932.2738** (TTY: **1.800.735.2929**). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский слоган (Russian)
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1.877.932.2738** (линия TTY: **1.800.735.2929**). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1.877.932.2738** (линия TTY: **1.800.735.2929**). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al **1.877.932.2738** (TTY: **1.800.735.2929**). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1.877.932.2738** (TTY: **1.800.735.2929**). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1.877.932.2738** (TTY: **1.800.735.2929**). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1.877.932.2738** (TTY: **1.800.735.2929**). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1.877.932.2738** (TTY: **1.800.735.2929**) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1.877.932.2738** (TTY: **1.800.735.2929**)ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1.877.932.2738** (TTY: **1.800.735.2929**). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер **1.877.932.2738** (TTY: **1.800.735.2929**). Ці послуги безкоштовні.

Khẩu Hiệu Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1.877.932.2738** (TTY: **1.800.735.2929**). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **1.877.932.2738** (TTY: **1.800.735.2929**). Các dịch vụ này đều miễn phí.

ADDRESS AND PHONE NUMBER CHANGES

If you move or get a new phone number, please let us know by calling the Alliance Member Services Department at **1.510.747.4567**.

PROGRAM AND MATERIALS AT NO COST

Would you like to get more resources or learn more about classes and programs? Just fill out the **Alliance Wellness Programs & Materials Request Form** on page **20**, check the programs or materials that you want, and send it to us. Programs and materials are at no cost to you as our Alliance member. To learn more, please call the Alliance Member Services Department at **1.510.747.4567** or visit **www.alamedaalliance.org/live-healthy**.

LANGUAGE SERVICES AT NO COST

We offer our Alliance members interpreters for health care visits and health plan calls. We provide documents in their language or other formats such as Braille, audio, or large print. For help with your language needs, please call the Alliance Member Services Department at **1.510.747.4567**.

QUALITY IMPROVEMENT PROGRAM

The Alliance Quality Improvement (QI) program helps improve care for our members. We look to see if you are getting regular exams, screenings, and tests that you need. We also find out if you are happy with the care you get from our providers and the services we provide to you. Each year, we set goals to improve the care our members receive. The goals address care and service. We look yearly to see if we meet our goals.

To learn more about our QI program goals, progress, and results, please visit **www.alamedaalliance.org/members**.

If you would like a paper copy of the QI program, please call the Alliance Member Services Department at **1.510.747.4567**.

IMPORTANT PHONE NUMBERS

Service	Contact Number
Emergency	**911**
Poison Control	**1.800.222.1222**
Alameda County Social Services Medi-Cal Center	**1.800.698.1118** or **1.510.777.2300**
Medi-Cal Plan Enrollment/Changes	**1.800.430.4263**

ALAMEDA ALLIANCE FOR HEALTH (ALLIANCE)

Main Line	**1.510.747.4500**
Member Services Department Monday – Friday, 8 am – 5 pm	**1.510.747.4567**
Toll-Free	**1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY)	**711/1.800.735.2929**

CARE SERVICES

Behavioral Health Care Services	
Alameda Alliance for Health	**1.855.856.0577**
Alameda County Behavioral Health Care Services (ACCESS)	**1.800.491.9099**
Dental Care Services	
Medi-Cal Members: Medi-Cal Dental	**1.800.322.6384**
Group Care Members: Please call Public Authority for In-Home Supportive Services (IHSS)	**1.510.577.3552**
Vision Care Services	
Medi-Cal Members: MARCH Vision Care	**1.844.336.2724**
Group Care Members: Please call Public Authority for In-Home Supportive Services (IHSS)	**1.510.577.3552**
Nurse Advice Line	
Medi-Cal Members	**1.888.433.1876**
Group Care Members	**1.855.383.7873**

KEEP IN TOUCH WITH US AND JOIN THE CONVERSATION!

facebook.com/alamedaallianceforhealth

@alamedaalliance

@alamedaallianceforhealth

@alameda-alliance-for-health

@alamedaalliance

Alameda Alliance for Health

Wellness Programs & Materials

Member Request Form – Alameda Alliance for Health (Alliance) provides health education at no cost. We want you to take charge of your health by having the best information possible. Please select from the topics below the written materials that you want us to send you. Please contact us to request these materials in other formats. More information and tools for living healthy can be found at **www.alamedaalliance.org**.

CLASSES & PROGRAM REFERRALS

- ☐ Asthma
- ☐ Breastfeeding Support
- ☐ CPR/First Aid
- ☐ Diabetes
- ☐ Diabetes Prevention Program *(prediabetes)*
- ☐ Healthy Eating, Exercise, and Weight
- ☐ Heart Health
- ☐ Parenting
- ☐ Pregnancy and Childbirth
- ☐ Quit Smoking
  (We partner with Kick It California. If this box is marked, they will call the member directly. A valid phone number is required.)

MEDICAL ID

Choose ID Type:

☐ Bracelet ☐ Necklace

Choose condition(s):

- ☐ Asthma
  ☐ Child ☐ Adult
- ☐ Diabetes
  ☐ Child ☐ Adult

WRITTEN MATERIALS

- ☐ Advance Directive *(medical power of attorney)*
- ☐ Alcohol and Other Substance Use
- ☐ Anxiety, Depression, and Stress
  ☐ Child ☐ Teen ☐ Adult
- ☐ Applied Behavior Analysis (ABA)
- ☐ Asthma
- ☐ Back Pain
- ☐ Birth Control
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Diabetes
- ☐ Domestic Violence
- ☐ Healthy Eating, Exercise, and Weight
  ☐ Child ☐ Adult
- ☐ Heart Health
- ☐ Parenting
- ☐ Pregnancy
- ☐ Preventive Care
- ☐ Quit Smoking
- ☐ Safety
  ☐ Child ☐ Adult
- ☐ Sexual Health

Name (self): _____

Alliance Member ID Number: _____

Child's Name (if applies): _____

Child's Member ID Number: _____

Address: _____

City: _____ Zip Code: _____

Signature: _____

(parent/guardian signature if signing for a child)

Written Language: _____

Spoken Language: _____

The requested materials will be mailed to you. Are there any other ways the Alliance can contact you?

Please select all that apply:

- ☐ Phone: _____
- ☐ Email: _____
- ☐ Text: _____

You can access the online form on the Alliance Member Portal at www.alamedaalliance.org, or mail a completed form to:

Alliance Health Programs • 1240 South Loop Road, Alameda, CA 94502

Phone Number: **1.510.747.4577** • **Toll Free: 1.855.891.9169**

People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

ALAMEDA Alliance FOR HEALTH

HE_MBR_WPM REQ FORM 08/2024
HED W-1 08/2024

ALAMEDA Alliance FOR HEALTH

PROVIDER PULSE

INSIDE THIS ISSUE

THE ALLIANCE ANNOUNCES NEW CHIEF MEDICAL OFFICER (CMO), DR. DONNA WHITE CAREY

Alameda Alliance for Health (Alliance) is honored to announce that Dr. Donna White Carey has been selected for our Chief Medical Officer (CMO) position. Dr. Carey served as the interim CMO since February 2024 and has been a valuable partner with the Alliance for many years.

In her role as CMO, Dr. Carey will be responsible for creating programs to improve the quality of care and health outcomes for Alliance members. She will lead all areas of clinical operations, including case and disease management, utilization management, pharmacy, quality improvement, health education, and behavioral health.

Dr. Carey is a physician and healthcare leader with over two (2) decades of experience in clinical medicine and hospital administrative roles. She served as the first African American Chief of the Division of Pediatrics and later became the inaugural Chair of the Department of Pediatrics at Alameda Health System. Dr. Carey is a past President of Sinkler Miller Medical Association and has served on numerous Boards, including her current service on the Board of Samuel Merritt University's Ethnic Health Institute.

THE ALLIANCE ANNOUNCES NEW CHIEF MEDICAL OFFICER (CMO), DR. DONNA WHITE CAREY

(CONTINUED FROM PAGE 1)

"Dr. Carey is a dedicated health care leader who cares deeply about addressing inequities that shape health care outcomes," said Matthew Woodruff, Alliance Chief Executive Officer. "Her background as a physician coupled with her passion to achieve health equity will help us fulfill our mission and reinforce the work that we do every day in serving our community."

"I am thrilled for the opportunity to lead and support the Alliance's Health Care Services Department as we find meaningful ways to improve the health and well-being of our members and the communities we serve," said Dr. Carey, Alliance CMO.

Dr. Carey also serves our community as a leader in the faith community who spearheaded her church's – True Vine Ministries – COVID-19 response efforts during the pandemic, organizing vaccination clinics that served over 7,000 people and forming contact tracing and health education teams in collaboration with the Alameda County Public Health Department and Lifelong Medical Clinics.

PROVIDER SPOTLIGHT: EMPOWERING MENTAL HEALTH CARE IN OUR COMMUNITY – SUNGILA BLACK CALF'S STORY

Do you want to learn more about Sungila? Please visit our website to watch a short video at **www.alamedaalliance.org**.

You can also connect with us on Facebook, Instagram, LinkedIn, YouTube, or X (formerly known as Twitter) to access the video.

www.facebook.com/alamedaallianceforhealth

@alamedaallianceforhealth

@linkedin

@alamedaalliance

@alamedaalliance

Sungila Black Calf, licensed clinical social worker (LCSW), is a proud supporter of the Native American community in the Bay Area. Sungila is a behavioral health clinician at the Native American Health Center (NAHC) in Oakland, California. Sungila provides mental health care services to people at different stages of their lives. For example, Sungila provides mental health care services to our Alameda Alliance for Health (Alliance) members – whose numbers include patients who received care while their mothers carried them. She is amazed and proud of the community where she works and is a part of.

Born to a Diné mother and Sicangu Lakota father, Sungila was born in Pine Ridge, South Dakota. Her clans are Honághááhnii (Walks About) and Nakai dine'é (Mexican Clan). She grew up in Arizona living on the Navajo Reservation and in surrounding communities. The cultural resources of the Native American community and the rich history and social justice movements in the Bay Area drew Sungila to Oakland to attend Mills College, where she earned a Bachelor of Arts in ethnic studies and sociology.

Sungila first began working at NAHC in 2011 as an Intake Worker after college. The community embraced her and she was inspired to continue her education. She added to her achievements by earning her Master of Social Welfare, with a focus in Community Mental Health from University of California, Berkeley, School of Social Welfare in 2017. After a few years as a clinician, Sungila happily returned to NAHC in 2022.

For Sungila, working with the Alliance is a positive way for NAHC patients to access culturally relevant services. Sungila is grateful that community members can receive the behavioral health care and other medical care they need from the NAHC. She encourages patients to learn about the benefits and services available to them. Talking with her patients about their medical conditions and offering referrals are two of the many ways that Sungila provides support.

PROVIDER SPOTLIGHT: EMPOWERING MENTAL HEALTH CARE IN OUR COMMUNITY – SUNGILA BLACK CALF'S STORY

(CONTINUED FROM PAGE 3)

Along with traditional providers, Sungila sees the value in the NAHC's specialized events and services for Indigenous people like social care and community engagement for those who want to connect to or reconnect with health care and their Native American heritage.

The Alliance is honored to have Sungila as a provider. Her passion for behavioral health care and providing services and support are invaluable to the Alliance, our members, provider partners, and the community.

We look forward to continuing our partnership with Sungila and NAHC.

Alliance members can choose Native American Health Center as their clinic by calling:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

NAHC HAS THREE (3) CLINICS THROUGHOUT OAKLAND:

7 Generations
2920 International Blvd.
Oakland, CA 94601
Monday – Friday, 8:30 am – 5 pm
Phone Number: **1.510.485.5901**

7 Directions
2950 International Blvd.
Oakland, CA 94601
Monday – Friday, 8:30 am – 5 pm [and second (2nd) and fourth (4th) Saturdays of each month]
Medical Phone Number: **1.510.535.4410**
Dental Phone Number: **1.510.535.4450**

American Indian Human Services
3124 International Blvd.
Oakland, CA 94601
Monday – Friday, 8:30 am – 5 pm
Phone Number: **1.510.535.4400**

NAHC offers services throughout the Bay Area. For more information and locations, please visit **nativehealth.org.**

NOW RECRUITING PHYSICIANS AND COMMUNITY PROVIDERS TO JOIN ONE (1) OF OUR ALLIANCE COMMITTEES

INQUIRE TODAY

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We want to invite our contracted physicians and community providers to join one (1) of our committees.

We have several openings and are happy to review specific eligibility criteria, duties, schedules, and the availability needed for participation in any of the committees.

We are looking for Alliance contracted physicians (MD or DO), primary care providers (PCPs), specialists, psychologists, safety-net providers, behavioral health care providers, local education authorities, and dental providers that represent Alameda County.

Medical professionals working at Federally Qualified Health Centers (FQHCs), regional centers, Indian Health Service (HIS) facilities, and community-based organizations representing Alameda County are also welcomed to apply.

Below are our new and existing committees and meeting frequency (some meetings are virtual):

1. Community Advisory Committee (CAC) – Meets quarterly
2. Community Advisory Selection Sub-committee – Anticipated to meet two (2) – four (4) times a year
3. Quality Improvement Health Equity Committee – Meets quarterly
4. Peer Review Credentialing Committee (PRCC) – Meets monthly, every third (3rd) Tuesday
5. Pharmacy & Therapeutics (P&T) Committee – Meets quarterly

If you are interested or want to learn more about any of the committees listed above, please email us at **providerservices@alamedaalliance.org**.

We always appreciate and thank you for the high-quality care you give your patients. Your continued partnership helps build a healthier community for all.

THE ALLIANCE IS ONE OF THE HIGHEST-RATED MEDI-CAL HEALTH PLANS IN THE STATE

The Alliance is a top-rated California Medi-Cal managed care plan.

Alameda Alliance for Health (Alliance) is a local health plan that serves more than 400,000 Alameda County residents. In 2023, the Alliance was rated a top health plan in California. The Alliance was the only Medi-Cal health plan in Alameda County to receive a rating of four (4) out of five (5) in the National Committee for Quality Assurance's (NCQA) 2023 Medicaid Health Plan Ratings. No other Medi-Cal (California's Medicaid benefits program) health plan in the state earned a rating higher than four (4) out of five (5) stars.

NCQA's Health Plan Ratings are scored on a one (1)- to five (5)- star scale and with three (3) quality measures. This includes patient experience – such as encounters with doctors, plan services, and customer service. Additionally, plans are rated on clinical measures. This refers to the number of members who received preventive services and the third is the number of members who received care for certain health conditions.

"We know that patient experience and access to preventive services are associated with better health outcomes," said Matthew Woodruff, Alliance CEO. "That is why we are proud to have achieved a four (4) out of five (5) stars in NCQA's 2023 Medicaid Health Plan Ratings. This achievement could not be reached without the dedication and hard work of our provider partners, care teams, and customer service department."

The Alliance would like to thank its member engagement and programs, community providers, and customer service efforts for this success.

ALLIANCE LANGUAGE ASSISTANCE SERVICES

Alameda Alliance for Health (Alliance) works hard to help make sure that all of our members can talk to their providers and with us about their health care needs. We provide over-the-phone, in-person, and video remote interpreter services. We also provide translations and alternative formats of written member information, all at no cost to our members or their Authorized Representative.

Alliance members can request:

- A trained and qualified American Sign Language (ASL) interpreter.
- A trained and qualified foreign language interpreter.
- Alliance-written information in formats such as braille, large print, audio CD, or data CD.
- Alliance-written information in a language that members can understand.

Over-the-phone interpreter services are available to our members, 24 hours a day, 7 days a week for their health care visits. For American Sign Language (ASL), or highly sensitive or complex health care visits, providers can request an in-person interpreter at no cost. Members do not have to use family or friends. To request interpreter services or learn more, Providers can visit **www.alamedaalliance.org**, call 1.510.747.4510, or **click here**.

Members can learn more by visiting **www.alamedaalliance.org** or calling:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567** (for after hours, select the preferred language then option "1")
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

THE ALLIANCE WELCOMES TWO (2) NEW BOARD MEMBERS

The Alliance Announces New Board Members, Tosan O. Boyo and Wendy Peterson.

The board is the governing body of the Alliance with 19 member seats representing specific stakeholder groups.

The Alliance recently announced the appointment of Mr. Boyo to the Alameda County Hospital seat and Ms. Peterson to the Long-Term Services and Supports Seat of the Alliance Board of Governors.

"*With nearly three decades of advocating for services for older adults, Mrs. Peterson will provide a much-needed aging policy lens to our Board of Governors,"* said Matthew Woodruff, Alliance CEO. *"Her depth of knowledge will be a huge asset to the Alliance and our aging members."*

Mr. Woodruff continued, *"As a long-time health care leader dedicated to eliminating health disparities, Mr. Boyo will provide a valuable perspective to our Board of Governors. I am confident that they both will help the Alliance move our mission and vision forward to achieve optimal health and well-being for our members and the larger community throughout every stage of life."*

Mr. Boyo is President of Sutter Health's East Bay Market and oversees six (6) hospitals, 15 ambulatory centers, and four (4) surgery centers with 10,000 staff and physicians that provide care to 500,000 patients across Alameda, Contra Costa, and Solano Counties.

Mr. Boyo previously served as the Chief Operating Officer of San Francisco General Hospital (SFGH) – the city's only Level 1 Trauma Center, Psychiatric Emergency Center, and largest Primary Care Center. During the pandemic, he served as the Chief of Operations for the city's COVID-19 Command Center. Before his roles at SFGH, Mr. Boyo led the Ambulatory Network of San Mateo Medical Center. Mr. Boyo is a board-certified fellow in healthcare management and was the first graduate of Montclair's Master of Public Health program.

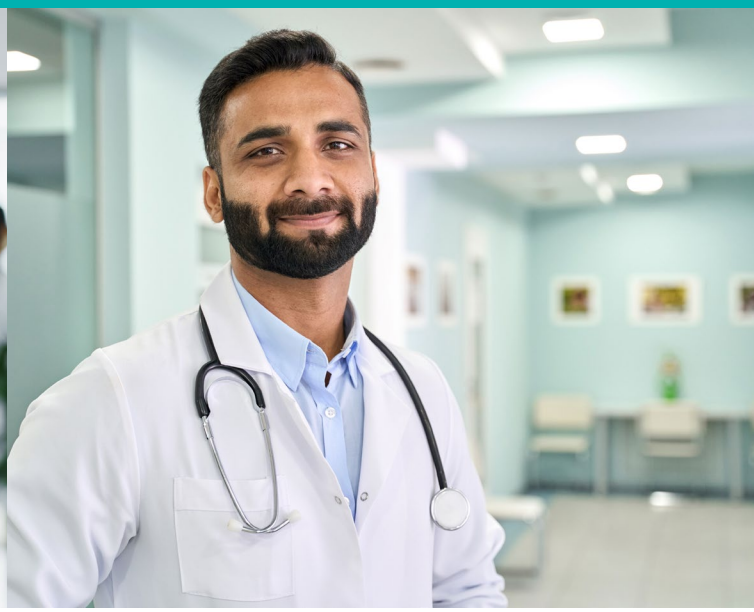
Tosan O. Boyo

Wendy Peterson

Last fall, the Alameda County Board of Supervisors adopted an ordinance adding four (4) additional seats to the Alliance Board of Governors, including a subject-matter expert seat to represent Long-Term Services and Supports that Ms. Peterson fills.

Ms. Peterson is the Director of the Senior Services Coalition of Alameda County, representing providers of health and supportive services for older adults throughout the county. The Coalition and its members advance policy change and collaborative initiatives to improve the lives of older adults and their families. Together, members of the Coalition serve more than over 90,000 older adults. Ms. Peterson serves on the leadership team for the Alameda County Council for Age-Friendly Communities and helped develop the 2016 and 2020 Countywide Area Plan and advanced the Board resolution designating Alameda County as an Age-Friendly County. She also serves on various organizational boards that serve older adults in Alameda County.

THE ALLIANCE ANNOUNCES PROVIDER RECRUITMENT INITIATIVE



The Alliance launched its Provider Recruitment Initiative and Training Supports Grants Program June 1st.

The initiative aims to support the hiring of and expand access to health care professionals for the Alameda County Safety Net. As part of this initiative, grant funds will be available to support training and certifications for community health workers whose role is to assist and provide support to individuals with navigating the health care system.

Workforce shortages throughout the state and rising costs are directly linked to the estimated millions of Californians and tens of thousands of Alameda County residents who are struggling to get access to the care they need today. Many factors, including burnout, early retirement, and departure after the COVID-19 pandemic, have contributed to this health care crisis.

The Provider Recruitment Initiative was developed to provide grants to expand the Alliance's safety net partners and community-based organizations to hire and retain health professionals who serve the local Medi-Cal population. The initiative aims to improve member access to key provider types and services by further expanding the Alliance's provider network.

"We know that workforce shortages contribute to poor population health," said Matthew Woodruff, Alliance CEO. "That is why we are excited to launch this initiative that will help us attract new providers and address the medical and mental health needs of the families that we serve."

In addition to expanding the Alliance's Provider network, the Provider Recruitment Initiative will improve members' access to primary care providers (PCPs), specialists, and behavioral health professionals. It will also provide skill training opportunities for supportive staff, such as community health workers, and it will promote diverse and culturally inclusive care reflective of the Alameda County community.

To learn more about the Alliance's Provider Recruitment Initiative, visit us at **www.alamedaalliance.org**. Questions about the initiative can be directed to **fundinginfo@alamedaalliance.org**.

DOULA SERVICES

Alameda Alliance for Health (Alliance) provides doula services to its members. Doulas are birth workers who are trained in labor and childbirth support. They provide physical, emotional, and non-medical support for pregnant and postpartum people. This includes the time before, during, and after childbirth.

BENEFITS

Studies have shown that persons who work with a doula:

- Have better birth outcomes
- Are less likely to have a baby with a low birth weight
- Reduce the risk of a birth problem (complication)
- Are more likely to breastfeed

SERVICES

If you are pregnant, or were pregnant in the last year, you can receive doula services. This includes members who may have had an abortion, a miscarriage, or stillbirth.

Services offered by doulas include:

- Birth planning
- Emotional, physical, and non-medical support
- Health education
- Help to access care
- Lactation support (breastfeeding help)
- Link to community-based resources

PLEASE NOTE: Services can be provided online or in person.

Alliance members can connect with a doula today to learn more about prenatal and postpartum visits.

To connect with a doula, members can:

- Search the Alliance Provider Directory at **www.alamedaalliance.org/help/find-a-doctor** and contact a doula directly.
- Call:

  Alliance Member Services Department
  Monday – Friday, 8 am – 5 pm
  Phone Number: **1.510.747.4567**
  Toll-Free: **1.877.932.2738**
  People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

Source:
1. www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-024.pdf
2. www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/

HELPING PATIENTS LEARN ABOUT HEPATITIS B AND C

Hepatitis is the inflammation (swelling) of the liver. The liver helps to process nutrients, filter (clean) the blood, and fight infections. When the liver is swollen or damaged, it does not work as well as it should,

WHAT CAUSES HEPATITIS?

Heavy alcohol use, toxins, and some medications and medical conditions can cause hepatitis. However, hepatitis is often caused by a virus. In the United States, some of the most common hepatitis viruses are hepatitis B (or hep B) and hepatitis C (or hep C).

WHAT IS HEPATITIS B AND HEPATITIS C?

Hepatitis B (hep B) and hepatitis C (hep C) are liver infections that affect millions of people across the world. They are caused by the hep B virus (HBV) or hep C virus (HCV). The Centers for Disease Control and Prevention (CDC) recommends adults 18 years of age and older to be screened for hep B and hep C at least once. These infections can lead to serious health issues if left untreated.

HOW DOES HEPATITIS B AND HEPATITIS C SPREAD?

- Blood transfusions
- Childbirth
- Healthcare exposures
- Organ transplants
- Sexual contact
- Sharing drug-injection equipment like needles
- Sharing personal items (razors, toothbrushes)
- Unregulated tattoos or piercings

COMMON SYMPTOMS

People with hep B show no symptoms. It is why hep B is sometimes referred to as the "silent killer."

People with hep C rarely show symptoms and can take two (2) weeks to six (6) months to show up. Hep C symptoms may include yellow skin or eyes, low appetite, throwing up, stomach pain, fever, dark-colored urine, light-colored stool, joint pain, and feeling tired.

HELPING PATIENTS LEARN ABOUT HEPATITIS B AND C
(CONTINUED FROM PAGE 11)

The following medications are recommended for the treatment of hep B:

1. Baraclude (entecavir)
2. Vemlidy (tenofovir alafenamide fumarate)
3. Viread (tenofovir disoproxil fumarate)

The following medications are recommended for the treatment of hep C:

1. Mavyret (glecaprevir/pibrentasvir)
2. Sofosbuvir/Velpatasvir (generic Epclusa)
3. Ledipasvir/Sofosbuvir (generic Harvoni)

HOW DOES ANTIVIRAL TREATMENT HELP?

Antiviral treatment can reduce the amount of HBV or HCV in your body. It also lowers the risk of liver problems, such as cirrhosis (liver scarring), liver failure, and liver cancer. Hep C can be cured in 8 to 12 weeks.

If one of our members needs coordination of care for hep b or hep c, please contact the Alameda Alliance for Health (Alliance) Case and Disease Management (CMDM) Department toll-free at **1.877.251.9612** or email **DeptCMDM@alamedaalliance.org**.

Source:
www.cdc.gov/hepatitis
hepB.com

HOME HEALTH REQUIREMENTS

We have an important update for our provider partners requesting authorization for Home Health services and Home Health agencies.

Alameda Alliance for Health (Alliance) aims to process authorizations for medically necessary Home Health services, both routine and urgent requests, following our regulatory prior authorization processing time.

The Alliance Medi-Cal member Home Health service request requirements are outlined in the California Department of Health Care Services (DHCS) Provider Manual. You can view the DHCS Provider Manual Guidelines **here**.

In addition, the Alliance Medi-Cal and Group Care member Home Health services requests follow the evidence-based MCG 27th edition for medical necessity criteria. We will share provider notification updates when the Alliance adopts the MCG 28th edition in 2024.

To help ensure these decisions are as timely as possible, we summarized the following Home Health documentation requirements to help support these requests.

HOME HEALTH REFERRAL ELEMENTS	DOCUMENTATION REQUIREMENTS *(Please include all listed items for each Home Health Referral Element)*
Start of Care Only	• Documentation of a face-to-face encounter with the treating physician within 90 days prior to the start of care date or 30 days following the start of care date • Current OASIS/485 and frequency order
Start of Care Requests	• Written physician's order • Supporting documentation of the member's Home Health services • Current completed OASIS/485 and frequency order(s) • Date of last face-to-face encounter with treating physician • Clinical supporting documentation
Continuing Care Requests	• Written physician's order for continuing Home Health services from the treating physician • Frequency of order(s) • Date of last face-to-face encounter with treating physician if >60 days have elapsed since the last Home Health request. • Clinical supporting documentation

HOME HEALTH REQUIREMENTS
(CONTINUED FROM PAGE 13)

HOME HEALTH REFERRAL ELEMENTS	DOCUMENTATION REQUIREMENTS *(Please include all listed items for each Home Health Referral Element)*
Clinical Documentation	• Primary diagnosis and significant comorbidities and/or other diagnosis • Current health status/prognosis • Date of onset of the illness • For requested Home Health nurse visits and units, indicate the specific skilled nursing need to support the request • Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals • The extent to which Home Health Aides or skilled care has been previously provided, and benefits or improvements demonstrated by such care • A description of the member's support system, including whether assistance is available from household members, homemakers, attendants, or others • If for a reauthorization, needs to include a statement as to the member's progress toward achieving the therapeutic goals
Homebound status	• Defined California Code of Regulations (CCR), Title 22, Section 51146 • Must be full scope eligible for the month(s) that the service is rendered. • TARs address the requirements, restrictions, and limitations (including time limits and lowest cost factors) as referenced in CCR, Title 22, Section 51337; includes a written treatment plan which the physician reviews every 60 days; one (1) visit per six (6) months is allowed without prior authorization.

EAR, NOSE, AND THROAT (ENT) MEDICAL NECESSITY CRITERIA

In 2023, the **MCG 27th guidelines changed** for common ear, nose, and throat (ENT) surgeries like **turbinate resection** and **septoplasty**. One (1) of those major changes is the requirement for the trial of both intranasal steroids and intranasal antihistamines before proceeding with these surgeries. If your patient has a **contraindication for using either intranasal medicines**, or **if a medication is not clinically indicated**, we encourage medical providers to **document these reasons in the clinical note**. We want to ensure that medically necessary ENT prior authorization (PA) requests are reviewed for relevant provider treatment plans and medical management details.

For the **MCG 27th edition criteria for CT imaging of the sinuses**, the utilization review process verifies that one (1) of the following criteria is met:

- Chronic sinusitis (more than 12 weeks of symptoms)
- Fungal infection is suspected or known
- Immunocompetent patient with refractory sinusitis
- Immunosuppressed patient and **ALL** of the following criteria must be met:
  - o Allergies are managed
  - o Obstruction and/or facial pain
  - o Symptoms persist despite trial of nasal corticosteroids and saline rinse
  - o Symptoms persist despite two (2) courses of antibiotics, and one (1) medication must be Augmentin unless contraindicated
  - o Symptoms lasted more than four (4) weeks after starting the above therapy
- Polyposis (unilateral on exam)
- Recurrent acute rhinosinusitis (four (4) or more episodes in a year)
- Sinusitis complication (i.e., cellulitis, osteomyelitis, periorbital infections)

Provider notifications will occur when the Alameda Alliance for Health (Alliance) adopts the MCG 28th edition in 2024.

US FOOD AND DRUG ADMINISTRATION (FDA) VOLUNTARY RECALL OF PHILIPS RESPIRONICS CPAP MACHINES, BIPAP MACHINES, AND VENTILATORS

We have an important update regarding a medical device that you may have ordered for your patients, related to a Food and Drug Administration (FDA) device recall.

In June 2021, Philips Respironics[1] issued a voluntary recall on specific brands of their continuous positive airway pressure (CPAP) machines, bilevel positive airway pressure (BiPAP) machines, and ventilators. The recalled machines have a foam piece inside that may break down into very small pieces that can be inhaled or swallowed.[2] The foam may also emit a chemical that may be harmful if inhaled. These factors present the following potential health risks to patients: irritation in the eyes, lungs, and on the skin, headaches, nausea, vomiting, toxic and cancer-causing effects, and breathing difficulties.[3] Following a settlement with the FDA, Philips agreed, for the time being, to stop selling respiratory care devices in the US but will continue to service existing devices.[4]

Philips Respironics has established a registration process that allows patients, users, and caregivers to look up their device's serial number, initiate a device return, and receive $100 from Philips if returned before Friday, August 9, 2024.

PLEASE NOTE: All ventilation machine remediation will be handled directly with the durable medical equipment (DME) vendor[5]. Alameda Alliance for Health (Alliance) works with California Home Medical Equipment (CHME) to supply DME. The CHME contact information is included. All other recalled items like the BIPAP and CPAP machines, require user registration for the device.

To view the recall information and where members can register their devices, please visit **expertinquiry.com**.

Please help ensure that devices are registered to appropriately identify recalled units and to help ensure that impacted patients, users, and caregivers receive the most up-to-date information from Philips Respironics. Members, caregivers, and guardians can register their Philips medical device and initiate a device return by phone or online.

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1. Philips Respironics is an independent company manufacturing and providing medical devices and services in the US.
2. Recalled Philips Ventilators, BiPAP Machines, and CPAP Machines | FDA
3. Recommendations for Recalled Philips Ventilators, BiPAP Machines, and CPAP Machines | FDA
4. Philips announces its 2023 Fourth-Quarter and Annual Results | Philips
5. Medical Device Recall Information – Philips Respironics Sleep and Respiratory Care devices

US FOOD AND DRUG ADMINISTRATION (FDA) VOLUNTARY RECALL OF PHILIPS RESPIRONICS CPAP MACHINES, BIPAP MACHINES, AND VENTILATORS

(CONTINUED FROM PAGE 16)

To register a Philips medical device, please contact:

Philips Respironics
Toll-Free: **1.877.907.7508**
Registration: **www.philipssrcupdate.expertinquiry.com**
Recall Updates: **www.philips.com/src/updates**

You may also contact the medical device equipment vendor that provided the device to your patient to verify whether the device was impacted by the Philips recall. If so, you can request a new device from a different manufacturer.

The Alliance's in-network medical device equipment vendor is:
California Home Medical Equipment (CHME)
Monday – Friday, 8:30 am – 5 pm (answering service during evenings and weekends)
Toll-Free: **1.800.906.0626**
Respiratory Therapist Email: **respiratory@chme.org**
www.chme.org/contact-us

You can find the FDA updates about these medical devices **here**.

If you would like to report problems or safety issues to the FDA, you can submit your concerns through their online form at **www.accessdata.fda.gov/scripts/medwatch**.

TIMELY ACCESS STANDARDS*

Alameda Alliance for Health (Alliance) is committed to working with our provider network in offering our members the highest quality of health care services.

Timely access standards* are state-mandated appointment timeframes for which you are evaluated.

All providers contracted with the Alliance are required to offer appointments within the following timeframes:

APPOINTMENT WAIT TIMES	
APPOINTMENT TYPE:	**APPOINTMENT WITHIN:**
Urgent Appointment that does not require PA	48 Hours of the Request
Urgent Appointment that requires PA	96 Hours of the Request
Non-Urgent **Primary Care** Appointment	10 Business Days of the Request
First Prenatal Visit	10 Business Days of the Request
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of the Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of the Request
Non-Urgent Appointment with an **Ancillary Services** for the diagnosis or treatment of injury, illness, or other health conditions	15 Business Days of the Request

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
APPOINTMENT TYPE:	**APPOINTMENT WITHIN:**
In-Office Wait Time	60 Minutes
Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
Telephone Access – Provide coverage 24 hours a day, 7 days a week.	
Telephone Triage and Screening – Wait time not to exceed 30 minutes.	
Emergency Instructions – Ensure proper emergency instructions.	
Language Services – Provide interpreter services 24 hours a day, 7 days a week.	

***Per DMHC and DHCS Regulations, and NCQA HP Standards and Guidelines**

PA – Prior authorization

Urgent Care – Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Non-urgent Care – Routine appointments for non-urgent conditions.

Triage or Screening – The assessment of a member's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice. This individual must be trained to screen or triage, and determine the urgency of the member's need for care.

Shortening or Extending Appointment Timeframes – The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.

ALLIANCE 2024-2025 HOLIDAY CALENDAR

The Alliance office will be closed in observance of the following holidays:

2024

Thanksgiving Day
Thursday, November 28th

Day After Thanksgiving
Friday, November 29th

Floating Holiday (Christmas Eve)
Tuesday, December 24th

Christmas Day (Observed)
Wednesday, December 25th

2025

New Year's Day
Wednesday, January 1st

Martin Luther King Jr. Day
Monday, January 20th

Presidents' Day
Monday, February 17th

Cesar Chavez Day
Monday, March 31st

Memorial Day
Monday, May 26th

Juneteenth Holiday
Thursday, June 19th

Independence Day
Friday, July 4th

Labor Day
Monday, September 1st

Veterans Day
Tuesday, November 11th

Thanksgiving Day
Thursday, November 27th

Day After Thanksgiving
Friday, November 28th

Floating Holiday (Christmas Eve)
Wednesday, December 24th

Christmas Day
Thursday, December 25th

PROVIDER TRAINING CORNER

Community Resources for Provider Training Opportunities

To learn more about upcoming training opportunities in our community, please visit the new Provider Resources for Training and Technical Assistance Opportunities section of our website **here**.

WE WANT TO HEAR FROM YOU!

If you would like to be featured in our newsletters or have a story idea or a topic that you would like to see covered in the Provider Pulse newsletter, please contact us.

Alliance Provider Services Department
Email: **providerpulse@alamedaalliance.org**
Phone Number: **1.510.747.4510**

ALL FEEDBACK IS WELCOME

ALAMEDA Alliance FOR HEALTH

CONNECT WITH US!

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE PRINT ADS

2024 | Annual Report

Print Ad Examples:

Since 1972, the Native American Health Center (NAHC) has been improving the health and well-being of American Indians, Alaska Natives, and residents with respect to cultural and linguistic differences. The Alliance is honored to be a part of the center's 2024 Gala Celebration. We value having NAHC as our community partner in supporting us in our mission of improving the health and well-being of our members through every stage of life.

ALAMEDA Alliance FOR HEALTH

www.alamedaalliance.org

ALAMEDA Alliance FOR HEALTH

www.alamedaalliance.org

The Alliance is honored to join the Sinkler Miller Medical Association, which for 41 years has made *Above and Beyond – Transforming the Future of Health Care* to provide annual scholarships to help underrepresented students pursuing medical careers and honor the trailblazers in service to our community for generations to come, a great work to celebrate.

THE ALLIANCE IS HONORED TO JOIN IN CELEBRATING THE GLAD TIDINGS FAMILY LIFE COMPLEX DEDICATION CEREMONY.

With their strong commitment to communities and families and a passion for all people, the Alliance recognizes Glad Tidings International's passion for and involvement in the community.

The Alliance values having Glad Tidings International as a community partner and supporting us in our mission of improving the health and well-being of our members through every stage of life.

ALAMEDA Alliance FOR HEALTH

www.alamedaalliance.org

Billboard, BART, and Bus Ad Examples:

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

2024 | **ANNUAL OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

2024 | ANNUAL OUTREACH REPORT

Between **January 2024** and **December 2024**, the Alliance initiated and/or was invited to participate in **103** events throughout Alameda County. The Alliance completed **29** community events, **30** member education events, **1** community meeting/presentation, more than **12,796** live member orientation outreach calls among net new members and non-utilizers and completed **1,482** member orientations by phone. The Alliance reached a total of **10,468** people and spent **$2,987.55*** on donations, fees, and/or sponsorships in 2024. In addition, during 2024, the Outreach team completed **655** Alliance website inquiries, **98** service requests, and **11** social media inquiries.

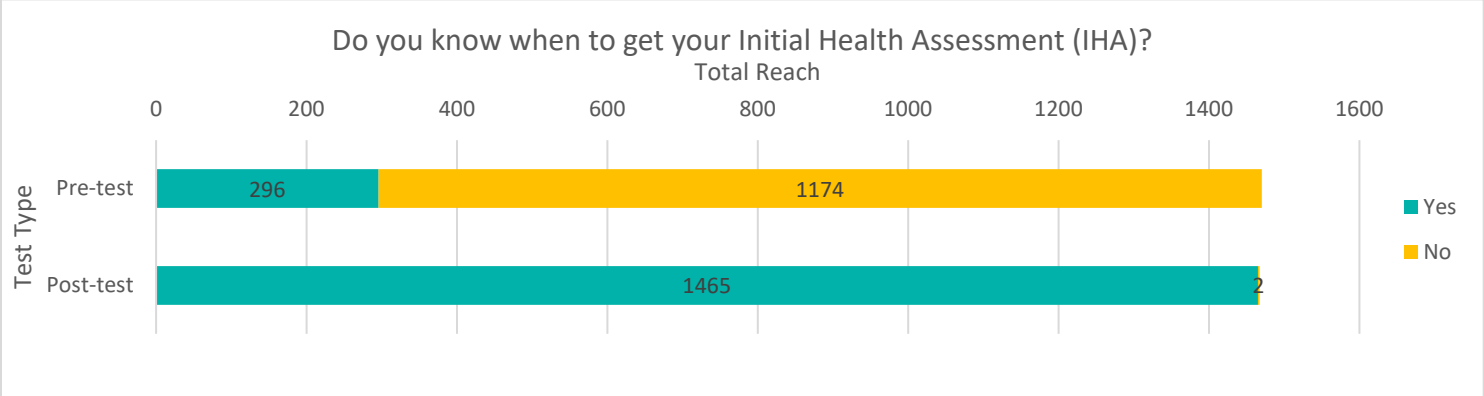
The majority of people reached at member orientations (MO) are Alliance Members. Approximately 30% of the people reached during community events are covered by Medi-Cal, and approximately 80% of people with Medi-Cal coverage have Alliance Medi-Cal based on Managed Care Enrollment Reports. Additionally, the Outreach Team began tracking Alliance members at community events in late February 2018. Since July 2018, **35, 857** self-identified Alliance members were reached during outreach activities.

On **Monday, March 16, 2020**, the Alliance began assisting members by telephone only, following the statewide Shelter-in-Place (SIP) guidance to protect the general public from the Coronavirus Disease (COVID-19).

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of December 31, 2024, the Outreach Team completed **45,067** member orientation outreach calls and non-utilizer calls and conducted **9,279** member orientations (**20.6%** member participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment (IHA), by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18, 2020, through December 31, 2024 – **9,279** members completed our MO program by phone.

After completing a MO **99.86%** of members who completed the post-test survey in 2024 reported knowing when to get their IHA, compared to only **20.1%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 24-25\Q2\3. December 2024**

ALLIANCE IN THE COMMUNITY
2024 | ANNUAL OUTREACH REPORT

2024 TOTALS

29	COMMUNITY EVENTS
30	MEMBER EDUCATION EVENTS
1482	MEMBER ORIENTATIONS (By Phone)
1	MEETINGS/ PRESENTATIONS
103	TOTAL INITIATED / INVITED EVENTS
1542	**TOTAL EVENTS**

7059	TOTAL REACHED AT COMMUNITY EVENTS
3396	TOTAL REACHED AT MEMBER EDUCATION EVENTS
1482	TOTAL REACHED AT MEMBER ORIENTATIONS
13	TOTAL REACHED AT MEETINGS/PRESENTATIONS
6373	TOTAL MEMBERS REACHED AT EVENTS
11950	**TOTAL REACHED AT ALL EVENTS**

ALAMEDA
ALBANY
BERKELEY
CASTRO VALLEY
DUBLIN
FREMONT
HAYWARD
LIVERMORE
NEWARK
OAKLAND
PLEASANTON
SAN LEANDRO
SAN LORENZO
UNION CITY

TOTAL REACH 39 CITIES

**Cities not listed represent the mailing addresses for members who completed a Member Orientation by phone and Community Events. The italicized cities are outside of Alameda County. The C&O Department started including these cities in the FY20 Q3 Outreach Report. Please see event details for complete listings of cities.*

$2,987.55

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

COMMUNICATIONS & OUTREACH DEPARTMENT

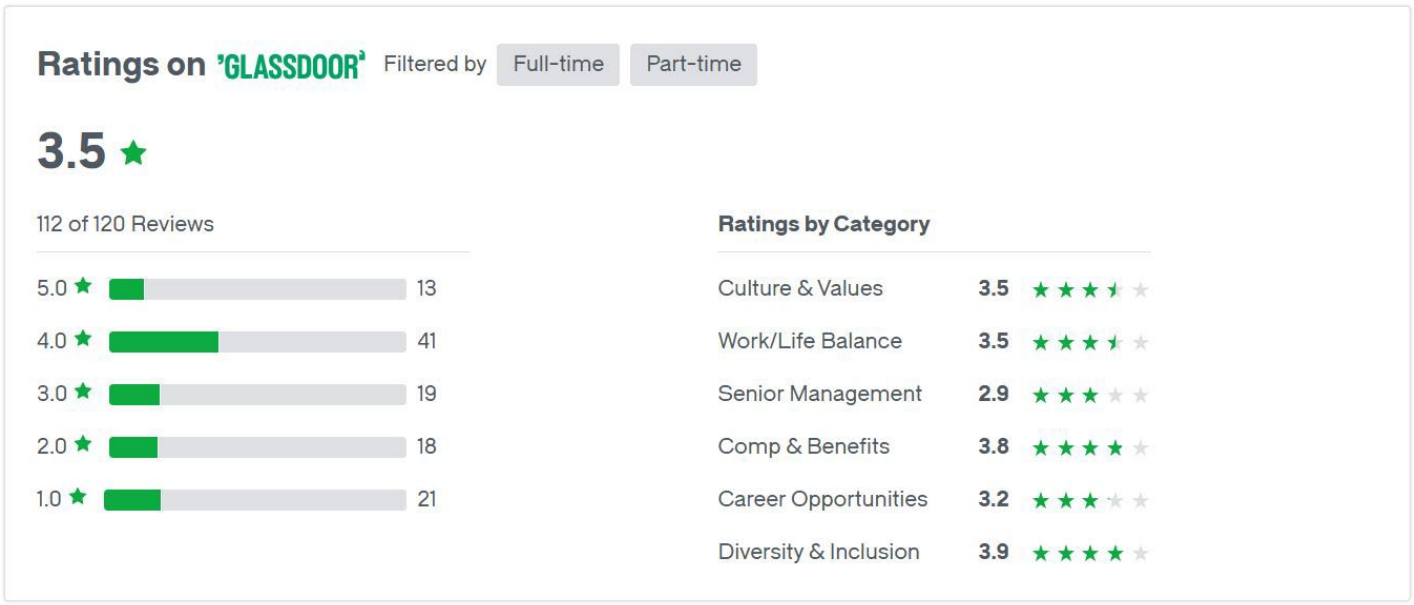
SOCIAL MEDIA AND WEBSITE REPORT

2024 | ANNUAL SOCIAL MEDIA AND WEBSITE REPORT

The Alliance Communication and Outreach (C&O) Department created the Social Media and Website (SM&W) Report to provide a high-level overview of stakeholder engagement through various digital media platforms. Between January 2024 and December 2024, the Alliance:

1. Alliance Website:
    - Received 203,000 unique visits
    - Received 200,000 new user visits
    - The top 10 website page visits were as follows:
        i. Homepage
        ii. Providers
        iii. Find a Doctor
        iv. Medi-Cal Benefits and Covered Services
        v. Careers
        vi. Contact Us
        vii. Members
        viii. Check In for Check-Ups
        ix. Medi-Cal
        x. Get a New ID Card
2. Glassdoor Page:
    - Increased from 3.0 to 3.5 out of 5-star overall rating
    - Received nine (9) crowdsourced Glassdoor Reviews
3. Facebook Page:
    - Completed 276 compared to 173 original posts in 2023
    - Increased page likes to 633 compared to 628 in 2023
4. Instagram Page:
    - Debuted page June 10, 2021
    - Completed 295 compared to 208 original posts in 2023
    - Increased 595 Followers compared to 483 in 2023
5. Twitter Page:
    - Completed 395 compared to 322 tweets in 2023
    - Increased followers to 359 compared to 358 in 2023
6. LinkedIn Page:
    - Completed 232 compared to 164 posts in 2023
    - Increased followers 6.1k compared to 4.7k followers in 2023
7. Yelp Page:
    - Appeared in Yelp searches 1,200
    - Received four (4) crowdsourced reviews
8. Google Page:
    - 54,127 business profile interactions.
    - 21,239 calls made from the business profile
    - Received seventeen (17) reviews

GLASSDOOR OVERVIEW:

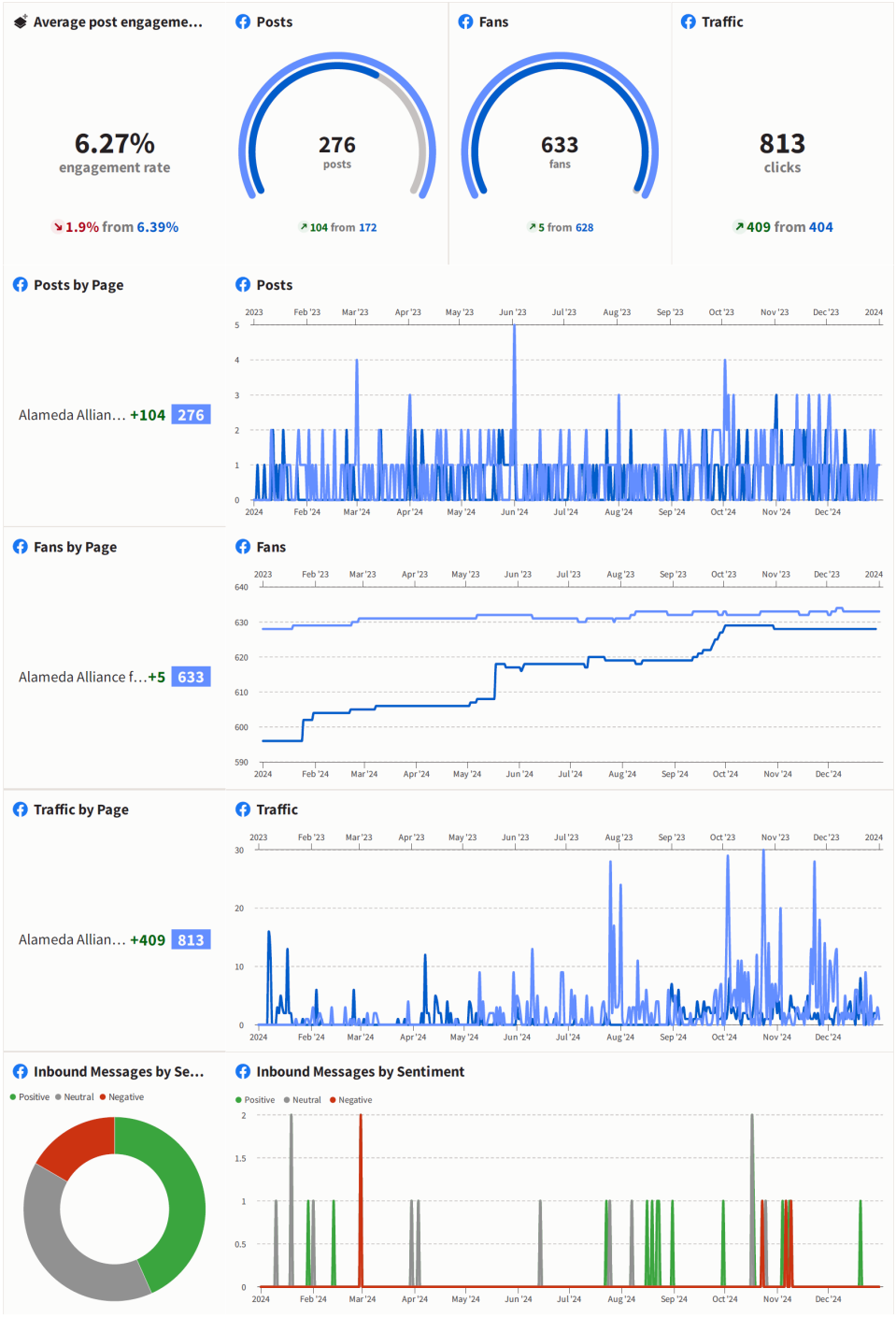


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\4. Annual 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE REPORT

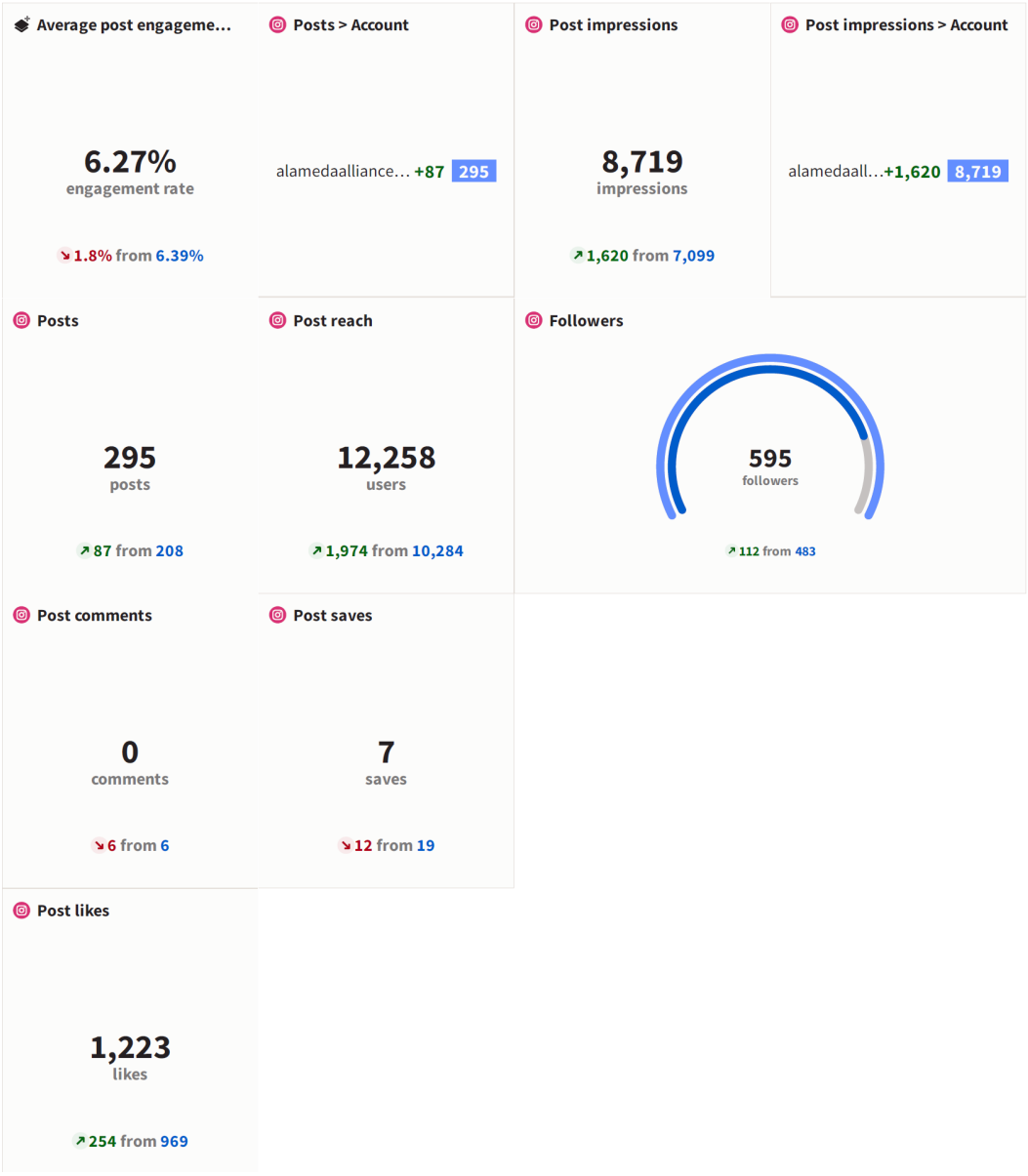
2024 | Annual Report

FACEBOOK OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\4. Annual 2024

INSTAGRAM OVERVIEW:

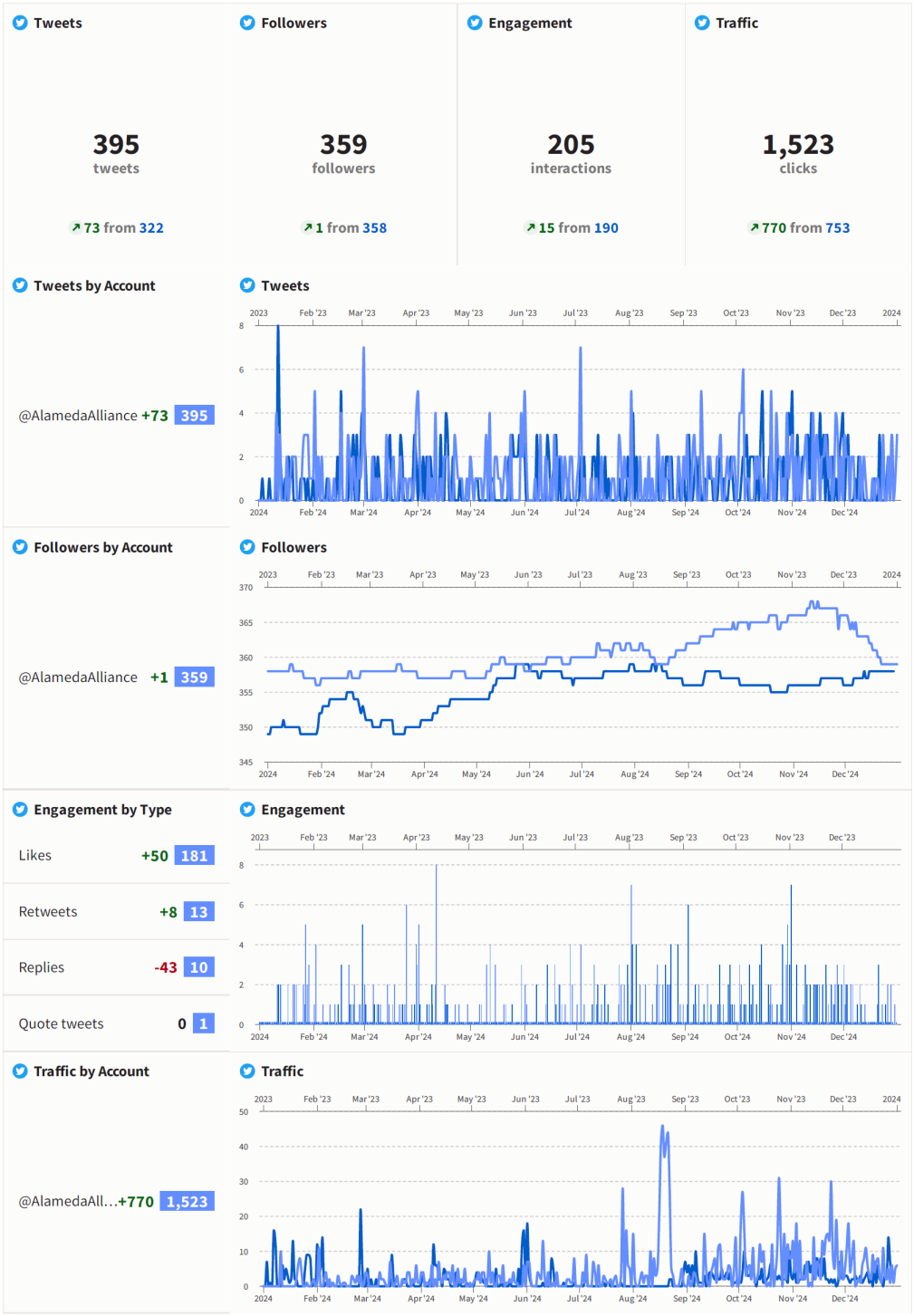


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\4. Annual 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE REPORT

2024 | Annual Report

TWITTER OVERVIEW:

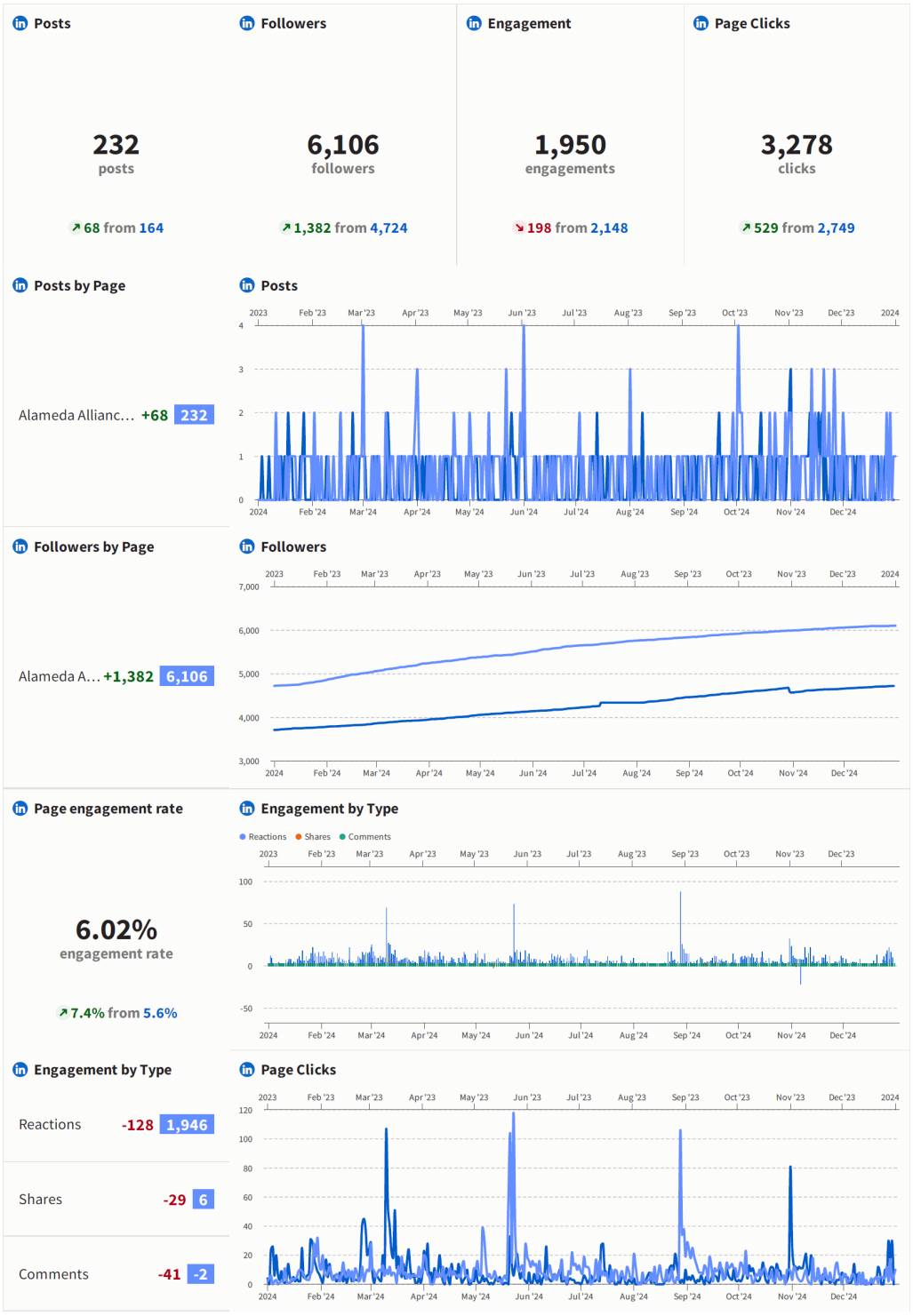


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\4. Annual 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE REPORT

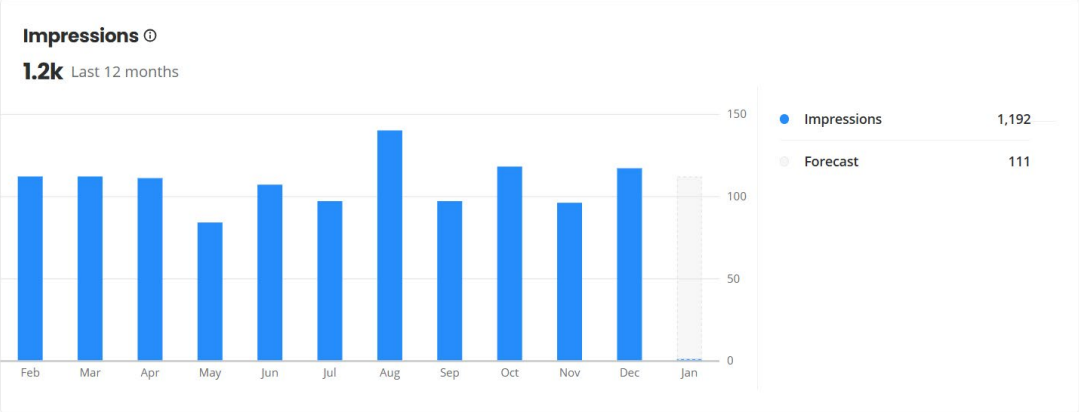
2024 | Annual Report

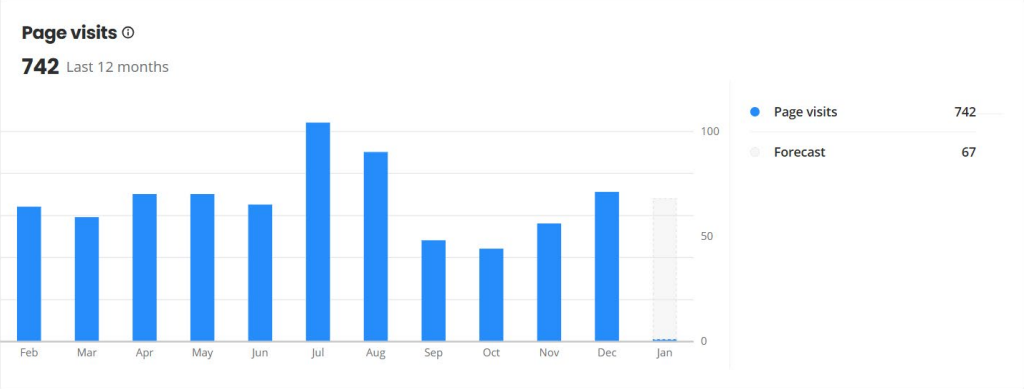
LINKEDIN OVERVIEW:

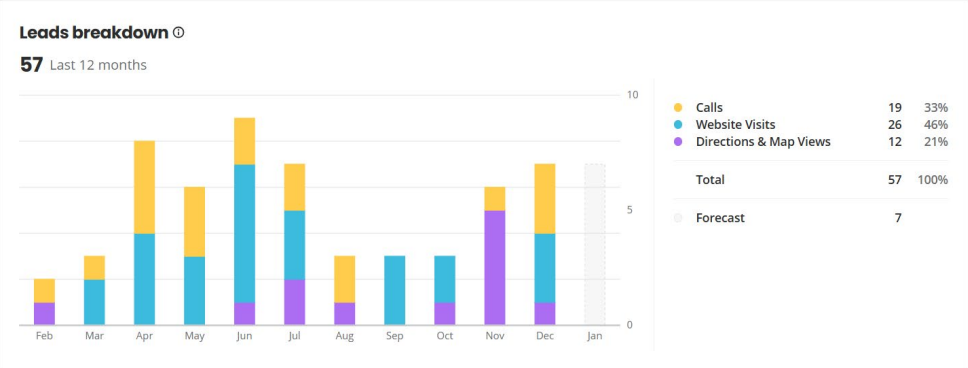


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\4. Annual 2024

YELP OVERVIEW:





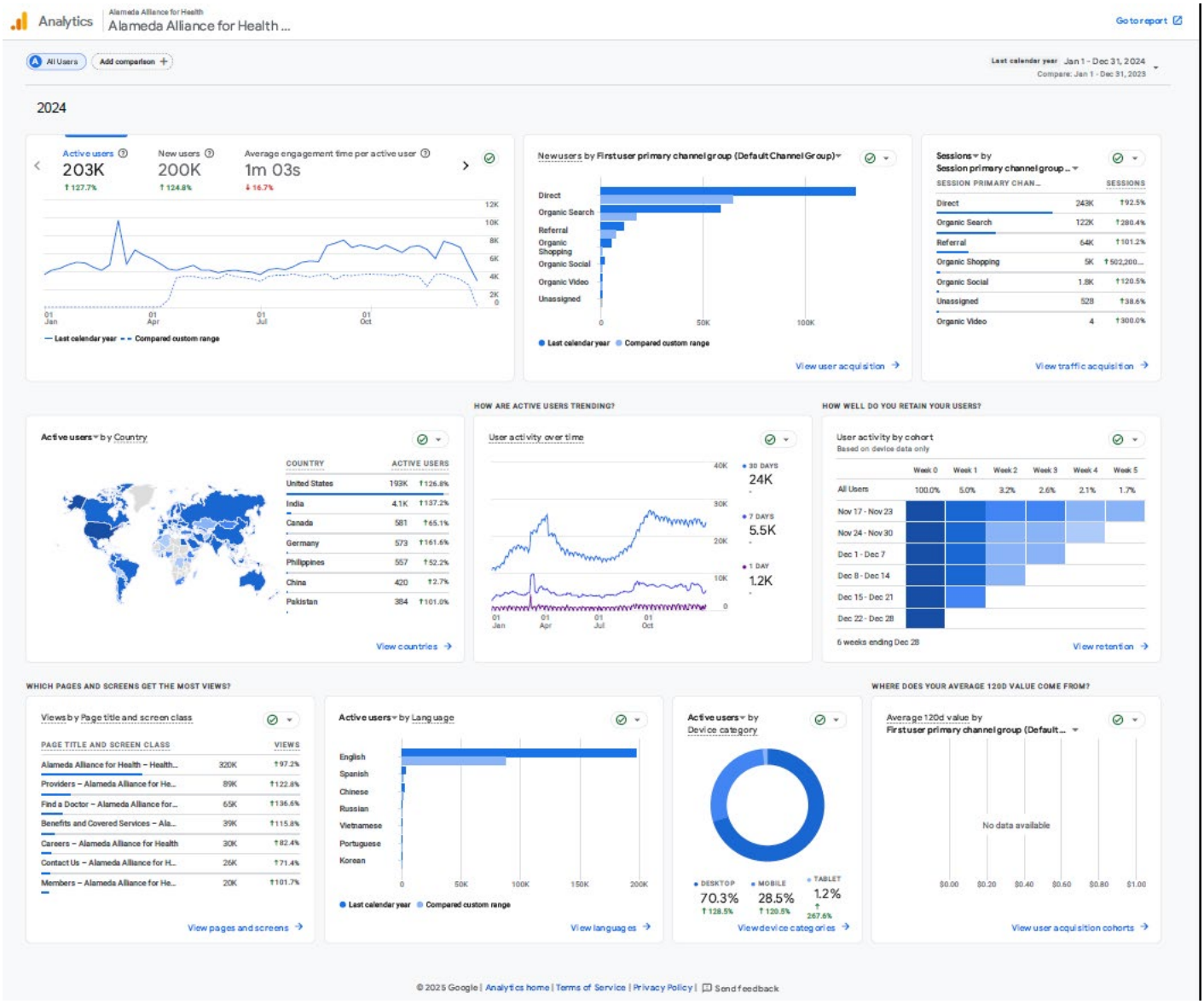


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\4. Annual 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE REPORT

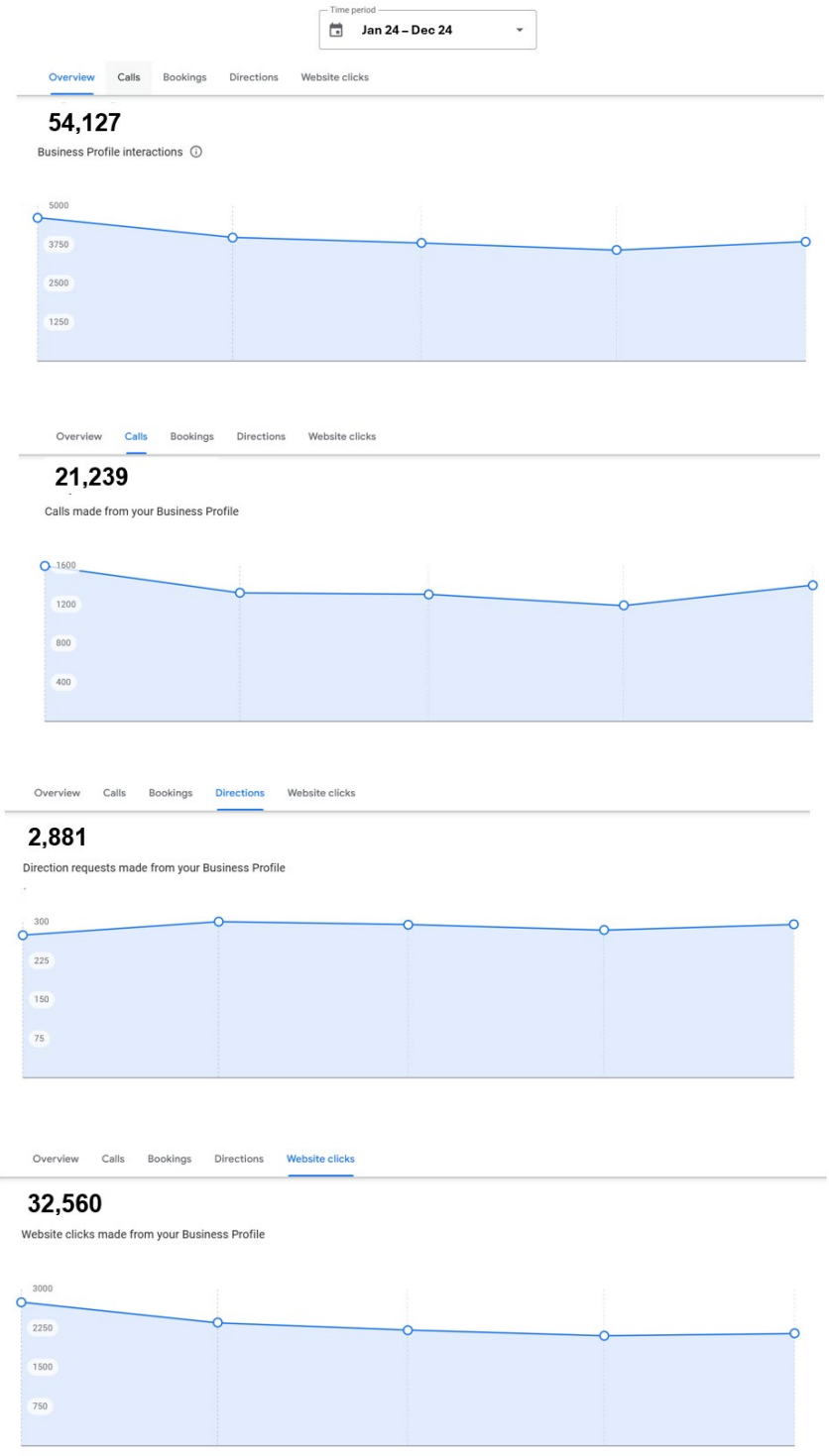
2024 | Annual Report

Alliance Website OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\4. Annual 2024

Google OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\4. Annual 2024

Compliance

Richard Golfin III

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

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

Date: **January 10th, 2025**

Subject: **Compliance Division Report**

Compliance Audit Updates

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

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

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

      Case files are due to DMHC on January 10th, 2025. On January 2nd, 2025, the Plan received an additional request for delegate case files related to Customer Service and Utilization Management. A request for one hundred and fifty-five (155) case files were made to Plan delegates CHCN, CFMG, and Carelon Health (Beacon). Delegate case files are due to the department on January 16th, 2025.The audit will be held onsite March 3rd, 2025 through March 7th, 2025 with virtual follow-up meetings to continue through March 14th, 2025.

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

    - The DHCS conducted its 2024 Routine Full Medical Survey from June 17th, 2024, through June 28th, 2024. The Plan received its Final Audit Report on November 18th, 2024, citing twenty (20) final audit findings. On December 23rd, 2024, the Plan's CAP response was submitted timely to the DHCS. CAP updates are provided to the DHCS on the 15th of each month with the next update due on January 15th, 2025.

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

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

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

    - On September 17th, 2024, the DHCS conducted its random full-scope FSR and MRR Review consistent with APL 22-017. The Final Report required a CAP from all ten (10) providers. The Plan submitted its CAP response to DHCS on November 21st, 2024. The PCP's CAPs are all closed and eight (8) were submitted to DHCS' Site Review Unit on December 6th, 2024. Due to the file sizes, two (2) CAPs are pending submission via-SFTP.

Compliance Activity Updates

- Centers for Medicare & Medicaid Services (CMS) D-SNP Application

    - The Plan is preparing to submit its CMS Medicare Advantage Dual Eligible Special Needs Plan application due on February 12th, 2025. The Plan will upload the application via-CMS' Health Plan Management System (HPMS). HPMS is a web enabled information system that facilitates data collection and reporting and provides ongoing operational support for Medicare Advantage and Part D programs. The Plan will need to submit the application annually.

- Department of Managed Health Care (DMHC) Medicare Filings – CY26 Medicare, 2024 EAE D-SNP Material Modification Filing (E-Filing *No. 20244060*):

    - The Plan received comments from the DMHC on November 21st, 2024. The responses to comments were due to DMHC by December 21st, 2024. Compliance worked with internal SMEs to provide adequate responses and submitted them on December 18th, 2024. The Plan expects DMHC to close by mid-January 2025.

- 2024 Corporate Compliance Annual Training

    - The Plan launched its Annual Corporate Compliance Trainings on Monday, September 9th, 2024. The training courses cover HIPAA, FWA, and Cultural Sensitivity. As of this writing, more than ninety-nine percent (99%) of staff have completed their assigned training.

- 2024 Board of Governors Training
    - As outlined in the Compliance Plan, the Plan has assigned HIPAA and FWA training to all new and standing members of the Board. Of the nineteen Board members, eight (42%) have either completed their training or submitted sufficient proof of equivalent outside training. The Plan is coordinating with the Board Clerk and the Board Chair to improve Board training rates of compliance.
- 2022 Behavioral Health Insourcing Material Modification:

Undertaking No. 6		
Undertaking Deliverable	**Progress**	**Next Milestone**
"Submit an Amendment filing to demonstrate compliance with the Federal Mental Health Parity and Addiction Equity Act ("MHPAEA") (42 USC § 300 gg-26) and its regulations (45 CFR § 146.136) and Section 1374.76 of the Act."	The Plan must demonstrate it does not impose financial requirements and/or treatment limitations on mental health/ substance use disorder (MH/SUD) benefits are on par with or are no more restrictive than the financial requirements and treatment limitations (TL) that it applies to medical/ surgical (Med/Surg) benefits in the same classification.	The Plan received five comments on November 27th. The Plan updated the applicable behavioral health policies for Group Care and submitted its responses on December 27h, 2024. The team expects that DMHC will be able to close this filing by the close of Q1 2025.

Compliance

Supporting Documents

Q1 2024 - PRESENT APL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
1	DHCS	24-001	1/12/2024	Street Medicine Provider: Definitions and Participation in Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on opportunities to utilize street Medicine providers to address clinical and non-clinical needs of their Medi-Cal Members experiencing unsheltered homelessness.
2	DMHC	24-001	1/12/2024	Amendment to Rule 1300.71.31 regarding calculation of the “Average Contracted Rate” for AB 72 (2016) purposes	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-001 to provide guidance to plans on the Amendment to section 1300.71.31 of title 28 of the California Code of Regulations (Rule 1300.71.31).
3	DMHC	24-002	1/22/2024	Large Group Renewal Notice Requirements	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-002 to provide guidance to plans on the timing and content requirements for renewal notices to large group contract holders under HSC section 1374.21 and HSC section 1385.046.
4	DMHC	24-003	1/29/2024	Plan Year 2025 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-003 to assist in the preparation of Plan Year 2025 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules).
5	DHCS	24-002	2/8/2024	Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members	MEDI-CAL	The purpose of this All Plan Letter (APL) is to summarize and clarify existing federal and state protections and alternative health coverage options for American Indian Members enrolled in Medi-Cal managed care plans (MCPs). Additionally, this APL consolidates various MCP requirements pertaining to protections for Indian Health Care Providers (IHCPs), including requirements related to contracting with IHCPs and reimbursing claims from IHCPs in a timely and expeditious manner. This APL also provides guidance regarding MCP tribal liaison requirements and expectations in relation to their role and responsibilities.
6	DMHC	24-004	2/22/2024	Coverage of Over-the Counter FDA Approved Contraceptives	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-004 to remind health plans, effective January 1, 2024, the rules changed regarding health plan coverage of over-the-counter (OTC) contraceptive drugs, devices, and products approved by the federal Food and Drug Administration (FDA).
7	DMHC	24-005	3/11/2024	Change Healthcare Cyberattack	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-005 to encourage health plans to be flexible to ensure stability of the health care system following the cyberattack of Change Healthcare
8	DMHC	24-006	3/20/2024	Provider Directory Annual Filing Requirements	GROUP CARE & MEDI-CAL	This All Plan Letter (APL) reminds health care service plans of California Health and Safety Code section 1367.27, subdivision (m)’s requirement to annually submit provider directory policies and procedures to the Department of Managed Health Care (Department).
9	DHCS	24-003	3/28/2024	Abortion Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCP) with information regarding their responsibility to provide Members with timely access to abortion services.
10	DMHC	24-007	4/3/2024	Implementation of Senate Bill 855 Regulation, Mental Health and Substance Use Disorder Coverage	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-007 to provide guidance regarding implementation of the regulation as well as filing and compliance requirements for commercial full-service health plans and specialized health care service plans (plan or plans) offering behavioral health services.
11	DHCS	24-004	4/8/2024	Quality Improvement and Health Equity Transformation Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to notify Medi-Cal managed care plans (MCPs), including MCPs delivering services to Members with specialized health care needs under the Population-Specific Health Plan (PSP) model, of requirements for quality and health equity improvement. Unless otherwise noted, all MCP requirements set forth in this APL apply to PSPs.
12	DMHC	24-008	4/15/2024	2024 Health Plan Annual Assessments	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-008 to provide information to health care service plans (health plans) pertaining to the DMHC’s fiscal year (FY) 2024-25 annual assessments.
13	DHCS	24-005	4/29/2024	California Housing and Homelessness Incentive Program	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCP) with guidance on the incentive payments linked to the Housing and Homelessness Incentive Program (HHIP) implemented by the California Department of Health Care Services (DHCS) in accordance with the Medi-Cal Home and Community-Based Services (HCBS) Spending Plan.
14	DMHC	24-008	4/15/2024	2024 Health Plan Annual Assessments	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-008 to provide information to health care service plans (health plans) pertaining to the DMHC’s fiscal year (FY) 2024-25 annual assessments.

#	Regulatory Agency	APL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
15	DMHC	24-009	5/6/2024	Change Healthcare Cyberattack Response Filing	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-009 to request information from plans regarding their response and outreach to enrollees potentially impacted by the Change Healthcare cyberattack.
16	DHCS	24-006	5/13/2024	Community Health Worker Services Benefit	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the qualifications for becoming a Community Health Worker (CHW), the definitions of eligible populations for CHW services, and descriptions of applicable conditions for the CHW benefit.
17	DMHC	24-010	6/13/2024	Coverage of Ground Ambulance Services Provided by a Noncontracted Provider	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-010 to provide additional guidance regarding Assembly Bill 716.
18	DMHC	24-011	6/17/2024	Request for Health Plan Information and Addendum Revisions	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-011 to notify health care service plans the Department has revised the attached, Request for Health Plan Information (RHPI) and RHPI Addendum forms.
19	DHCS	24-007	6/20/2024	Targeted Provider Rate Increases	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on Network Provider payment requirements applicable to Medi-Cal Targeted Rate Increases (TRI), as defined herein, effective for dates of service on or after January 1, 2024.
20	DHCS	24-008	6/21/2024	Immunization Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify requirements related to the provision of immunization services.
21	DHCS	20-016	6/24/2024	Blood Lead Screening of Young Children (TECHNICAL CHANGE)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements for blood lead screening tests and associated monitoring and reporting for Medi-Cal managed care plans (MCPs).
22	DMHC	24-012	6/25/2024	Single Point of Contact for Hospitals to Request Authorization for Poststabilization Care	GROUP CARE & MEDI-CAL	This All Plan Letter (APL) reminds plans they may not require a hospital to make more than one telephone call to request authorization to provide poststabilization care to plan enrollees.
23	DMHC	24-013	6/28/2024	Health Equity and Quality Program Policies and Requirements	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-013 to inform all health care service plans (health plans) of the DMHC Health Equity and Quality (HEQ) program policies and requirements. The instructions provided herein supersede those previously published in APL 22-028 and REVISED APL 23-029.
24	DMHC	24-014	7/8/2024	Guidance Regarding Dental Rate Review Reporting Requirements	N/A	Assembly Bill 1048 (Wicks, 2023) added section 1385.14 to the California Health and Safety Code. Section 1385.14 requires health plans offering a specialized health care service plan contract covering dental services to file premium rate information and information regarding the methodology, factors, and assumptions used to determine rates with the Department of Managed Health Care (DMHC) annually and at least 120 days before implementing any change in the methodology, factors, or assumptions that would affect rates. This All Plan Letter (APL) provides guidance on dental rate review filing requirements.
25	DMHC	24-015	7/22/2024	High Deductible Health Plan Products and Coverage of COVID-19 Testing	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-015 which addresses coverage of COVID-19 tests delivered to enrollees in high deductible health plan (HDHP) products.
26	DMHC	24-016	7/25/2024	Request for Health Plan Contact Information	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-016 to request that all health care service plans (health plans) provide the Department with updated health plan contact information.
27	DMHC	24-017	7/31/2024	RY 2025 MY 2024 Provider Appointment Availability Survey NPMH Provider Follow-Up Appointment Rate of Compliance	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) hereby issues APL 24-017 (OPM) – RY 2025/MY 2024 Provider Appointment Availability Survey NPMH Provider Follow-Up Appointment Rate of Compliance.
28	DMHC	24-018	8/15/2024	Compliance with Senate Bill 923	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) hereby issues All Plan Letter (APL) 24-018 – Compliance with Senate Bill 923 to provide guidance regarding the implementation of SB 923, including filing and compliance requirements for all full-service and certain specialized health care service plans (plan or plans).
29	DHCS	24-009	9/16/2024	Skilled Nursing Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) on the Skilled Nursing Facility (SNF) Long Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of Medi-Cal members to managed care.

#	Regulatory Agency	APL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
30	DHCS	24-010	9/16/2024	Subacute Care Facilities - Long Term Care Benefit Stnadardization and Transition of Members to Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) on the Subacute Care Facility Long Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of Medi-Cal members to managed care.
31	DHCS	24-011	9/16/2024	Intermediate Care Facilities for Individuals with Developmental Disabilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) for the Long-Term Care (LTC) Intermediate Care Facility/Home for Individuals with Developmental Disabilities services provisions of the California Advancing and Innovating Medi-Cal (CalAIM) benefit standardization initiative. This APL contains requirements related to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes.
32	DHCS	24-012	9/17/2024	Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) regarding requirements for Member outreach, education, and assessing Member experience for Non-Specialty Mental Health Services (NSMHS), as required by Senate Bill (SB) 1019 (Gonzalez, Chapter 879, Statutes of 2022).
33	DHCS	24-013	9/18/2024	Managed Care Plan Child Welfare Liaison	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify the intent and objectives of the Medi-Cal managed care plan (MCP) Child Welfare Liaison, formerly referred to as the Foster Care Liaison, as outlined and required by the 2024 MCP Contract (MCP Contract) with the Department of Health Care Services (DHCS). Additionally, this APL provides guidance regarding the requirements and expectations in relation to the role and responsibilities of the MCP Child Welfare Liaison.
34	DHCS	24-014	9/27/2024	Continuity of Care for Medi-Cal Members who are Foster Youth and Former Foster Youth in Single Plan Counties	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) in Single Plan counties with guidance on enhanced continuity of care protections for Foster Youth and Former Foster Youth Medi-Cal members who live in a Single Plan county and are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) to enroll as Members in Medi-Cal managed care.
35	DMHC	24-019	10/30/2024	Amendments to Rule 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2025	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to inform health care service plans (health plans) of new amendments to 28 CCR § 1300.67.2.2 and the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for the reporting year (RY) 2025 Annual Network Report submission.
36	DHCS	18-022	10/31/2024	Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services (TECHNICAL CHANGE)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify the requirements for Medi-Cal managed care health plans (MCPs) regarding their responsibilities to provide members with access to freestanding birth centers (FBCs) as well as to services provided by Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs).
37	DHCS	23-024	11/3/2024	Doula Services (TECHNICAL CHANGE)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the qualifications for providing doula services, effective for dates of service on or after January 1, 2023.
38	DMHC	24-020	11/13/2024	RY 2026/MY 2025 Provider Availability Survey Manual and Report Form Amendments	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide notice to health care service plans (health plans) of amendments to Rule 1300.67.2.2 and the following reporting year (RY) 2026/measurement year (MY) 2025 Timely Access Compliance Report documents: Provider Appointment Availability Survey (PAAS) Manual, PAAS Report Forms and the Timely Access Submission Instruction Manual (TA Instruction Manual).
39	DHCS	24-016	12/5/2024	Diversity, Equity, and Inclusion Training Program Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the Diversity, Equity, and Inclusion (DEI) training program requirements.
40	DHCS	24-017	12/5/2024	Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the transgender, gender diverse, intersex (TGI) cultural competency training program and Provider Directory changes required by Senate Bill (SB) 923 (Chapter 822, Statutes of 2022) for the purpose of providing trans-inclusive health care to MCP Members.
41	DMHC	24-021	12/12/2024	Notice of Amendments to Rules 1300.67.2.1, 1300.67.2 and Incorporated Documents – Network Adequacy Standards and Methodology for RY 2025	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to notice amendments to 28 CCR § 1300.67.2.1, 28 CCR § 1300.67.2, and documents incorporated by reference. References to “Rule” refer to the California Code of Regulations (CCR), title 28. The amendments are noticed pursuant to Senate Bill (SB) 225 (Wiener, Chapter 601, Statutes of 2022).

#	Regulatory Agency	APL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
42	DHCS	24-018	12/13/2024	Medical Loss Ratio Requirements For Subcontractors And Downstream Subcontractors	MEDI-CAL	The purpose of this All-Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on the Medical Loss Ratio (MLR) requirements set forth by the federal Centers for Medicare & Medicaid Services (CMS) in the California Advancing & Innovating Medi-Cal (CalAIM) Section 1915(b) waiver's Special Terms and Conditions (STCs) and pursuant to the MCPs' contractual requirements in Exhibit A, Attachment III, Provision 3.1.5(B)(31).
43	DMHC	24-022	12/13/2024	Children and Youth Behavioral Health Initiative, Certified Wellness Coaches	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC), together with the Department of Health Care Access and Information (HCAI), issues this All-Plan Letter (APL) 24-022 - Children and Youth Behavioral Health Initiative, Certified Wellness Coaches to provide health care service plans with information regarding the establishment of the state Wellness Coach certification program and encourage health plans to provide access to Wellness Coach services as a means of increasing behavioral health resources to health plan members.
44	DMHC	24-023	12/20/2024	Newly Enacted Statutes Impacting Health Plans (2024 Legislative Session)	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) 24-023, which outlines the newly enacted statutory requirements for health care service plans (plans) regulated by the Department of Managed Health Care (DMHC).
45	DHCS	24-019	12/31/2024	Minor Consent to Outpatient Mental Health Treatment or Counseling	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) regarding the provision of non-specialty mental health outpatient treatment or counseling services to minors as a result of Assembly Bill (AB) 665 (Chapter 338, Statutes of 2023)1 which amended Family Code (Fam. Code) section 6924.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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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

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

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

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

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

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

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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**			
#	**Category**	**Deficiency**	**Department Responsible**
1	Grievances & Appeals	When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform complainants of their right to contact the Department.	G&A
3	Grievances & Appeals	The Plan does not correctly display the statement required by Section 1368.02(b) in all required enrollee communications.	G&A Member Services UM Rx
6	Prescription (Rx) Drug Coverage	The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.	Rx

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

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

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

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

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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
4	Access and Availability	(3.1.1) First Prenatal Visit The Plan's policies and procedures for a first prenatal visit for a pregnant member is not compliant with the standard of two weeks upon request.	The Plan has edited Timely Access Standard table, policy QI-107 and QI-114 to reflect the first prenatal visit standard within 2 weeks of the request. (Completed)	Q4 2023	Completed	Quality	State	DHCS	2023
5	Family Planning and State Supported Services	(3.6.1) Non-contracted Provider Payments The Plan did not pay non-contracted providers at the appropriate Medi-Cal fee-for-service rate.	A Change Request was entered to change non-contract mid-level providers reimbursements to 100% of the Medi-Cal rate moving forward. (Completed)	11/16/2023	Completed	Claims	State	DHCS	2023
6	Family Planning and State Supported Services	(3.6.2) Proposition 56 Family Planning Payments The Plan did not distribute add-on payments for institutional family planning service claims as required by APL 22-011.	1. P&P has been revised to ensure that Family Planning services paid on institutiona claims are paid As part of Prop 56 payments. 1a. The Plan's Analytics Team is in the midst of preparing the payment details for the retro payment on the FP institutional data and looking to complete by 11/30/2023 timeline. (On Track) 2. The Analytics dept has calculated the retroactive payments due to facilities as a result of finding 3.6.2, APL 22-011 and APL 23-008. (On Track) 2a. Payments will be distributed to providers prior to or latest by Nov 30, 2023. (On Track) 2b. Facility providers with qualifying Family Planning services as per APL 23-008 will be included as part of our monthly Prop 56 payment processing going forward starting Dec 2023. (On Track)	1/15/2024	Completed	Claims	State	DHCS	2023
7	NMT & NEMT	(3.8.1) R Physician Certificate Statement (PCS) Forms The Plan did not ensure PCS forms were on file for members receiving NEMT services.	1.The Plan made the decision to no longer allow courtesy NEMT trips for members without a PCS form on file and the decision to insource PCS form acquisition to the Plan's Case Management Department beginning 3/1/23. Working alongside the Plan's transportation subcontractor, the Plan created new workflows to ensure the transportation subcontractor was not scheduling NEMT trips for members unless there was a confirmed valid PCS form on file, or the Plan provided a verbal authorization due to a trip being of an urgent nature. The Plan hired two transportation coordinators to focus on PCS acquisition leveraging the Plan's preexisting relationships with the provider network and access to EHR's. Through the end of 2022 and beginning of 2023, the Plan's transportation subcontractor trained its call center agents on the new workflow. On 2/14/23, the Plan trained its transportation coordinators on PCS acquisition. On 2/21/23, the Plan trained its entire case management team, that participates in phone shifts for the Plan's case management phone line, on the parameters for verbal authorizations for NEMT trips of an urgent nature. The Plan continues to report on the success of the new workflows at the Plan's UM Committee. (On Track) 1a.The Plan is working with its analytics team to create a report using PCS data elements to match up against subcontractor's report of all NEMT trips taken each month. This report will assist in finding any gaps in PCS compliance. The Plan estimates this report to go live 12/1/2023. (On Track)	12/15/2023	Completed	Case Management	State	DHCS	2023
8	NMT & NEMT	(3.8.2) Transportation Providers' Medi-Cal Enrollment Status The Plan did not ensure all transportation providers were enrolled in the Medi-Cal program.	The Plan has updated the P&P VMG-005 from reviewing the Transportation Providers (TP) on a quarterly review to a monthly review. Attached for reference is the updated P&P. The Plan began reviewing the TP monthly for the utilization from April 2023 to current. (Completed and Ongoing)	4/1/2023	Completed	Vendor Management	State	DHCS	2023

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ALAMEDA Alliance FOR HEALTH

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Health Care Services

Donna Carey, MD

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

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

Date: **January 9th, 2025**

Subject: **Health Care Services Report**

2023 Trilogy Document Summary

Case Management (CM)

- Types of CM: Enhanced Case Management (ECM), Complex Case Management (CCM), Basic Case Management (BCM), Care Coordination, Transitional Care Services (TCS)

- Trilogy documents also include CM teams of Behavioral Health and Long-term Support Services

- Health Risk Assessment (HRA) & HIF/MET Screener
    - Overall, 12% HRA completion rate (2% decrease compared to 2022)
    - Increase in HIF/MET screening return rate in Q4 2023

- Case Volumes (open/active)
    - PH Care Coordination: average 434 cases/month
    - BH Care Coordination: average 147 cases/month
    - Disease Management – Asthma: 128 members served
    - Disease Management – Diabetes: 514 members served
    - Complex Case Management: average 34 cases/month
    - Enhanced Case Management: 972 adults & 369 children/youth served
    - Transitional Care Services: average 253 cases/month

- Opportunities incorporated into 2024 Program/Workplan:
    - Incorporate DHCS PHM Key Performance Indicators into the workplan:
        - Increase % members enrolled in CCM & ECM
        - Care manager engagement for high-risk members within 7 days post-discharge
    - Expand ECM network providers (to increase access to ECM services)
    - Expand CS services and network providers (to increase access to and availability of CS services)

Utilization Management (UM)

- Authorization Volumes
    - Significant increase in total auth volume (+99,578 compared to 2022)
        - Membership growth, increased utilization with LTC membership
        - System and reporting configuration updates leading to more accurate data capture

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

- Authorization Turn-Around Times (goal = 95%)
    - Inpatient/outpatient: overall 98%, above goal
    - LTC: overall 97%, above goal
    - BH: overall 82%, below goal

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

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

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

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

- There was a month-over-month increase in total authorization volume from November to December 2024.

Total Authorization Volume (Medical Services)			
Authorization Type	**October 2024**	**November 2024**	**December 2024**
Inpatient	3,127	2,755	3,346
Outpatient	5,257	4,090	4,310
Long-Term Care	736	691	918
Total	**9,120**	**7,536**	**8,574**

***Source**: #02569_AuthTAT_Summary*

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

Utilization Management: Outpatient

- Anthem CoC volume has reduced to 5-7% of all incoming authorizations at any given time. Adult expansion CoC represents 4%.

- We have successfully transitioned Anthem DME under CoC to our in-network provider CHME. Final transition will occur at the end of the year when our specific Anthem CoC DME contracts expire.

- The team is also preparing for the transition of the Foster Youth Population to ensure CoC. Open DHCS treatment authorizations have been identified for case creation 1/1/25. For OON providers identified as having foster youths in active treatment, contracting is making initial contact with the providers for ongoing services. Those providers who agree to continue care will have authorizations generated in January when our eligibility files are received. For members where their previous providers won't be continuing services, CM will work with the members to secure in-network providers for their ongoing care needs.

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

- OP processed a total of 4,310 authorizations in the month of December.

- OP Turnaround times continue to exceed the benchmark of 95% with the average being 99% in the month of December.

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

Total Outpatient Authorization Volume			
Authorization Status	**October 2024**	**November 2024**	**December 2024**
Approvals	5,041	3,885	4,088
Partial Approvals	25	27	28
Denials	191	178	194
Total	**5,257**	**4,090**	**4,310**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**October 2024**	**November 2024**	**December 2024**
Overall Denial Rate	**3.1%**	**3.5%**	**3.1%**
Denial Rate Excluding Partial Denials	**2.8%**	**3.2%**	**2.8%**
Partial Denial Rate	**0.3%**	**0.3%**	**0.3%**

***Source**: #03690_Executive_Dashboard*

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

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- As of November 1st, 2024 IP UM implemented TAT change from 24 hours to 72 hours for concurrent review determination and notification, in alignment with regulatory guidance, applying to all lines of business. Provider notification was sent, with a reminder that TAT for notification of acute admission and prior authorization requirements have not changed. The change was operationalized internally. Staff training, monitoring and oversight for adherence to TAT change are ongoing.

- Total inpatient auth volume increased from 2,755 in November to 3,346 authorizations processed in December.

- Inpatient overall average LOS continues to remain consistent from 5.4 in September, to 5.5 in October and 5.4 in November. Trends in admits per thousand from show mild variability with 50.7 in September, 53.9 in October and back down to 52.7 in November. Days per thousand aligned with admits per 1,000 with a spike in the month of October from 275.0 in September to 294.2 in October and 285.6 in November. The trend is consistent among Child, Adult, ACA and SPD categories.

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

- IP Auth TAT compliance continues to surpass benchmark, with overall TAT of 99% in October, 97% in November and 96% in December.

- IP UM team identifies members eligible for care management services including ECM, and those enrolled in LTC, who are currently admitted to a hospital. Team conducts inpatient discharge risk assessment, provides the name of Care Manager for inclusion in the discharge summary, and refers to Case Management departments for follow up. The TCS process continues to be refined to ensure all members with care transitions receive the correct level of support.

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

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

- We have initiated interdisciplinary rounds with ABSMC to discuss members with specific complex heart failure conditions that are resulting in high ER and Inpatient Utilization with the goal of ensuring care coordination post-discharge and decreased LOS.

Total Inpatient Authorization Volume			
Authorization Status	**October 2024**	**November 2024**	**December 2024**
Approvals	3,079	2,717	3,281
Partial Approvals	0	0	0
Denials	48	38	65
Total	**3,127**	**2,755**	**3,346**

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**September 2024**	**October 2024**	**November 2024***
Authorized LOS	**5.4**	**5.5**	**5.4**
Admits/1,000	**50.7**	**53.9**	**52.7**
Days/1,000	**275.0**	**294.2**	**285.6**

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

Inpatient Authorization Denial Rates			
Denial Rate Type	**October 2024**	**November 2024**	**December 2024**
Full Denials Rate	**0.8%**	**1.1%**	**1.0%**
Partial Denials	**2.1%**	**1.2%**	**1.7%**
All Types of Denials Rate	**2.8%**	**2.4%**	**2.7%**

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance			
Line of Business	**October 2024**	**November 2024**	**December 2024**
Overall	**99%**	**97%**	**96%**
Medi-Cal	**99%**	**97%**	**95%**
IHSS	**100%**	**96%**	**97%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during December 2024 was 2,406 members. This is a decrease of 1.63% from November 2024.

- Month to Month, the admissions, days and readmissions are decreasing. From August to October the admissions decreased by 35.14%, the days decreased by 50.59% and the readmissions also decreased by 18.52%. Some of this could be due to a lag in claims data being available, but we are seeing a decrease overall.

Totals	September 2024	October 2024	November 2024*
Admissions	117	126	50
Days	787	750	280
Readmissions	32	33	19

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

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

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

- 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 monthly and quarterly basis depending on census to assist with discharge planning and access to other resources. The team continues referrals to TCS and other internal/external programs to provide wraparound support to members preparing to discharge from an LTC custodial facility.

- LTSS Liaison is visiting and meeting with facilities to discuss any claims issues and educating on processes.

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

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

- Authorization volume increased in December, compared to November 2024.

- Authorization processing turn-around time (TAT) increased to 94% in December 2024 and remains below threshold. This is related to staffing gaps; temporary staff started in mid-December and are moving through onboarding & training quickly to support production volumes.

Total LTC Authorization Volume			
Authorization Status	**October 2024**	**November 2024**	**December 2024**
Approvals	694	647	863
Partial Approvals	0	0	0
Denials	42	44	55
Total	**736**	**691**	**918**

Source: #02569_AuthTAT_Summary
****Numbers change month over month based on the void and copy process to adjust authorizations for bed holds***

LTC Turn Around Time Compliance			
Line of Business	**October 2024**	**November 2024**	**December 2024**
Medi-Cal	**97%**	**92%**	**94%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Behavioral Health

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

Total BH Authorization Volume			
	24-Oct	**24-Nov**	**24-Dec**
Approvals	589	474	634
Partial Approval	0	0	0
Denials	2	1	2
Total	591	475	636

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
**Goal ≥95%*	**24-Oct**	**24-Nov**	**24-Dec**
Determination TAT%	99%	95%	98%
Notification TAT%	94%	97%	97%

Source: 14939_BH_AuthTAT

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
*Goal ≥95%	24-Oct	24-Nov	24-Dec
Determination TAT%	97%	98%	100%
Notification TAT%	99%	100%	96%

Source: 14939_BH_AuthTAT

Behavioral Health Denial Rates

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

Source: 14939_BH_AuthTAT

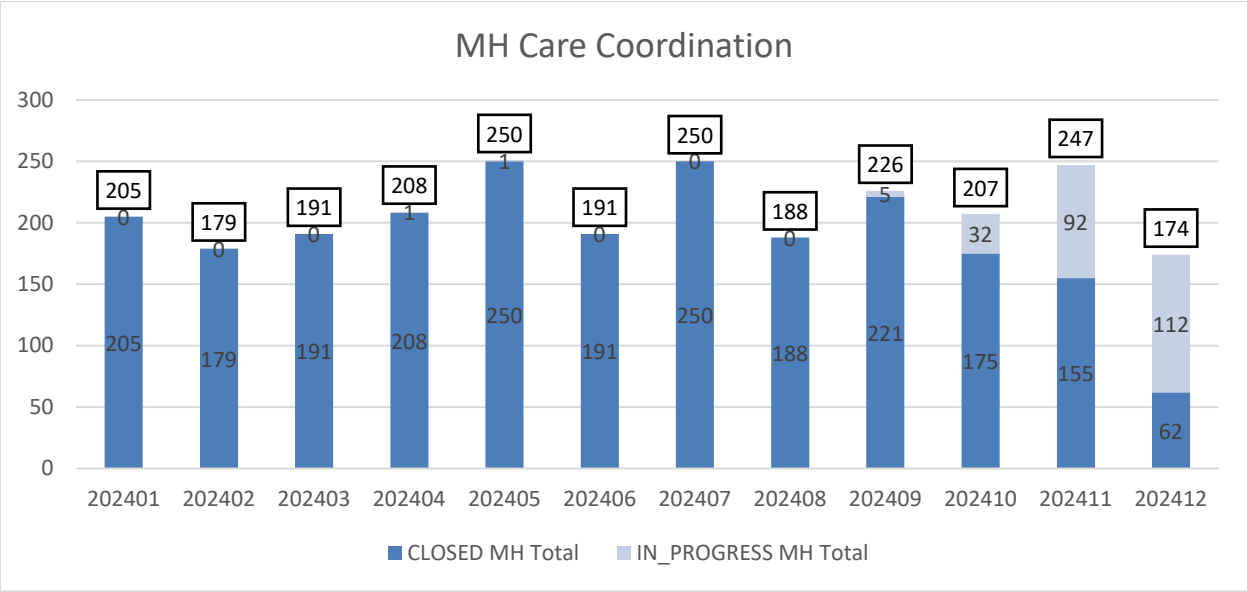
Mental Health Care Coordination

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

Total # Medi-Cal Screening Tools			
	24-Oct	24-Nov	24-Dec
Youth Screenings	60	60	69
Adults Screenings	127	124	134

Source: PBI_14460 – MLS BH TruCare Assessments

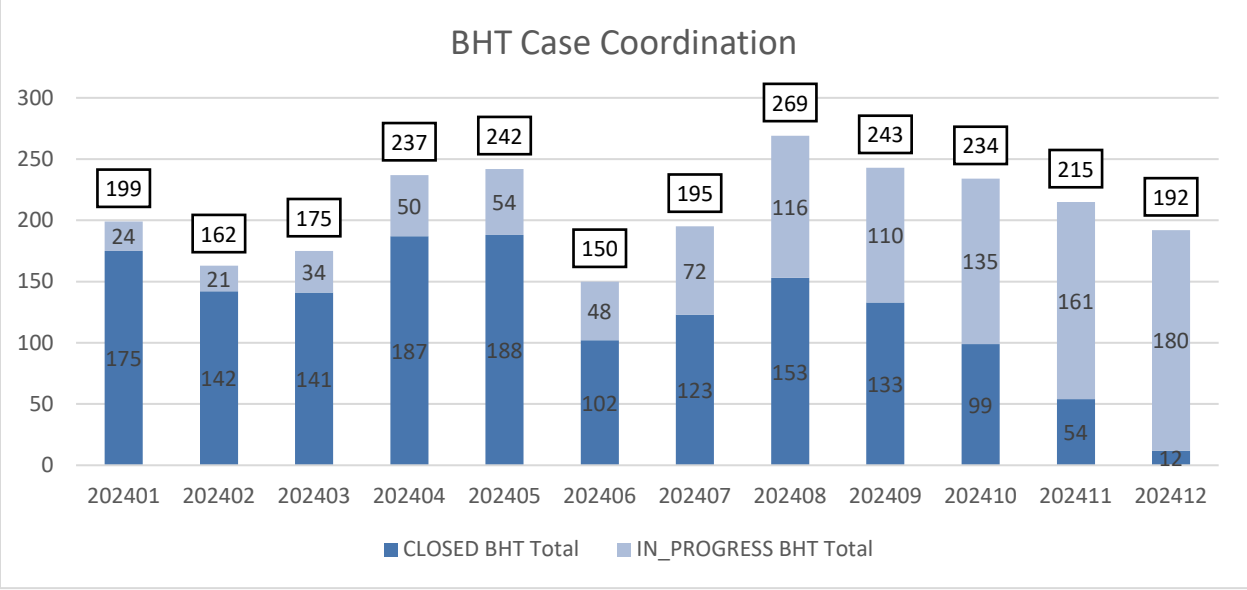
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA)

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

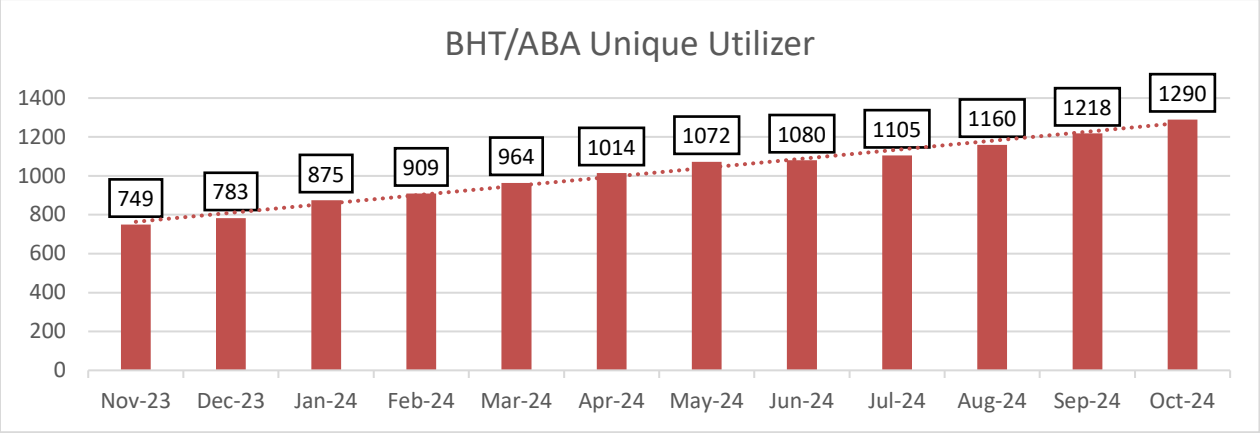


Source: 14665_BH_Cases

Behavioral Health Unique Utilizers

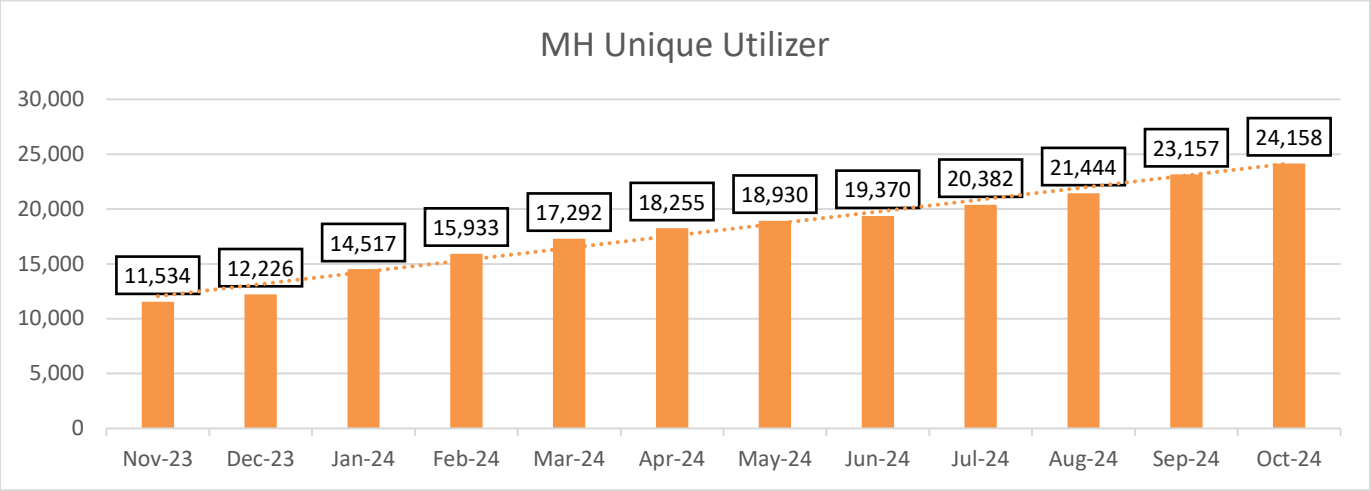
- Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.

- We observed a continuing rise in unique utilizers of BHT/ABA services, reflecting a 6% increase compared to the previous month.



Source: PBI 14621 BHT Utilization Report

- The number of unique utilizers of mental health services has increased by 4% compared to the previous month.



Source: PBI 14637 BH12M Report

Pharmacy

- The Pharmacy Transitional Care Services (TCS) program is focused on helping outreach to members after hospital discharge to help prevent readmission due to medication related errors, with a focus on lower-volume but higher-risk cases. Current diagnoses of focus are heart failure and sepsis, with plans of adding more diagnoses in the near future. There has been an increase in direct referral case volume thanks to interdepartmental collaboration with Case Management. Upcoming Pharmacy TCS projects include reviewing data from our highest recurring readmit members to assist in filling gaps between members and providers.

Case and Disease Management

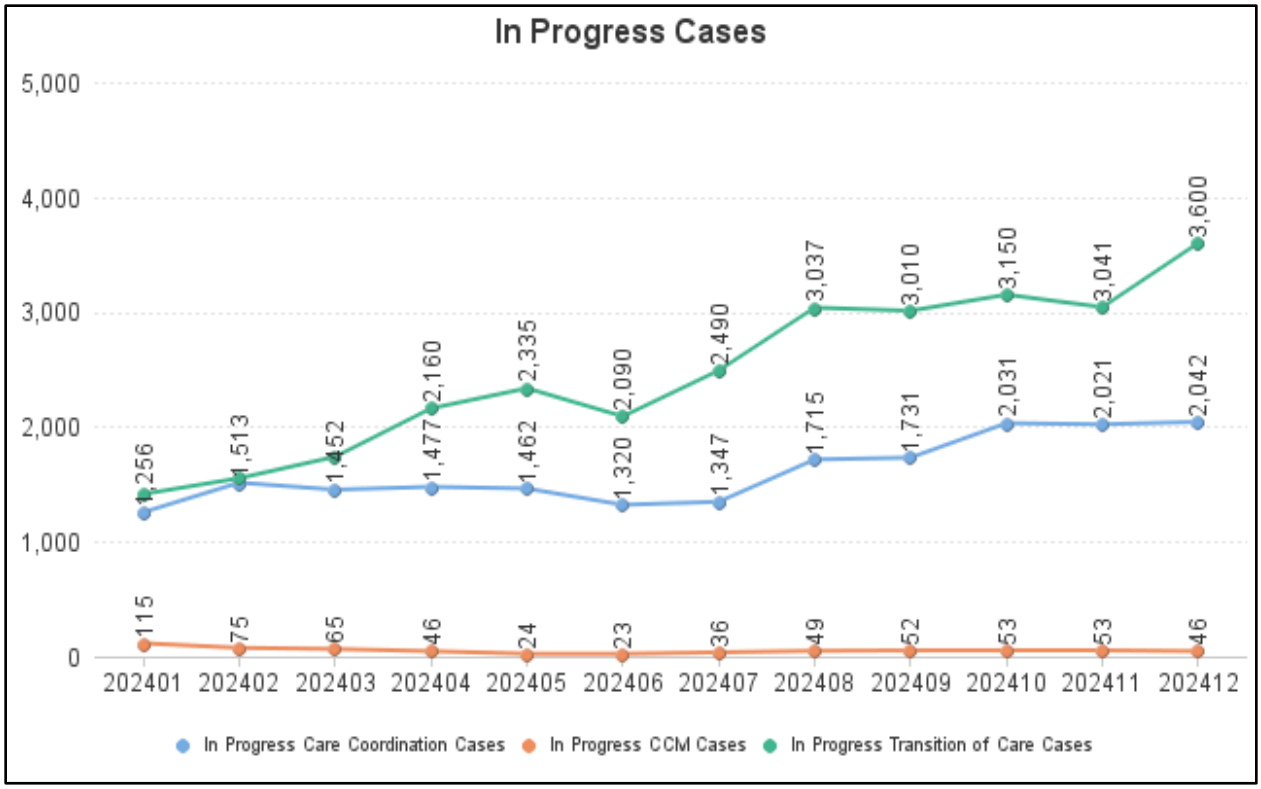
- The CM Team is assisting with coordination of continuity of care for the incoming foster youth population.

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

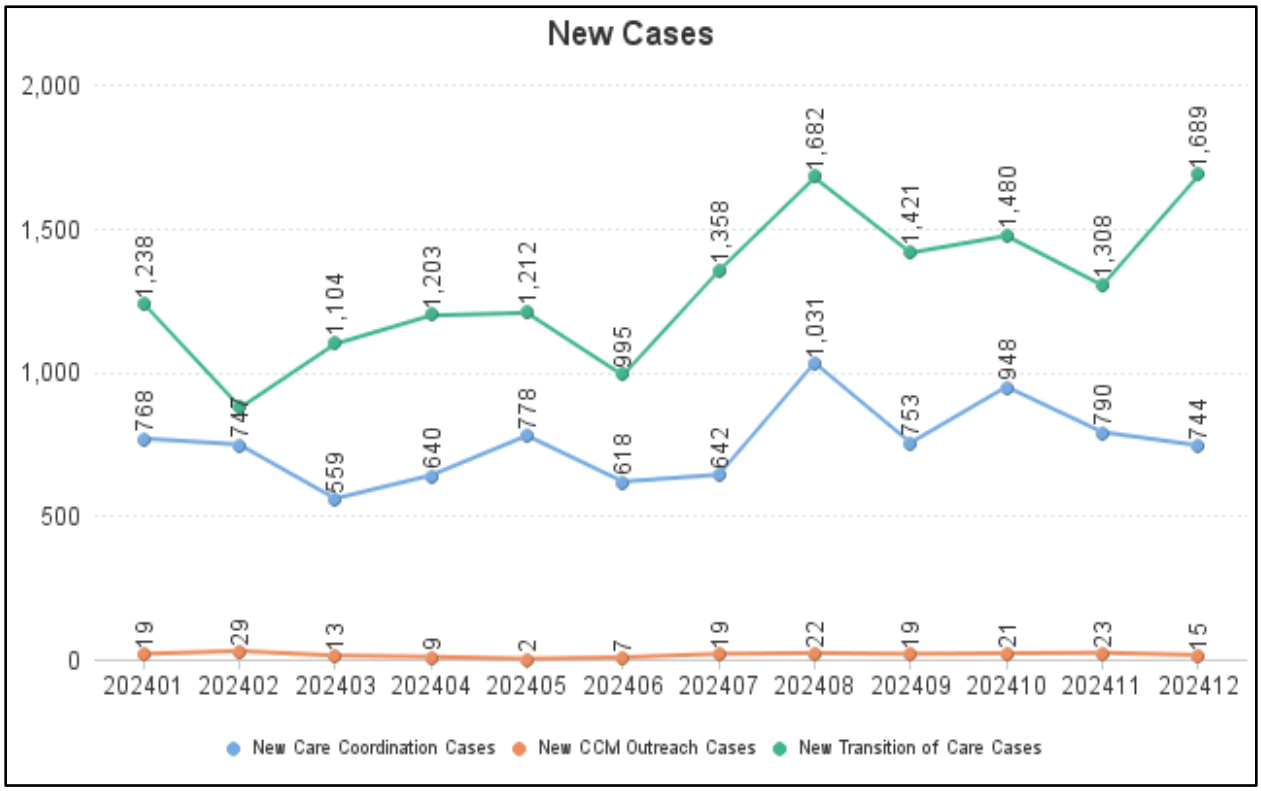
- The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including but not limited to scheduling and ensuring follow-up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners,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

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

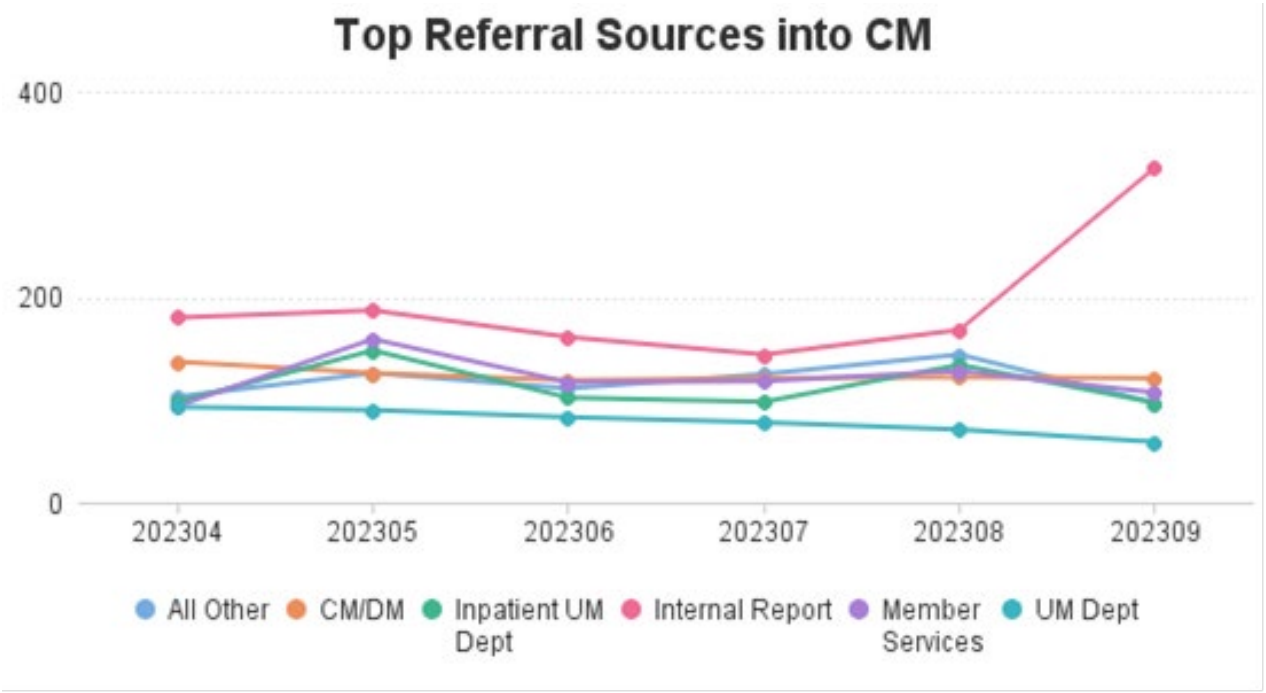
- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues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



Source: #03342 TruCare Caseload



Source: #03342 TruCare Caseload



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

CalAIM

Enhanced Case Management

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

- The Alliance continues to meet with Roots regarding the Justice Involved (JI) Pilot. The Alliance has gained a better understanding of how previously incarcerated members are assisted post-release, including member interest in any level of case management service.

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

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

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

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

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

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

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

	September 2024		October 2024		November 2024	
ECM Providers	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**
ACBH	-	14	-	14	-	14
Alameda Health System (AHS)	13	214	16	191	13	197
Bay Area Community Services (BACS)	-	108	6	118	-	122
California Cardiovascular Consultants	-	176	-	170	-	170
California Children's Services (CCS)	16	22	16	21	11	23
CHCN	67	882	66	928	83	968
East Bay Innovations (EBI)	-	110	2	111	2	114
Full Circle	115	223	68	215	-	191
Institute on Aging	8	183	333	202	-	201
La Familia	57	39	36	33	-	32
MedZed	27	540	41	537	49	541
Roots Community Health Center	-	171	12	203	1	212
Seneca Family Services	47	43	56	45	41	55
Pair Team	305	478	372	554	456	616
Titanium Health Care	116	494	420	491	790	497
Tiburcio Vasquez Health Center (Street Medicine)	-	87	-	88	-	96
BACH (Street Medicine)	8	214	8	219	4	218
Lifelong (Street Medicine)	-	179	-	179	-	184
Roots Community Health Center (Street Medicine)	Combined with Roots 'traditional' ECM program					

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

Community Supports (CS)

- The team implemented new authorization criteria and Utilization Management processes effective 12/1/2024. The changes were needed to ensure full compliance with regulatory and contractual expectations. We continue to meet with CS providers to address questions about the new processes and support this change.

- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance offers the following community supports:
    - Housing Navigation
    - Housing Deposits
    - Tenancy Sustaining Services
    - Medical Respite
    - Medically Tailored/Supportive Meals
    - Asthma Remediation
    - (Caregiver) Respite Services
    - Personal Care & Homemaker Services
    - Environmental Accessibility Adaptations (Home Modifications)
    - Nursing Facility Transition/Diversion to Assisted Living Facilities
    - Community Transition Services/Nursing Facility Transition to a Home

- Further CS service & network expansion is paused; potential providers have been notified.

- AAH CS staff continue to meet with CS providers to work through logistical issues as they arise, including referral management, claims payment and member throughput.
- DHCS outlined new closed loop referral requirements and moved the closed loop referral target date to 07/01/25. AAH is working on requirements to comply with the new DHCS requirements.
- Housing-related community supports have transitioned to the Operations team effective 10/01/24. The Health Care Services and Operations teams coordinate to ensure communication and process alignment, where possible.

Community Supports	Services Authorized in September 2024	Services Authorized in October 2024	Services Authorized in November 2024
Housing Navigation	1,078	985	849
Housing Deposits	280	258	229
Housing Tenancy	1,141	1,038	966
Asthma Remediation	82	93	89
Meals	1,591	1,539	1,355
Medical Respite	137	128	103
Transition to Home	21	21	22
Nursing Facility Diversion	31	28	28
Home Modifications	3	1	0
Homemaker Services	113	113	96
Caregiver Respite	7	8	5
Total	**4,484**	**4,212**	**3,742**

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

Grievances & Appeals

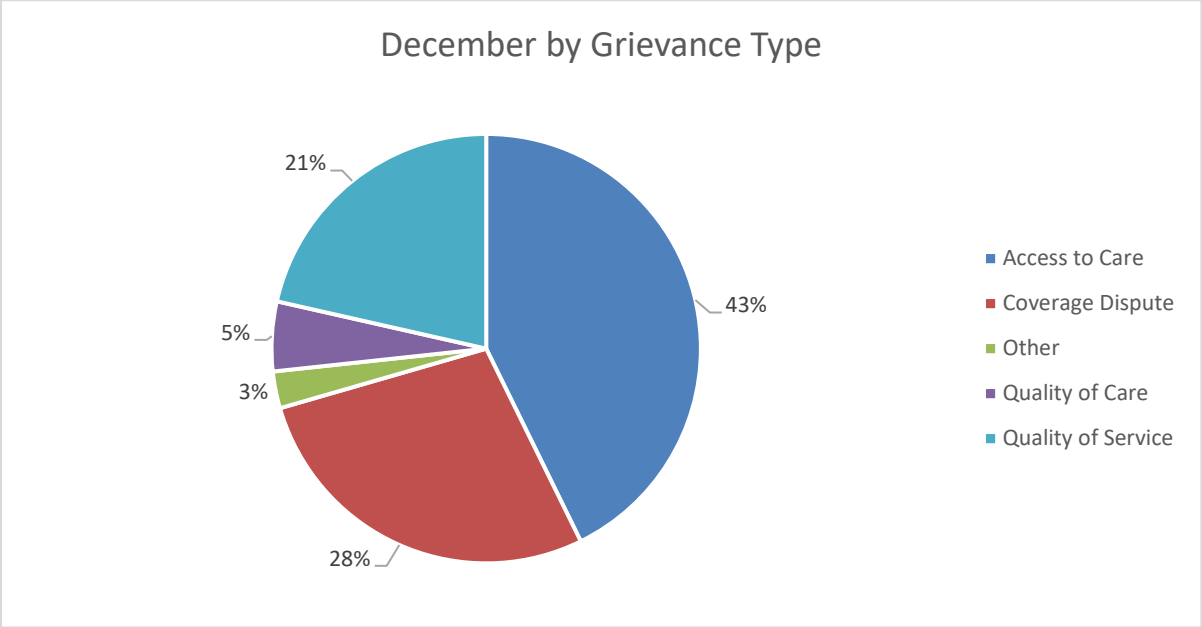
- All cases were resolved within the goal of 95% of regulatory timeframes.
- Total Unique grievances resolved in December were 8.56 complaints per 1,000 members.

December 2024 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,659	30 Calendar Days	95% compliance within standard	1,644	99.1%	4.02
Expedited Grievance	0	72 Hours	95% compliance within standard	0	NA	NA
Exempt Grievance	1,817	Next Business Day	95% compliance within standard	1,809	99.6%	4.41
Standard Appeal	53	30 Calendar Days	95% compliance within standard	53	100.0%	0.13
Expedited Appeal	0	72 Hours	95% compliance within standard	0	NA	NA
Total Cases:	3,528		95% compliance within standard	3,506	99.4	8.56

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

Standard Grievances:

There were 1,418 unique grievance cases resolved during the reporting period, with a total of 1,659 grievances including all 241 shadow cases.



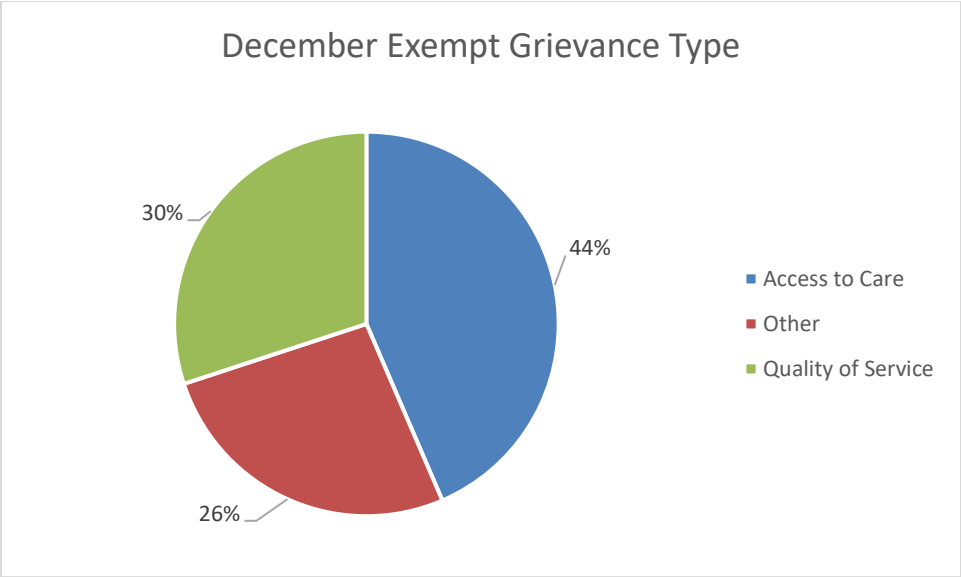
- **709** of 1,659 (43%) cases were related to Access to Care, the top 4 grievance categories are:
  - (282) Timely Access
  - (177) Technology/Telephone
  - (100) Authorization
  - (86) Provider Availability

- **356** of 1,659 (21%) cases were related to Quality of Service, the top 3 categories are:
  - (86) Plan Customer Service
  - (72) Transportation
  - (62) Provider/Staff Attitude

- **461** of 1,659 (28%) cases were related to Coverage Dispute, the top 3 grievance categories are:
  - (258) Provider Direct Member Billing
  - (136) Provider Balance Billing
  - (45) Reimbursement

Exempt Grievances:

- There were 1,817 unique exempt grievance cases resolved during the reporting period.



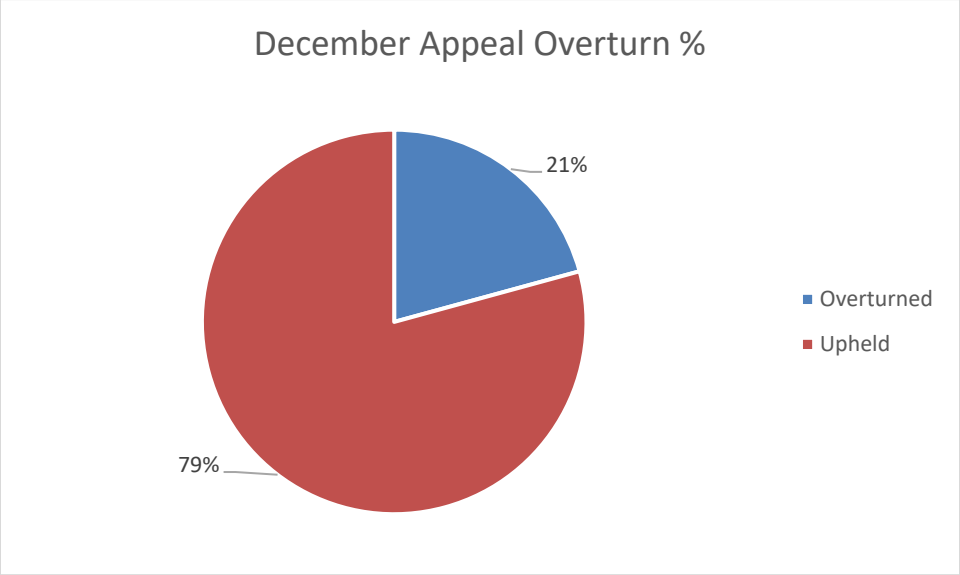
- 791 of 1,817 (44%) cases were related to Access to Care, the top 3 categories were:
  - (347) Telephone/Technology
  - (224) Provider Availability
  - (139) Geographic Access

- 546 of 1,817 (30%) cases were related to Quality of Service, the top 2 categories were:
  - (286) Plan Customer Service
  - (220) Provider/Staff Attitude

- 480 of 1,817 (26%) cases were related to Other, the 2 categories were:
  - (444) Enrollment
  - (36) Eligibility

Appeals:

- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of December 2024, we met our goal with a 20.8% overturn rate.



- **11** out of 53 (20.8%) cases were overturned or partially overturned for the month of December 2024:
  - (1) Out of Network (no INN)
  - (10) Disputes Involving Medical Necessity

Quality

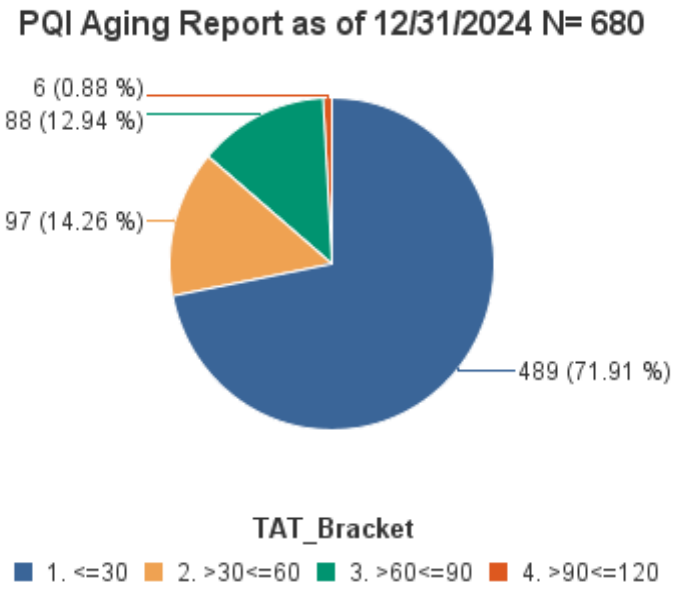
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQI cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

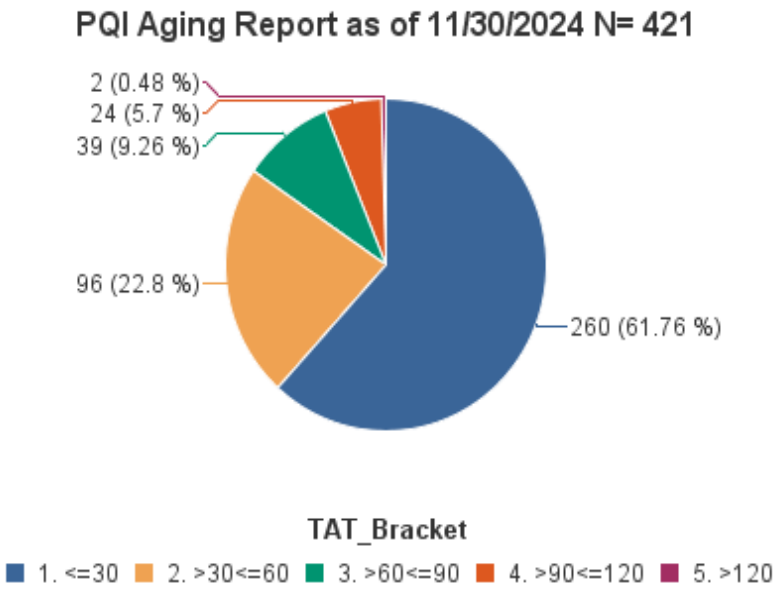
- Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics Services team after they are triaged by the QI Clinical team. Quality of Care and Service issues are reviewed by the QI RN Reviewers. Final leveling for Quality-of-Care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

- 0.48% cases in November and 0% in December were still open past the 120-day TAT. Therefore, turnaround times for case review and closure remain well within the benchmark of 95% per PQI P&P QI-104 for this lookback period.

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

- The total number of PQIs including all categories increased by 259 referrals from November to December TATs are closely monitored on a weekly basis to ensure timely closure of cases within the standard 95%.





Alameda Alliance Provider Inventive Programs

Provider Pay for Performance

- The Alliance Pay-for-Performance (P4P) program goal is to enhance quality, performance, and outcomes through provider incentives. The P4P program offers performance-based incentives payments for delivered services. Through this program primary care providers (PCPs) and PCP Groups are rewarded for superior performance and yearly improvement. The 2025 P4P Program is aligned with Managed Care Accountability Set (MCAS), DHCS Quality Factor rating and the DHCS Clinical Quality Bold Goals. It focuses on three key areas: Preventative Care, Access, and aims for members to connect to care with their PCPs. To boost provider participation and elevate quality rates the funding for the 2025 P4P Program is 6 million dollars.

Clinical Quality Measure	
1	Breast Cancer Screening (BCS)
2	Cervical Cancer Screening (CCS)
3	Child and Adolescent Well-Care Visits (WCV)
4	Childhood Immunization: Combo 10 (CIS)
5	Colorectal Cancer Screening (COL-E)
6	Controlling High Blood Pressure (140/90) (CBP)
7	Developmental Screening in the Frist Three Years of Life (DEV)
8	Follow-up After ED Visits for Mental Illness (FUM) – 30 day
9	Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD)
10	Immunizations for Adolescents: Combo 2 (IMA)
11	Lead Screening in Children (LSC)
12	Well-Child Visits in the First 30 Months of Life: Two or More Visits (W30)
13	Well-Child Visits in the First 30 Months of Life: Two or More Visits (W30)
Other Measures	
14	Initial Health Appointment (IHA)
15	Percentage of acute hospital stay discharges which had follow-up ambulatory visits within 7 days post hospital discharge (PHM/IPP measure)
16	Member Satisfaction Survey: Non-Urgent Appt Availability
17	Member Satisfaction Survey: Urgent Appt Availability

Health Information Exchange (HIE) Participation

- As part of the 2025 P4P program, the Alliance is continuing to offer an incentive payment to encourage participation in the Manifest MedEx Health Information Exchange (HIE). Manifest MedEx, the largest nonprofit health data network in California, is poised to enhance efficiency and member experience by facilitating faster, more informed care coordination. It also aides in identifying and resolving care gaps, managing population health, and streamlining HEDIS reporting. Provider/Provider Groups can earn the following incentive payment through participation in the HIE program:

Members at the end of the Measurement Year	15-999	1,000 - 4,999	5,000 - 14,999	15,000+
New Participant	$2,000	$ 3,000	$ 5,000	$10,000
Ongoing Participant	$1,000	$ 1,500	$ 2,500	$ 5,000

ALAMEDA Alliance FOR HEALTH

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

Health Equity

Lao Paul Vang

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

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

Date: **January 10th, 2025**

Subject: **Health Equity Report**

Internal Collaboration

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

- **Faith-Based Community Engagement (FBCE) Update**
    - FBCE is one of the three-tier communities in our Community Engagement Strategy, milestone # 5 in our Health Equity Roadmap.
    - The newly established committee FBCE continues to meet to identify potential faith-based organizations that the Alliance could work with to advance health equity.
    - We use the three (3) critical factors to identify our priority FBOs: 1) members' relationships with the faith-based organization, 2) the health disparity gap, and 3) available funding and resources. Based on these criteria, we have identified one FBO, namely the San Lorenzo Samoan Free Methodist Church. A comprehensive project management plan with action items, stakeholders, and resources has been developed. The focus of interventions for this FBO are Breast and Cervical cancer screening and Child-Adolescent well-care visits.
    - FBCE workgroup represents the cross-functional collaboration among staff (such as PHM, QI, UM, and C&O) and is the foundation of successful and sustainable health equity work.
    - Another high-health disparity area identified is the Doula Services which has seen low utilization among certain ethnic minority groups. The FBCE will conduct a feasibility study and determine its priority and success via FBO engagement.

External Collaboration

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

- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**

    - DHCS CHEO and MCPs CHEOs met to collaborate on Health Equity and DEI initiatives.
    - The meeting consisted of DHCS and CHEO Updates.

Advancing Health Equity Initiative (AHEI) Update

- **DEI Training APL 23-025 Update**

    - Completed DEI training was submitted to DHCS for review in December 2024. Awaiting approval from DHCS
    - A comprehensive work plan has been put in place to administer the Pilot DEI (estimated implementation date Feb 2025) as well as the General DEI Rollout (estimated implementation date July 2025)

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

    - The Health Equity Department continued to work with IPD to address all the moving pieces as per APL 24-018, which is designed only for all the Alliance staff.
    - Timeline:
        - Dec 2024: confirmation of vendor
        - Jan-Feb 2025: implementation of training for all staff
        - Feb 14, 2025: submission of all documents to the state, which include Evidence-based TGI training curriculum, updated online Providers Directory for gender-confirming services, G&A, and P&P.

- **Alliance Health Equity Strategic Roadmap**

    - The multi-stakeholder Health Equity Strategic Committee has wrapped up its work as of December 2024.
    - The Health Equity Division will continue to validate and adjust the recommendations based on prevailing health equity best practices and subject matter expertise of the Health Equity Division.

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

- **DEIB Committee Update**

    - The DEIB Committee on December 6th was canceled.

- **VIA Committee Update**

    - At the December 16th VIA meeting, the Committee was updated on the

gift drive for Building Futures.

- The Committee also approved the PowerPoint presentation for the Holiday Cultural Celebrations to be shared at the All Staff Meeting.

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
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Information Technology

Sasikumar Karaiyan

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

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

Date: **January 10th, 2025**

Subject: **Information Technology Report**

Call Center System Availability

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

- Call center applications now support English speech to text. The Alliance is aiming to extend the system to include Spanish language.

    - The project to enable the Spanish language pack for Calabrio is currently underway, including the installation scripts. Translation review and phrase tuning will be conducted by selected Member Services staff and are expected to start by the end of January 2025.

Encounter Data

- In the month of December 2024, the Alliance submitted 204 encounter files to the Department of Health Care Services (DHCS) with a total of 437,285 encounters.

Enrollment

- The Medi-Cal Enrollment file for the month of December 2024 was received and loaded to HEALTHsuite.

HEALTHsuite

- The Alliance received 332,108 claims in the month of December 2024.

- A total of 293,624 claims were finalized during the month out of which 260,396 claims auto adjudicated. This sets the auto-adjudication rate for this period to 88.7%.

TruCare

- A total of 17,582 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.9%.

IT Security Program

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

- As part of the IT Security 3.0 initiative, InfoSec will be adopting the National Institute of Standards and Technology's Cyber Security Framework (NIST CSF) along with supplementals (CIS + 800-53) as guidance in managing digital risk across the business.

- The newly formed Information IT Security team will be responsible for securing the organization's data, managing cyber risk, incident response, and ensuring governance and compliance.

- Ongoing collaboration between IT Security, IT Infrastructure, and IT Service Desk will be crucial as we move forward with the 2025 edition of the IT Security Program.

- IT vulnerability scanning (via Tenable Nessus), a tool that helps find vulnerabilities in network, systems, and devices, is expected kickoff in late-January / early-February. The results will provide visibility and identification of IT security gaps.

- Operationally - (1) hardened workstation login PIN security, requiring eight alphanumeric to reduce security exposure of guessing and (2) reducing IT service/app down time through collecting server trust certificates and maintaining them in a timely manner.

- Draft of AI policy is undergoing revision and review.

Microsoft InTune roll-out

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

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

- 364 migrations were completed, covering 8 departments, bringing project completion to 56.2%. Migrations are ramping up and remaining waves will be scheduled.

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

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrolment in the month of December 2024”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of December 2024”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal and Group Care Member enrollment in the month of December 2024

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
December	412,297	12,527	7,673	5,791	142	123

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 December 2024

Auto-Assignments	Member Count
Auto-assignments MC	2,613
Auto-assignments Expansion	2,263
Auto-assignments GC	59
PCP Changes (PCP Change Tool) Total	4,935

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of December 2024”.
- There were 17,582 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 December 2024*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,124
Provider Portal Requests (Zipari)	5,220
EDI (CHCN)	5,864
Provider Portal to AAH Online (Long Term Care)	23
ADT	1264
Behavioral Health COC Update - Online	238
Behavioral initial evaluation - Online	60
Manual Entry (all other not automated or faxed vs portal use)	2,789
Total	17,582

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 November 2024

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	7,867	5,699	456,551	737
MCAL	119.875	3,281	7,595	1,106
IHSS	3,882	83	246	27
Total	131,624	9,063	464,392	1,870

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

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1,523,312
Provider - Claims	Claim Status	216,276
Provider - authorizations	Auth Submit	14,928
Provider - eligibility/claim	Claim Status	12,811
Directory Config	Provider Directory	9,770
Provider - authorizations	Auth Search	7,056
Member Config	Provider Directory	4,728
Provider - Claims	Submit professional claims	4,502
Member My Care	Member Eligibility	4,038
Member Help Resources	Find a Doctor or Hospital	2,731
Provider - eligibility	Member Eligibility	2,422
Member Help Resources	ID Card	2,147
Member Help Resources	Select or Change Your PCP	1,801
Provider - eligibility/claim	Member Roster	1,776
Member Home	MC ID Card	1,267
Member My Care	My Claims Services	1,223
Provider - Provider Directory	Provider Directory 2019	913
Provider - reports	Reports	880
Member My Care	Authorization	664
Provider - Home	Behavior Health Forms SSO	431
Member My Care	My Pharmacy Medication Benefits	399
Provider - Home	Forms	397
Member My Care	Member Benefits Materials	296
Member Help Resources	FAQs	294
Member Help Resources	Authorizations Referrals	262

Call Center – Call Volume Overview:

Members - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
October	8437	7798	269
November	7427	6186	390
December	8438	6912	414
Grand Total	**24302**	**20896**	**1073**

Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
October	10863	8972	1751
November	8931	6786	2007
December	9598	7285	2152
Grand Total	**29392**	**23043**	**5910**

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

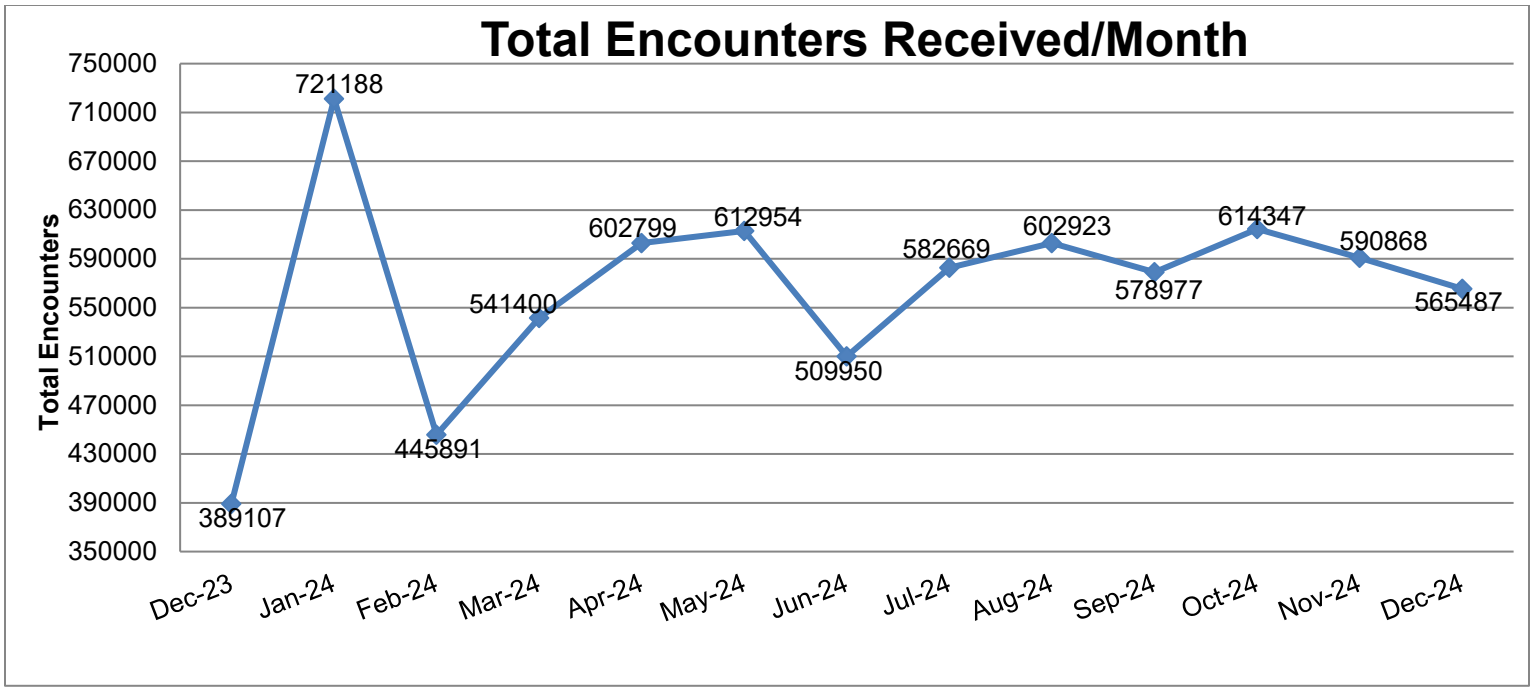
Note: It is important to note that there is a slight discrepancy between the number of calls presented, handled, and abandoned. This discrepancy is due to calls being rerouted to the XAQT vendor, which are not included in the calls handled or abandoned statistics. This rerouting can account for some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

Encounter Data from Trading Partners 2024

- **AHS**: December weekly files (7,261 records) were received on time.
- **BACH**: December monthly files (0 records) were received on time.
- **BACS**: December monthly files (104 records) were received on time.
- **CHCN**: December weekly files (127,327 records) were received on time.
- **CHME**: December monthly files (7,458 records) were received on time.
- **CFMG**: December monthly files (16,696 records) were received on time.
- **Docustream**: December monthly files (828 records) were received on time.
- **EBI**: December monthly files (1,476 records) were received on time.
- **FULLCIR**: December monthly files (1,085 records) were received on time.
- **HCSA**: December monthly files (2,335 records) were received on time.
- **IOA**: December monthly files (0 records) were received on time.
- **Kaiser**: December bi-weekly files (0 records) were received on time.
- **LAFAM**: December monthly files (83 records) were received on time.
- **LIFE**: December monthly files (997 records) were received on time
- **LogistiCare**: December weekly files (34,122 records) were received on time.
- **March Vision**: December monthly files (6,285 records) were received on time.
- **MED**: December monthly files (619 records) were received on time.
- **OMATOCHI**: December monthly files (0 records) were received on time.
- **PAIRTEAM**: December monthly files (5,816 records) were received on time.
- **Quest Diagnostics**: December weekly files (18,003 records) were received on time.
- **SENECA**: December monthly files (131 records) were received on time.
- **SERENE**: December monthly files (654 records) were received on time.
- **TITANIUM**: December monthly files (2,099 records) were received on time.
- **TVHC**: December monthly files (0 records) were received on time.
- **Magellan**: December monthly files (446,901 records) were received on time.

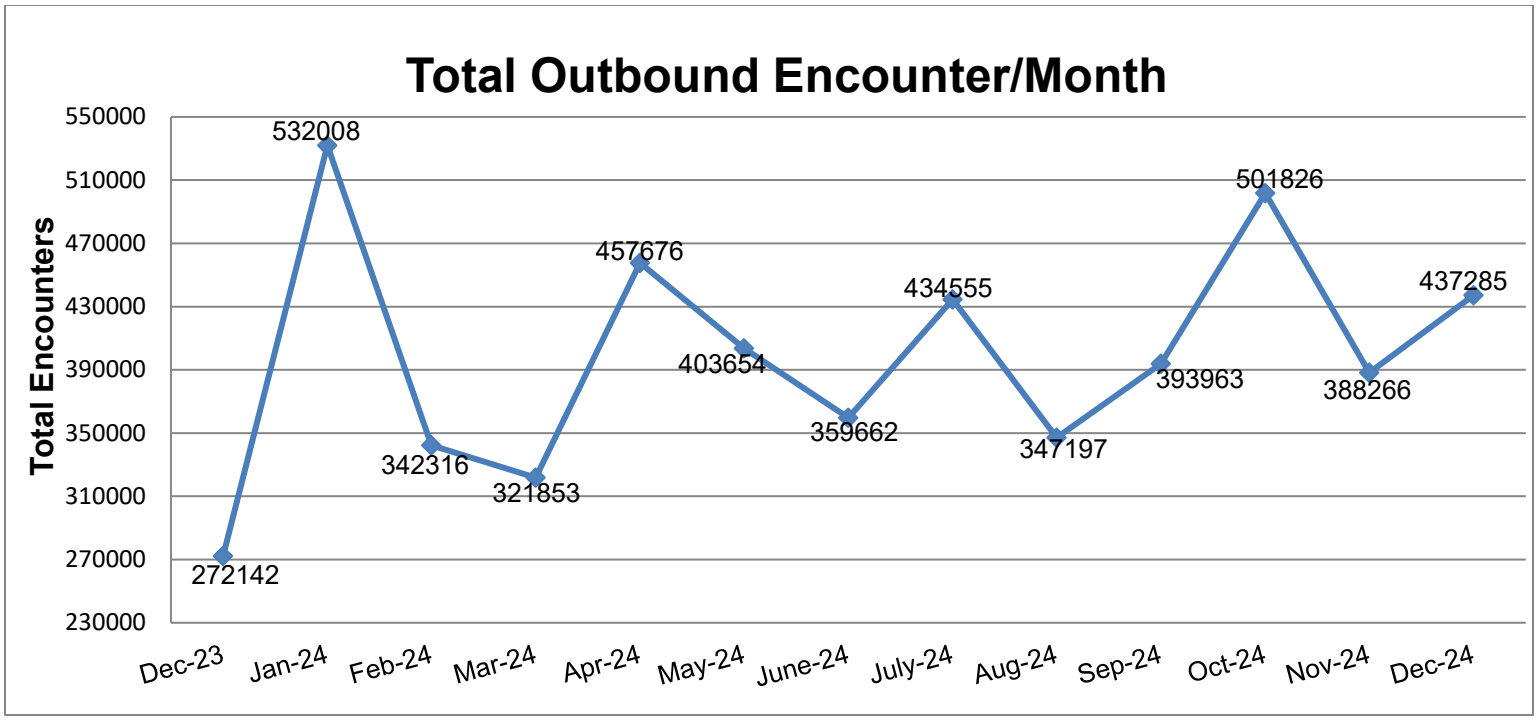
Trading Partner Encounter Inbound Submission History

Trading Partners	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Health Suite	215246	298465	266339	308453	322786	375454	297267	332150	368235	322196	367989	364130	332108
AHS	6284	4570	7736	7005	6573	8412	13316	7296	8859	7498	8309	10535	7261
BACH												795	
BACS	55	59	57	55	64	70	77	88	86	85	76	98	104
CHCN	58566	96124	103674	122217	170653	122445	110650	135444	122293	155825	125042	127223	127327
CHME	5694	5843	5560	6022	7969	7107	7449	7242	6902	7680	7102	7589	7458
Claimsnet	18995	12043	10557	12651	16394	15934	21143	10776	22335	16421	16045	21352	16696
Docustream	476	930	814	698	302	1589	749	934	1102	1067	704	678	828
EBI	811	1047	2903	1625	1700	184	2043	1623	1825	3394	1640	1725	1476
FULLCIR	177	828	1586	213	2261	8478	2842	1362	1798	3809	2523	2038	1085
HCSA	2087	2223	2097	2822	7118	5535	3663	6841	3256	3386	2389	3423	2335
IOA	1250	1453	1233	1054	1925	1163	1280	847	752	4227	588	1064	
Kaiser	26208	77407	3725	9966	2286	886	1079	2052	172	236	159		
LAFAM			60	39	105	116	86	70	88	63	89	76	83
LIFE							1694		614	168	119	335	997
LogistiCare	32181	182822	20774	35600	32632	27531	16205	43038	29732	16139	49941	16183	34122
March Vision	4562	9693		6183	3633	8546	7092	6404	7719	5769	5143	6016	6285
MED	532	535	742	683	633	722	744	615	608	610	645	656	619
OMATOCHI					29				2				
PAIRTEAM					5344	7582		5763		9359	1108	2204	5816
Quest	15834	27022	17658	22306	18000	18001	22500	18000	22502	18004	18002	22501	18003
SENECA	52	124	222	112	159	113	71	109	129	101	105	117	131
SERENE													654
TITANIUM	97		154	3696	2233	3086		2015	3914	2815	6192	1537	2099
TVHC										125	437	593	
Total	389107	721188	445891	541400	602799	612954	509950	582669	602923	578977	614347	590868	565487



Outbound Encounter Submission

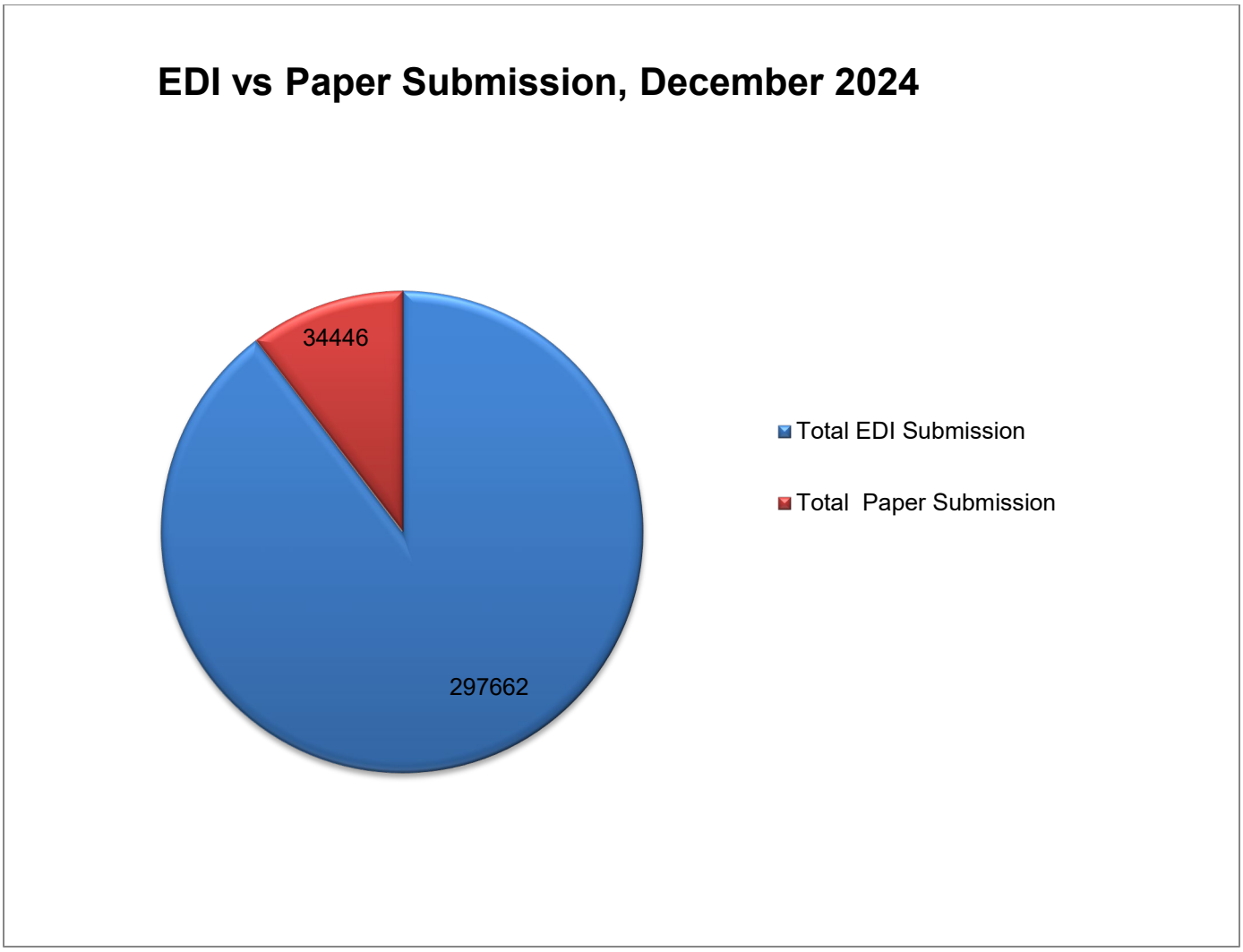
Trading Partners	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Health Suite	136233	172386	177658	147776	250835	198595	204068	230706	183371	210971	276473	218194	263242
AHS	4936	5667	7497	6968	6524	7002	10684	6703	7101	8727	8201	10403	6850
BACH												739	6
BACS	53	55	55	47	59	66	72	80	80	78	74	79	41
CHCN	39846	67063	74336	80498	104625	107577	77200	94476	87485	87806	108806	88573	84649
CHME	5588	5703	5470	5889	7558	6749	7310	7095	6762	6994	6974	7474	7342
Claimsnet	11581	10145	7730	6757	13467	11561	11506	9994	4	24076	13152	13882	11342
Docustream	404	387	600	377	267	839	570	725	806	715	545	482	239
EBI	802	987	1347	1002	1589	60	1835	1443	1727	3242	1559	1641	494
FULLCIR	124	653	540	116	1636	5401	2410	1084	674	1515	1767	1470	79
HCSA	1991	2142	2013	2769	4710	5363	3493	6757	3171	3310	2376	3394	2255
IOA	1228	1378	1156	1000	1868	1029	1221	749	680	1374	549	949	
Kaiser	26113	76335	3542	9650	1905	1292	812	1404	113	216	62		23
LAFAM				16	92	103	58	66	81	58	86	62	3
LIFE							28		598	159	91	76	202
LogistiCare	31546	157548	40529	34931	32247	27487	16221	43019	30006	16046	49705	15235	34035
March Vision	2752	2700	2616	3736	2407	5719	4553	3766	3482	4066	3543	3980	4156
MED	428	446	624	528	518	579	654	552	540	514	579	568	55
OMATOCHI					56								
PAIRTEAM					4279	4422		3246		4617	782	1960	994
Quest	8394	28299	16589	16333	20983	16912	16898	20898	16854	16937	21144	16909	21044
SENECA	48	114	14	199	140	109	69	108	127	94	91	100	6
TITANIUM	75			3261	1911	2789		1684	3535	2332	5267	1278	228
TVHC										116		818	
Total	272142	532008	342316	321853	457676	403654	359662	434555	347197	393963	501826	388266	437285



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
24-Dec	297662	34446	332108

Key: EDI – Electronic Data Interchange


EDI vs Paper Submission, December 2024
34446
297662
Total EDI Submission
Total Paper Submission

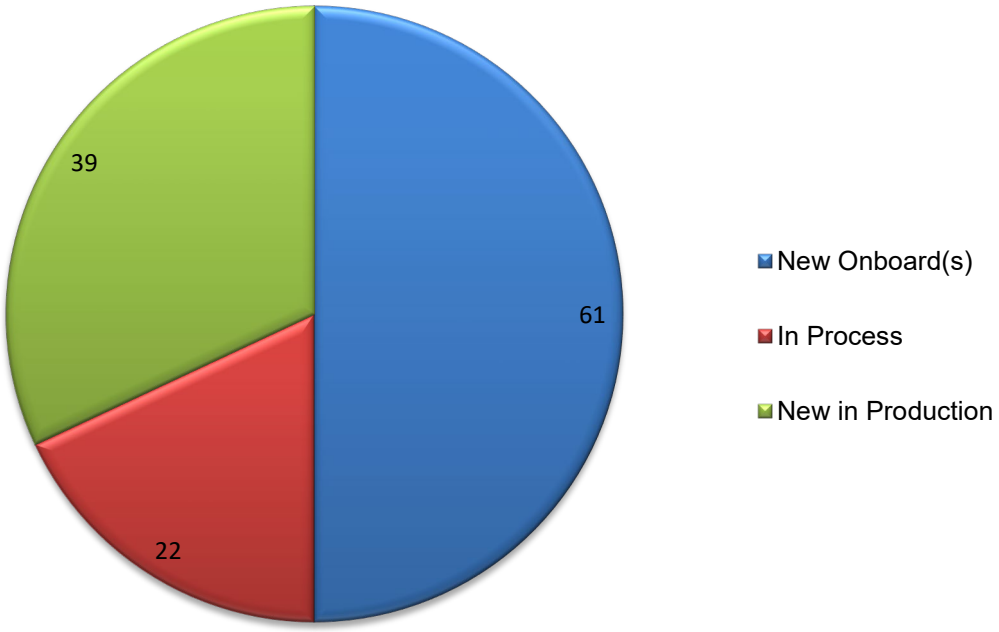
Onboarding EDI Providers – Updates

- Dec 2024 EDI Claims:
  - A total of 2819 new EDI submitters have been added since October 2015, with 39 added in December 2024.
  - The total number of EDI submitters is 3559 providers.

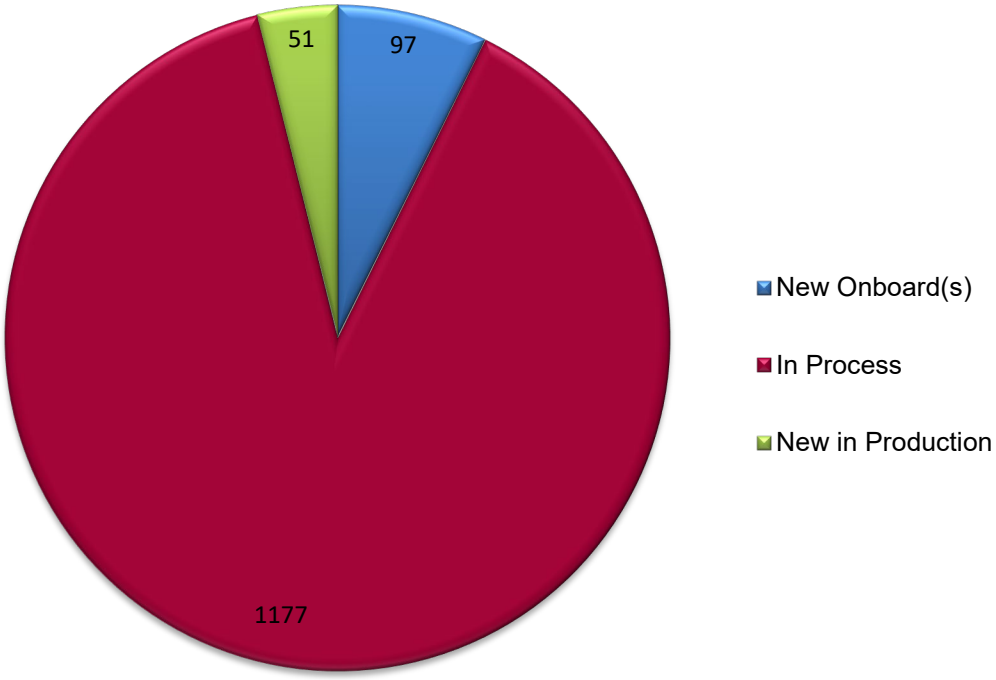
- Dec 2024 EDI Remittances (ERA):
  - A total of 1267 new ERA receivers have been added since October 2015, with 51 added in December 2024.
  - The total number of ERA receivers is 1254 providers.

	837				835			
	New on Boards	In Process	New In Production	Total in Production	New on Boards	In Process	New In Production	Total in Production
Jan-24	63	2	61	2794	76	751	41	910
Feb-24	37	17	20	2814	59	783	27	937
Mar-24	111	25	86	2900	60	822	21	958
Apr-24	120	3	117	3017	83	851	54	1012
May-24	81	13	68	3085	63	874	40	1052
Jun-24	39	4	35	3120	50	908	16	1068
Jul-24	86	3	83	3203	54	937	25	1093
Aug-24	181	2	179	3382	62	982	17	1110
Sep-24	46	5	41	3423	73	1027	28	1138
Oct-24	60	4	56	3479	80	1071	36	1174
Nov-24	61	20	41	3520	89	1131	29	1203
Dec-24	61	22	39	3559	97	1177	51	1254

837 EDI Submitters - DEC 2024



835 EDI Receivers - DEC 2024



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 **December** 2024.

File Type	Dec-24
837 I Files	40
837 P Files	164
Total Files	204

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Dec-24	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	92%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	88%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	95%	80%

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

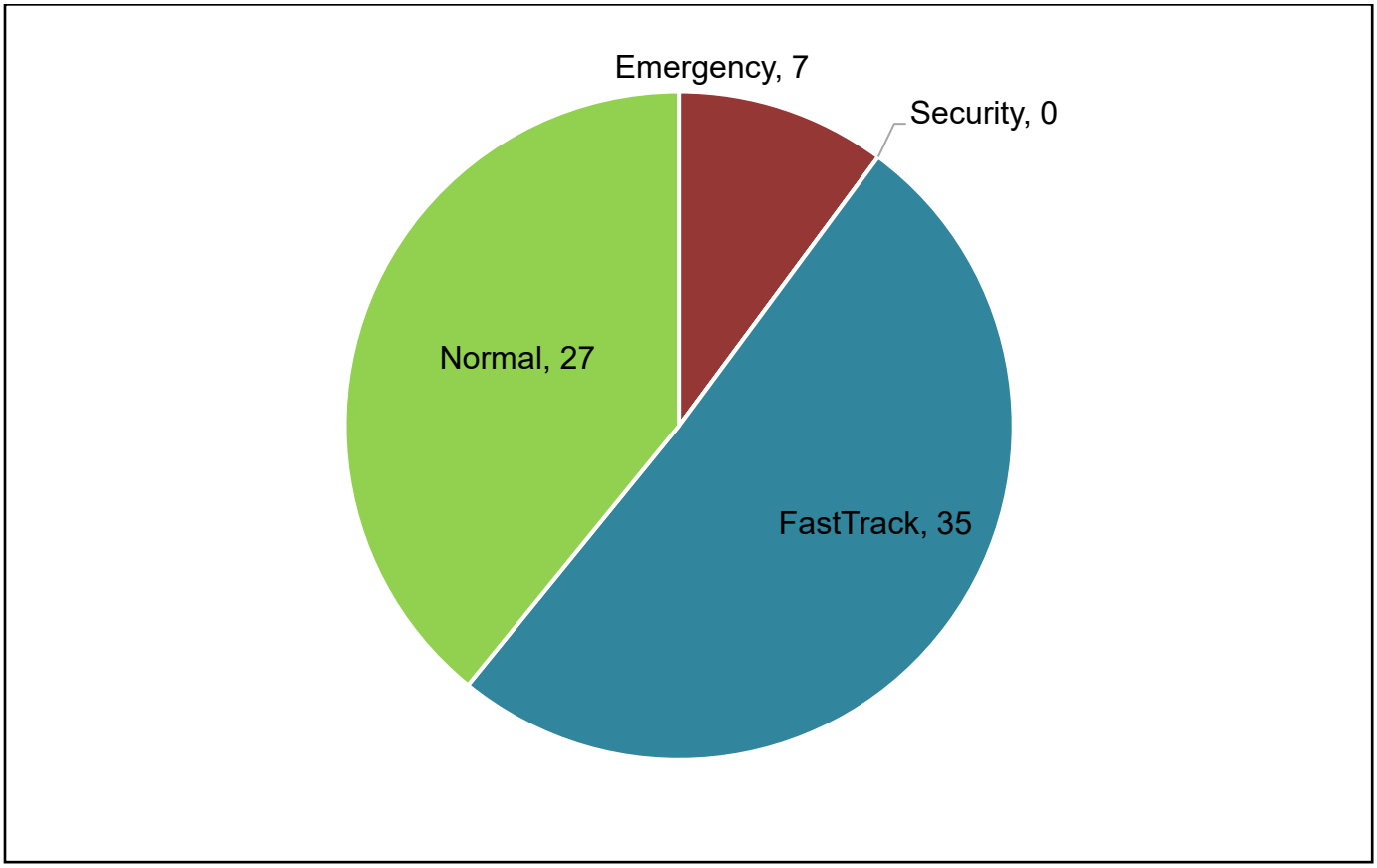
Encounter Data

In the month of **December** 2024, the Alliance submitted **204** encounter files to the Department of Health Care Services (DHCS) with a total of **437,285** encounters.

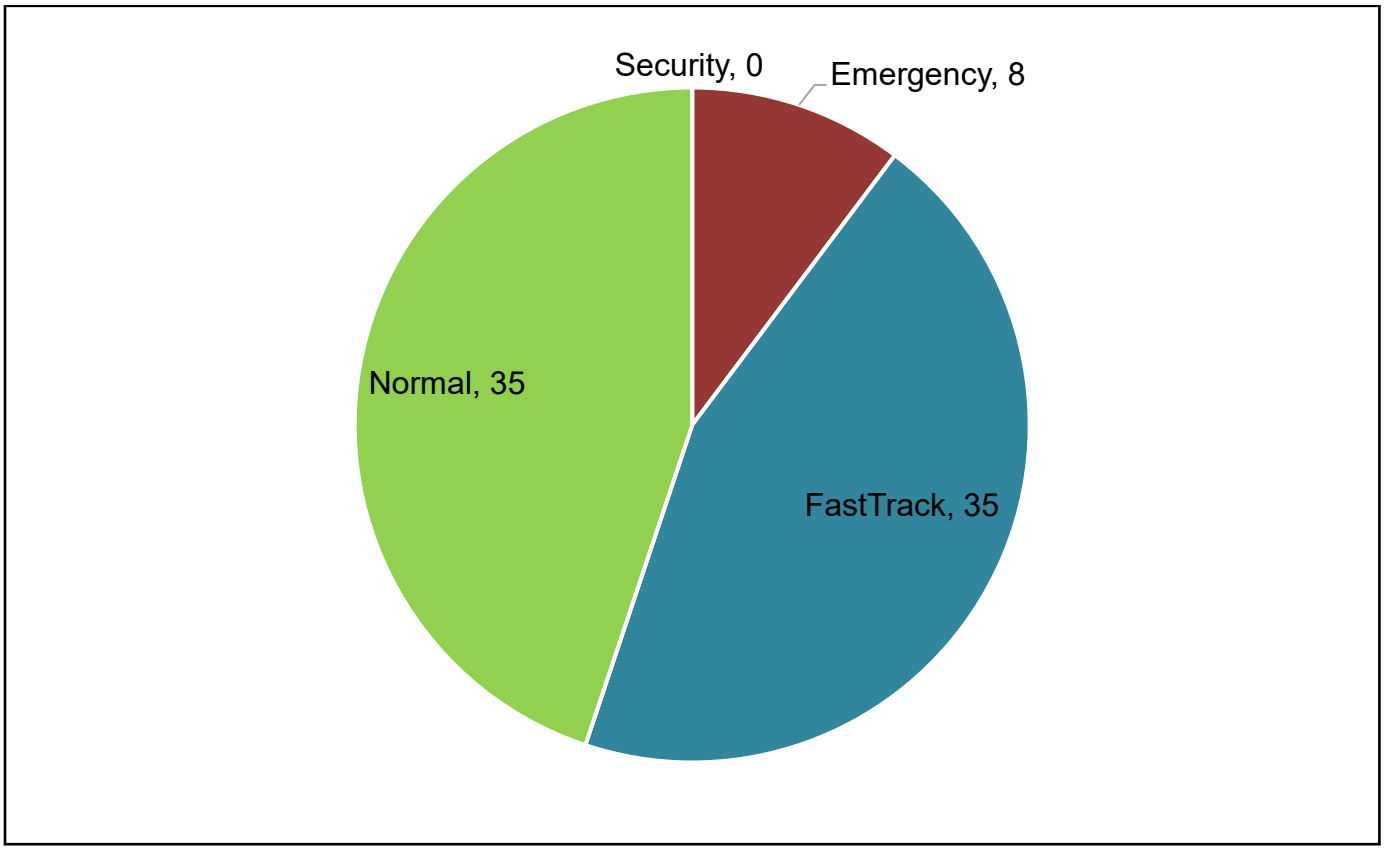
Change Management Key Performance Indicator (KPI)

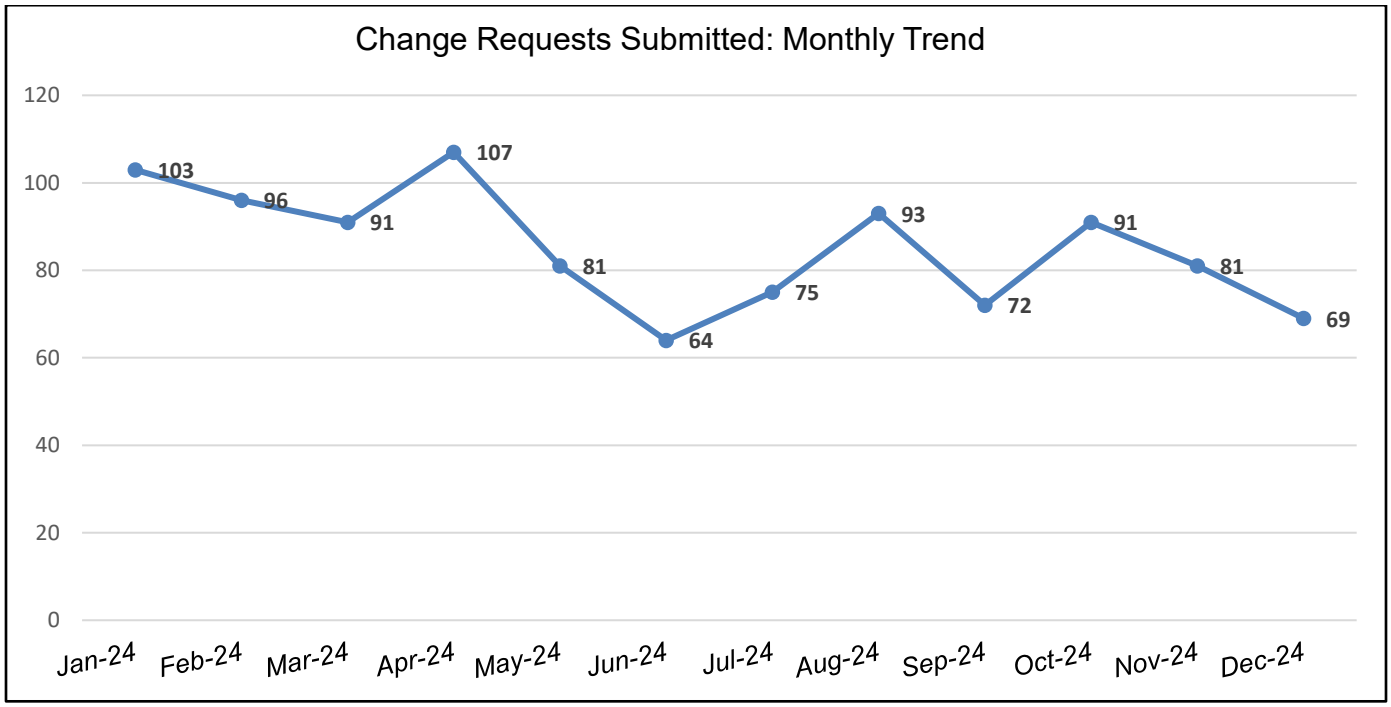
- Change Request Overall Summary in the month of December 2024 KPI:
  - 69 Changes Submitted.
  - 78 Changes Completed and Closed.
  - 100 Active Change Requests in pipeline.
  - 7 Change Requests Cancelled or Rejected.

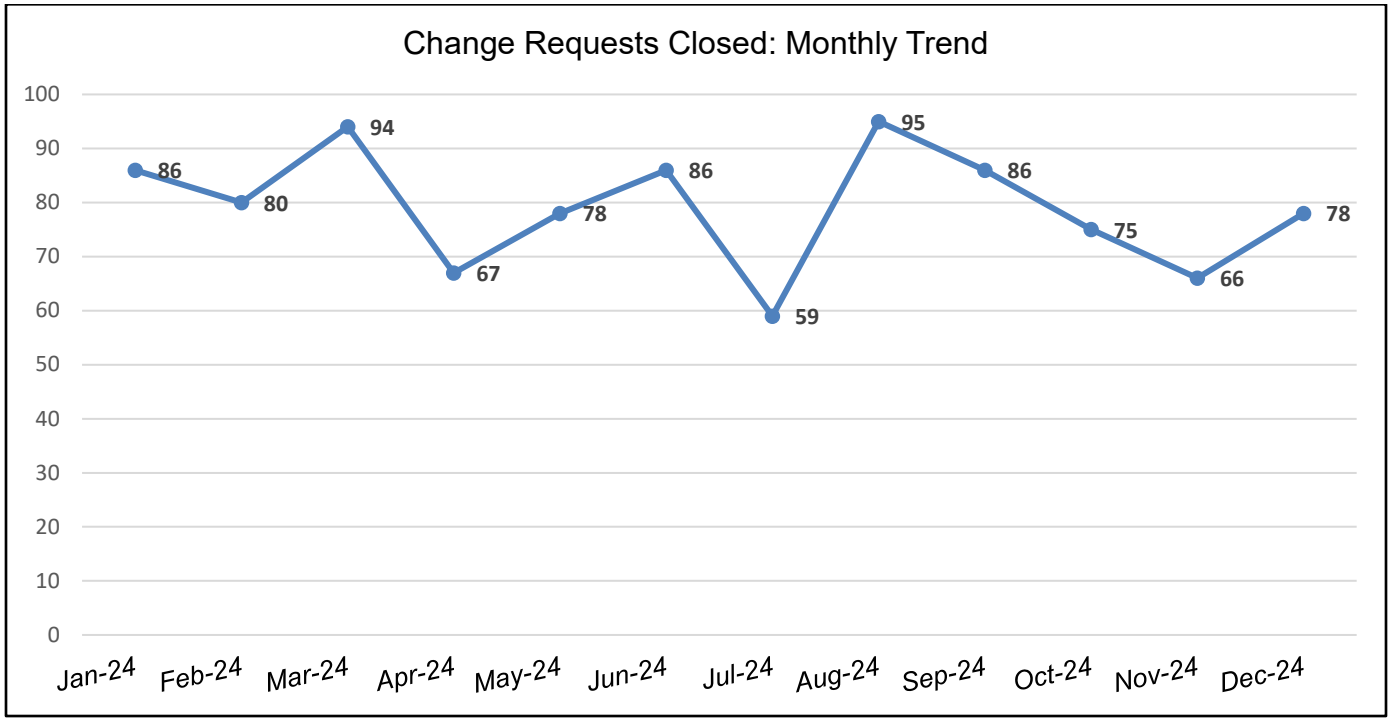
- 69 Change Requests Submitted/Logged in the month of December 2024



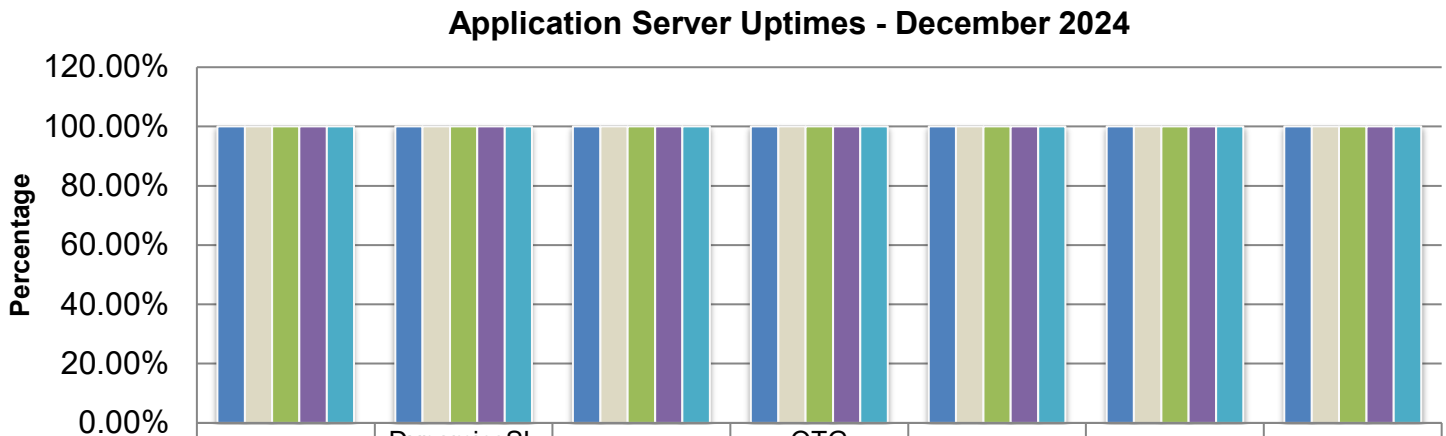
- 78 Change Requests Closed in the month of December 2024




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
103
96
91
107
81
64
75
93
72
91
81
69
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24


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

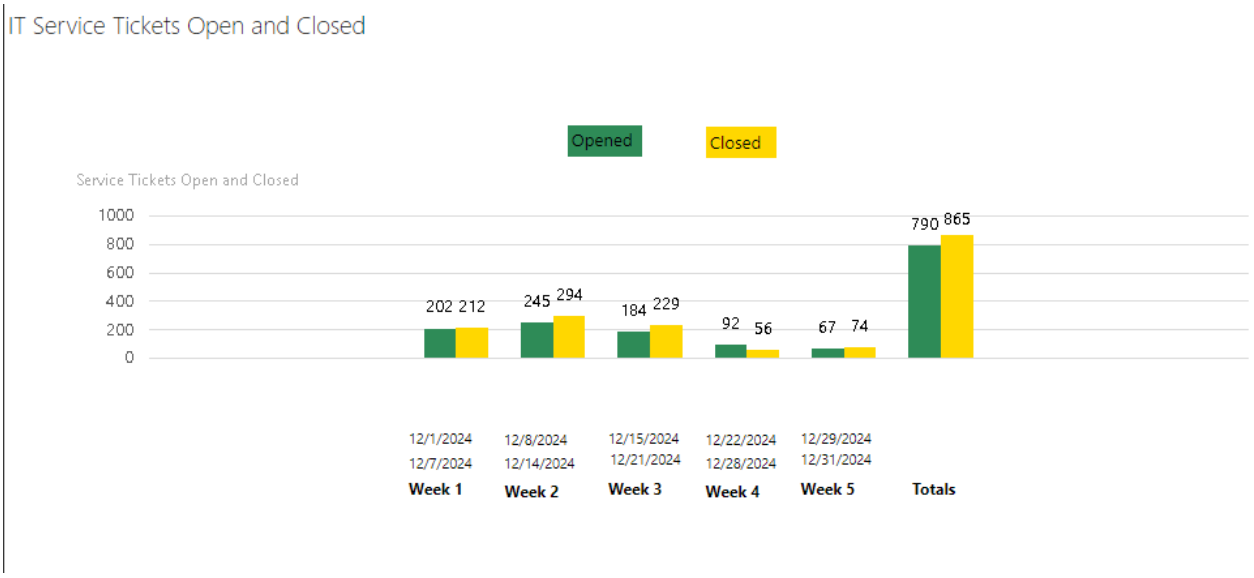
IT Stats: Infrastructure



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

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

IT Stats: Service Desk

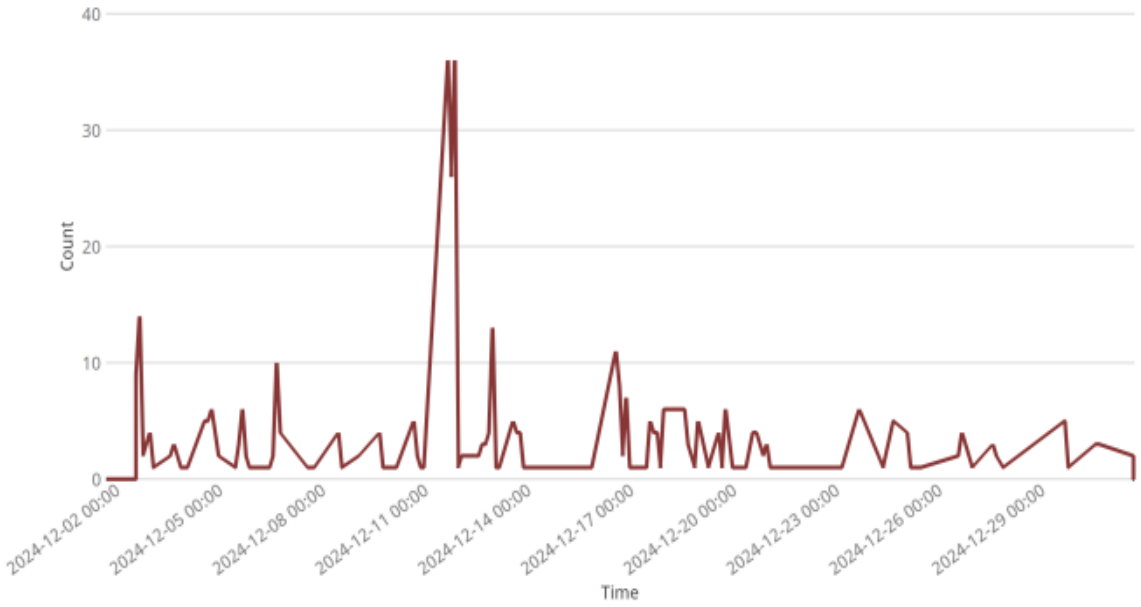


- 790 Service Desk tickets were opened in the month of December 2024, which is 7.90% lower than the previous month (858) and 12.51% lower than the previous 3-month average of 903.
- 865 Service Desk tickets were closed in the month of November 2024, which is 12.25% higher than the previous month (759) and 3.46% lower than the previous 3-month average of 896.

IT Stats: Network

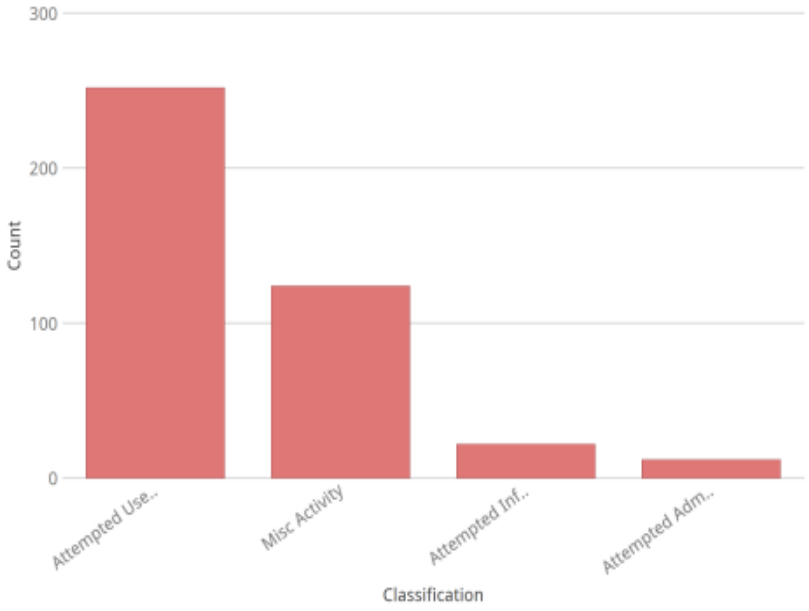
All Intrusion Events

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



Dropped Intrusion Events

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



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

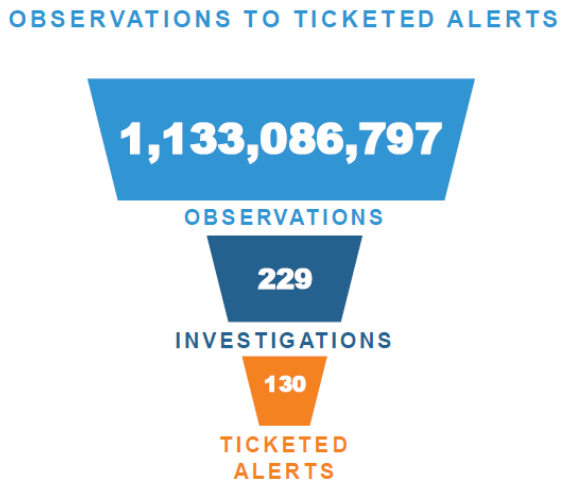
Item / Date	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	*May-24*	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	*Nov-24*	*Dec-24*
Attempted Admin Privilege Gain	1	7	4	48	3	1	4	1	3	250	5	23	***12***
Attempted User Privilege Gain	48	69	330	526	569	554	474	17	8	329	337	302	***252***
Attempted Information Leak	50	65	51	72	57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

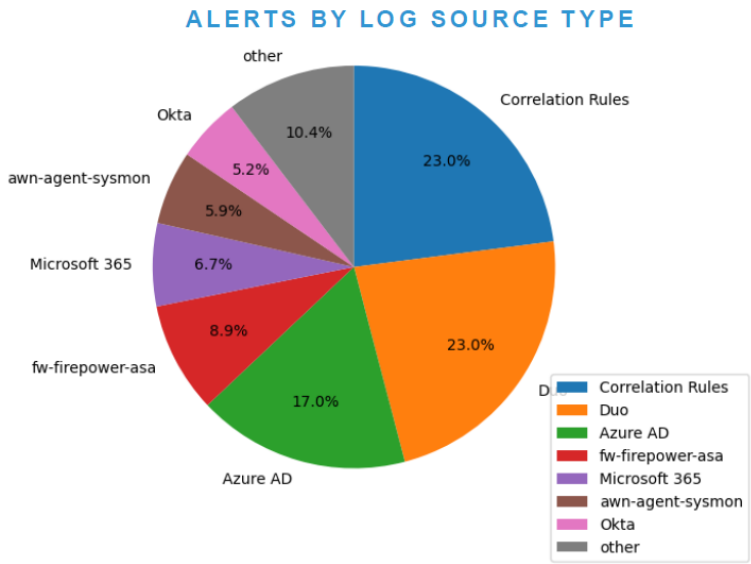
- All security activity data is based on the current month's metrics as a percentage. This is compared to the previous three month's average, except as noted.
- Attempted information leaks detected and blocked at the firewall is at 22 for the month of December 2024.
- Network scans returned a value of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

IT Stats: Security

- Of 1.1 billion event observations from our log sources with an almost 0% ticketed alert, indicates the Alliance's user behaviour on the computer is relatively well-behaved.

3 Month Summary – Pipeline





All critical + high external vulnerabilities are solved – improving our security posture to external partners/vendors/scoring entities.

Analytics

Tiffany Cheang

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

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

Date: **January 10th, 2025**

Subject: **Performance & Analytics Report**

Member Cost Analysis

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

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

- For the Current reporting period, the top 9.7% of members account for 88.9% of total costs.

- In comparison, the Prior reporting period was slightly higher at 10.0% of members accounting for 83.6% of total costs.

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

    - The SPD (non duals) and ACA OE categories of aid decreased to account for 55.0% of the members, with SPDs accounting for 20.9% and ACA OE's at 34.1%.
    - The percent of members with costs >= $30K slightly decreased from 2.7% to 2.6%.
    - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.8%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 33.3%.
    - Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
    - However, the age distribution of the top 9.7% is more concentrated in the 45-66 year old category (36.3%) compared to the overall population (20.7%).

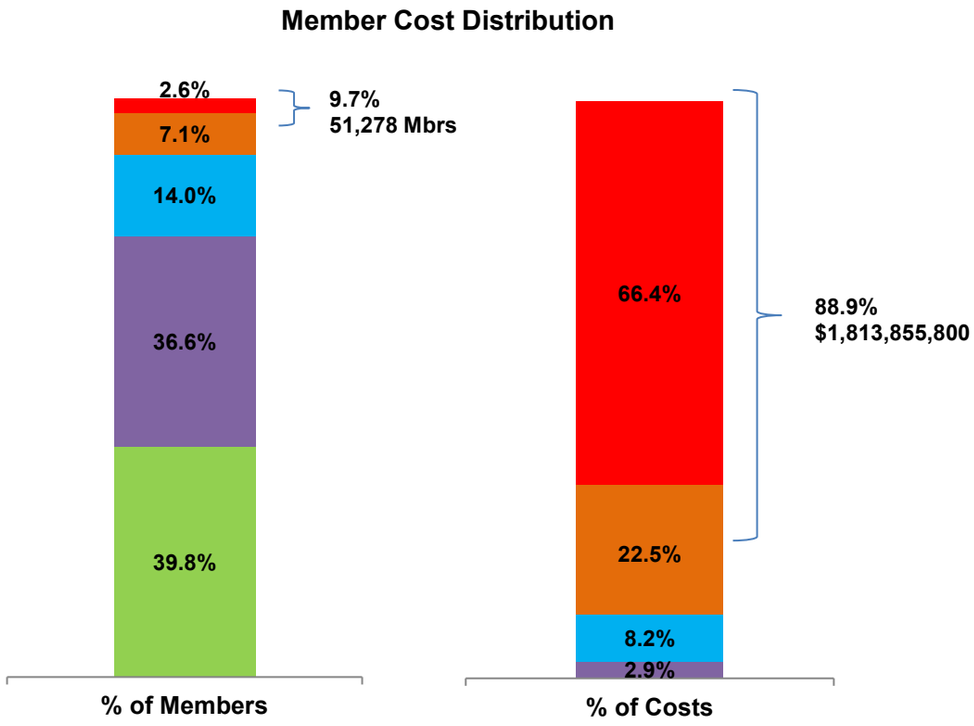
Analytics

Supporting Documents

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

Note: Data incomplete due to claims lag

Run Date: 12/27/2024



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	13,578	2.6%	$ 1,355,124,723	66.4%
$5K - $30K	37,700	7.1%	$ 458,731,078	22.5%
$1K - $5K	74,535	14.0%	$ 166,849,019	8.2%
< $1K	194,043	36.6%	$ 59,444,078	2.9%
$0	211,028	39.8%	$ -	0.0%
Totals	**530,884**	**100.0%**	**$ 2,040,148,897**	**100.0%**

Top 9.7% of Members = 88.9% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	4,029	0.8%	$ 829,822,983	40.7%
$75K to $100K	1,973	0.4%	$ 171,459,375	8.4%
$50K to $75K	2,696	0.5%	$ 165,123,449	8.1%
$40K to $50K	1,974	0.4%	$ 88,127,614	4.3%
$30K to $40K	2,906	0.5%	$ 100,591,302	4.9%
SubTotal	***13,578***	***2.6%***	***$ 1,355,124,723***	***66.4%***
$20K to $30K	5,274	1.0%	$ 128,693,866	6.3%
$10K to $20K	14,306	2.7%	$ 200,575,407	9.8%
$5K to $10K	18,120	3.4%	$ 129,461,805	6.3%
SubTotal	***37,700***	***7.1%***	***$ 458,731,078***	***22.5%***
Total	**51,278**	***9.7%***	**$ 1,813,855,800**	***88.9%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Sep 2024	406,195	$ 1,850,138,668
Dis-Enrolled During Year	124,689	$ 190,010,230
Totals	**530,884**	**$ 2,040,148,897**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
9.7% of Members = 88.9% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Oct 2023 - Sep 2024
Note: Data incomplete due to claims lag
Run Date: 12/27/2024

9.7% of Members = 88.9% of Costs
20.9% of members are SPDs and account for 27.4% of costs.
34.1% of members are ACA OE and account for 32.9% of costs.
8.8% of members disenrolled as of Sep 2024 and account for 9.3% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	182	861	1,043	2.0%
MCAL	MCAL - ADULT	1,169	6,931	8,100	15.8%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	582	3,506	4,088	8.0%
	MCAL - ACA OE	4,257	13,241	17,498	34.1%
	MCAL - SPD	3,722	6,974	10,696	20.9%
	MCAL - DUALS	1,016	3,007	4,023	7.8%
	MCAL - LTC	195	9	204	0.4%
	MCAL - LTC-DUAL	1,034	80	1,114	2.2%
Not Eligible	Not Eligible	1,421	3,091	4,512	8.8%
Total		**13,578**	**37,700**	**51,278**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 14,713,439	$ 9,890,110	$ 24,603,549	1.4%
MCAL	MCAL - ADULT	$ 107,278,737	$ 82,517,981	$ 189,796,718	10.5%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 43,517,415	$ 39,158,029	$ 82,675,444	4.6%
	MCAL - ACA OE	$ 436,387,180	$ 160,128,399	$ 596,515,579	32.9%
	MCAL - SPD	$ 405,404,090	$ 90,695,544	$ 496,099,633	27.4%
	MCAL - DUALS	$ 88,216,335	$ 35,556,617	$ 123,772,952	6.8%
	MCAL - LTC	$ 28,008,890	$ 141,787	$ 28,150,677	1.6%
	MCAL - LTC-DUAL	$ 101,410,290	$ 1,306,183	$ 102,716,473	5.7%
Not Eligible	Not Eligible	$ 130,188,347	$ 39,336,429	$ 169,524,776	9.3%
Total		**$ 1,355,124,723**	**$ 458,731,078**	**$ 1,813,855,800**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
31.6% of members are SPDs and account for 32.9% of costs.
28.3% of members are ACA OE and account for 33.1% of costs.
8.3% of members disenrolled as of Sep 2024 and account for 8.6% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	44	1.1%
MCAL	MCAL - ADULT	247	6.1%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	78	1.9%
	MCAL - ACA OE	1,141	28.3%
	MCAL - SPD	1,272	31.6%
	MCAL - DUALS	344	8.5%
	MCAL - LTC	138	3.4%
	MCAL - LTC-DUAL	432	10.7%
Not Eligible	Not Eligible	333	8.3%
Total		**4,029**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 7,897,903	1.0%
MCAL	MCAL - ADULT	$ 59,753,104	7.2%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 19,083,737	2.3%
	MCAL - ACA OE	$ 274,705,621	33.1%
	MCAL - SPD	$ 273,159,801	32.9%
	MCAL - DUALS	$ 45,645,808	5.5%
	MCAL - LTC	$ 23,832,583	2.9%
	MCAL - LTC-DUAL	$ 54,309,584	6.5%
Not Eligible	Not Eligible	$ 71,434,842	8.6%
Total		**$ 829,822,983**	**100.0%**

% of Total Costs By Service Type

Breakout by Service Type/Location

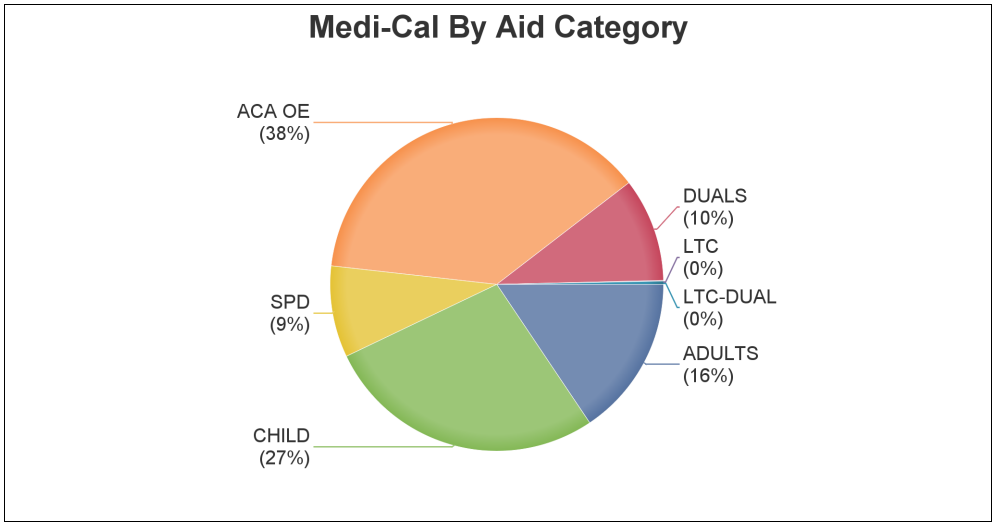
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	6%	0%	1%	14%	40%	1%	11%	3%	2%	29%
$75K to $100K	4%	0%	1%	15%	23%	2%	4%	3%	4%	48%
$50K to $75K	4%	0%	2%	23%	28%	4%	6%	5%	4%	29%
$40K to $50K	6%	0%	2%	33%	28%	7%	5%	6%	2%	19%
$30K to $40K	10%	0%	3%	32%	22%	14%	5%	7%	1%	20%
$20K to $30K	3%	1%	5%	36%	23%	7%	7%	7%	1%	19%
$10K to $20K	0%	0%	11%	35%	24%	6%	9%	9%	1%	15%
$5K to $10K	0%	0%	6%	32%	13%	10%	13%	13%	1%	18%
Total	**4%**	**0%**	**3%**	**22%**	**31%**	**4%**	**9%**	**5%**	**2%**	**27%**

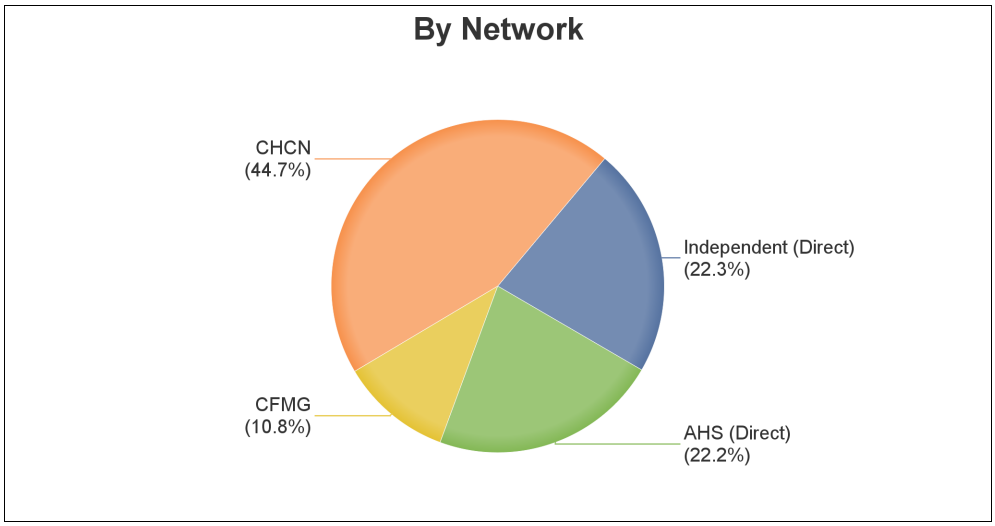
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

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

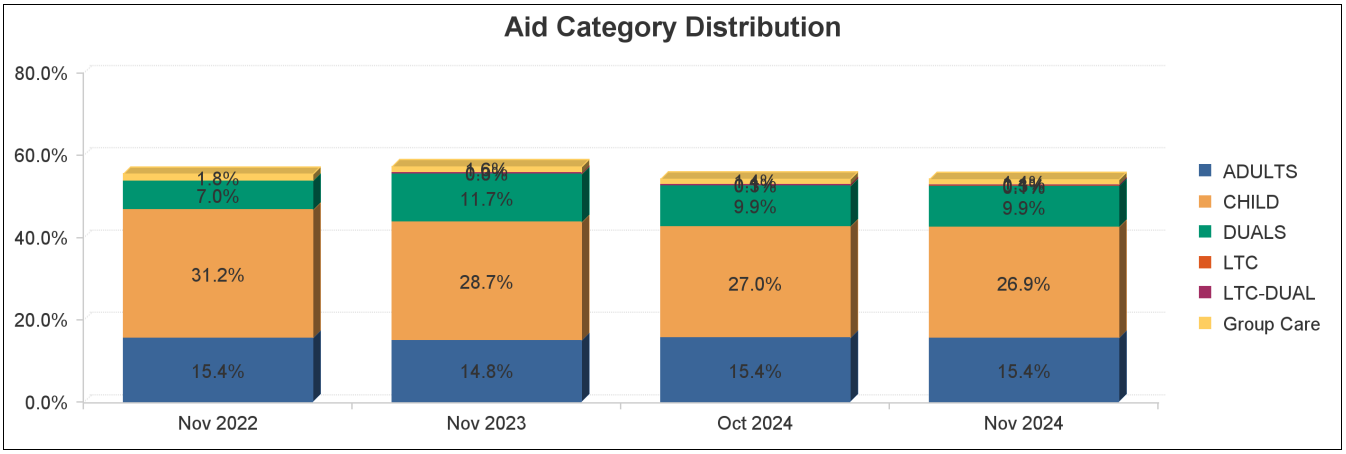




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

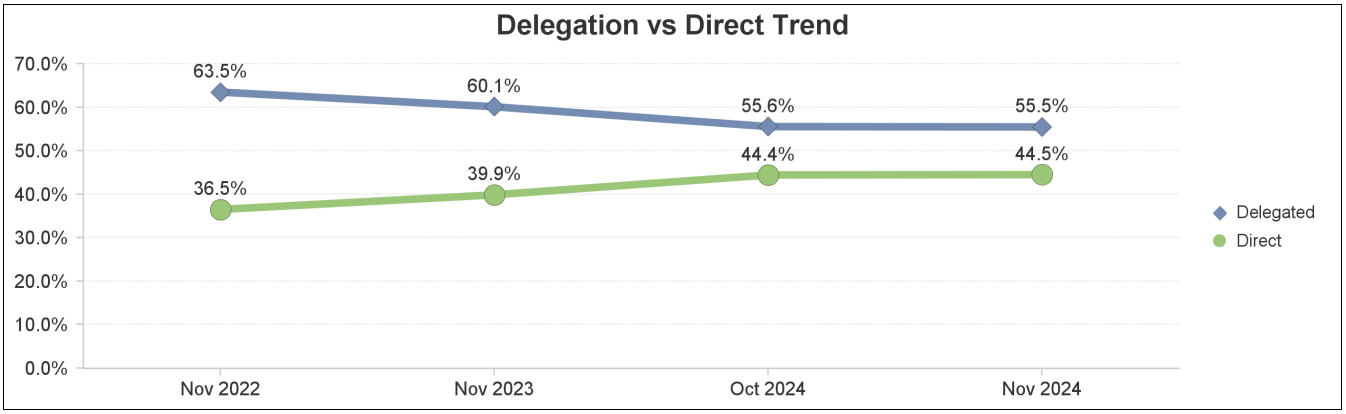
Category of Aid Trend

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



Delegation vs Direct Trend

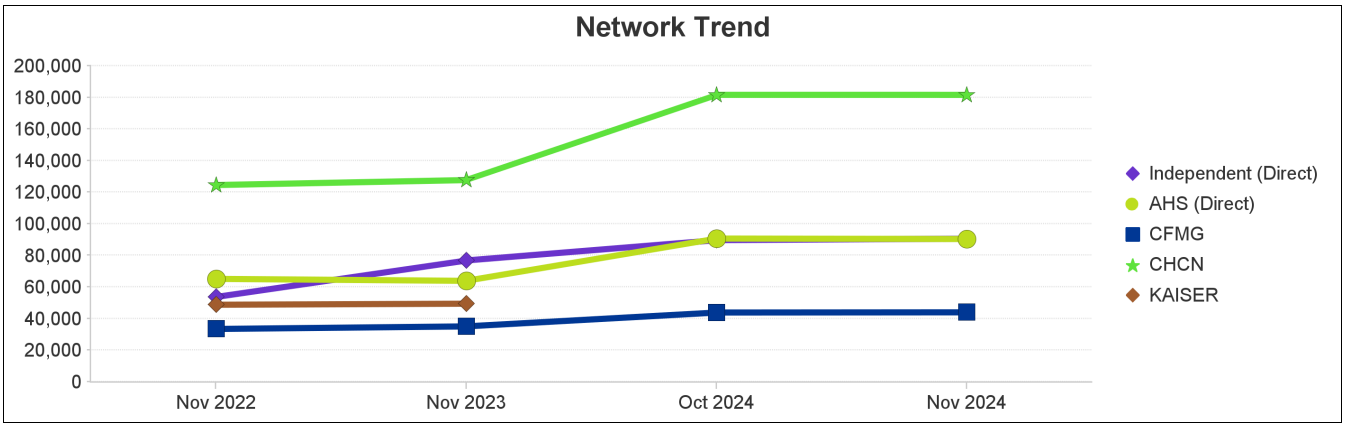
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Delegated	206,973	212,412	225,684	**225,785**	63.5%	60.1%	55.6%	55.5%	2.6%	6.3%	0.0%
Direct	118,952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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Network Trend

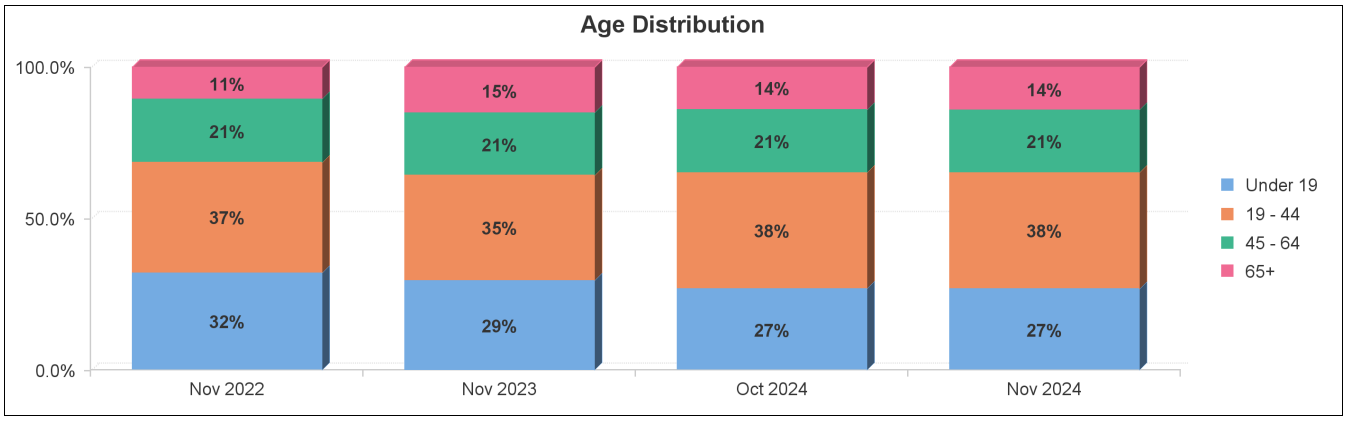
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Independent (Direct)	53,736	76,872	89,756	**90,681**	16.5%	21.8%	22.1%	22.3%	43.1%	18.0%	1.0%
AHS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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

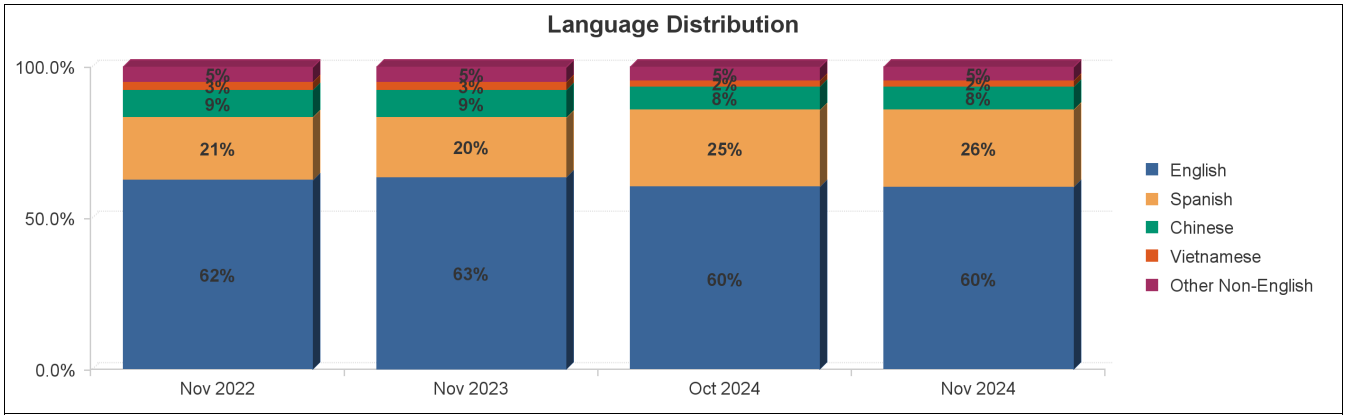
Age Category Trend

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



Language Trend

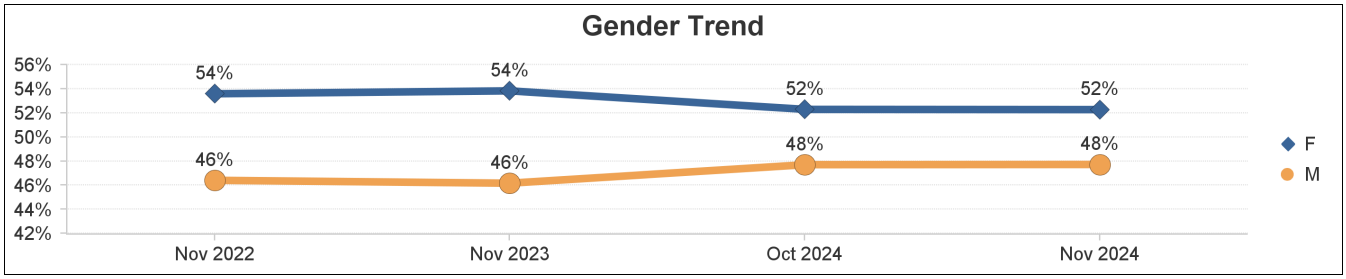
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Nov 2022	Nov 2023	Oct 2024	Nov 2024	ov 2022	ov 2023	Oct 2024	ov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
English	203,441	223,617	244,693	**244,547**	62%	63%	60%	60%	10%	9%	0%
Spanish	67,653	69,914	103,228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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

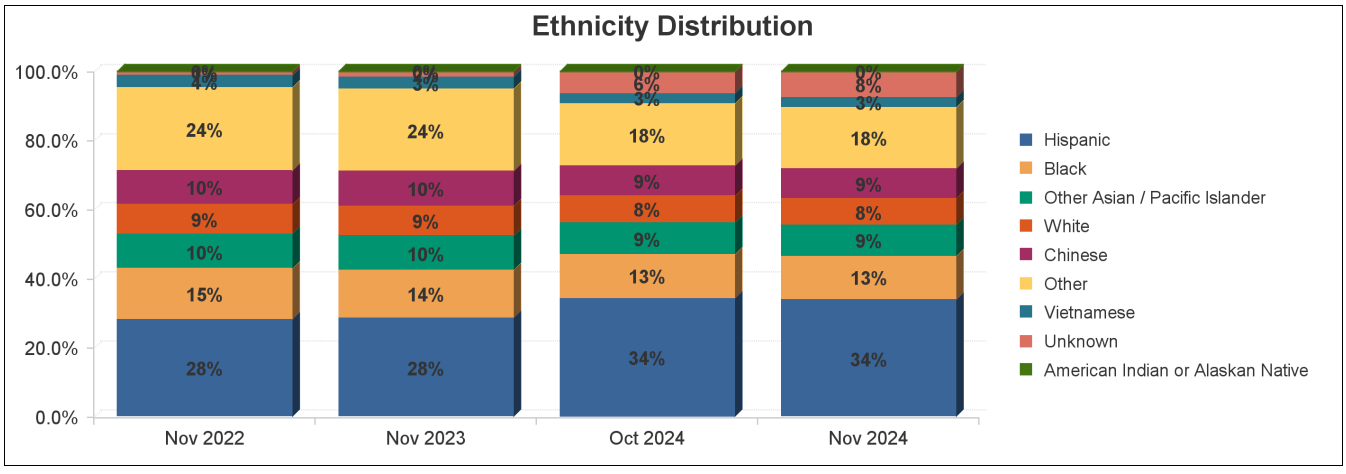
Gender Trend

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



Ethnicity Trend

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



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

Medi-Cal By City

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

Group Care By City

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

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

Total By City

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

ALAMEDA Alliance FOR HEALTH

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

Human Resources

Anastacia Swift

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

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

Date: **January 10th, 2025**

Subject: **Human Resources Report**

Staffing

- As of January 1st, 2025, the Alliance had 646 full time employees and 0-part time employee.

- On January 1st, 2025, the Alliance had 42 open positions in which 8 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 34 positions open to date. The Alliance is actively recruiting for the remaining 34 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by division:

Division	Open Position January 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	5	1	4
Operations	23	3	20
Healthcare Analytics	0	0	0
Information Technology	6	1	5
Finance	3	3	0
Compliance	2	0	2
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	42	8	34

- Our current recruitment rate is 6%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in December 2024 included:

  5 years:
  - Mai Trinh (Grievance & Appeals)
  - Stacey Woody (Provider Services)
  - Dominique Crosby (Provider Services)

  6 years:
  - Charles Walmann (Legal Services)

  7 years:
  - Alka Puri (Finance)
  - Anish Reddy (IT - Apps Management, IT Quality & Process Improvement)

  8 years:
  - Gil Riojas (Finance)

  9 years:
  - Beverly Juan (Medical Services)
  - Guneet Wadhwa (IT – Ops and Quality Apps Mgt)

  10 years:
  - Tammia Jackson (Case/Disease Management)
  - Jenny Jiang (Healthcare Analytics)
  - Alexandria Moore (Provider Services)

  11 years:
  - Ann Chu (Case/Disease Management)

  12 years:
  - Katherine Gordon (IT - Apps Management, IT Quality & Process Improvement)
  - Elizabeth Nunez (Member Services)

  13 years:
  - Annie Lam (Provider Services)

  20 years:
  - Monica Cabral (Claims)

  26 years:
  - Famina Perry (Claims)