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Board of Governors PACKET

JANUARY 9th, 2026



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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 9th, 2026
Subject: CEO Report

- **Financials:**

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

	<u>November</u>	<u>YTD</u>
Medi-Cal	\$7.7M	\$26.2M
Group Care	\$18K	(\$627K)
Medicare	(\$661K)	(\$4.1M)
Total	\$7.1M	\$21.4M

- **Revenue was \$183.3 million in November 2025 and \$941.8 million Year-to-Date (YTD).**
 - Medical expenses were \$169.5 million in November and \$883.8 million for the fiscal year-to-date; the medical loss ratio is 92.5% for the month and 93.8% for the fiscal year-to-date.
 - Administrative expenses were \$8.8 million in November and \$48.6 million for the fiscal year-to-date; the administrative loss ratio is 4.8% of net revenue for the month and 5.2% of net revenue year-to-date.
- **Tangible Net Equity (TNE):** Financial reserves are 239% of the required DMHC minimum, representing \$110.9 million in excess TNE.
- **Total enrollment in November 2025 was 403,393**, decreased by 746 Medi-Cal members compared to October 2025.

- **Key Performance Indicators:**

- **Regulatory Metrics:**

- The Claims team missed one processing timeline. The team processed 81% of claims within 30 calendar days. The State regulatory metric should be 90% to be considered compliant.
- Member grievances scored 94% processing time, which is below the 95% compliance mark.

- **Non-Regulatory Metrics:**

- All non-regulatory metrics were met for May.

- **Legislative Updates:**
 - State And Federal Updates
 - Legislative update attached.
- **Strategic Planning**
 - Please review the Strategic Plan and send in questions or edits by January 12, 2026.
- **IT Workflow Automation - Quarterly Updates – Next Update March 2026**
- **Alliance in the Community – Quarterly Updates – Next Update March 2026**
- **Medicare Overview**
 - **D-SNP**
 - 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 82 projects, of which 62 are active, seven (7) requested, one (1) on hold, and 11 complete.
 - For active projects, critical 1/1 deliverables have been achieved, and other deliverables are in a monitoring status until closing out.
 - Requested projects are enhancements to the Medicare product that will be worked throughout 2026.
 - 100% completion of training for internal D-SNP Medicare 101, Model of Care (MOC) Training, Stars 101, Marketing & Communications, Enrollment, and Facilities Mailroom.
 - Alameda Alliance Wellness (HMO D-SNP) Provider Tool Kit has been posted regarding multiple materials that includes provider orientation, care management, supplemental benefits, provider quick reference guide, etc.
 - External provider/vendor MOC Training has been deployed and sent out.
 - All D-SNP policies and procedures have been reviewed by the Administrative Oversight Committee (AOC) and finalized. The Alliance is working on the Medicare D-SNP 3-year strategy and collaborating with actuaries on PY2027 new D-SNP benefit design.
 - IT has had multiple deployments for various core systems, eligibility file exchanges with new vendors, CMS connection to various new databases, and other releases for enhancements/ad-ons.

- **Medi-Cal Incentive Programs**

- **Overview**

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

Incentive Program Summary (2022 – 2025)

<i>Incentive Program</i>	<i>Duration</i>	<i>Maximum</i>	<i>Awarded</i>	<i>Paid Out</i>
1) <i>Behavioral Health Integration*</i>	2021-2022	\$3.2M	\$3.2M	\$3.0M
2) <i>COVID-19 Vaccine*</i>	2021-2022	\$8.4M	\$3.0M	\$1.4M
3) <i>CalAIM IPP*</i>	2022-2024	\$29.9M	\$19.4M	\$17.0M
4) <i>Student Behavioral Health*</i>	2022-2024	\$9.7M	\$9.7M	\$9.1M
5) <i>Housing and Homelessness*</i>	2022-2023	\$44.3M	\$38.0M	\$25.3M
6) <i>Provider Recruitment Initiative</i>	2024-2025	\$2.0M	\$1.9M	\$400k
7) <i>Doula Scholarship Program</i>	2024-2025	\$20k	\$20k	\$15k
8) <i>Provider Recruitment Initiative</i>	2025-2026	\$2.0M	\$1.9M	\$0
9) <i>Doula Scholarship Program</i>	2025-2026	\$40k**	\$5k	\$5k
Totals		\$99.5M*	\$77.1M	\$56.2M



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Demographics

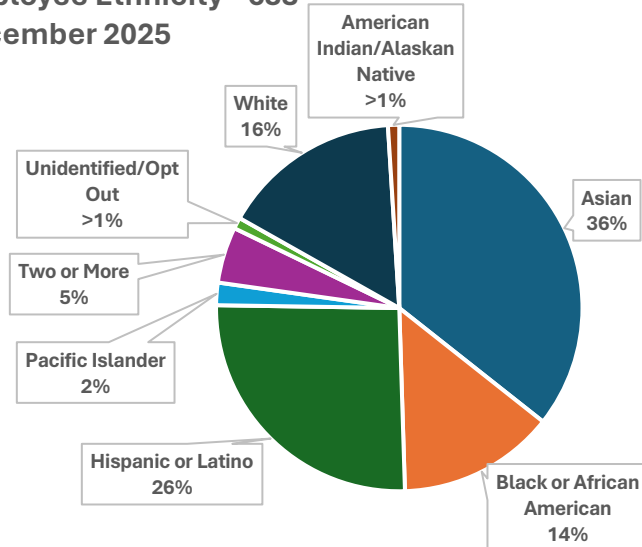
This report provides a comparative analysis of the demographic composition of Alameda Alliance for Health’s workforce in relation to the population profile of Alameda County. The evaluation focuses on key demographic indicators, including race/ethnicity, gender, and age distribution. The objective is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

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

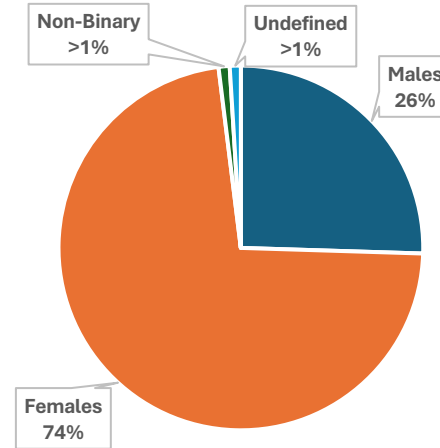
Category	Alameda Alliance for Health (Workforce information last updated December 2025)	Alameda County (Population Information last updated in May 2025)
Population/Total Employees	683	1,626,575
Race & Ethnicity		
Asian	36%	35.39%
Hispanic	26%	23.94%
White	16%	28.26%
Black/African American	14%	9.15%
Native Hawaiian/Pacific Islander	2%	0.82%
American Indian/Alaskan Native	>1%	1.18%
Two or More Races	5%	11.62%
Unidentified/Opt Out	>1%	-
Gender		
Male	26%	49.67%
Female	74%	50.33%
Non-Binary	>1%	-
Undefined	>1%	-
Age Distribution		
Under 25	>1%	8.33%
25-34	20%	13.92%
35-44	36%	16.13%
45-54	26%	13.59%
55-Older	18%	29.03%

AAH Employee Demographics Data Report December 2025

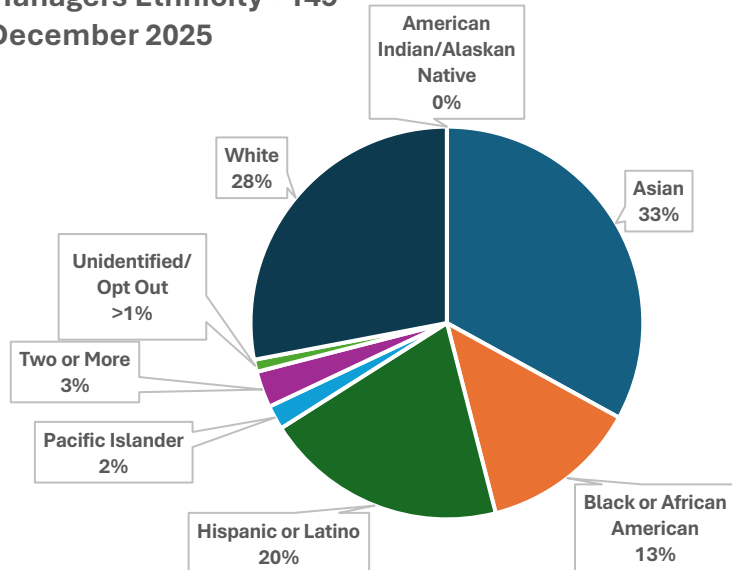
Employee Ethnicity - 683
December 2025



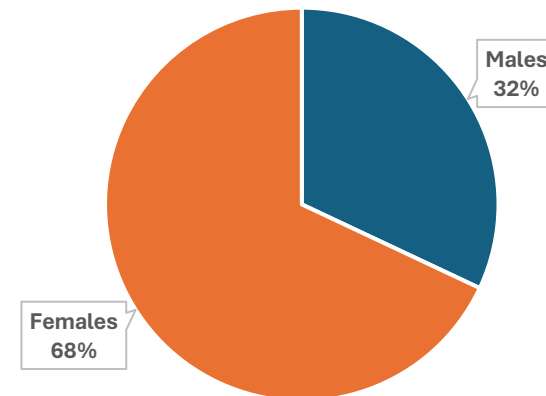
Employee Gender - 683
December 2025



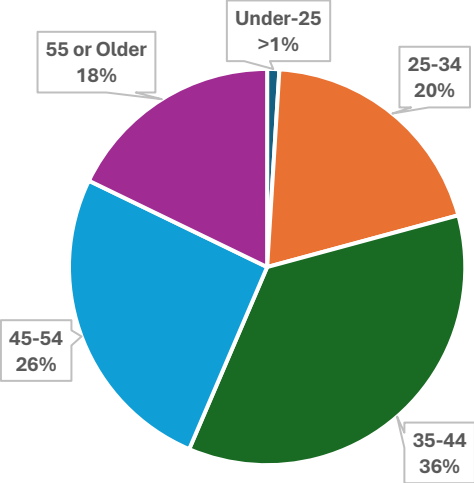
Managers Ethnicity - 149
December 2025



Managers Gender - 149
December 2025



Employee Age Demographics - 683
December 2025





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Legislative Tracking



January 2026 Legislative Update

Public Affairs and Media Relations Department

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

Federal Policy Update

Congress returned to Washington this week with a packed agenda that includes funding federal agencies and health extenders beyond the end of this month. While three appropriations bills (Agriculture, Legislative Branch and Military Construction/Veterans Affairs) were signed into law in late 2025, funding for most other federal agencies, including the Department of Health and Human Services, passed through a continuing resolution through January 30, 2026. The House is also expected to vote on a three-year clean APTC extension bill; however, it remains unclear how many Republican members will vote for the bill.

On December 18, 2025, the Department of Health and Human Services published two proposed rules that would prohibit Medicaid and CHIP funds to be used for gender affirming care and would prohibit hospitals from providing gender affirming care to minors. In response to these proposed rules, leaders of the California Health & Human Services Agency released a joint statement reminding health plans that the rules are not final and that California laws protecting health care for transgender individuals remain in full effect.

Throughout December, the Alliance continued to participate in various health care coalitions working to coordinate outreach strategies related to ongoing and upcoming state/federal changes. As part of those efforts, nearly 45,000 postcards were mailed to Alliance members with January and February renewals, encouraging them to renew their Medi-Cal coverage.

State Legislative Update

On January 5, 2026, California entered a new two-year legislative session which will run through the end of this calendar year. Lawmakers will begin to introduce hundreds of new bills as well as hold hearings for 2-year bills that were introduced in 2025, and which must pass their house of origin by January 31st if they are to advance through the legislative process.

As Governor Newsom enters his final year as California's governor, he is expected to focus on issues related to housing and homelessness, affordability, climate, as well as other issue areas, while managing a looming budget deficit. The Governor will deliver his State of the State address before a joint session of the California Legislature later this week, which will be followed by the release of his January budget proposal. A summary of the proposal will be provided in next month's Board of Governors report.



The state's new Senate President pro Tempore, Monique Limon announced the new Senate Democratic Leadership and committee membership assignments, which notably include Senator Menjivar as the new Chair of the Budget Subcommittee #3 on Health and Human Services and Senator Akilah Weber Pierson as the Chair of the Health Committee. Senator Menjivar is expected to engage on Medi-Cal issues along with the anticipated budget shortfall and rising Medi-Cal costs.

Priority Bill List

The Legislature reconvened on January 5, 2026, for the 2026-2027 legislative cycle. A list of 2-year bills that make it through their house of origin by the January 31st deadline along with new bills introduced that are of interest to the Alliance will be included in next month's Board of Governors report.



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Executive Dashboard

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Financials

Income & Expenses

NOVEMBER 2025

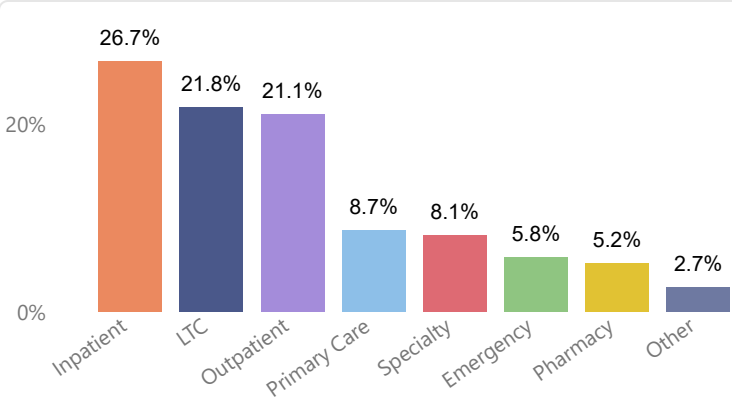
FISCAL YTD

REVENUE	\$ 247.5 M	\$ 1.3 B
MEDICAL EXPENSE	\$ (169.5) M	\$ (883.8) M
ADMIN EXPENSE	\$ (8.8) M	\$ (48.6) M
OTHER/TAX	\$ (62.2) M	\$ (312.0) M
NET INCOME	\$ 7.1 M	\$ 21.4 M

Medical Loss % (Fiscal YTD)

93.8%

Medical Expenses



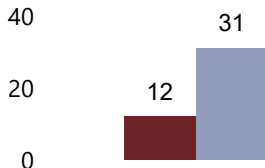
Liquid Reserves

Reinsurance Cases

TNE %
239.1%

TNE \$
\$190.6M

New Submitted



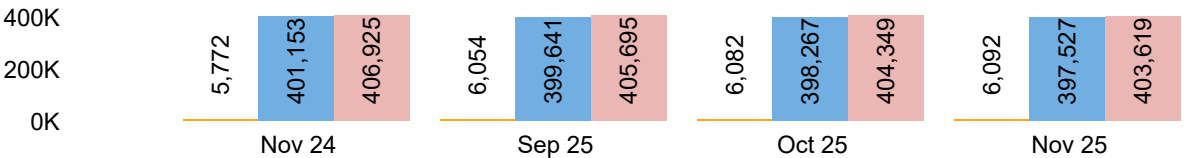
Balance Sheet

Cash Equivalents	\$558.2M	Current Ratio 1.14
Pass-Through Liabilities	\$162.2M	
Uncommitted Cash	\$396.0M	
Working Capital	\$136.3M	

Membership

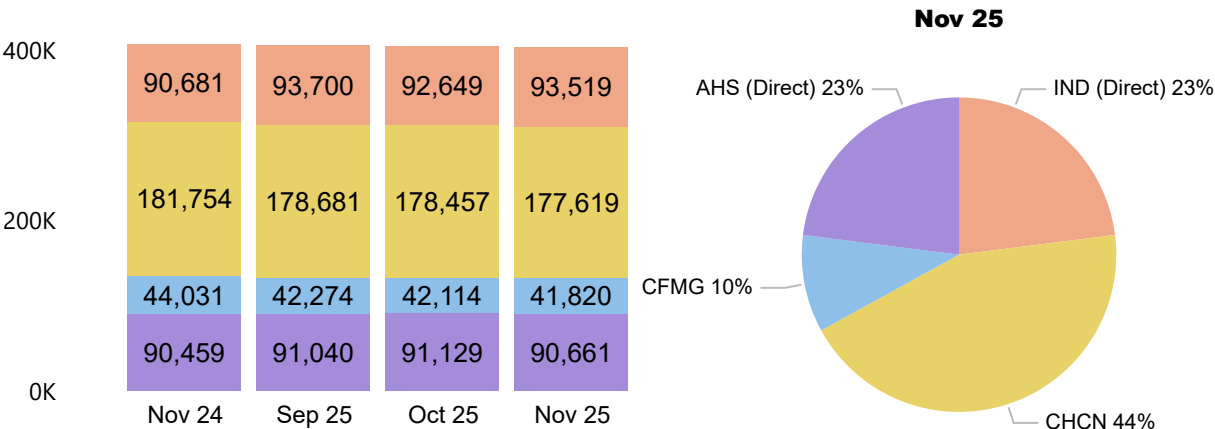
By Plan

IHSS Medi-Cal Total



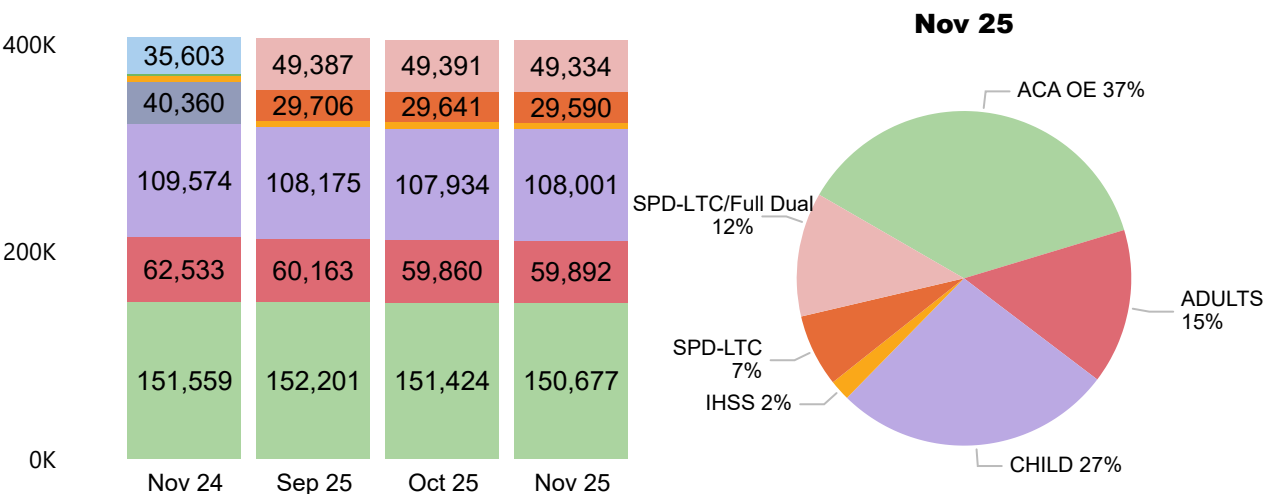
By Network

AHS (Direct) CFMG CHCN Independent (Direct)



By Category

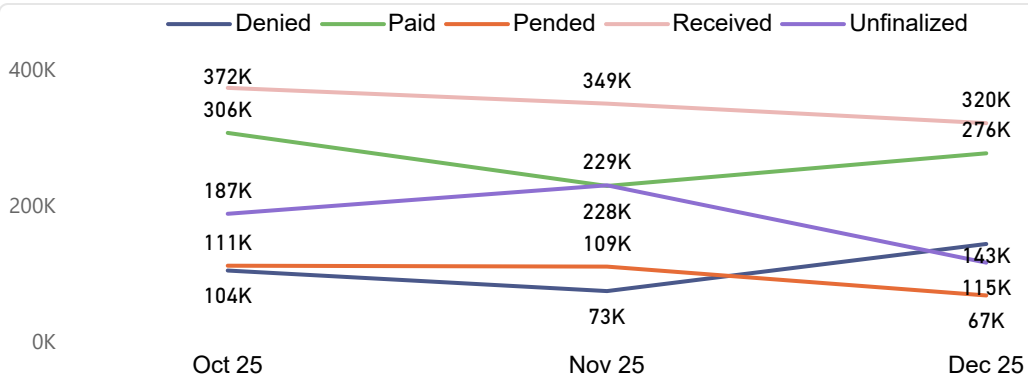
ACA OE ADULTS CHILD DUALS IHSS LTC LTC-DUAL SPD SPD-LTC SPD-LTC/Full Dual



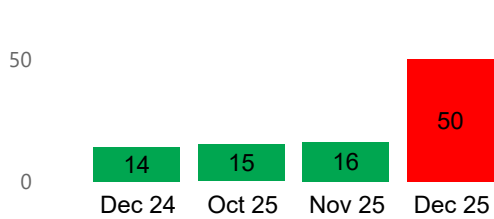
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Claims

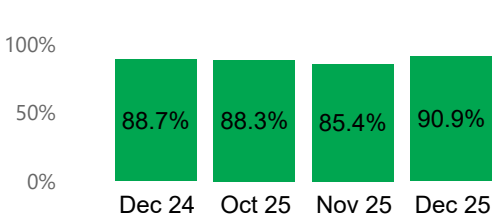
Claims Processing



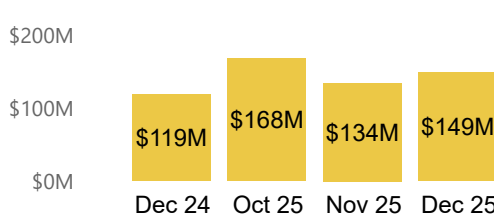
Average Payment TAT (Days)



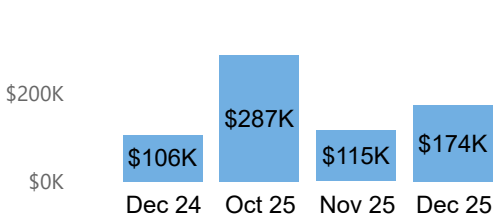
Auto Adjudication Rate (%)



Claims Paid (\$)

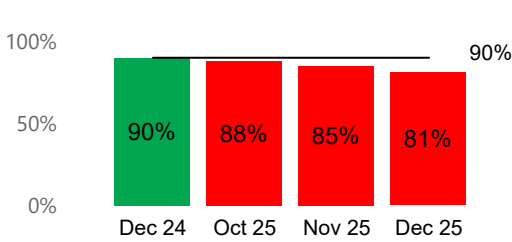


Interest Paid (\$)

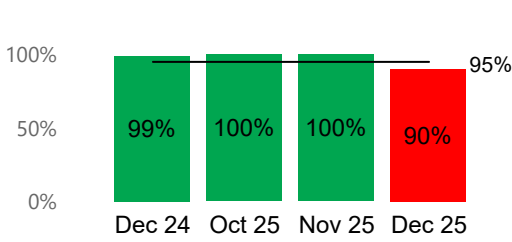


Claims Compliance

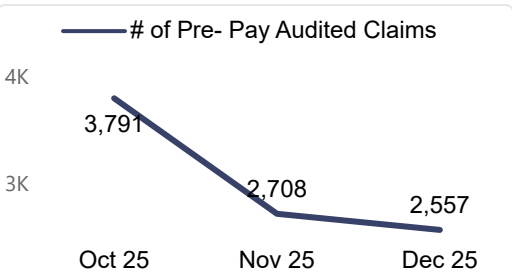
Processed 30 Cal Days (%)



Processed 45 Work Days (%)

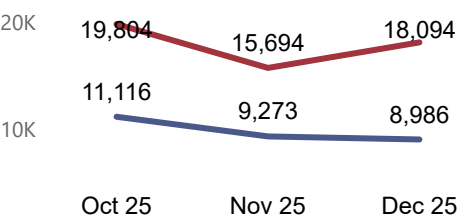


Claims Auditing

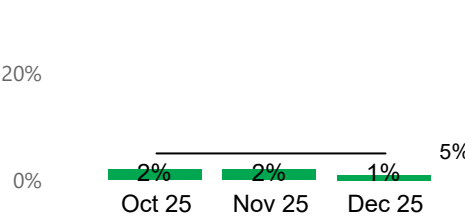


Member Services

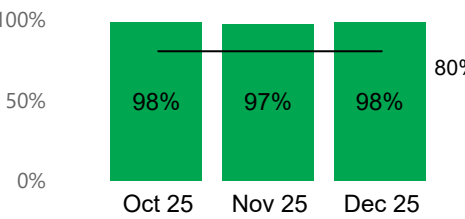
Inbound Calls Outbound Calls



Abandoned Call Rate (%)



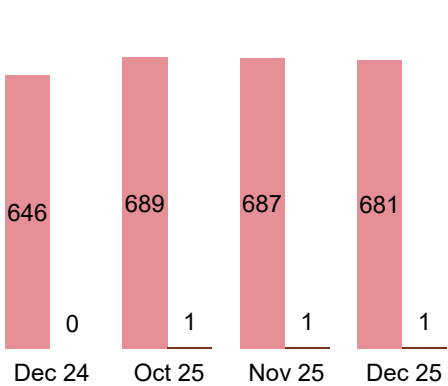
Calls Answered in 30 Seconds (%)



Average Call Times	Oct 25	Nov 25	Dec 25
Wait Time	00:07	00:07	00:07
Call Duration	07:00	06:47	06:38

Human Resources

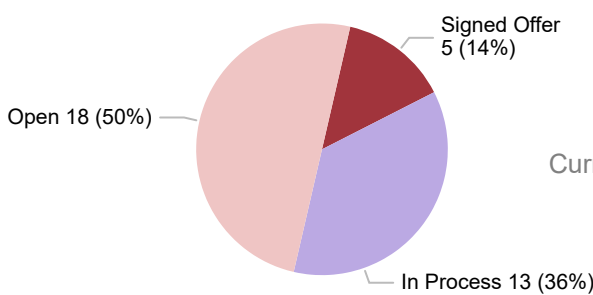
Full Time Part Time



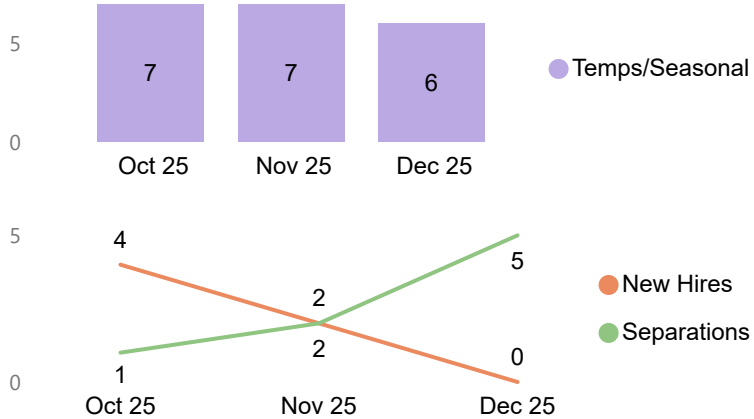
Recruiting Status

Dec 25

Trans/Proms Signed Offer In Process Open



Current Vacancy
3%



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Provider Services

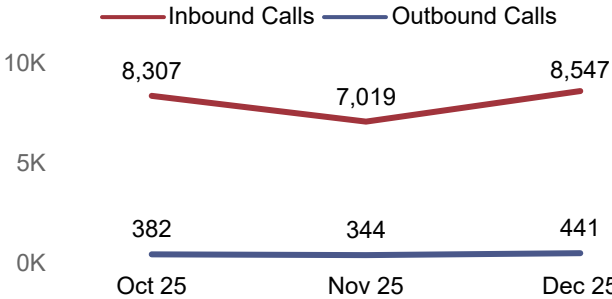
Provider Network

Hospital	17
Specialist	11,889
Primary Care Physician	781
Skilled Nursing Facility	107
Urgent Care	18
Health Centers (FQHCs and Non-FQHCs)	87
TOTAL	12,899

Provider Credentialing

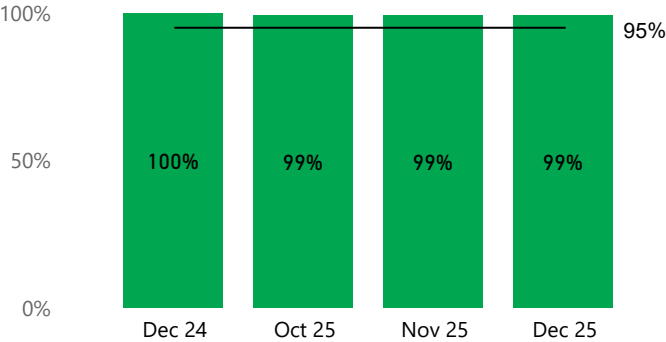
5,581

Provider Call Center



Provider Disputes & Resolutions

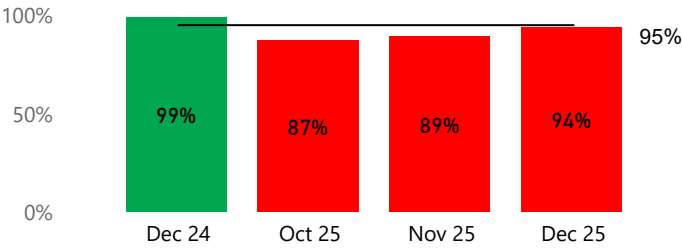
Turnaround Compliance (45 business days)



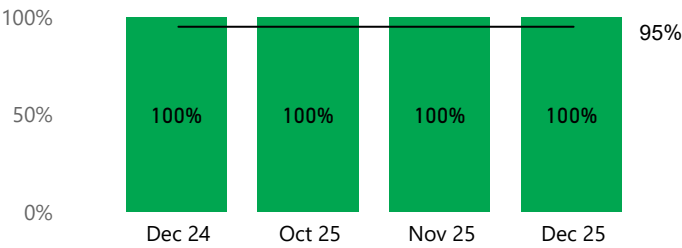
Compliance

Member Grievances

Standard (30 calendar days)

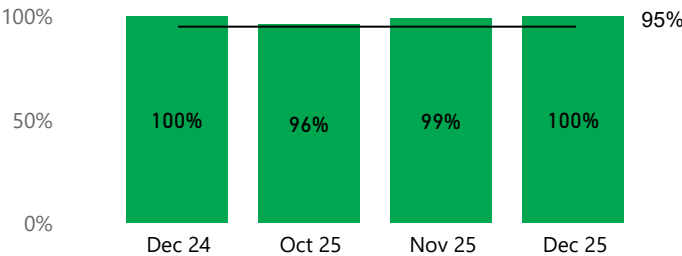


Expedited (3 calendar days)

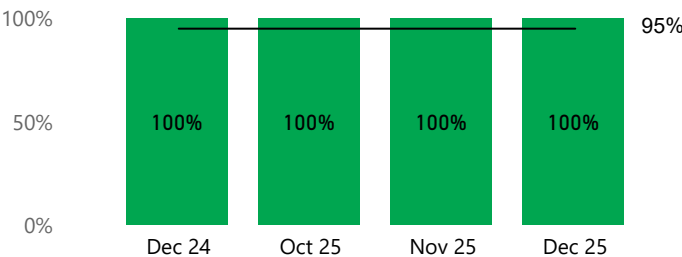


Member Appeals

Standard (30 calendar days)

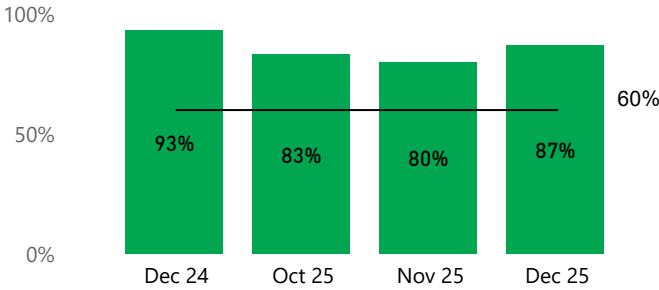


Expedited (3 calendar days)

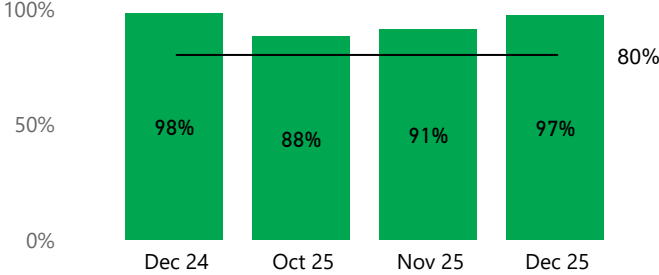


Encounter Data

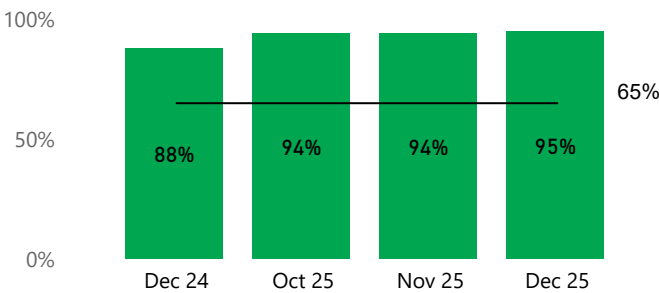
Institutional 0-90 days



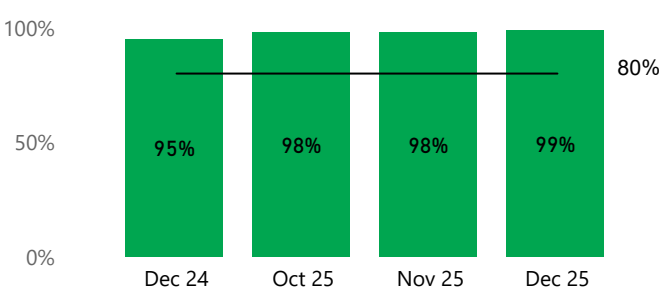
Institutional 0-180 days



Professional 0-90 days



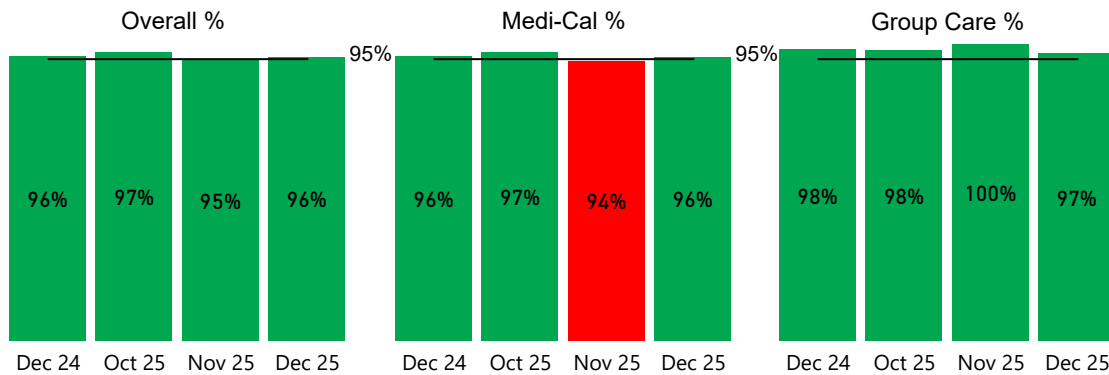
Professional 0-180 days



Health Care Services

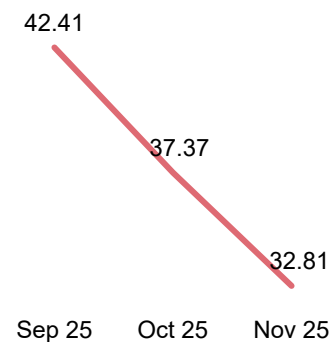
Authorization Turnaround

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



ED Utilization

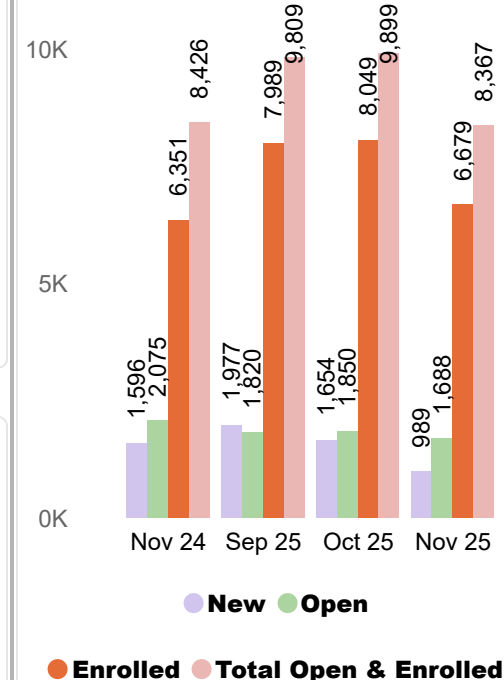
ED Visits / 1000



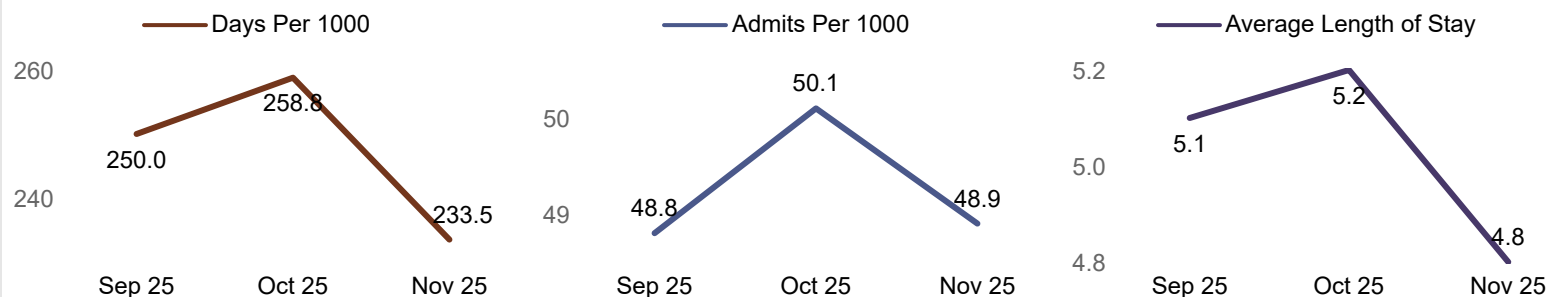
Case Management

Total Cases^

^ ECM Metrics since 2022



Inpatient Utilization

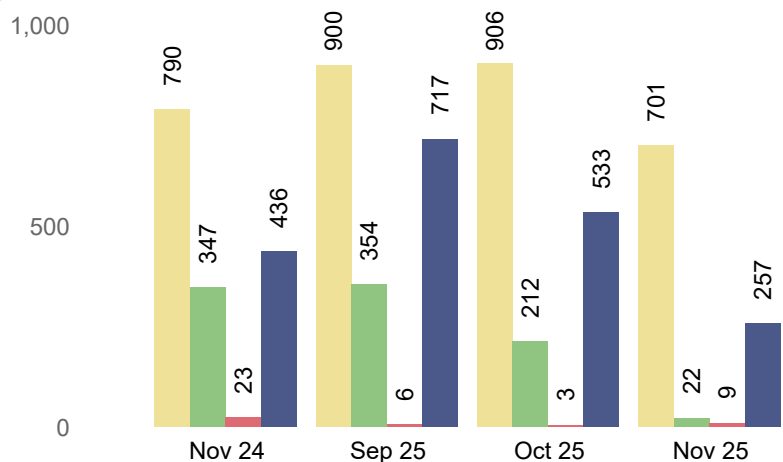


Case Management^

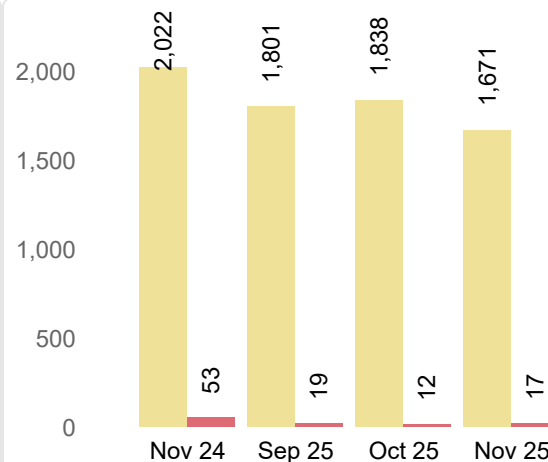
● Care Coordination ● Community Supports ● Complex Cases ● Enhanced Case Management

^ ECM Metrics since 2022

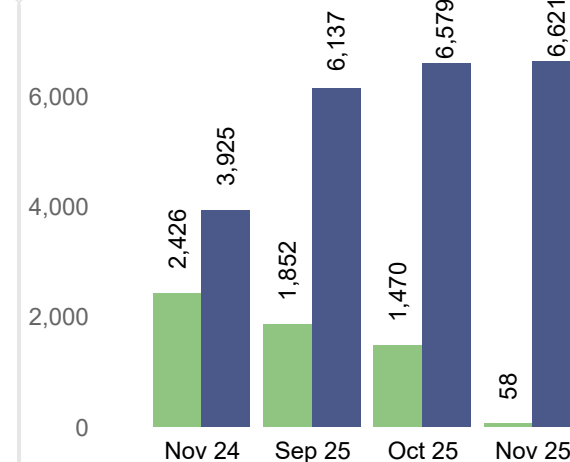
New Cases



Open Cases



Enrolled Cases



Technology (Business Availability)

Applications ▲	Dec 24	Oct 25	Nov 25	Dec 25
HEALTHsuite System	100.0%	99.9%	100.0%	100.0%
Other Applications	100.0%	99.9%	99.9%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Dec 24	Oct 25	Nov 25	Dec 25
Denial Rate Excluding Partial Denials (%)	4.3%	3.5%	3.8%	3.4%
Overall Denial Rate (%)	4.6%	3.7%	4.0%	3.7%
Partial Denial Rate (%)	0.4%	0.2%	0.2%	0.4%

* IHSS and Medi-Cal Line Of Business

Pharmacy Authorizations

Authorizations ▲	Dec 24	Oct 25	Nov 25	Dec 25
Approved Prior Authorizations	43	44	31	34
Closed Prior Authorizations	26	33	18	14
Denied Prior Authorizations	73	106	81	88
Total Prior Authorizations	142	183	130	136



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Finance

Gil Riojas

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

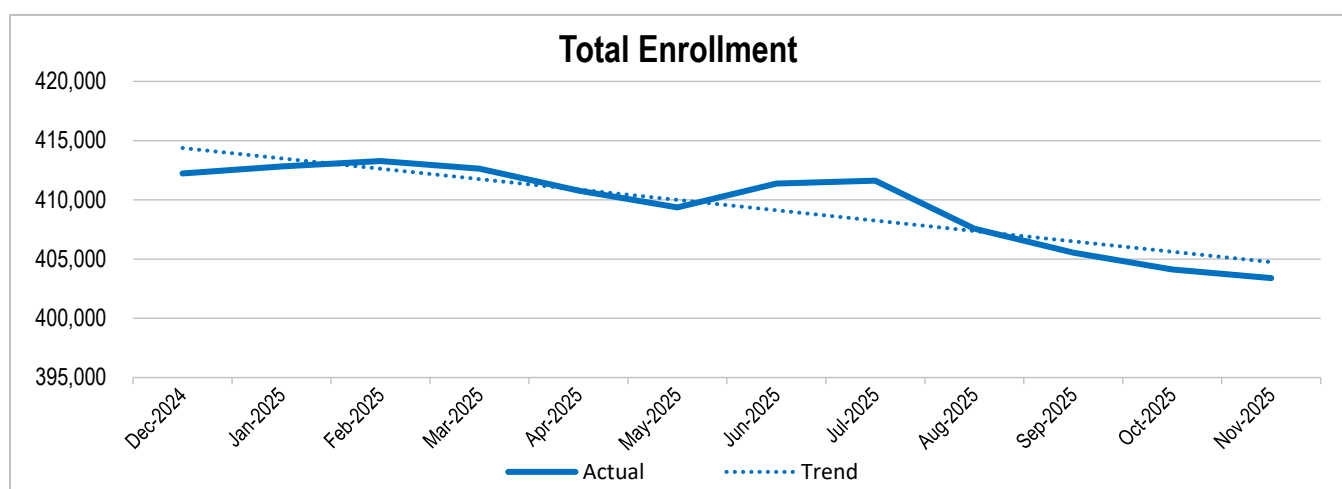
Date: January 9th, 2026

Subject: Finance Report – November 2025 Financials

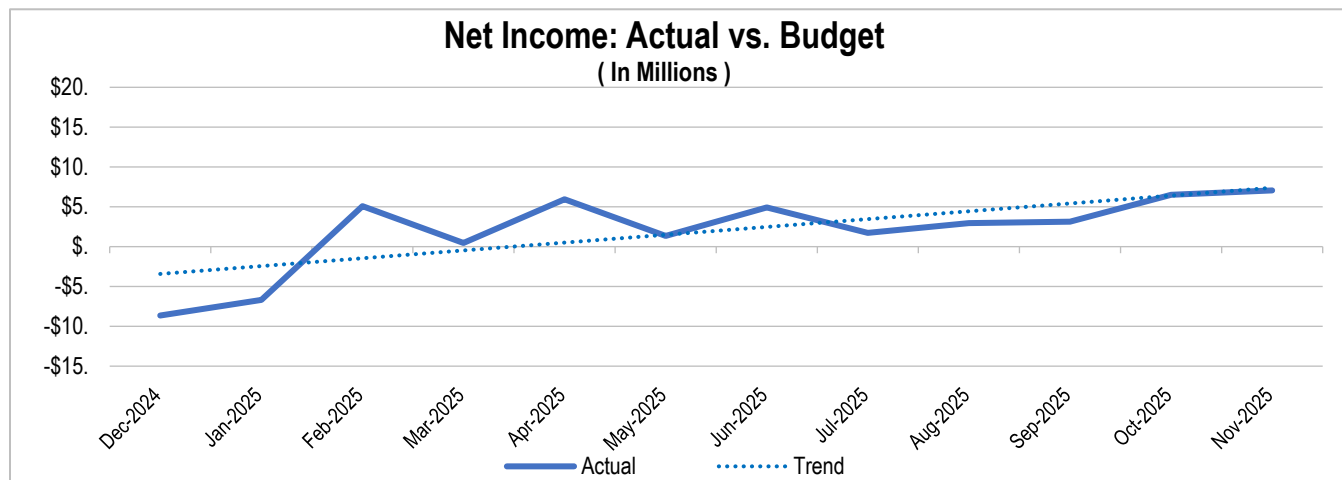
Executive Summary

For the month of November, the Alliance decreased in enrollment, down slightly to 403,393 members. Net Income of \$7.1 million was reported, and the Plan's Medical Expenses represented 92.5% of Premium Revenue. Alliance reserves increased slightly to 239% of required and continue to remain above minimum requirements.

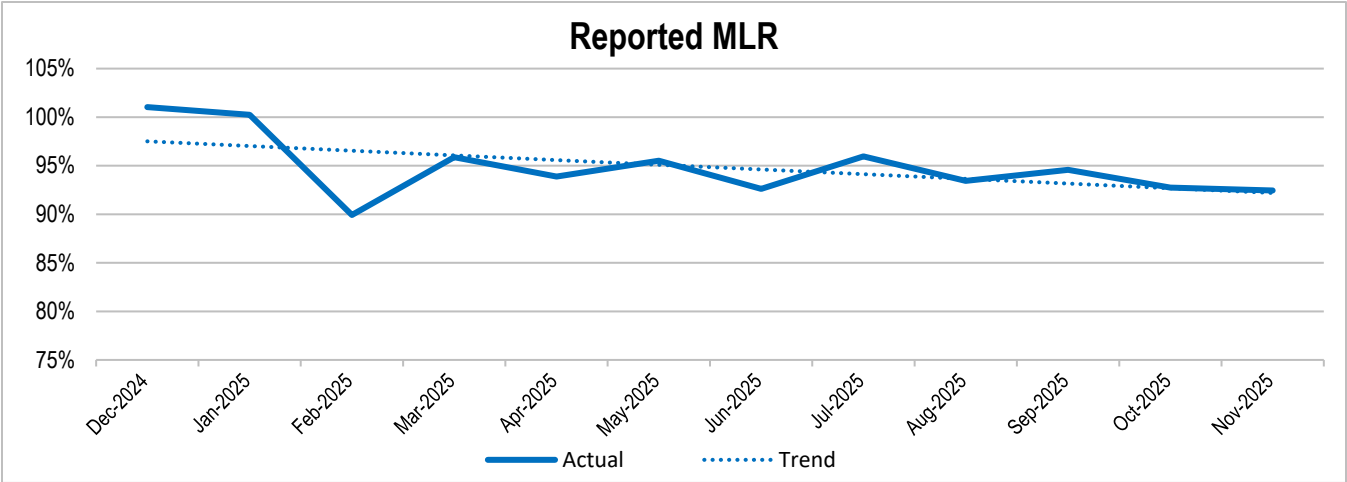
Enrollment – In November, Enrollment decreased by 735 members.



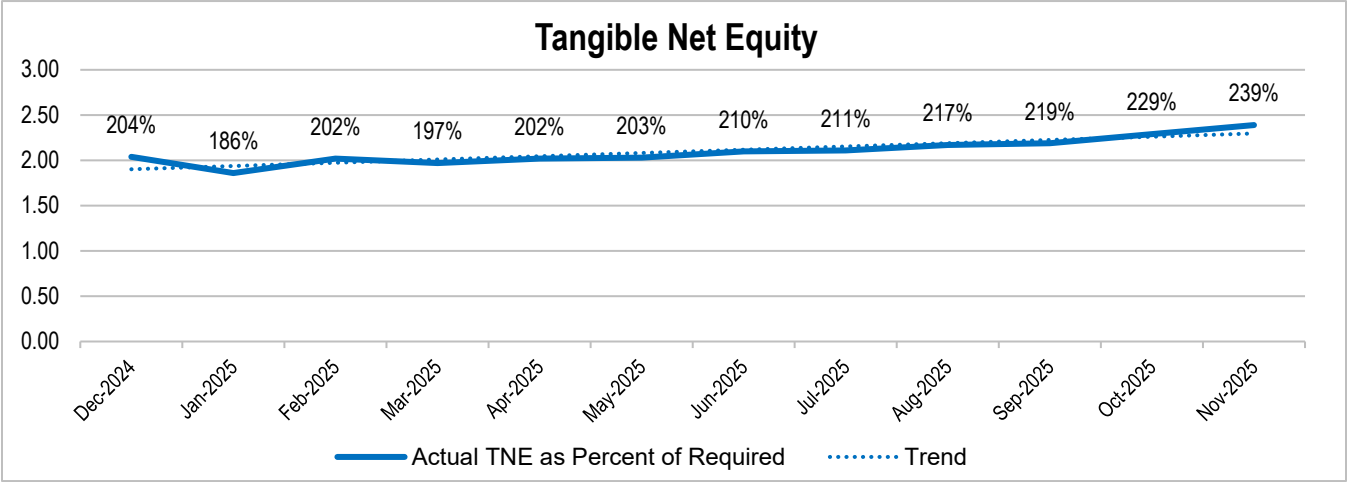
Net Income – For the month ended November, actual Net Income was \$7.1 million vs. budgeted Net Income of \$5.1 million. For the fiscal YTD, actual Net Income was \$21.4 million vs. budgeted Net Income of \$19.4 million. For the month, Premium Revenue was unfavorable to budget, actual Revenue was \$183.3 million vs. budgeted Revenue of \$192.3 million. Premium Revenue unfavorable variance of \$9.0 million is primarily due to blended Medi-Cal capitation rate variance for the current month.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 92.5% for the month, and 93.8% for fiscal YTD. The major unfavorable variance was Premium Revenue. The major favorable variances were Primary Care Physician Expense and Administrative Expense.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required \$79.8 million in reserves, we reported \$190.6 million. Our overall TNE remains above DMHC requirements at 239%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, investments show a gain of \$12.1 million and capital assets acquired are \$24,000.

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: January 9th, 2026

Subject: Finance Report – November 2025

Executive Summary

- For the month ended November 30th, 2025, the Alliance had enrollment of 403,393 members, a Net Income of \$7.1 million and 239% of required Tangible Net Equity (TNE).

<u>Overall Results: (in Thousands)</u>		
	Month	YTD
Revenue	\$247,538	\$1,265,766
Medical Expense	169,484	883,816
Admin. Expense	8,840	48,617
MCO Tax Expense	64,213	324,009
Other Inc. / (Exp.)	2,057	12,042
Net Income	\$7,058	\$21,366

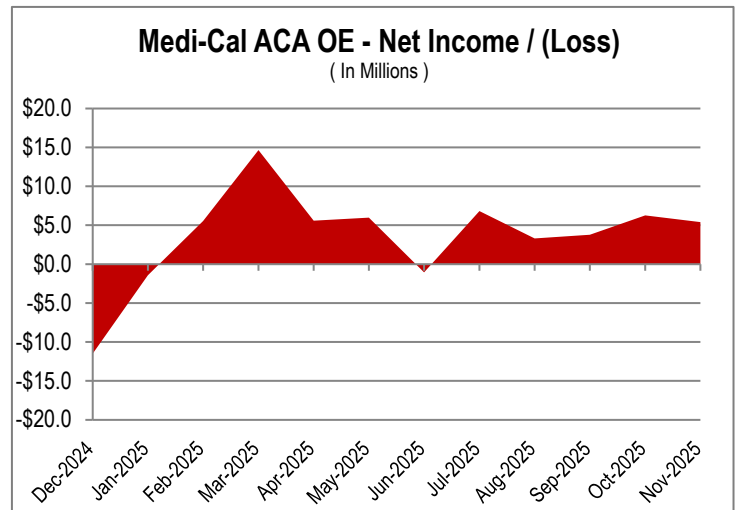
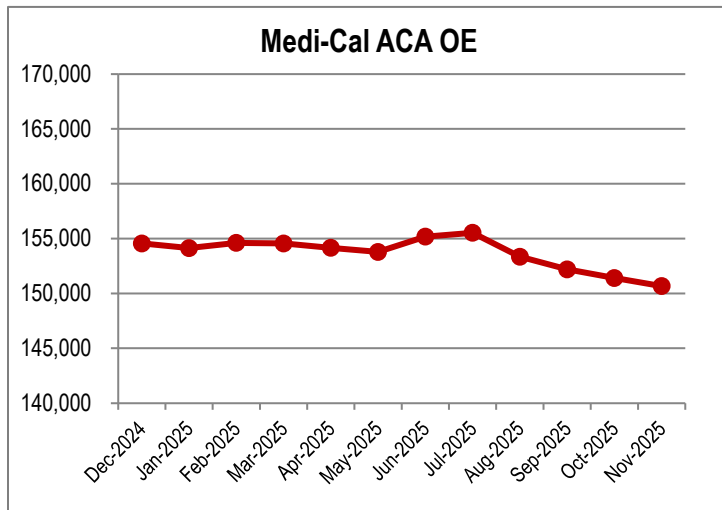
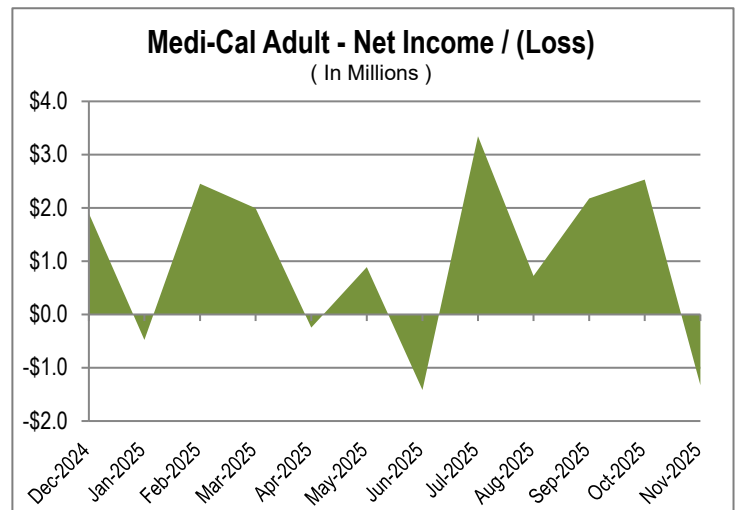
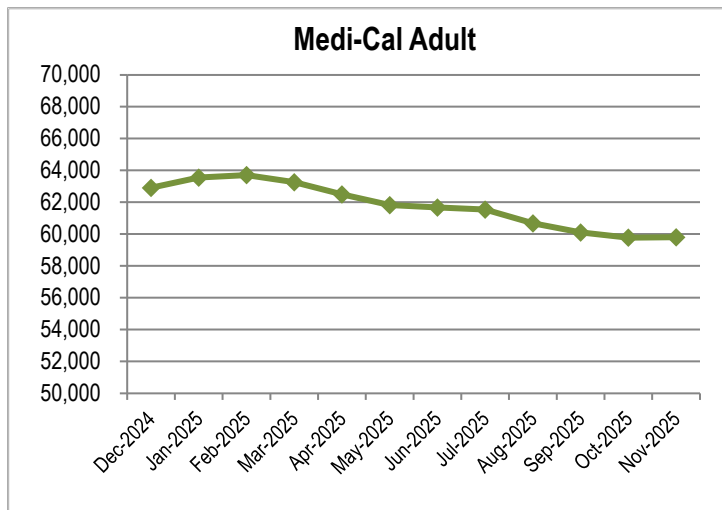
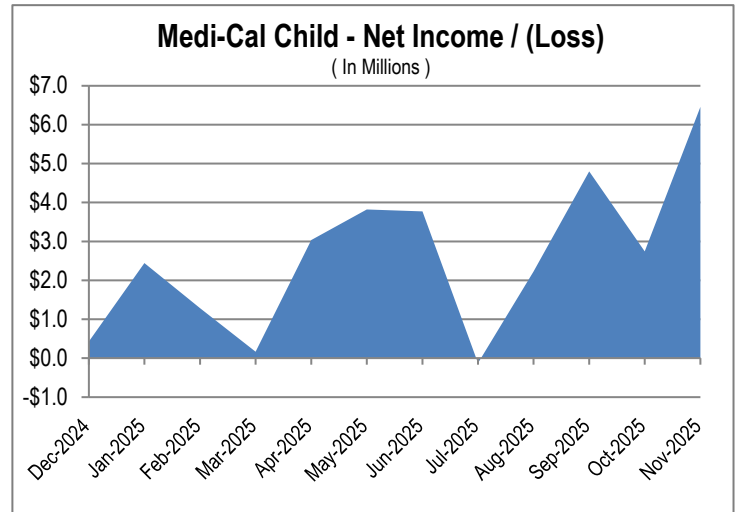
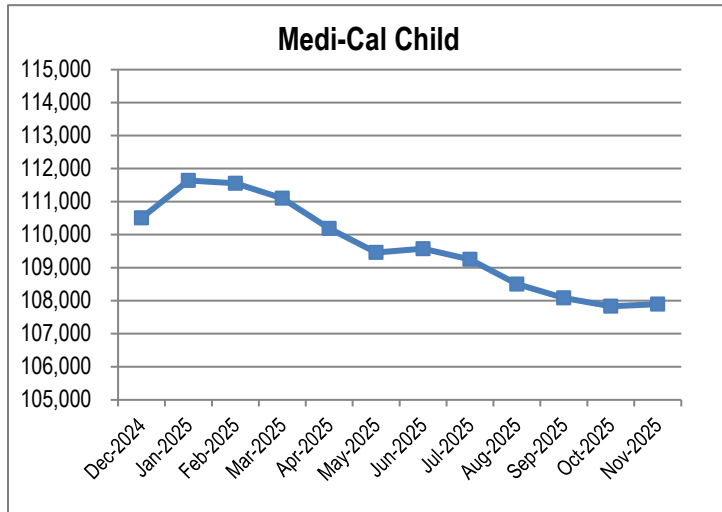
<u>Net Income by Program: (in Thousands)</u>		
	Month	YTD
Medi-Cal	\$7,701	\$26,189
Group Care	18	(627)
Medicare	(661)	(4,197)
	\$7,058	\$21,366

Enrollment

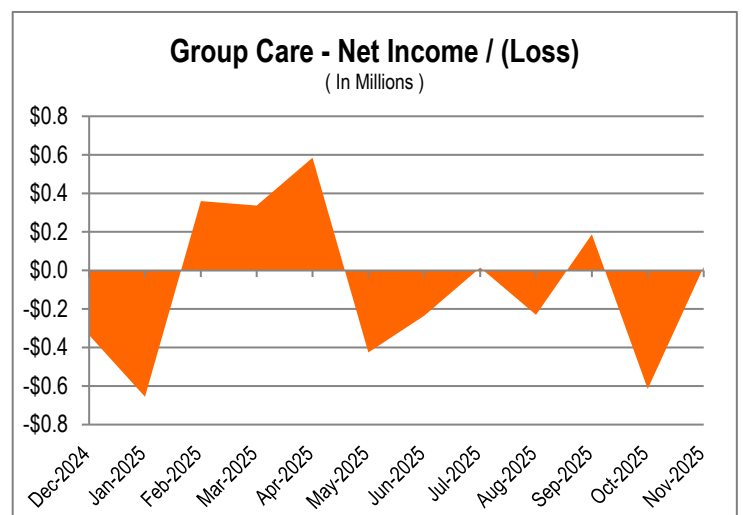
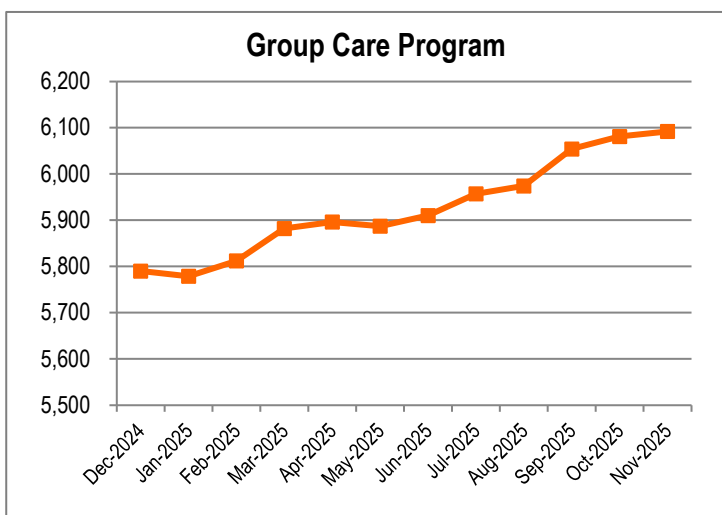
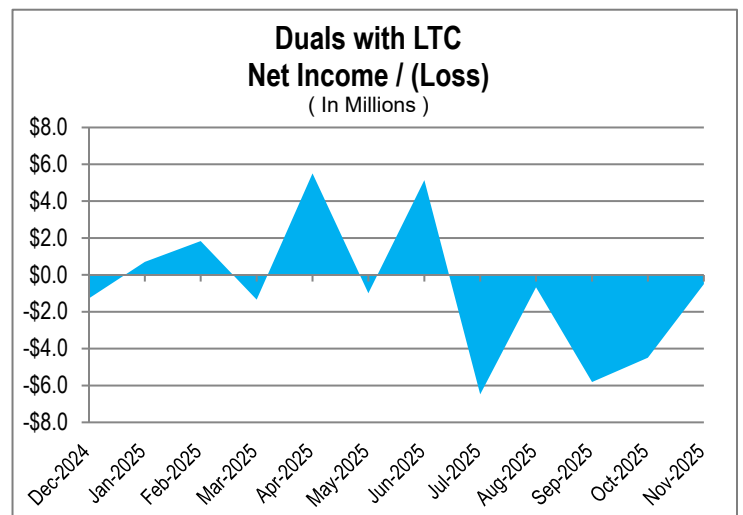
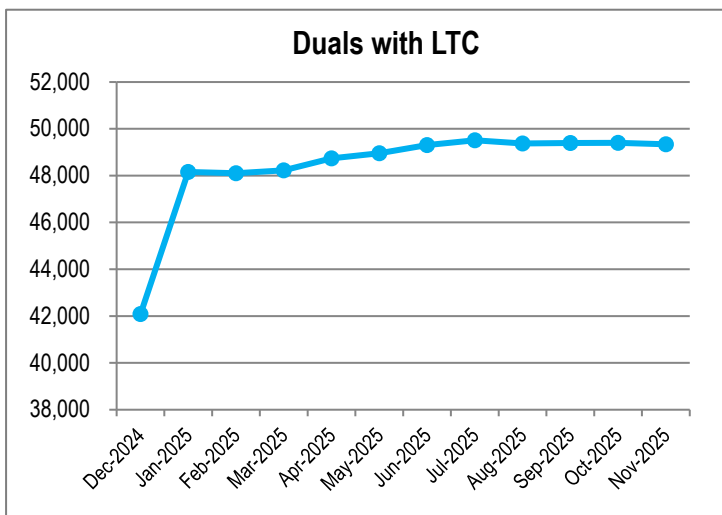
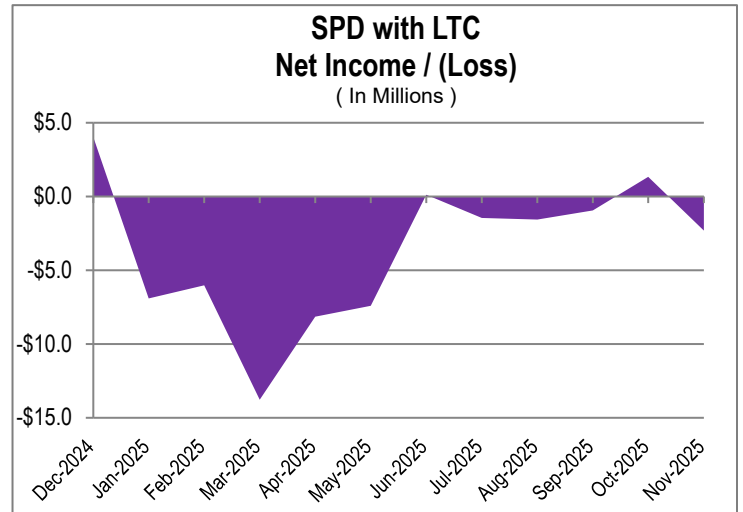
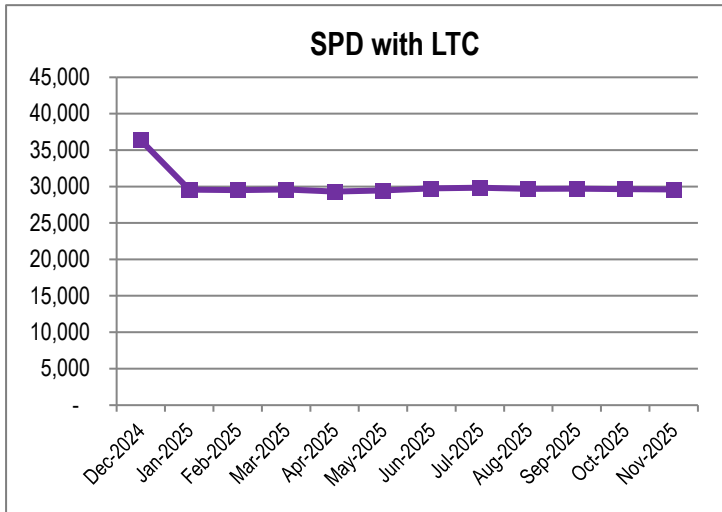
- Total enrollment decreased by 735 members since October 2025.
- Total enrollment decreased by 7,990 members since June 2025.

Monthly Membership and YTD Member Months								
Actual vs. Budget								
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
107,894	107,623	271	0.3%	Child	541,562	541,291	271	0.1%
59,806	59,301	505	0.9%	Adult	301,907	301,402	505	0.2%
150,677	150,461	216	0.1%	ACA OE	763,158	762,942	216	0.0%
29,590	29,574	16	0.1%	SPD with LTC	148,448	148,432	16	0.0%
49,334	49,195	139	0.3%	Duals with LTC	247,005	246,866	139	0.1%
397,301	396,154	1,147	0.3%	Medi-Cal Total	2,002,080	2,000,933	1,147	0.1%
6,092	6,079	13	0.2%	Group Care	30,158	30,145	13	0.0%
403,393	402,233	1,160	0.3%	Total	2,032,238	2,031,078	1,160	0.1%

Enrollment and Profitability by Program and Category of Aid

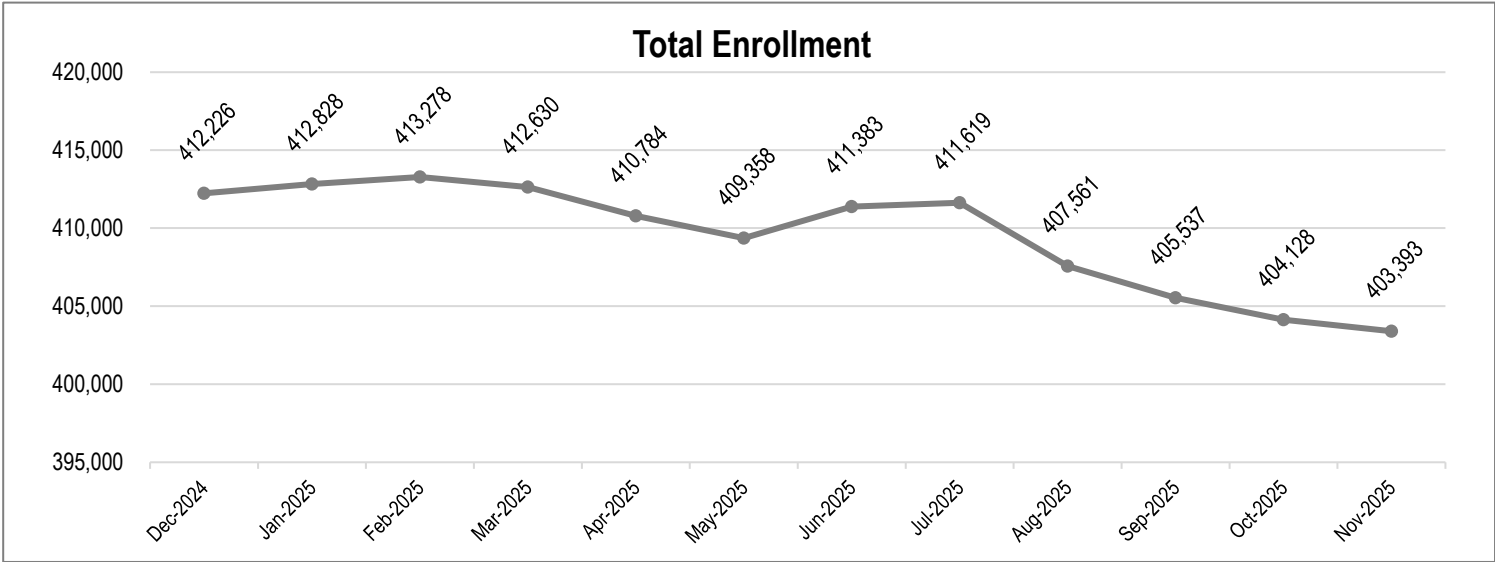


Enrollment and Profitability by Program and Category of Aid

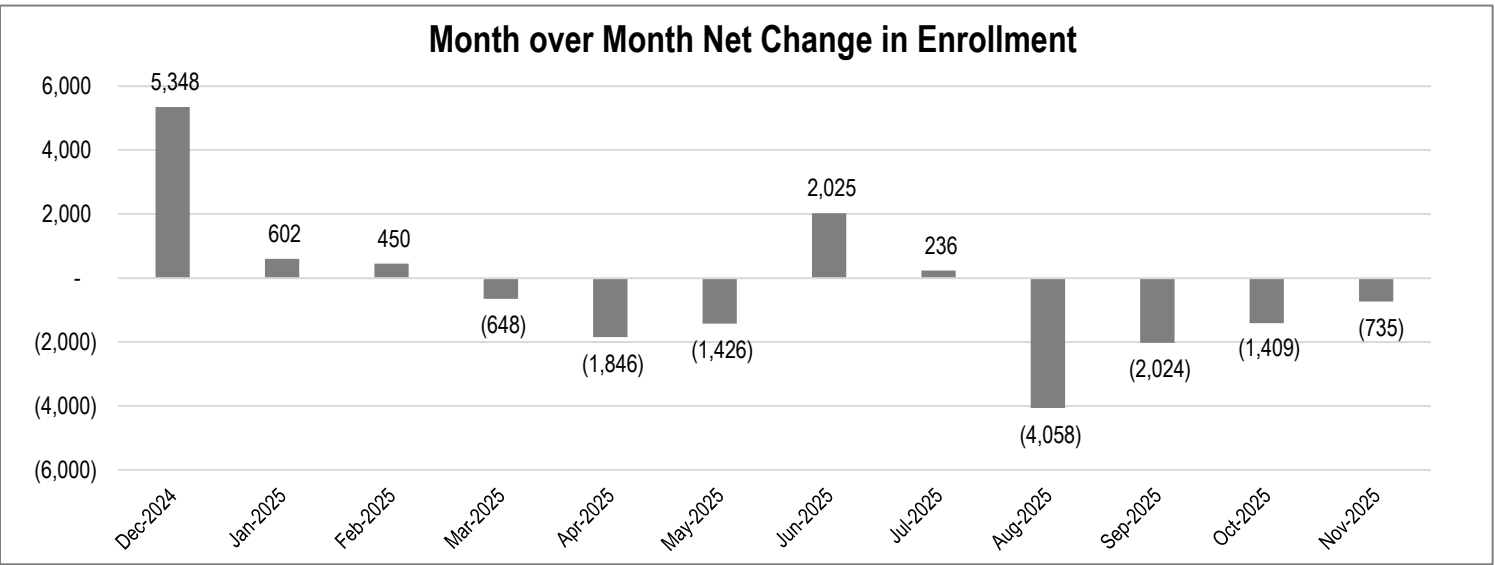


Enrollment and Profitability by Program and Category of Aid

Total Enrollment

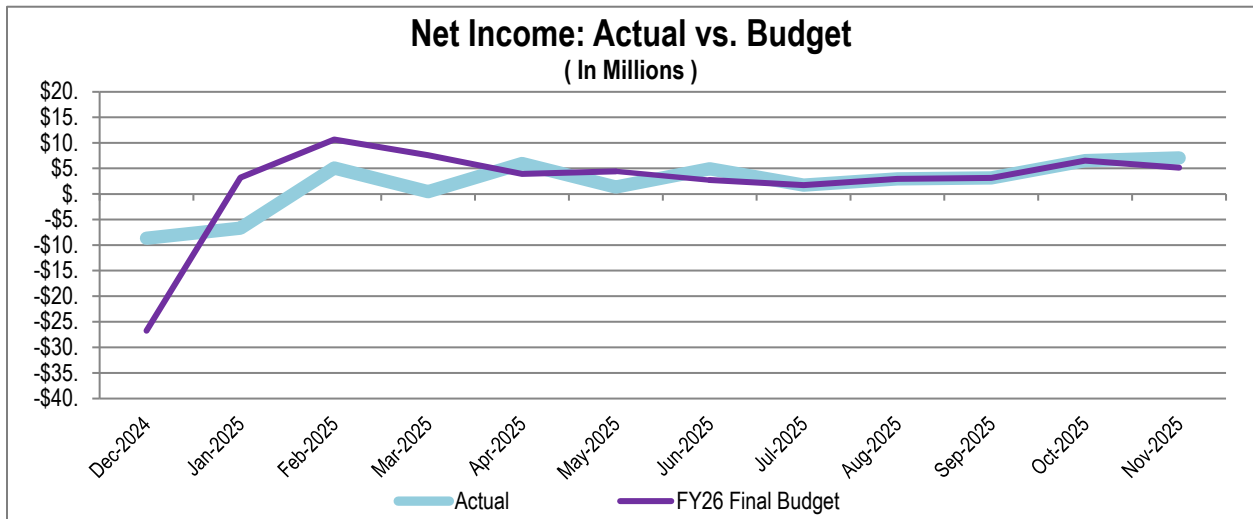


Month over Month Net Change in Enrollment



Net Income

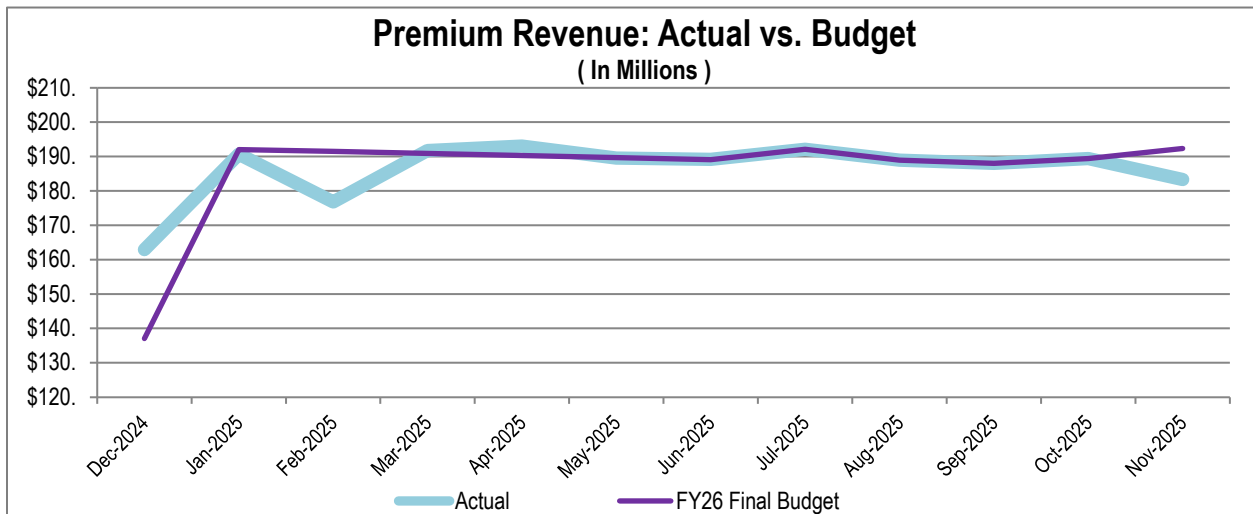
- For the month ended November 30th, 2025:
 - Actual Net Income: \$7.1 million.
 - Budgeted Net Income: \$5.1 million.
- For the fiscal YTD ended November 30th, 2025:
 - Actual Net Income \$21.4 million.
 - Budgeted Net Income \$19.4 million.



- The favorable variance of \$1.9 million in the current month is primarily due to:
- Favorable \$8.8 million lower than anticipated Medical Expense.
 - Favorable \$3.0 million lower than anticipated Administrative Expense.
 - Unfavorable \$9.0 million lower than anticipated Premium Revenue.

Premium Revenue

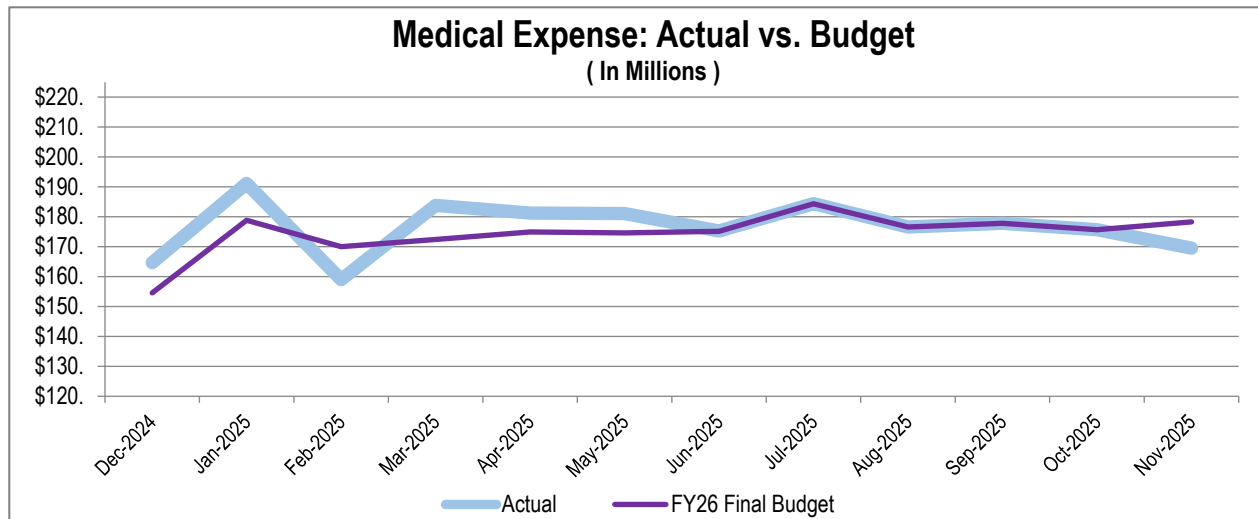
- For the month YTD ended November 30th, 2025:
 - Actual Revenue: \$183.3 million.
 - Budgeted Revenue: \$192.3 million.
- For the fiscal YTD ended November 30th, 2025:
 - Actual Revenue: \$941.8 million.
 - Budgeted Revenue: \$950.8 million.



- For the month ended November 30th, 2025, the unfavorable Premium Revenue variance of \$9.0 million is primarily due to an unfavorable blended Medi-Cal capitation rate variance.

Medical Expense

- For the month ended November 30th, 2025:
 - Actual Medical Expense: \$169.5 million.
 - Budgeted Medical Expense: \$178.2 million.
- For the fiscal YTD ended November 30th, 2025:
 - Actual Medical Expense: \$883.8 million.
 - Budgeted Medical Expense: \$892.6 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 actuarial consultants.
- For November, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by \$4.2 million. Year to date, the estimate for prior years increased by \$6.6 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)						
Adjusted to Eliminate the Impact of Prior Period IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical Expense	\$96,353,511	\$0	\$96,353,511	\$96,335,523	(\$17,987)	0.0%
Primary Care FFS	\$14,074,444	\$10,068,624	\$24,143,068	\$27,298,163	\$13,223,719	48.4%
Specialty Care FFS	\$42,236,826	\$1,708,765	\$43,945,590	\$44,627,507	\$2,390,681	5.4%
Outpatient FFS	\$69,218,978	(\$215,863)	\$69,003,116	\$71,163,861	\$1,944,883	2.7%
Ancillary FFS	\$99,599,661	\$1,590,814	\$101,190,475	\$100,476,438	\$876,777	0.9%
Pharmacy FFS	\$49,612,964	(\$3,694,847)	\$45,918,117	\$48,472,780	(\$1,140,184)	(2.4%)
ER Services FFS	\$50,743,679	\$372,683	\$51,116,362	\$51,884,761	\$1,141,083	2.2%
Inpatient Hospital FFS	\$235,598,638	\$256,481	\$235,855,120	\$236,810,120	\$1,211,481	0.5%
Long Term Care & SNF FFS	\$196,295,940	(\$3,516,034)	\$192,779,906	\$191,410,013	(\$4,885,927)	(2.6%)
Other Benefits & Services	\$18,028,489	\$0	\$18,028,489	\$19,525,113	\$1,496,624	7.7%
Net Reinsurance	(\$177,295)	\$0	(\$177,295)	(\$88,038)	\$89,256	101.4%
Provider Incentive	\$5,659,099	\$0	\$5,659,099	\$4,659,099	(\$1,000,000)	(21.5%)
	\$877,244,934	\$6,570,624	\$883,815,558	\$892,575,340	\$15,330,406	1.7%

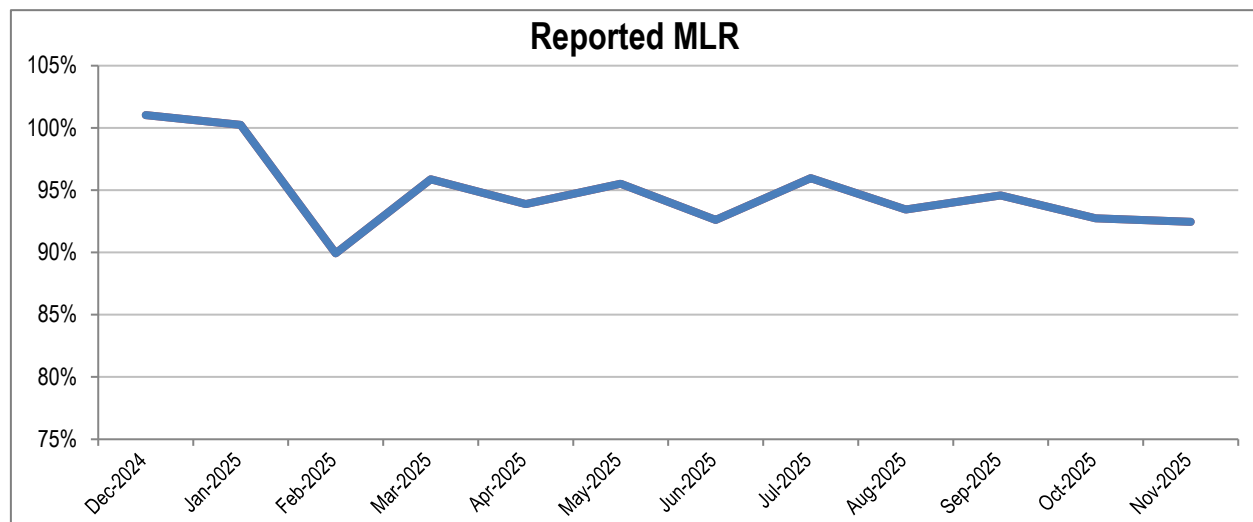
Medical Expense - Actual vs. Budget (Per Member Per Month)						
Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical Expense	\$47.41	\$0.00	\$47.41	\$47.43	\$0.02	0.0%
Primary Care FFS	\$6.93	\$4.95	\$11.88	\$13.44	\$6.51	48.5%
Specialty Care FFS	\$20.78	\$0.84	\$21.62	\$21.97	\$1.19	5.4%
Outpatient FFS	\$34.06	(\$0.11)	\$33.95	\$35.04	\$0.98	2.8%
Ancillary FFS	\$49.01	\$0.78	\$49.79	\$49.47	\$0.46	0.9%
Pharmacy FFS	\$24.41	(\$1.82)	\$22.59	\$23.87	(\$0.55)	(2.3%)
ER Services FFS	\$24.97	\$0.18	\$25.15	\$25.55	\$0.58	2.3%
Inpatient Hospital & SNF FFS	\$115.93	\$0.13	\$116.06	\$116.59	\$0.66	0.6%
Long Term Care & SNF FFS	\$96.59	(\$1.73)	\$94.86	\$94.24	(\$2.35)	(2.5%)
Other Benefits & Services	\$8.87	\$0.00	\$8.87	\$9.61	\$0.74	7.7%
Net Reinsurance	(\$0.09)	\$0.00	(\$0.09)	(\$0.04)	\$0.04	101.3%
Provider Incentive	\$2.78	\$0.00	\$2.78	\$2.29	(\$0.49)	(21.4%)
	\$431.66	\$3.23	\$434.90	\$439.46	\$7.79	1.8%

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is \$15.3 million favorable to budget. On a PMPM basis, medical expense is 1.8% favorable to budget. For per-member-per-month expense:
 - Capitated Expense is over budget, primarily driven by unfavorable PCP Capitation FQHC expense.
 - Primary Care Expense is under budget due to TRI reclassifications across all populations.

- Specialty Care Expense is under budget, driven by low unit cost and utilization.
- Outpatient Expense is under budget due to lower facility other and dialysis utilization.
- Ancillary Expense is under budget due to lower utilization in all populations except for Child.
- Pharmacy Expense is over budget driven by expected future recoveries in the SPD with LTC and Adult aid code categories related to hospital administered drug overpayments.
- Emergency Expense is under budget driven by lower utilization in the ACA OE and Child aid code categories.
- Inpatient Expense is under budget driven by unit cost in the SPD with LTC and ACA OE aid code categories and Child utilization.
- Long Term Care Expense is over budget due to utilization and unit cost in the SPD with LTC and Duals with LTC Duals aid code categories.
- Other Benefits & Services is over budget, due to lower than expected employee, interpreter, professional services, community reinvestment, licenses, insurance and fees expenses.
- 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 92.5% for the month and 93.8% for the fiscal year-to-date.



Administrative Expense

- For the month ended November 30th, 2025:
 - Actual Administrative Expense: \$8.8 million.
 - Budgeted Administrative Expense: \$11.8 million.
- For the fiscal YTD ended November 30th, 2025:
 - Actual Administrative Expense: \$48.6 million.
 - Budgeted Administrative Expense: \$51.6 million.

Summary of Administrative Expense (In Dollars)									
For the Month and Fiscal Year-to-Date									
Current Month					Year-to-Date				
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %	
\$6,015,670	\$6,716,099	\$700,429	10.4%		Personnel Expense	\$31,616,711	\$32,317,140	\$700,429	2.2%
(55,877)	78,726	134,603	171.0%		Medical Benefits Admin Expense	258,336	392,938	134,603	34.3%
2,568,709	3,072,960	504,252	16.4%		Purchased & Professional Services	10,369,682	10,873,934	504,252	4.6%
311,442	1,975,503	1,664,061	84.2%	Other Admin Expense	6,372,282	8,036,343	1,664,061	20.7%	
\$8,839,944	\$11,843,288	\$3,003,344	25.4%	Total Administrative Expense	\$48,617,011	\$51,620,355	\$3,003,344	5.8%	

The year-to-date variances include:

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

The Administrative Loss Ratio (ALR) is 4.8% of net revenue for the month and 5.2% of revenue year-to-date. Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is \$958,000.

Other Income / (Expense)

Other Income & Expense is comprised primarily of investment income. Fiscal year-to-date net investments show a gain of \$12.1 million.

Managed Care Organization (MCO) Provider Tax

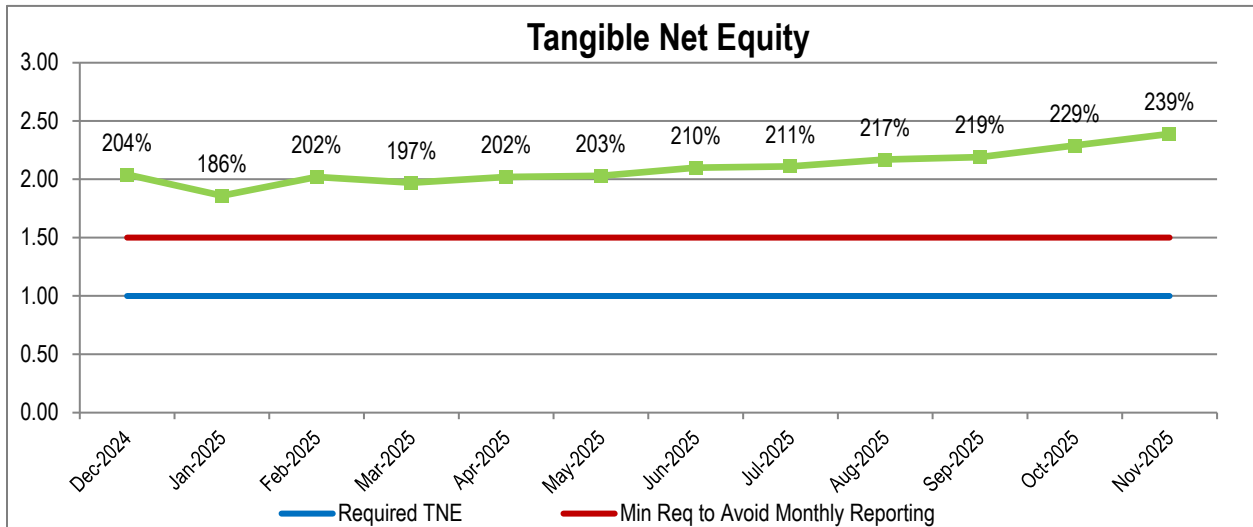
- Revenue:
 - For the month ended November 30th, 2025:
 - Actual: \$64.2 million.
 - Budgeted: \$64.0 million.
 - For the fiscal YTD ended November 30th, 2025:
 - Actual: \$324.0 million.
 - Budgeted: \$323.8 million.
- Expense:
 - For the month ended November 30th, 2025:
 - Actual: \$64.2 million.
 - Budgeted: \$64.0 million.

- For the fiscal YTD ended November 30th, 2025:
 - Actual: \$324.0 million.
 - Budgeted: \$323.8 million.

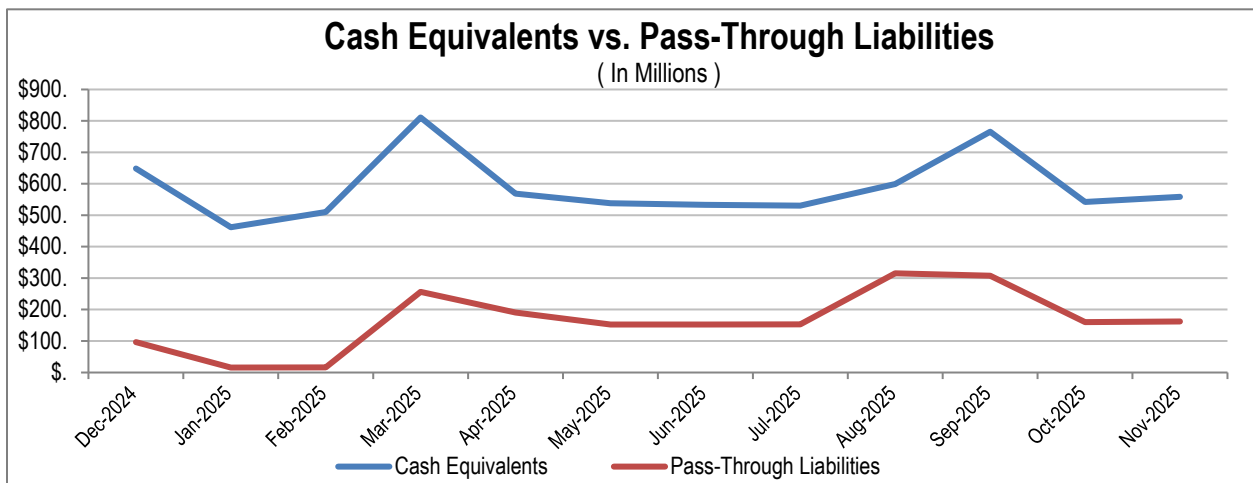
Tangible Net Equity (TNE)

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

- Required TNE \$79.8 million
- Actual TNE \$190.6 million
- Excess TNE \$110.9 million
- TNE % of Required TNE 239%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
 - Cash & Cash Equivalents \$558.2 million
 - Pass-Through Liabilities \$162.2 million



○ Uncommitted Cash	\$396.0 million
○ Working Capital	\$136.3 million
○ Current Ratio	1.14 (regulatory minimum is 1.00)

Capital Investment

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

Caveats to Financial Statements

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

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED 30 NOVEMBER, 2025

CURRENT MONTH				Account Description	FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
		(Unfavorable)	(Unfavorable)				(Unfavorable)	(Unfavorable)
MEMBERSHIP								
397,301	396,154	1,147	0.3%	1. Medi-Cal	2,002,080	2,000,933	1,147	0.1%
6,092	6,079	13	0.2%	2. GroupCare	30,158	30,145	13	0.0%
403,393	402,233	1,160	0.3%	3. TOTAL MEMBER MONTHS	2,032,238	2,031,078	1,160	0.1%
REVENUE								
\$183,325,089	\$192,345,331	(\$9,020,242)	(4.7%)	4. Premium Revenue	\$941,756,714	\$950,776,956	(\$9,020,242)	(0.9%)
\$64,212,959	\$64,002,640	\$210,319	0.3%	5. MCO Tax Revenue AB119	\$324,008,861	\$323,798,542	\$210,319	0.1%
\$247,538,048	\$256,347,971	(\$8,809,923)	(3.4%)	6. TOTAL REVENUE	\$1,265,765,575	\$1,274,575,498	(\$8,809,923)	(0.7%)
MEDICAL EXPENSES								
Capitated Medical Expenses								
\$15,950,439	\$15,932,452	(\$17,987)	(0.1%)	7. Capitated Medical Expense	\$96,353,511	\$96,335,523	(\$17,987)	(0.0%)
Fee for Service Medical Expenses								
\$51,862,467	\$52,817,467	\$955,000	1.8%	8. Inpatient Hospital Expense	\$235,855,120	\$236,810,120	\$955,000	0.4%
\$832,025	\$3,987,119	\$3,155,095	79.1%	9. Primary Care Physician Expense	\$24,143,068	\$27,298,163	\$3,155,095	11.6%
\$7,913,029	\$8,594,946	\$681,917	7.9%	10. Specialty Care Physician Expense	\$43,945,590	\$44,627,507	\$681,917	1.5%
\$20,694,244	\$19,980,207	(\$714,038)	(3.6%)	11. Ancillary Medical Expense	\$101,190,475	\$100,476,437	(\$714,038)	(0.7%)
\$10,335,431	\$12,496,177	\$2,160,746	17.3%	12. Outpatient Medical Expense	\$69,003,116	\$71,163,861	\$2,160,746	3.0%
\$9,681,696	\$10,450,096	\$768,400	7.4%	13. Emergency Expense	\$51,116,362	\$51,884,761	\$768,400	1.5%
\$10,180,078	\$12,734,741	\$2,554,663	20.1%	14. Pharmacy Expense	\$45,918,117	\$48,472,780	\$2,554,663	5.3%
\$37,453,401	\$36,083,508	(\$1,369,893)	(3.8%)	15. Long Term Care Expense	\$192,779,906	\$191,410,013	(\$1,369,893)	(0.7%)
\$148,952,371	\$157,144,260	\$8,191,889	5.2%	16. Total Fee for Service Expense	\$763,951,754	\$772,143,643	\$8,191,889	1.1%
\$3,059,718	\$4,556,342	\$1,496,624	32.8%	17. Other Benefits & Services	\$18,028,489	\$19,525,113	\$1,496,624	7.7%
\$521,614	\$610,871	\$89,256	14.6%	18. Reinsurance Expense	(\$177,295)	(\$88,038)	\$89,256	(101.4%)
\$1,000,000	\$0	(\$1,000,000)	0.0%	19. Risk Pool Distribution	\$5,659,099	\$4,659,099	(\$1,000,000)	(21.5%)
\$169,484,142	\$178,243,925	\$8,759,782	4.9%	20. TOTAL MEDICAL EXPENSES	\$883,815,558	\$892,575,340	\$8,759,782	1.0%
\$78,053,906	\$78,104,047	(\$50,141)	(0.1%)	21. GROSS MARGIN	\$381,950,017	\$382,000,158	(\$50,141)	0.0%
ADMINISTRATIVE EXPENSES								
\$6,015,670	\$6,716,099	\$700,429	10.4%	22. Personnel Expense	\$31,616,711	\$32,317,140	\$700,429	2.2%
(\$55,877)	\$78,726	\$134,603	171.0%	23. Benefits Administration Expense	\$258,336	\$392,938	\$134,603	34.3%
\$2,568,709	\$3,072,960	\$504,252	16.4%	24. Purchased & Professional Services	\$10,369,682	\$10,873,934	\$504,252	4.6%
\$311,442	\$1,975,503	\$1,664,061	84.2%	25. Other Administrative Expense	\$6,372,282	\$8,036,343	\$1,664,061	20.7%
\$8,839,944	\$11,843,288	\$3,003,344	25.4%	26. TOTAL ADMINISTRATIVE EXPENSES	\$48,617,011	\$51,620,355	\$3,003,344	5.8%
\$64,212,959	\$64,002,640	(\$210,319)	(0.3%)	27. MCO TAX EXPENSES	\$324,008,861	\$323,798,542	(\$210,319)	(0.1%)
\$5,001,003	\$2,258,119	\$2,742,885	121.5%	28. NET OPERATING INCOME / (LOSS)	\$9,324,145	\$6,581,261	\$2,742,885	41.7%
OTHER INCOME / EXPENSES								
\$2,057,481	\$2,875,464	(\$817,983)	(28.4%)	29. TOTAL OTHER INCOME / (EXPENSES)	\$12,041,853	\$12,859,836	(\$817,983)	(6.4%)
\$7,058,484	\$5,133,583	\$1,924,901	37.5%	30. NET SURPLUS (DEFICIT)	\$21,365,998	\$19,441,097	\$1,924,901	9.9%
92.5%	92.7%	0.2%	0.2%	31. Medical Loss Ratio	93.8%	93.9%	0.1%	0.1%
4.8%	6.2%	1.4%	22.6%	32. Administrative Expense Ratio	5.2%	5.4%	0.2%	3.7%
2.9%	2.0%	0.9%	45.0%	33. Net Surplus (Deficit) Ratio	1.7%	1.5%	0.2%	13.3%

**ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED 30 NOVEMBER, 2025**

	11/30/2025	10/31/2025	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	\$16,838,857	\$26,501,375	(\$9,662,519)	(36.5%)
CNB Short-Term Investment	541,345,700	515,608,723	25,736,977	5.0%
Interest Receivable	4,063,416	3,161,948	901,467	28.5%
Premium Receivables	553,681,606	488,393,147	65,288,459	13.4%
Reinsurance Recovery Receivable	10,997,104	9,339,992	1,657,113	17.7%
Other Receivables	5,450,972	8,986,780	(3,535,809)	(39.3%)
Prepaid Expenses	1,124,162	1,005,028	119,134	11.9%
TOTAL CURRENT ASSETS	1,133,501,817	1,052,996,995	80,504,822	7.6%
OTHER ASSETS				
CNB Long-Term Investment	40,810,148	40,544,475	265,673	0.7%
CalPERS Net Pension Asset	(6,465,233)	(6,465,233)	0	0.0%
Deferred Outflow	15,271,214	15,271,214	0	0.0%
Restricted Asset-Bank Note	358,857	357,840	1,017	0.3%
GASB 87-Lease Assets (Net)	62,225	65,500	(3,275)	(5.0%)
GASB 96-SBITA Assets (Net)	2,716,991	2,551,550	165,441	6.5%
TOTAL OTHER ASSETS	52,754,201	52,325,345	428,856	0.8%
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,867,101	9,842,648	24,453	0.2%
Furniture And Equipment	13,400,309	13,400,309	0	0.0%
Leasehold Improvement	902,447	902,447	0	0.0%
Internally Developed Software	14,824,002	14,824,002	0	0.0%
Fixed Assets at Cost	38,993,858	38,969,405	24,453	0.1%
Less: Accumulated Depreciation	(33,702,522)	(33,639,999)	(62,524)	0.2%
PROPERTY AND EQUIPMENT (NET)	5,291,335	5,329,406	(38,071)	(0.7%)
TOTAL ASSETS	1,191,547,354	1,110,651,746	80,895,607	7.3%
CURRENT LIABILITIES				
Trade Accounts Payable	10,764,045	10,629,367	134,678	1.3%
Provider/Vendor Capitation Payable	0	6,403,056	(6,403,056)	(100.0%)
Incurred But Not Reported Claims	384,468,960	383,562,554	906,406	0.2%
Other Medical Liabilities	132,718,854	120,203,824	12,515,030	10.4%
Pass-Through Liabilities	162,155,010	159,736,829	2,418,181	1.5%
MCO Tax Liabilities	298,635,842	234,422,883	64,212,959	27.4%
GASB 87 and 96 ST Liabilities	602,791	438,139	164,652	37.6%
Payroll Liabilities	7,812,419	8,181,590	(369,171)	(4.5%)
TOTAL CURRENT LIABILITIES	997,157,919	923,578,241	73,579,678	8.0%
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	503,770	246,325	257,445	104.5%
Deferred Inflow	3,240,306	3,240,306	0	0.0%
TOTAL LONG TERM LIABILITIES	3,744,076	3,486,631	257,445	7.4%
TOTAL LIABILITIES	1,000,901,995	927,064,872	73,837,123	8.0%
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	168,439,128	168,439,128	0	0.0%
Year-To-Date Net Surplus (Deficit)	21,365,998	14,307,514	7,058,484	49.3%
TOTAL NET WORTH	190,645,359	183,586,874	7,058,484	3.8%
TOTAL LIABILITIES AND NET WORTH	1,191,547,354	1,110,651,746	80,895,607	7.3%
Cash Equivalents	558,184,557	542,110,099	16,074,458	3.0%
Pass-Through	162,155,010	159,736,829	2,418,181	1.5%
Uncommitted Cash	396,029,547	382,373,270	13,656,277	3.6%
Working Capital	136,343,898	129,418,754	6,925,144	5.4%
Current Ratio	113.7%	114.0%	(0.3%)	(0.3%)

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

November 30, 2025

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	\$3,324,483	\$9,959,234	\$19,707,442	\$16,477,538
GroupCare Receivable	(2,216)	590	(7,888)	(2,109)
Total	3,322,267	9,959,824	19,699,554	16,475,429
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	244,213,565	809,071,773	1,502,106,814	1,249,288,036
Premium Receivable	(65,286,244)	(97,765,178)	(125,906,693)	(55,406,826)
Total	178,927,321	711,306,595	1,376,200,121	1,193,881,210
Investment & Other Income Cash Flows				
Other Revenues	180,277	(374,808)	535,882	(21,451)
Interest Income	1,888,050	7,146,886	13,836,888	12,084,382
Interest Receivable	(901,467)	(149,555)	(1,327,554)	(476,458)
Total	1,166,860	6,622,523	13,045,216	11,586,473
Medical & Hospital Cash Flows				
Total Medical Expenses	(169,484,145)	(522,942,396)	(1,059,018,036)	(883,815,559)
Other Health Care Receivables	1,873,044	9,538,888	(6,915,856)	(6,259,086)
Capitation Payable	(6,403,056)	-	-	-
IBNP Payable	906,406	(19,260,007)	(19,104,443)	(27,648,336)
Other Medical Payable	13,933,212	(138,206,351)	8,774,975	23,420,299
Risk Share Payable	1,000,000	(1,608,243)	1,050,856	1,050,856
New Health Program Payable	-	-	-	-
Total	(158,174,539)	(672,478,109)	(1,075,212,504)	(893,251,826)
Administrative Cash Flows				
Total Administrative Expenses	(8,850,793)	(27,876,069)	(60,023,490)	(48,638,091)
Prepaid Expenses	(119,133)	(433,867)	(371,193)	(406,351)
Other Receivables	5,652	134,827	8,038	(7,864)
CalPERS Pension	-	-	(630,580)	-
Trade Accounts Payable	134,677	(486,907)	197,888	(752,879)
Payroll Liabilities	(369,171)	(1,738,886)	(443,278)	(1,551,495)
GASB Assets and Liabilities	259,931	5,797	442,183	399,495
Depreciation Expense	62,524	186,226	371,780	309,929
Total	(8,876,313)	(30,208,879)	(60,448,652)	(50,647,256)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(64,212,959)	(258,296,922)	(390,867,283)	(324,008,861)
MCO Tax Liabilities	64,212,959	195,480,500	139,662,286	72,817,439
Total	0	(62,816,422)	(251,204,997)	(251,191,422)
Net Cash Flows from Operating Activities	16,365,596	(37,614,468)	22,078,738	26,852,608

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

November 30, 2025

	MONTH	3 MONTHS	6 MONTHS	YTD
<u>CASH FLOWS FROM INVESTING ACTIVITIES</u>				
Investment Cash Flows				
Long Term Investments	(265,667)	(3,347,902)	(1,790,171)	(1,654,778)
Total	(265,667)	(3,347,902)	(1,790,171)	(1,654,778)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(1,017.00)	(3,009.00)	(5,994.00)	(4,991.00)
Total	(1,017.00)	(3,009.00)	(5,994.00)	(4,991.00)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	(24,453)	(24,453)	(24,453)	(24,453)
Purchases of Property and Equipment	(24,453)	(24,453)	(24,453)	(24,453)
Net Cash Flows from Investing Activities	(291,137)	(3,375,364)	(1,820,618)	(1,684,222)
Net Change in Cash	16,074,459	(40,989,832)	20,258,120	25,168,386
Rounding	-	-	-	-
Cash @ Beginning of Period	542,110,097	599,174,388	537,926,436	533,016,170
Cash @ End of Period	\$558,184,556	\$558,184,556	\$558,184,556	\$558,184,556
Variance	-	-	-	-

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

November 30, 2025

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	\$7,058,478	\$16,687,698	\$26,278,217	\$21,365,994
Add back: Depreciation & Amortization	62,524	186,226	371,780	309,929
Receivables				
Premiums Receivable	(65,286,244)	(97,765,178)	(125,906,693)	(55,406,826)
Interest Receivable	(901,467)	(149,555)	(1,327,554)	(476,458)
Other Health Care Receivables	1,873,044	9,538,888	(6,915,856)	(6,259,086)
Other Receivables	5,652	134,827	8,038	(7,864)
GroupCare Receivable	(2,216)	590	(7,888)	(2,109)
Total	(64,311,231)	(88,240,428)	(134,149,953)	(62,152,343)
Prepaid Expenses	(119,133)	(433,867)	(371,193)	(406,351)
Trade Payables	134,677	(486,907)	197,888	(752,879)
Claims Payable and Shared Risk Pool				
IBNP Payable	906,406	(19,260,007)	(19,104,443)	(27,648,336)
Capitation Payable & Other Medical Payable	7,530,156	(138,206,351)	8,774,975	23,420,299
Risk Share Payable	1,000,000.00	(1,608,243.00)	1,050,856	1,050,856
Claims Payable				
Total	9,436,562	(159,074,601)	(9,278,612)	(3,177,181)
Other Liabilities				
CalPERS Pension	-	-	(630,580.00)	-
Payroll Liabilities	(369,171)	(1,738,886)	(443,278)	(1,551,495)
GASB Assets and Liabilities	259,931	5,797	442,183	399,495
New Health Program	-	-	-	-
MCO Tax Liabilities	64,212,959	195,480,500	139,662,286	72,817,439
Total	64,103,719	193,747,411	139,030,611	71,665,439
Rounding	-	-	-	-
Cash Flows from Operating Activities	16,365,596	(37,614,468)	22,078,738	26,852,608
Variance	-	-	-	-

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

November 30, 2025

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	\$178,927,321	\$711,306,595	\$1,376,200,121	\$1,193,881,210
Medicare Revenue	\$0	\$0	\$0	\$0
GroupCare Premium Revenue	3,322,267	9,959,824	19,699,554	16,475,429
Other Income	180,277	(374,808)	535,882	(21,451)
Interest Income	986,583	6,997,331	12,509,334	11,607,924
Less Cash Paid				
Medical Expenses	(158,174,539)	(672,478,109)	(1,075,212,504)	(893,251,826)
Vendor & Employee Expenses	(8,876,313)	(30,208,879)	(60,448,652)	(50,647,256)
MCO Tax Expense AB119	0	(62,816,422)	(251,204,997)	(251,191,422)
Net Cash Flows from Operating Activities	16,365,596	(37,614,468)	22,078,738	26,852,608
Cash Flows from Investing Activities:				
Long Term Investments	(265,667)	(3,347,902)	(1,790,171)	(1,654,778)
Restricted Assets-Treasury Account	(1,017)	(3,009)	(5,994)	(4,991)
Purchases of Property and Equipment	(24,453)	(24,453)	(24,453)	(24,453)
Net Cash Flows from Investing Activities	(291,137)	(3,375,364)	(1,820,618)	(1,684,222)
Net Change in Cash	16,074,459	(40,989,832)	20,258,120	25,168,386
Rounding	-	-	-	-
Cash @ Beginning of Period	542,110,097	599,174,388	537,926,436	533,016,170
Cash @ End of Period	\$558,184,556	\$558,184,556	\$558,184,556	\$558,184,556
Variance	\$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	\$7,058,478	\$16,687,699	\$26,278,216	\$21,365,994
Add Back: Depreciation	62,524	186,226	371,780	309,929
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(64,311,231)	(88,240,428)	(134,149,953)	(62,152,343)
Prepaid Expenses	(119,133)	(433,868)	(371,192)	(406,351)
Trade Payables	134,677	(486,907)	197,888	(752,879)
Claims Payable, IBNP and Risk Sharing	9,436,562	(159,074,601)	(9,278,612)	(3,177,181)
Deferred Revenue	0	0	0	0
Other Liabilities	64,103,719	193,747,411	139,030,611	71,665,439
Total	16,365,596	(37,614,468)	22,078,738	26,852,608
Rounding	-	-	-	-
Cash Flows from Operating Activities	\$16,365,596	(37,614,468)	\$22,078,738	\$26,852,608
Variance	\$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF NOVEMBER 2025

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal ACA OE	Medi-Cal SPD with LTC*	Medi-Cal Duals with LTC*	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	107,894	59,806	150,677	29,590	49,334	397,301	6,092	-	403,393
Revenue	\$35,587,025	\$30,362,677	\$86,334,903	\$48,856,179	\$43,072,781	\$244,213,566	\$3,324,483	\$0	\$247,538,048
Medical Expense	\$11,443,808	\$21,351,032	\$54,523,372	\$44,392,662	\$34,618,804	\$166,329,679	\$3,154,463	\$0	\$169,484,142
Gross Margin	\$24,143,217	\$9,011,645	\$31,811,531	\$4,463,518	\$8,453,976	\$77,883,886	\$170,020	\$0	\$78,053,906
Administrative Expense	\$376,475	\$920,738	\$2,855,951	\$2,522,849	\$1,320,977	\$7,996,991	\$182,176	\$660,777	\$8,839,944
MCO Tax Expense	\$17,407,709	\$9,658,230	\$24,238,847	\$4,885,048	\$8,023,125	\$64,212,959	\$0	\$0	\$64,212,959
Operating Income / (Expense)	\$6,359,033	(\$1,567,323)	\$4,716,732	(\$2,944,380)	(\$890,126)	\$5,673,937	(\$12,156)	(\$660,777)	\$5,001,003
Other Income / (Expense)	\$99,981	\$237,604	\$676,815	\$626,437	\$386,024	\$2,026,861	\$30,620	\$0	\$2,057,481
Net Income / (Loss)	\$6,459,014	(\$1,329,719)	\$5,393,547	(\$2,317,943)	(\$504,102)	\$7,700,797	\$18,464	(\$660,777)	\$7,058,484
PMPM Metrics:									
Revenue PMPM	\$329.83	\$507.69	\$572.98	\$1,651.10	\$873.09	\$614.68	\$545.71	\$0.00	\$613.64
Medical Expense PMPM	\$106.07	\$357.00	\$361.86	\$1,500.26	\$701.72	\$418.65	\$517.80	\$0.00	\$420.15
Gross Margin PMPM	\$223.77	\$150.68	\$211.12	\$150.85	\$171.36	\$196.03	\$27.91	\$0.00	\$193.49
Administrative Expense PMPM	\$3.49	\$15.40	\$18.95	\$85.26	\$26.78	\$20.13	\$29.90	\$0.00	\$21.91
MCO Tax Expense PMPM	\$161.34	\$161.49	\$160.87	\$165.09	\$162.63	\$161.62	\$0.00	\$0.00	\$159.18
Operating Income / (Expense) PMPM	\$58.94	(\$26.21)	\$31.30	(\$99.51)	(\$18.04)	\$14.28	(\$2.00)	\$0.00	\$12.40
Other Income / (Expense) PMPM	\$0.93	\$3.97	\$4.49	\$21.17	\$7.82	\$5.10	\$5.03	\$0.00	\$5.10
Net Income / (Loss) PMPM	\$59.86	(\$22.23)	\$35.80	(\$78.34)	(\$10.22)	\$19.38	\$3.03	\$0.00	\$17.50
Ratio:									
Medical Loss Ratio	62.9%	103.1%	87.8%	101.0%	98.8%	92.4%	94.9%	0.0%	92.5%
Administrative Expense Ratio	2.1%	4.4%	4.6%	5.7%	3.8%	4.4%	5.5%	0.0%	4.8%
Net Income Ratio	18.1%	-4.4%	6.2%	-4.7%	-1.2%	3.2%	0.6%	0.0%	2.9%

*As of January 2025 service month, "SPD", "Duals", "LTC", and "LTC Duals" will be discontinued. Effective January 2025, service month new consolidated groupings will be "SPD with LTC" and "Duals with LTC".

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE NOVEMBER 2025

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal ACA OE	Medi-Cal SPD with LTC*	Medi-Cal Duals with LTC*	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	541,562	301,907	763,158	148,448	247,005	2,002,080	30,158	-	2,032,238
Revenue	\$174,956,546	\$161,639,628	\$458,049,593	\$241,219,031	\$213,423,238	\$1,249,288,037	\$16,477,538	\$0	\$1,265,765,575
Medical Expense	\$69,666,478	\$101,824,176	\$297,726,895	\$211,936,138	\$185,953,650	\$867,107,337	\$16,367,652	\$340,569	\$883,815,558
Gross Margin	\$105,290,068	\$59,815,452	\$160,322,698	\$29,282,894	\$27,469,588	\$382,180,700	\$109,886	(\$340,569)	\$381,950,017
Administrative Expense	\$2,221,021	\$5,029,349	\$15,638,577	\$13,602,272	\$7,353,807	\$43,845,026	\$915,762	\$3,856,223	\$48,617,011
MCO Tax Expense	\$87,556,393	\$48,731,980	\$123,087,838	\$24,304,226	\$40,328,424	\$324,008,861	\$0	\$0	\$324,008,861
Operating Income / (Expense)	\$15,512,654	\$6,054,123	\$21,596,282	(\$8,623,603)	(\$20,212,643)	\$14,326,813	(\$805,876)	(\$4,196,792)	\$9,324,145
Other Income / (Expense)	\$585,175	\$1,390,614	\$3,962,150	\$3,666,392	\$2,258,182	\$11,862,513	\$179,340	\$0	\$12,041,853
Net Income / (Loss)	\$16,097,829	\$7,444,737	\$25,558,432	(\$4,957,211)	(\$17,954,460)	\$26,189,326	(\$626,536)	(\$4,196,792)	\$21,365,998
PMPM Metrics:									
Revenue PMPM	\$323.06	\$535.40	\$600.20	\$1,624.94	\$864.04	\$624.00	\$546.37	\$0.00	\$622.84
Medical Expense PMPM	\$128.64	\$337.27	\$390.12	\$1,427.68	\$752.83	\$433.10	\$542.73	\$0.00	\$434.90
Gross Margin PMPM	\$194.42	\$198.13	\$210.08	\$197.26	\$111.21	\$190.89	\$3.64	\$0.00	\$187.95
Administrative Expense PMPM	\$4.10	\$16.66	\$20.49	\$91.63	\$29.77	\$21.90	\$30.37	\$0.00	\$23.92
MCO Tax Expense PMPM	\$161.67	\$161.41	\$161.29	\$163.72	\$163.27	\$161.84	\$0.00	\$0.00	\$159.43
Operating Income / (Expense) PMPM	\$28.64	\$20.05	\$28.30	(\$58.09)	(\$81.83)	\$7.16	(\$26.72)	\$0.00	\$4.59
Other Income / (Expense) PMPM	\$1.08	\$4.61	\$5.19	\$24.70	\$9.14	\$5.93	\$5.95	\$0.00	\$5.93
Net Income / (Loss) PMPM	\$29.72	\$24.66	\$33.49	(\$33.39)	(\$72.69)	\$13.08	(\$20.78)	\$0.00	\$10.51
Ratio:									
Medical Loss Ratio	79.7%	90.2%	88.9%	97.7%	107.4%	93.7%	99.3%	0.0%	93.8%
Administrative Expense Ratio	2.5%	4.5%	4.7%	6.3%	4.2%	4.7%	5.6%	0.0%	5.2%
Net Income Ratio	9.2%	4.6%	5.6%	-2.1%	-8.4%	2.1%	-3.8%	0.0%	1.7%

*As of January 2025 service month, "SPD", "Duals", "LTC", and "LTC Duals" will be discontinued. Effective January 2025, service month new consolidated groupings will be "SPD with LTC" and "Duals with LTC".

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 November, 2025

CURRENT MONTH				Account Description	FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)		Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
ADMINISTRATIVE EXPENSES SUMMARY (ADMIN. DEPT. ONLY)								
\$6,015,670	\$6,716,099	\$700,429	10.4%	Personnel Expenses	\$31,616,711	\$32,317,140	\$700,429	2.2%
(\$55,877)	\$78,726	\$134,603	171.0%	Benefits Administration Expense	\$258,336	\$392,938	\$134,603	34.3%
\$2,568,709	\$3,072,960	\$504,252	16.4%	Purchased & Professional Services	\$10,369,682	\$10,873,934	\$504,252	4.6%
\$483,465	\$508,535	\$25,069	4.9%	Occupancy	\$2,386,419	\$2,411,489	\$25,069	1.0%
\$3,898,958	\$588,237	(\$3,310,721)	(562.8%)	Printing Postage & Promotion	\$998,278	(\$2,312,444)	(\$3,310,721)	143.2%
\$84,337	\$434,446	\$350,109	80.6%	Licenses Insurance & Fees	\$1,993,562	\$2,343,671	\$350,109	14.9%
(\$4,155,318)	\$444,286	\$4,599,603	1,035.3%	Other Administrative Expense	\$994,023	\$5,593,627	\$4,599,603	82.2%
\$2,824,274	\$5,127,189	\$2,302,915	44.9%	Total Other Administrative Expenses (excludes Personnel Expenses)	\$17,000,300	\$19,303,215	\$2,302,915	11.9%
\$8,839,944	\$11,843,288	\$3,003,344	25.4%	Total Administrative Expenses	\$48,617,011	\$51,620,355	\$3,003,344	5.8%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 November, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
3,958,460	4,514,274	555,814	12.3%	Salaries & Wages	20,867,060	21,422,874	555,814	2.6%
340,046	386,283	46,238	12.0%	Paid Time Off	2,101,675	2,147,913	46,238	2.2%
0	11,700	11,700	100.0%	Compensated Incentives	6,205	17,905	11,700	65.3%
63,723	67,286	3,564	5.3%	Payroll Taxes	344,904	348,468	3,564	1.0%
71,152	60,612	(10,540)	(17.4%)	Overtime	361,456	350,916	(10,540)	(3.0%)
301,873	323,624	21,751	6.7%	CalPERS ER Match	1,737,077	1,758,828	21,751	1.2%
1,080,956	1,095,033	14,076	1.3%	Employee Benefits	5,550,107	5,564,184	14,076	0.3%
(3,385)	0	3,385	0.0%	Personal Floating Holiday	(2,566)	819	3,385	413.1%
21,064	42,000	20,936	49.8%	Language Pay	112,335	133,272	20,936	15.7%
5,400	0	(5,400)	0.0%	Med Ins Opted Out Stipend	17,500	12,100	(5,400)	(44.6%)
104,045	0	(104,045)	0.0%	Sick Leave	181,940	77,895	(104,045)	(133.6%)
125	30,590	30,465	99.6%	Compensated Employee Relations	(2,287)	28,179	30,465	108.1%
21,220	24,590	3,370	13.7%	Work from Home Stipend	104,300	107,670	3,370	3.1%
1,827	5,159	3,332	64.6%	Mileage, Parking & Local Travel	5,906	9,238	3,332	36.1%
4,877	67,108	62,231	92.7%	Travel & Lodging	20,592	82,823	62,231	75.1%
25,265	26,416	1,151	4.4%	Temporary Help Services	105,232	106,383	1,151	1.1%
15,471	51,123	35,652	69.7%	Staff Development/Training	83,166	118,818	35,652	30.0%
3,553	10,301	6,748	65.5%	Staff Recruitment/Advertisement	22,107	28,855	6,748	23.4%
6,015,670	6,716,099	700,429	10.4%	Personnel Expense	31,616,711	32,317,140	700,429	2.2%
28,420	26,436	(1,985)	(7.5%)	Pharmacy Administrative Fees	131,963	129,978	(1,985)	(1.5%)
(136,422)	0	136,422	0.0%	Behavioral Hlth Administration	(136,422)	0	136,422	0.0%
52,125	52,290	165	0.3%	Telemedicine Admin. Fees	262,795	262,960	165	0.1%
(55,877)	78,726	134,603	171.0%	Benefits Administration Expense	258,336	392,938	134,603	34.3%
529,334	627,668	98,334	15.7%	Consultant Fees - Non Medical	2,540,267	2,638,601	98,334	3.7%
735,339	670,894	(64,445)	(9.6%)	Computer Support Services	2,288,222	2,223,777	(64,445)	(2.9%)
13,083	11,750	(1,333)	(11.3%)	Audit Fees	79,538	78,205	(1,333)	(1.7%)
0	100,000	100,000	100.0%	Consultant Fees - Medical	17,593	117,593	100,000	85.0%
250,949	409,855	158,906	38.8%	Other Purchased Services	1,006,487	1,165,393	158,906	13.6%
0	1,879	1,879	100.0%	Maint.&Repair-Office Equipment	0	1,879	1,879	100.0%
50,945	67,267	16,322	24.3%	Legal Fees	239,916	256,238	16,322	6.4%
0	0	0	0.0%	Member Health Education	(17)	(17)	0	0.0%
70,449	28,000	(42,449)	(151.6%)	Translation Services	313,971	271,523	(42,449)	(15.6%)
154,279	151,900	(2,379)	(1.6%)	Medical Refund Recovery Fees	980,429	978,050	(2,379)	(0.2%)
759,270	854,823	95,553	11.2%	Software - IT Licenses & Subsc	2,685,431	2,780,984	95,553	3.4%
2,170	88,524	86,354	97.5%	Hardware (Non-Capital)	198,021	284,375	86,354	30.4%
2,892	60,400	57,508	95.2%	Provider Credentialing	19,824	77,333	57,508	74.4%
2,568,709	3,072,960	504,252	16.4%	Purchased & Professional Services	10,369,682	10,873,934	504,252	4.6%
62,524	62,018	(506)	(0.8%)	Depreciation	309,929	309,423	(506)	(0.2%)
8,092	13,845	5,753	41.6%	Lease Rented Office Equipment	28,301	34,055	5,753	16.9%
14,450	15,965	1,515	9.5%	Utilities	85,544	87,058	1,515	1.7%
86,183	108,156	21,973	20.3%	Telephone	462,199	484,172	21,973	4.5%
13,286	58,551	45,264	77.3%	Building Maintenance	75,362	120,627	45,264	37.5%
298,930	250,000	(48,930)	(19.6%)	GASB96 SBITA Amort. Expense	1,425,084	1,376,154	(48,930)	(3.6%)
483,465	508,535	25,069	4.9%	Occupancy	2,386,419	2,411,489	25,069	1.0%
49,125	194,656	145,530	74.8%	Postage	338,417	483,947	145,530	30.1%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 November, 2025

CURRENT MONTH					FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	
5,143	5,700	558	9.8%	Design & Layout	24,684	25,242	558	2.2%	
46,585	260,104	213,519	82.1%	Printing Services	515,646	729,165	213,519	29.3%	
41,213	15,600	(25,613)	(164.2%)	Mailing Services	54,678	29,065	(25,613)	(88.1%)	
6,449	13,720	7,270	53.0%	Courier/Delivery Service	28,922	36,192	7,270	20.1%	
0	70	70	100.0%	Pre-Printed Materials & Public	0	70	70	100.0%	
0	17,687	17,687	100.0%	Promotional Products	(187)	17,500	17,687	101.1%	
0	150	150	100.0%	Promotional Services	358	508	150	29.5%	
3,750,443	80,550	(3,669,893)	(4,556.0%)	Community Relations	35,761	(3,634,132)	(3,669,893)	101.0%	
3,898,958	588,237	(3,310,721)	(562.8%)	Printing Postage & Promotion	998,278	(2,312,444)	(3,310,721)	143.2%	
0	75,000	75,000	100.0%	Regulatory Penalties	0	75,000	75,000	100.0%	
51,513	45,500	(6,013)	(13.2%)	Bank Fees	220,151	214,138	(6,013)	(2.8%)	
0	200	200	100.0%	Insurance Premium	1,043,881	1,044,081	200	0.0%	
13,022	227,872	214,850	94.3%	License,Permits, & Fee - NonIT	340,398	555,248	214,850	38.7%	
19,802	85,874	66,072	76.9%	Subscriptions and Dues - NonIT	389,132	455,203	66,072	14.5%	
84,337	434,446	350,109	80.6%	License Insurance & Fees	1,993,562	2,343,671	350,109	14.9%	
3,202	6,135	2,933	47.8%	Office and Other Supplies	14,153	17,086	2,933	17.2%	
17,978	41,512	23,533	56.7%	Ergonomic Supplies	58,835	82,368	23,533	28.6%	
4,313	16,160	11,847	73.3%	Meals and Entertainment	67,754	79,602	11,847	14.9%	
(707,843)	0	707,843	0.0%	Miscellaneous	(953,091)	(245,248)	707,843	(288.6%)	
0	3,125	3,125	100.0%	Member Incentive	0	3,125	3,125	100.0%	
115,290	210,687	95,397	45.3%	Provider Interest (All Depts)	958,037	1,053,434	95,397	9.1%	
(3,588,258)	166,667	3,754,925	2,253.0%	Community Reinvestment Expense	848,335	4,603,260	3,754,925	81.6%	
(4,155,318)	444,286	4,599,603	1,035.3%	Other Administrative Expense	994,023	5,593,627	4,599,603	82.2%	
2,824,274	5,127,189	2,302,915	44.9%	Total Other Administrative ExpenseS (excludes Personnel Expenses)	17,000,300	19,303,215	2,302,915	11.9%	
8,839,944	11,843,288	3,003,344	25.4%	TOTAL ADMINISTRATIVE EXPENSES	48,617,011	51,620,355	3,003,344	5.8%	

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

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

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 11/30/25	\$ 38,993,858
Fixed Assets @ Cost - 6/30/25	\$ 38,969,405
Fixed Assets Acquired YTD	\$ 24,453

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2025

<u>TANGIBLE NET EQUITY (TNE)</u>	QRT. END Jun-25	Jul-25	Aug-25	QRT. END Sep-25	Oct-25	Nov-25
Current Month Net Income / (Loss)	\$ 4,912,222	\$ 1,727,933	\$ 2,950,359	\$ 3,127,768	\$ 6,501,450	\$ 7,058,478
YTD Net Income / (Loss)	\$ (86,095,783)	\$ 1,727,938	\$ 4,678,300	\$ 7,806,066	\$ 14,307,514	\$ 21,365,998
Net Assets	\$ 169,279,360	\$ 171,007,298	\$ 173,957,660	\$ 177,085,426	\$ 183,586,874	\$ 190,645,358
Subordinated Debt & Interest	-	-	-	-	-	-
Total Actual TNE	\$ 169,279,360	\$ 171,007,298	\$ 173,957,660	\$ 177,085,426	\$ 183,586,874	\$ 190,645,358
Increase/(Decrease) in Actual TNE	\$ 4,912,222	\$ 1,727,933	\$ 2,950,359	\$ 3,127,768	\$ 6,501,450	\$ 7,058,478
Required TNE ⁽¹⁾	\$ 80,653,661	\$ 81,235,858	\$ 80,224,390	\$ 80,693,435	\$ 80,147,121	\$ 79,750,550
Min. Req'd to Avoid Monthly Reporting at 150% of Required TNE	\$ 120,980,491	\$ 121,853,786	\$ 120,336,585	\$ 121,040,152	\$ 120,220,681	\$ 119,625,824
TNE Excess / (Deficiency)	\$ 88,625,699	\$ 89,771,440	\$ 93,733,270	\$ 96,391,991	\$ 103,439,753	\$ 110,894,808
Actual TNE as a Multiple of Required	2.10	2.11	2.17	2.19	2.29	2.39
<u>LIQUID TANGIBLE NET EQUITY</u>						
Net Assets	\$ 169,279,360	\$ 171,007,298	\$ 173,957,660	\$ 177,085,426	\$ 183,586,874	\$ 190,645,358
Less: Fixed Assets at Net Book Value	(5,576,811)	(5,514,960)	(5,453,108)	(5,391,257)	(5,329,406)	(5,291,335)
Net Lease Assets	(2,072,151)	(1,979,137)	(1,678,452)	(1,751,482)	(1,932,587)	(1,672,654)
CD Pledged to DMHC	(353,866)	(354,839)	(355,847)	(356,859)	(357,840)	(358,857)
Liquid TNE (Liquid Reserves)	\$ 161,276,532	\$ 163,158,362	\$ 166,470,253	\$ 169,585,828	\$ 175,967,041	\$ 183,322,512
Liquid TNE as Multiple of Required	2.00	2.01	2.08	2.10	2.20	2.30

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

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

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,251	108,503	108,083	107,831	107,894								541,562
Adult	61,536	60,679	60,106	59,780	59,806								301,907
ACA OE	155,533	153,348	152,196	151,404	150,677								763,158
SPD with LTC	29,833	29,686	29,708	29,631	29,590								148,448
Duals with LTC	49,509	49,371	49,390	49,401	49,334								247,005
Medi-Cal Program	405,662	401,587	399,483	398,047	397,301								2,002,080
Group Care Program	5,957	5,974	6,054	6,081	6,092								30,158
Total	411,619	407,561	405,537	404,128	403,393								2,032,238
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(323)	(748)	(420)	(252)	63								(1,680)
Adult	(133)	(857)	(573)	(326)	26								(1,863)
ACA OE	357	(2,185)	(1,152)	(792)	(727)								(4,499)
SPD with LTC	83	(147)	22	(77)	(41)								(160)
Duals with LTC	205	(138)	19	11	(67)								30
Medi-Cal Program	189	(4,075)	(2,104)	(1,436)	(746)								(8,172)
Group Care Program	47	17	80	27	11								182
Total	236	(4,058)	(2,024)	(1,409)	(735)								(7,990)
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	26.9%	27.0%	27.1%	27.1%	27.2%								27.0%
Adult % of Medi-Cal	15.2%	15.1%	15.0%	15.0%	15.1%								15.1%
ACA OE % of Medi-Cal	38.3%	38.2%	38.1%	38.0%	37.9%								38.1%
SPD with LTC % of Medi-Cal	7.4%	7.4%	7.4%	7.4%	7.4%								7.4%
Duals with LTC % of Medi-Cal	12.2%	12.3%	12.4%	12.4%	12.4%								12.3%
Medi-Cal Program % of Total	98.6%	98.5%	98.5%	98.5%	98.5%								98.5%
Group Care Program % of Total	1.4%	1.5%	1.5%	1.5%	1.5%								1.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%

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

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

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	93,933	93,268	93,599	92,670	93,415								466,885
Alameda Health System	92,861	91,758	91,032	91,084	90,621								457,356
Directly-Contracted Subtotal	186,794	185,026	184,631	183,754	184,036								924,241
Delegated:													
CFMG	43,381	42,852	42,253	42,053	41,790								212,329
CHCN	181,444	179,683	178,653	178,321	177,567								895,668
Delegated Subtotal	224,825	222,535	220,906	220,374	219,357								1,107,997
Total	411,619	407,561	405,537	404,128	403,393								2,032,238
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(518)	(1,768)	(395)	(877)	282								(3,276)
Delegated:													
CFMG	(128)	(529)	(599)	(200)	(263)								(1,719)
CHCN	882	(1,761)	(1,030)	(332)	(754)								(2,995)
Delegated Subtotal	754	(2,290)	(1,629)	(532)	(1,017)								(4,714)
Total	236	(4,058)	(2,024)	(1,409)	(735)								(7,990)
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	45.4%	45.4%	45.5%	45.5%	45.6%								45.5%
Delegated:													
CFMG	10.5%	10.5%	10.4%	10.4%	10.4%								10.4%
CHCN	44.1%	44.1%	44.1%	44.1%	44.0%								44.1%
Delegated Subtotal	54.6%	54.6%	54.5%	54.5%	54.4%								54.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%

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

FINAL BUDGET

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

Month Over Month Enrollment Change:

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

0

Enrollment Percentages:

Medi-Cal Program:													
Child % of Medi-Cal	26.9%	27.0%	27.1%	27.1%	27.2%	27.2%	27.4%	27.6%	27.8%	28.0%	28.3%	28.5%	27.5%
Adult % of Medi-Cal	15.2%	15.1%	15.0%	15.0%	15.0%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	15.0%
ACA OE % of Medi-Cal	38.3%	38.2%	38.1%	38.0%	38.0%	38.0%	37.5%	37.1%	36.7%	36.3%	35.9%	35.5%	37.3%
SPD with LTC % of Medi-Cal	7.4%	7.4%	7.4%	7.4%	7.5%	7.5%	5.6%	5.7%	5.7%	5.7%	5.8%	5.8%	6.6%
Duals with LTC % of Medi-Cal	12.2%	12.3%	12.4%	12.4%	12.4%	12.5%	14.5%	14.7%	14.9%	15.0%	15.2%	15.4%	13.6%
Medi-Cal Program % of Total	98.6%	98.5%	98.5%	98.5%	98.5%	98.5%	98.5%	98.4%	98.4%	98.4%	98.4%	98.3%	98.5%
Group Care Program % of Total	1.4%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.6%	1.6%	1.6%	1.6%	1.7%	1.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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

FINAL BUDGET

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

0

Direct/Delegate Month Over Month Enrollment Change:

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

Direct/Delegate Enrollment Percentages:

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

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

	Variance Jul-25	Variance Aug-25	Variance Sep-25	Variance Oct-25	Variance Nov-25	Variance Dec-25	Variance Jan-26	Variance Feb-26	Variance Mar-26	Variance Apr-26	Variance May-26	Variance Jun-26	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	271								271
Adult	0	0	0	0	505								505
ACA OE	0	0	0	0	216								216
SPD with LTC	0	0	0	0	16								16
Duals with LTC	0	0	0	0	139								139
Medi-Cal Program	0	0	0	0	1,147								1,147
Group Care Program	0	0	0	0	13								13
Total	0	0	0	0	1,160								1,160
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	5								5
Alameda Health System	0	0	0	0	296								296
Directly-Contracted Subtotal	0	0	0	0	301								301
Delegated:													
CFMG	0	0	0	0	117								117
CHCN	0	0	0	0	742								742
Delegated Subtotal	0	0	0	0	859								859
Total	0	0	0	0	1,160								1,160

**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 NOVEMBER, 2025**

CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
<u>CAPITATED MEDICAL EXPENSES</u>								
\$531,362	\$506,649	(\$24,713)	(4.9%)	PCP Capitation	\$13,562,786	\$13,538,072	(\$24,713)	(0.2%)
6,500,279	6,322,587	(177,693)	(2.8%)	PCP Capitation FQHC	38,754,403	38,576,711	(177,693)	(0.5%)
463,436	456,615	(6,821)	(1.5%)	Specialty Capitation	2,352,440	2,345,619	(6,821)	(0.3%)
5,339,878	5,584,490	244,612	4.4%	Specialty Capitation FQHC	25,586,653	25,831,265	244,612	0.9%
791,177	747,634	(43,543)	(5.8%)	Laboratory Capitation	3,989,266	3,945,724	(43,543)	(1.1%)
337,088	335,145	(1,943)	(0.6%)	Vision Capitation	1,698,064	1,696,120	(1,943)	(0.1%)
105,409	103,857	(1,552)	(1.5%)	CFMG Capitation	535,066	533,514	(1,552)	(0.3%)
849,960	853,963	4,003	0.5%	ANC IPA Admin Capitation FQHC	4,714,610	4,718,612	4,003	0.1%
0	0	0	0.0%	Kaiser Capitation	(12,511)	(12,511)	0	0.0%
1,031,850	1,021,514	(10,336)	(1.0%)	DME Capitation	5,172,733	5,162,398	(10,336)	(0.2%)
15,950,439	15,932,452	(17,987)	(0.1%)	7. TOTAL CAPITATED EXPENSES	96,353,511	96,335,523	(17,987)	0.0%
<u>FEE FOR SERVICE MEDICAL EXPENSES</u>								
2,676,166	0	(2,676,166)	0.0%	IBNR Inpatient Services	(17,565,393)	(20,241,559)	(2,676,166)	13.2%
80,284	0	(80,284)	0.0%	IBNR Settlement (IP)	(526,961)	(607,245)	(80,284)	13.2%
214,093	0	(214,093)	0.0%	IBNR Claims Fluctuation (IP)	(1,405,232)	(1,619,093)	(214,093)	13.2%
44,344,954	47,657,160	3,312,206	7.0%	Inpatient Hospitalization FFS	230,778,573	234,090,779	3,312,206	1.4%
2,862,525	3,472,397	609,872	17.6%	IP OB - Mom & NB	16,656,097	17,265,969	609,872	3.5%
310,959	157,315	(153,645)	(97.7%)	IP Behavioral Health	1,208,705	1,055,060	(153,645)	(14.6%)
1,373,486	1,530,596	157,110	10.3%	Inpatient Facility Rehab FFS	6,709,331	6,866,441	157,110	2.3%
51,862,467	52,817,467	955,000	1.8%	8. Inpatient Hospital Expense	235,855,120	236,810,120	955,000	0.4%
(1,699,122)	0	1,699,122	0.0%	IBNR PCP	1,734,209	3,433,331	1,699,122	49.5%
(50,974)	0	50,974	0.0%	IBNR Settlement (PCP)	52,026	103,000	50,974	49.5%
(135,930)	0	135,930	0.0%	IBNR Claims Fluctuation (PCP)	138,739	274,669	135,930	49.5%
1,240,910	2,781,829	1,540,919	55.4%	PCP FFS	15,580,862	17,121,781	1,540,919	9.0%
0	0	0	0.0%	Special Needs Medical Expense	278	278	0	0.0%
651,958	409,991	(241,967)	(59.0%)	PCP FQHC FFS	2,475,586	2,233,619	(241,967)	(10.8%)
0	0	0	0.0%	Prop 56 Physician Pmt	(3,778)	(3,778)	0	0.0%
15,903	0	(15,903)	0.0%	Prop 56 Hyde	80,320	64,417	(15,903)	(24.7%)
75,380	0	(75,380)	0.0%	Prop 56 Trauma Screening	378,848	303,469	(75,380)	(24.8%)
90,117	0	(90,117)	0.0%	Prop 56 Developmentl Screening	451,962	361,844	(90,117)	(24.9%)
643,783	795,299	151,517	19.1%	Prop 56 Family Planning	3,254,276	3,405,792	151,517	4.4%
0	0	0	0.0%	Prop 56 VBP	(259)	(259)	0	0.0%
832,025	3,987,119	3,155,095	79.1%	9. Primary Care Physician Expense	24,143,068	27,298,163	3,155,095	11.6%
844,991	0	(844,991)	0.0%	IBNR Specialist	510,742	(334,249)	(844,991)	252.8%
25,350	0	(25,350)	0.0%	IBNR Settlement (SCP)	15,324	(10,026)	(25,350)	252.8%
67,598	0	(67,598)	0.0%	IBNR Claims Fluctuation (SCP)	40,855	(26,743)	(67,598)	252.8%
560,610	0	(560,610)	0.0%	Psychiatrist FFS	3,300,243	2,739,633	(560,610)	(20.5%)
2,640,146	8,453,313	5,813,167	68.8%	Specialty Care FFS	17,723,992	23,537,159	5,813,167	24.7%
236,550	0	(236,550)	0.0%	Specialty Anesthesiology	1,586,216	1,349,666	(236,550)	(17.5%)
1,454,481	0	(1,454,481)	0.0%	Specialty Imaging FFS	8,453,765	6,999,284	(1,454,481)	(20.8%)
38,538	0	(38,538)	0.0%	Obstetrics FFS	275,362	236,824	(38,538)	(16.3%)
414,020	0	(414,020)	0.0%	Specialty IP Surgery FFS	2,368,264	1,954,243	(414,020)	(21.2%)
866,175	0	(866,175)	0.0%	Specialty OP Surgery FFS	5,323,068	4,456,894	(866,175)	(19.4%)
578,358	0	(578,358)	0.0%	Specialty IP Physician	3,508,838	2,930,480	(578,358)	(19.7%)
186,213	141,633	(44,580)	(31.5%)	Specialist FQHC FFS	838,922	794,342	(44,580)	(5.6%)
7,913,029	8,594,946	681,917	7.9%	10. Specialty Care Physician Expense	43,945,590	44,627,507	681,917	1.5%
(69,196)	0	69,196	0.0%	IBNR Ancillary (ANC)	(3,275,155)	(3,205,959)	69,196	(2.2%)
(2,077)	0	2,077	0.0%	IBNR Settlement (ANC)	(98,258)	(96,181)	2,077	(2.2%)
(5,534)	0	5,534	0.0%	IBNR Claims Fluctuation (ANC)	(262,013)	(256,479)	5,534	(2.2%)

**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 NOVEMBER, 2025**

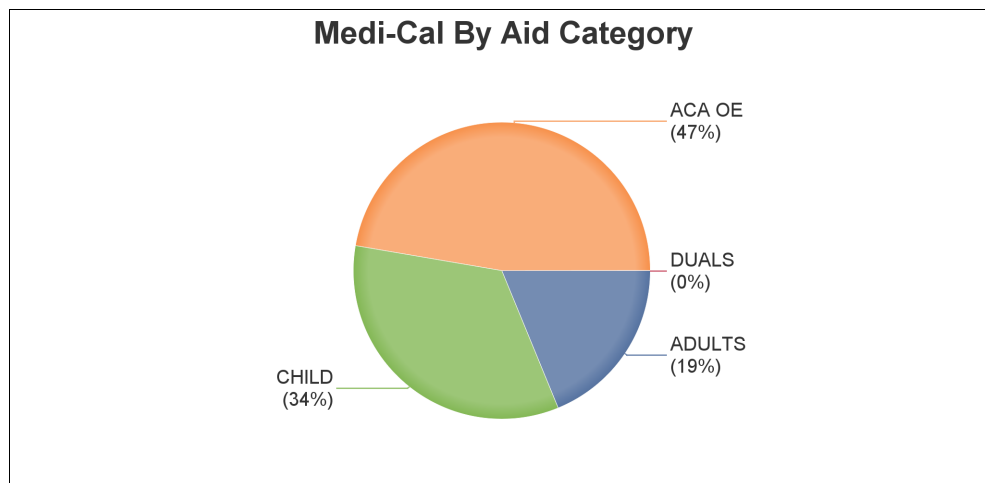
CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
329,535	0	(329,535)	0.0%	IBNR Transportation FFS	9,427	(320,108)	(329,535)	102.9%
2,816,499	2,643,978	(172,521)	(6.5%)	Behavioral Health Therapy FFS	15,615,686	15,443,166	(172,521)	(1.1%)
2,598,284	0	(2,598,284)	0.0%	Psychologist & Other MH Prof	13,160,664	10,562,380	(2,598,284)	(24.6%)
648,362	0	(648,362)	0.0%	Other Medical Professional	2,974,736	2,326,374	(648,362)	(27.9%)
192,952	0	(192,952)	0.0%	Hearing Devices	876,229	683,277	(192,952)	(28.2%)
18,944	0	(18,944)	0.0%	ANC Imaging	157,230	138,286	(18,944)	(13.7%)
57,591	0	(57,591)	0.0%	Vision FFS	387,619	330,028	(57,591)	(17.5%)
0	0	0	0.0%	Family Planning	5	5	0	0.0%
651,592	847,445	195,853	23.1%	Laboratory FFS	3,562,390	3,758,243	195,853	5.2%
148,258	0	(148,258)	0.0%	ANC Therapist	816,041	667,783	(148,258)	(22.2%)
1,697,315	1,786,321	89,006	5.0%	Transp/Ambulance FFS	8,888,687	8,977,693	89,006	1.0%
2,759,648	2,720,249	(39,399)	(1.4%)	Non-ER Transportation FFS	12,219,605	12,180,206	(39,399)	(0.3%)
1,446,834	2,243,748	796,914	35.5%	Hospice FFS	8,382,099	9,179,013	796,914	8.7%
3,139,714	3,324,283	184,569	5.6%	Home Health Services	13,031,298	13,215,867	184,569	1.4%
0	0	0	0.0%	Other Medical FFS	2,450	2,450	0	0.0%
(258,853)	0	258,853	0.0%	Medical Refunds through HMS	(1,142,822)	(883,969)	258,853	(29.3%)
2,452	1,992,469	1,990,017	99.9%	DME & Medical Supplies FFS	106,891	2,096,908	1,990,017	94.9%
2,576,979	2,346,145	(230,834)	(9.8%)	ECM Base/Outreach FFS ANC	12,951,075	12,720,241	(230,834)	(1.8%)
183,931	177,872	(6,059)	(3.4%)	CS Housing Deposits FFS ANC	858,490	852,432	(6,059)	(0.7%)
374,236	698,254	324,017	46.4%	CS Housing Tenancy FFS ANC	4,033,988	4,358,005	324,017	7.4%
184,388	419,046	234,657	56.0%	CS Housing Navi Servic FFS ANC	2,529,333	2,763,990	234,657	8.5%
164,010	367,160	203,150	55.3%	CS Medical Respite FFS ANC	1,504,512	1,707,662	203,150	11.9%
152,898	269,804	116,906	43.3%	CS Med. Tailored Meals FFS ANC	1,029,516	1,146,421	116,906	10.2%
25,139	21,313	(3,827)	(18.0%)	CS Asthma Remediation FFS ANC	124,621	120,794	(3,827)	(3.2%)
0	0	0	0.0%	MOT Wrap Around (Non Med MOT)	6,868	6,868	0	0.0%
0	2,580	2,580	100.0%	CS Home Modifications FFS ANC	0	2,580	2,580	100.0%
84,909	96,241	11,332	11.8%	CS P.Care & Hmker Svcs FFS ANC	354,131	365,464	11,332	3.1%
1,102	6,479	5,377	83.0%	CS Cgiver Respite Svcs FFS ANC	8,398	13,775	5,377	39.0%
0	(10)	(10)	100.0%	CS ST PostHospital Housing FFS	0	(10)	(10)	100.0%
140	998	858	86.0%	CS Housing Outreach	1,300	2,158	858	39.8%
754,324	0	(754,324)	0.0%	CommunityBased Adult Svc(CBAS)	2,273,864	1,519,540	(754,324)	(49.6%)
18,923	10,831	(8,092)	(74.7%)	CS LTC Diversion FFS ANC	82,771	74,679	(8,092)	(10.8%)
947	5,003	4,056	81.1%	CS LTC Transition FFS ANC	18,800	22,856	4,056	17.7%
20,694,244	19,980,207	(714,038)	(3.6%)	11. Ancillary Medical Expense	101,190,475	100,476,437	(714,038)	(0.7%)
(1,095,659)	0	1,095,659	0.0%	IBNR Outpatient	357,336	1,452,995	1,095,659	75.4%
(32,870)	0	32,870	0.0%	IBNR Settlement (OP)	10,718	43,588	32,870	75.4%
(87,653)	0	87,653	0.0%	IBNR Claims Fluctuation (OP)	28,588	116,241	87,653	75.4%
2,545,933	5,804,696	3,258,763	56.1%	Outpatient FFS	15,023,540	18,282,303	3,258,763	17.8%
2,531,239	0	(2,531,239)	0.0%	OP Ambul Surgery FFS	16,123,070	13,591,832	(2,531,239)	(18.6%)
2,473,761	3,590,953	1,117,192	31.1%	Imaging Services FFS	14,799,342	15,916,534	1,117,192	7.0%
133,337	0	(133,337)	0.0%	Behavioral Health FFS	626,876	493,539	(133,337)	(27.0%)
706,129	0	(706,129)	0.0%	Outpatient Facility Lab FFS	4,154,478	3,448,349	(706,129)	(20.5%)
198,974	0	(198,974)	0.0%	Outpatient Facility Cardio FFS	1,227,561	1,028,586	(198,974)	(19.3%)
118,552	0	(118,552)	0.0%	OP Facility PT/OT/ST FFS	579,724	461,172	(118,552)	(25.7%)
2,843,688	3,100,528	256,841	8.3%	OP Facility Dialysis Ctr FFS	16,071,882	16,328,723	256,841	1.6%
10,335,431	12,496,177	2,160,746	17.3%	12. Outpatient Medical Expense	69,003,116	71,163,861	2,160,746	3.0%
47,956	0	(47,956)	0.0%	IBNR Emergency	(2,465,713)	(2,513,669)	(47,956)	1.9%
1,439	0	(1,439)	0.0%	IBNR Settlement (ER)	(73,969)	(75,408)	(1,439)	1.9%
3,837	0	(3,837)	0.0%	IBNR Claims Fluctuation (ER)	(197,257)	(201,094)	(3,837)	1.9%
8,531,259	10,450,096	1,918,837	18.4%	ER Facility	47,804,316	49,723,154	1,918,837	3.9%
1,097,206	0	(1,097,206)	0.0%	Specialty ER Physician FFS	6,048,984	4,951,779	(1,097,206)	(22.2%)
9,681,696	10,450,096	768,400	7.4%	13. Emergency Expense	51,116,362	51,884,761	768,400	1.5%
(2,008,325)	0	2,008,325	0.0%	IBNR Pharmacy (OP)	(4,266,236)	(2,257,911)	2,008,325	(88.9%)
(60,250)	0	60,250	0.0%	IBNR Settlement Rx (OP)	(127,984)	(67,734)	60,250	(89.0%)

**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 NOVEMBER, 2025**

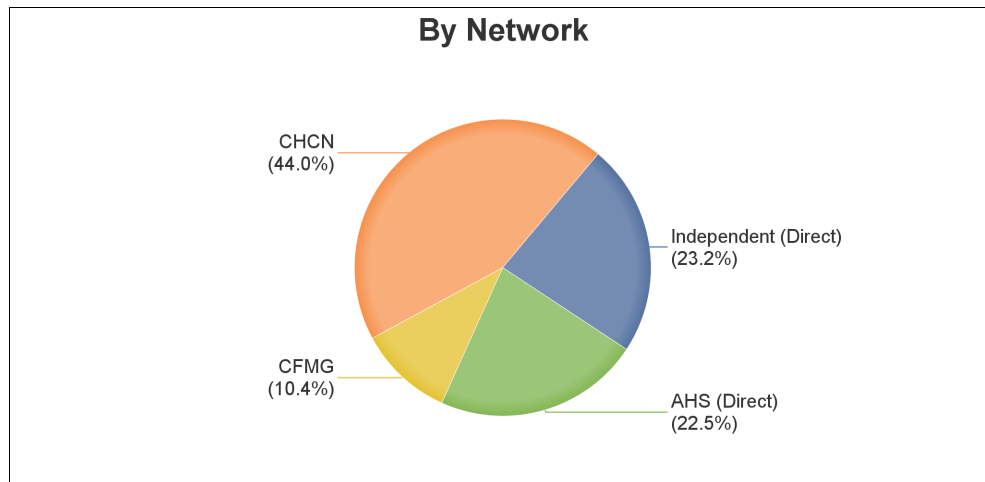
CURRENT MONTH					FISCAL YEAR TO DATE			
		\$ Variance	% Variance				\$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
(160,666)	0	160,666	0.0%	IBNR Claims Fluctuation Rx(OP)	(341,299)	(180,633)	160,666	(88.9%)
719,194	794,630	75,436	9.5%	Pharmacy FFS (OP)	3,688,102	3,763,538	75,436	2.0%
124,826	0	(124,826)	0.0%	Pharmacy Non PBM FFS Other-ANC	603,853	479,027	(124,826)	(26.1%)
8,149,180	12,026,708	3,877,528	32.2%	Pharmacy Non PBM FFS OP-FAC	30,104,735	33,982,264	3,877,528	11.4%
260,809	0	(260,809)	0.0%	Pharmacy Non PBM FFS PCP	1,401,692	1,140,883	(260,809)	(22.9%)
3,140,635	0	(3,140,635)	0.0%	Pharmacy Non PBM FFS SCP	14,920,361	11,779,726	(3,140,635)	(26.7%)
40,669	0	(40,669)	0.0%	Pharmacy Non PBM FFS FQHC	206,005	165,336	(40,669)	(24.6%)
24,007	0	(24,007)	0.0%	Pharmacy Non PBM FFS HH	102,433	78,426	(24,007)	(30.6%)
(50,000)	(86,597)	(36,597)	42.3%	Medical Expenses Pharm Rebate	(373,544)	(410,141)	(36,597)	8.9%
10,180,078	12,734,741	2,554,663	20.1%	14. Pharmacy Expense	45,918,117	48,472,780	2,554,663	5.3%
5,026,519	0	(5,026,519)	0.0%	IBNR LTC	(503,544)	(5,530,063)	(5,026,519)	90.9%
150,795	0	(150,795)	0.0%	IBNR Settlement (LTC)	(15,107)	(165,902)	(150,795)	90.9%
402,122	0	(402,122)	0.0%	IBNR Claims Fluctuation (LTC)	(40,285)	(442,407)	(402,122)	90.9%
1,735,840	1,867,665	131,825	7.1%	LTC - ICF/DD	9,682,116	9,813,941	131,825	1.3%
22,367,292	26,370,051	4,002,758	15.2%	LTC Custodial Care	139,128,638	143,131,396	4,002,758	2.8%
7,770,832	7,845,792	74,960	1.0%	LTC SNF	44,528,088	44,603,048	74,960	0.2%
37,453,401	36,083,508	(1,369,893)	(3.8%)	15. Long Term Care Expense	192,779,906	191,410,013	(1,369,893)	(0.7%)
148,952,371	157,144,260	8,191,889	5.2%	16. TOTAL FFS MEDICAL EXPENSES	763,951,754	772,143,643	8,191,889	1.1%
0	200,014	200,014	100.0%	Clinical Vacancy #102	0	200,014	200,014	100.0%
66,317	479,428	413,111	86.2%	Quality Analytics #123	719,379	1,132,489	413,111	36.5%
358,200	370,105	11,905	3.2%	LongTerm Services and Support #139	1,911,202	1,923,108	11,905	0.6%
859,729	901,930	42,201	4.7%	Utilization Management #140	4,677,336	4,719,537	42,201	0.9%
693,702	791,272	97,570	12.3%	Case & Disease Management #185	3,756,541	3,854,110	97,570	2.5%
(116,178)	(114,991)	1,186	(1.0%)	Medical Management #230	(1,104,211)	(1,103,025)	1,186	(0.1%)
716,195	1,228,290	512,095	41.7%	Quality Improvement #235	5,425,763	5,937,858	512,095	8.6%
357,760	458,237	100,477	21.9%	HCS Behavioral Health #238	1,943,140	2,043,617	100,477	4.9%
123,991	242,056	118,065	48.8%	Pharmacy Services #245	704,628	822,693	118,065	14.4%
0	0	0	0.0%	Regulatory Readiness #268	(5,289)	(5,289)	0	0.0%
3,059,718	4,556,342	1,496,624	32.8%	17. Other Benefits & Services	18,028,489	19,525,113	1,496,624	7.7%
(1,921,243)	(1,832,612)	88,631	(4.8%)	Reinsurance Recoveries	(12,491,696)	(12,403,065)	88,631	(0.7%)
2,442,858	2,443,483	625	0.0%	Reinsurance Premium	12,314,401	12,315,027	625	0.0%
521,614	610,871	89,256	14.6%	18. Reinsurance (Net)	(177,295)	(88,038)	89,256	(101.4%)
1,000,000	0	(1,000,000)	0.0%	P4P Risk Pool Provider Incenti	5,659,099	4,659,099	(1,000,000)	(21.5%)
1,000,000	0	(1,000,000)	0.0%	19. Risk Pool Distribution	5,659,099	4,659,099	(1,000,000)	(21.5%)
169,484,142	178,243,925	8,759,782	4.9%	20. TOTAL MEDICAL EXPENSES	883,815,558	892,575,340	8,759,782	1.0%

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend						
Category of Aid	Nov 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	59,892	15%	12,700	14,493	1	32,698
CHILD	108,001	27%	10,390	13,810	38,770	45,031
SPD	0	0%	0	0	0	0
ACA OE	150,677	38%	27,578	52,133	1,530	69,436
DUALS	33	0%	30	3	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,590	7%	8,640	5,501	1,518	13,931
SPD-LTC/Full Dual	49,334	12%	31,988	3,575	1	13,770
Other	0		0	0	0	0
Medi-Cal	397,527		91,326	89,515	41,820	174,866
Group Care	6,092		2,193	1,146	0	2,753
Total	403,619	100%	93,519	90,661	41,820	177,619
Other %	0.0%		0.0%	0.0%	0.0%	0.0%
Medi-Cal %	98.5%		97.7%	98.7%	100.0%	98.5%
Group Care %	1.5%		2.3%	1.3%	0.0%	1.5%
Network Distribution			23.2%	22.5%	10.4%	44.0%
			% Direct:	46%	% Delegated:	54%

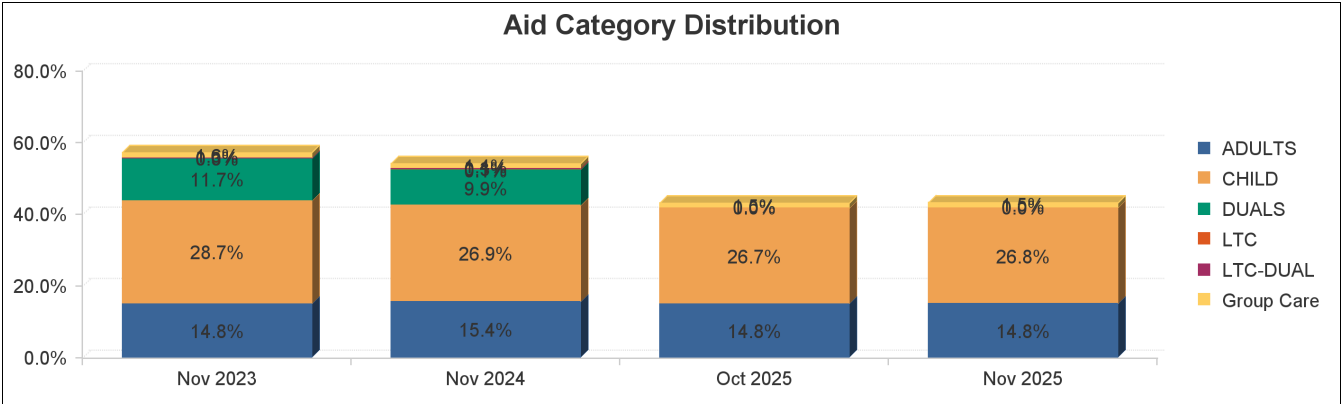


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

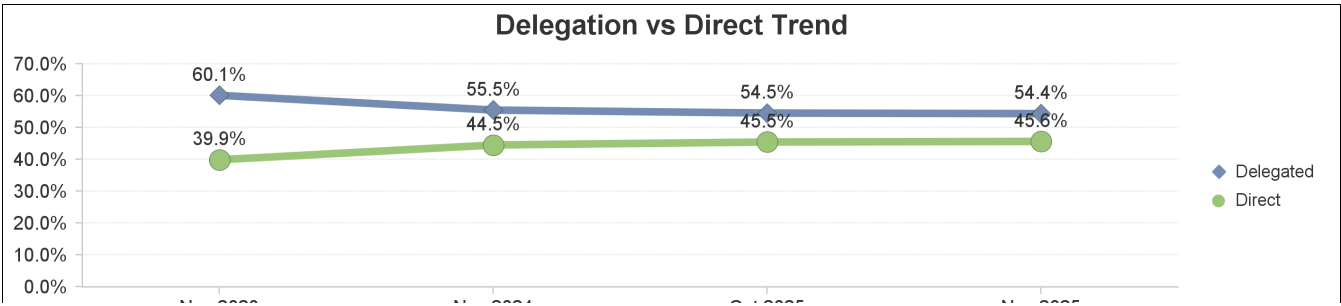


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend											
Category of Aid	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Nov 2023	Nov 2024	Oct 2025	Nov 2025	Nov 2023	Nov 2024	Oct 2025	Nov 2025	Nov 2023 to Nov 2024	Nov 2024 to Nov 2025	Oct 2025 to Nov 2025
ADULTS	52,222	62,533	59,861	59,892	14.8%	15.4%	14.8%	14.8%	16.5%	-4.4%	0.1%
CHILD	101,557	109,574	107,934	108,001	28.7%	26.9%	26.7%	26.8%	7.3%	-1.5%	0.1%
SPD	30,887	35,603	0	0	8.7%	8.7%	0.0%	0.0%	13.2%	0.0%	0.0%
ACA OE	120,666	151,559	151,424	150,677	34.2%	37.2%	37.4%	37.3%	20.4%	-0.6%	-0.5%
DUALS	41,217	40,360	17	33	11.7%	9.9%	0.0%	0.0%	-2.1%	-122,203.0%	48.5%
LTC	139	255	0	0	0.0%	0.1%	0.0%	0.0%	45.5%	0.0%	0.0%
LTC-DUAL	980	1,269	0	0	0.3%	0.3%	0.0%	0.0%	22.8%	0.0%	0.0%
SPD-LTC	0	0	29,641	29,590	0.0%	0.0%	7.3%	7.3%	0.0%	100.0%	-0.2%
SPD-LTC/ Full Dual	0	0	49,391	49,334	0.0%	0.0%	12.2%	12.2%	0.0%	100.0%	-0.1%
Other	0	0	1	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medi-Cal	347,668	401,153	398,267	397,527	98.4%	98.6%	98.5%	98.5%	13.3%	-0.9%	-0.2%
Group Care	5,586	5,772	6,082	6,092	1.6%	1.4%	1.5%	1.5%	3.2%	5.3%	0.2%
Total	353,254	406,925	404,350	403,619	100.0%	100.0%	100.0%	100.0%	13.2%	-0.8%	-0.2%



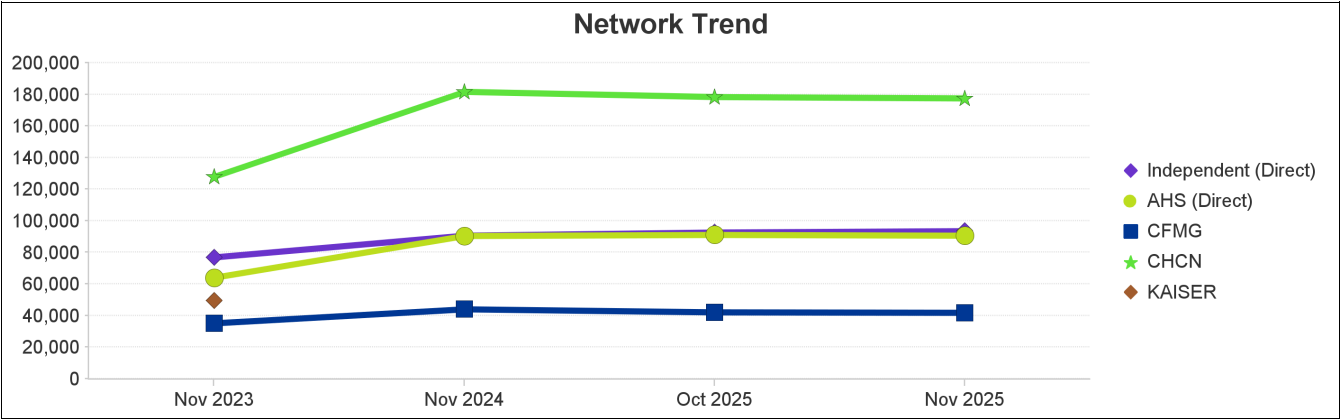
Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Nov 2023	Nov 2024	Oct 2025	Nov 2025	Nov 2023	Nov 2024	Oct 2025	Nov 2025	Nov 2023 to Nov 2024	Nov 2024 to Nov 2025	Oct 2025 to Nov 2025
Delegated	212,412	225,785	220,571	219,439	60.1%	55.5%	54.5%	54.4%	5.9%	-2.9%	-0.5%
Direct	140,842	181,140	183,779	184,180	39.9%	44.5%	45.5%	45.6%	22.2%	1.7%	0.2%
Total	353,254	406,925	404,350	403,619	100.0%	100.0%	100.0%	100.0%	13.2%	-0.8%	-0.2%



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

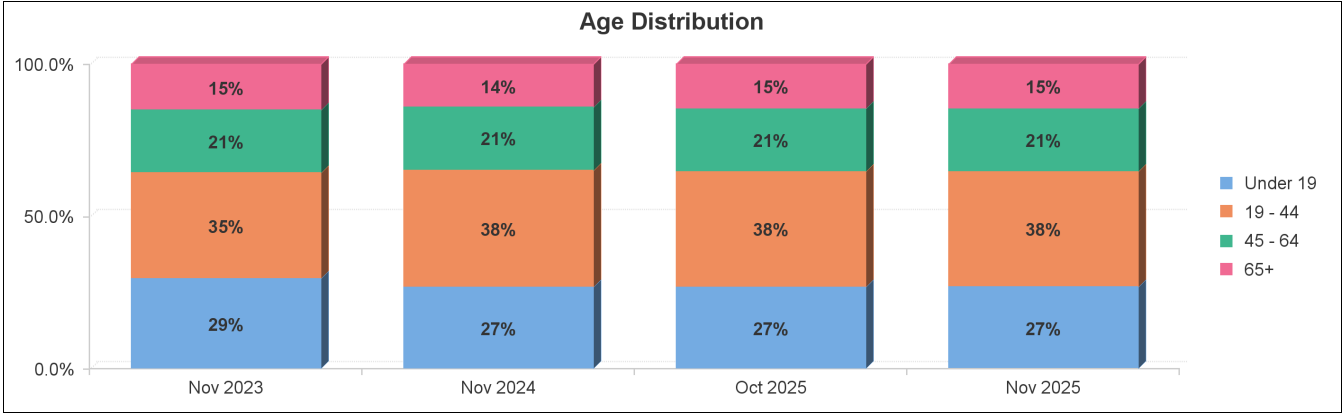
Nov 2023	Nov 2024	Oct 2025	Nov 2025

Network Trend											
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Nov 2023	Nov 2024	Oct 2025	Nov 2025	Nov 2023	Nov 2024	Oct 2025	Nov 2025	Nov 2023 to Nov 2024	Nov 2024 to Nov 2025	Oct 2025 to Nov 2025
Independent (Direct)	76,872	90,681	92,650	93,519	21.8%	22.3%	22.9%	23.2%	15.2%	3.0%	0.9%
AHS (Direct)	63,970	90,459	91,129	90,661	18.1%	22.2%	22.5%	22.5%	29.3%	0.2%	-0.5%
CFMG	35,124	44,031	42,114	41,820	9.9%	10.8%	10.4%	10.4%	20.2%	-5.3%	-0.7%
CHCN	127,787	181,754	178,457	177,619	36.2%	44.7%	44.1%	44.0%	29.7%	-2.3%	-0.5%
KAISER	49,501	0	0	0	14.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	353,254	406,925	404,350	403,619	100.0%	100.0%	100.0%	100.0%	13.2%	-0.8%	-0.2%

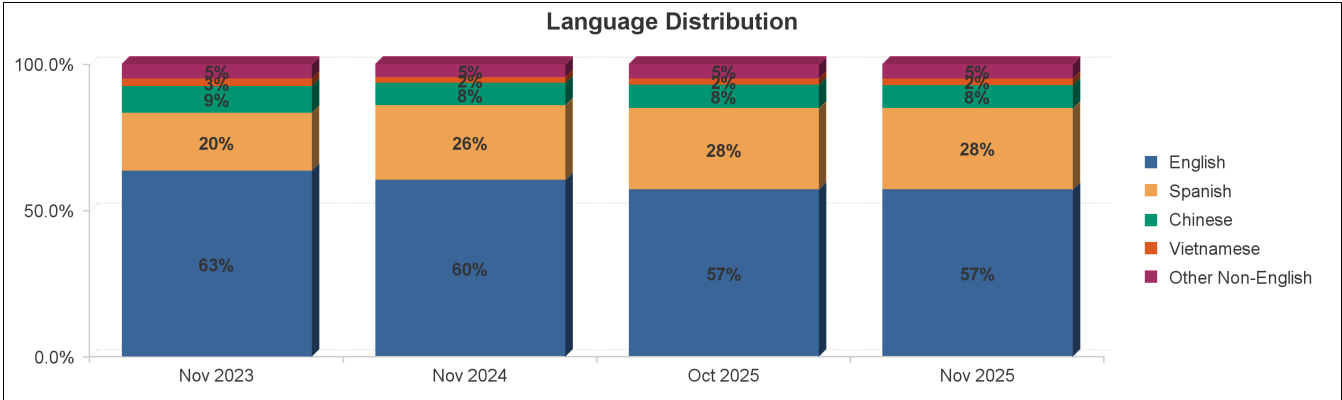


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Age Category Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Nov 2023	Nov 2024	Oct 2025	Nov 2025	Nov 2023	Nov 2024	Oct 2025	Nov 2025	Nov 2023 to Nov 2024	Nov 2024 to Nov 2025	Oct 2025 to Nov 2025
Under 19	103,970	108,407	107,763	107,820	29%	27%	27%	27%	4%	-1%	0%
19 - 44	122,671	155,955	153,189	152,698	35%	38%	38%	38%	21%	-2%	0%
45 - 64	72,867	84,411	83,403	83,208	21%	21%	21%	21%	14%	-1%	0%
65+	53,746	58,152	59,995	59,893	15%	14%	15%	15%	8%	3%	0%
Total	353,254	406,925	404,350	403,619	100%	100%	100%	100%	13%	-1%	0%

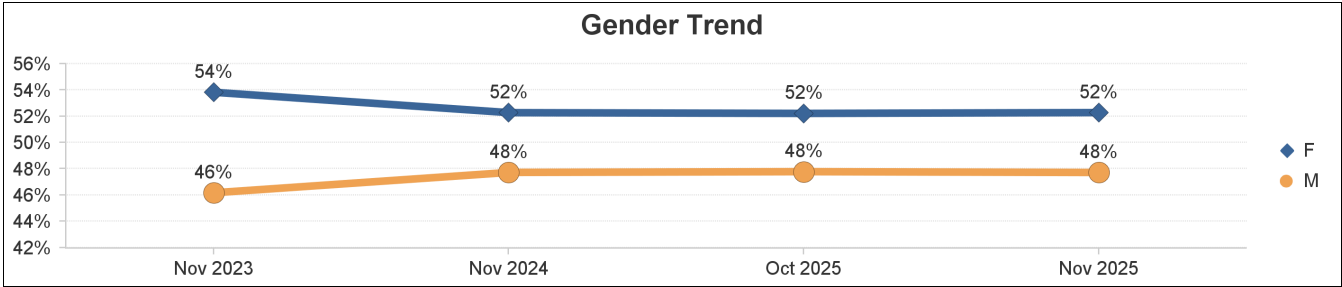


Language Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Nov 2023	Nov 2024	Oct 2025	Nov 2025	ov 2023	ov 2024	Oct 2025	ov 2025	Nov 2023 to Nov 2024	Nov 2024 to Nov 2025	Oct 2025 to Nov 2025
English	223,617	244,547	229,798	229,585	63%	60%	57%	57%	9%	-7%	0%
Spanish	69,914	104,072	112,430	112,007	20%	26%	28%	28%	33%	7%	0%
Chinese	32,047	30,682	32,053	31,981	9%	8%	8%	8%	-4%	4%	0%
Vietnamese	9,168	8,223	8,977	8,960	3%	2%	2%	2%	-11%	8%	0%
Other Non-English	18,508	19,401	21,092	21,086	5%	5%	5%	5%	5%	8%	0%
Total	353,254	406,925	404,350	403,619	100%	100%	100%	100%	13%	-1%	0%

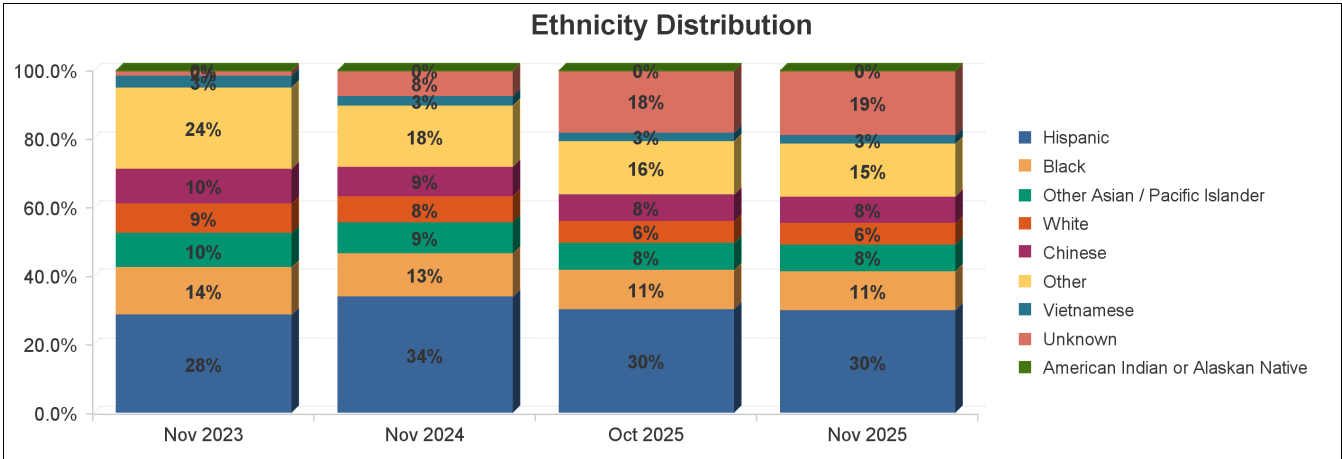


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Gender Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Nov 2023	Nov 2024	Oct 2025	Nov 2025	Nov 2023	Nov 2024	Oct 2025	Nov 2025	Nov 2023 to Nov 2024	Nov 2024 to Nov 2025	Oct 2025 to Nov 2025
F	190,163	212,721	211,148	211,017	54%	52%	52%	52%	11%	-1%	0%
M	163,091	194,204	193,202	192,602	46%	48%	48%	48%	16%	-1%	0%
Total	353,254	406,925	404,350	403,619	100%	100%	100%	100%	13%	-1%	0%



Ethnicity Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Nov 2023	Nov 2024	Oct 2025	Nov 2025	Nov 2023	Nov 2024	Oct 2025	Nov 2025	Nov 2023 to Nov 2024	Nov 2024 to Nov 2025	Oct 2025 to Nov 2025
Hispanic	100,583	137,424	121,473	120,200	28%	34%	30%	30%	27%	-14%	-1%
Black	48,956	51,258	46,427	46,008	14%	13%	11%	11%	4%	-11%	-1%
Other Asian / Pacific Islander	35,233	36,733	31,796	31,372	10%	9%	8%	8%	4%	-17%	-1%
White	30,370	31,272	25,853	25,360	9%	8%	6%	6%	3%	-23%	-2%
Chinese	35,686	34,944	31,241	30,984	10%	9%	8%	8%	-2%	-13%	-1%
Other	84,093	72,555	63,066	62,288	24%	18%	16%	15%	-16%	-16%	-1%
Vietnamese	12,048	11,441	10,228	10,119	3%	3%	3%	3%	-5%	-13%	-1%
Unknown	5,553	30,524	73,597	76,629	2%	8%	18%	19%	82%	60%	4%
American Indian or Alaskan Native	732	774	669	659	0%	0%	0%	0%	5%	-17%	-2%
Total	353,254	406,925	404,350	403,619	100%	100%	100%	100%	13%	-1%	0%



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

Medi-Cal By City						
City	Nov 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	157,764	40%	24,245	42,461	16,452	74,606
HAYWARD	51,708	13%	11,804	14,768	5,441	19,695
FREMONT	38,278	10%	15,905	6,761	2,129	13,483
SAN LEANDRO	25,045	6%	6,887	4,223	3,041	10,894
UNION CITY	14,342	4%	5,748	2,597	792	5,205
ALAMEDA	13,594	3%	3,449	2,547	2,022	5,576
BERKELEY	16,370	4%	3,822	2,630	1,742	8,176
LIVERMORE	12,953	3%	2,119	430	2,041	8,363
NEWARK	9,198	2%	2,776	3,868	487	2,067
CASTRO VALLEY	11,156	3%	3,302	1,795	1,723	4,336
SAN LORENZO	6,027	2%	1,246	1,413	684	2,684
PLEASANTON	8,007	2%	2,308	323	831	4,545
DUBLIN	7,658	2%	2,453	333	861	4,011
EMERYVILLE	3,008	1%	615	690	499	1,204
ALBANY	2,573	1%	584	303	531	1,155
PIEDMONT	468	0%	102	186	71	109
SUNOL	86	0%	32	9	6	39
ANTIOCH	31	0%	14	8	5	4
Other	19,261	5%	3,915	4,170	2,462	8,714
Total	397,527	100%	91,326	89,515	41,820	174,866

Group Care By City						
City	Nov 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,848	30%	332	420	0	1,096
HAYWARD	710	12%	321	196	0	193
FREMONT	676	11%	431	89	0	156
SAN LEANDRO	657	11%	263	112	0	282
UNION CITY	292	5%	176	48	0	68
ALAMEDA	311	5%	86	39	0	186
BERKELEY	164	3%	43	16	0	105
LIVERMORE	105	2%	34	1	0	70
NEWARK	143	2%	81	36	0	26
CASTRO VALLEY	221	4%	97	33	0	91
SAN LORENZO	163	3%	51	32	0	80
PLEASANTON	74	1%	26	4	0	44
DUBLIN	134	2%	49	8	0	77
EMERYVILLE	45	1%	13	8	0	24
ALBANY	22	0%	11	2	0	9
PIEDMONT	5	0%	0	2	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	28	0%	10	8	0	10
Other	493	8%	168	92	0	233
Total	6,092	100%	2,193	1,146	0	2,753

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

Total By City						
City	Nov 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	159,612	40%	24,577	42,881	16,452	75,702
HAYWARD	52,418	13%	12,125	14,964	5,441	19,888
FREMONT	38,954	10%	16,336	6,850	2,129	13,639
SAN LEANDRO	25,702	6%	7,150	4,335	3,041	11,176
UNION CITY	14,634	4%	5,924	2,645	792	5,273
ALAMEDA	13,905	3%	3,535	2,586	2,022	5,762
BERKELEY	16,534	4%	3,865	2,646	1,742	8,281
LIVERMORE	13,058	3%	2,153	431	2,041	8,433
NEWARK	9,341	2%	2,857	3,904	487	2,093
CASTRO VALLEY	11,377	3%	3,399	1,828	1,723	4,427
SAN LORENZO	6,190	2%	1,297	1,445	684	2,764
PLEASANTON	8,081	2%	2,334	327	831	4,589
DUBLIN	7,792	2%	2,502	341	861	4,088
EMERYVILLE	3,053	1%	628	698	499	1,228
ALBANY	2,595	1%	595	305	531	1,164
PIEDMONT	473	0%	102	188	71	112
SUNOL	87	0%	33	9	6	39
ANTIOCH	59	0%	24	16	5	14
Other	19,754	5%	4,083	4,262	2,462	8,947
Total	403,619	100%	93,519	90,661	41,820	177,619



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 9th, 2026

Subject: Operations Report

Member Services

- 12-Month Trend Blended Summary:
 - The Member Services Department received 18,094 calls in December 2025 compared to 16,913 in December 2024 and this represents a 7% increase in calls.
 - The abandonment rate for December 2025 was 1% compared to 4% in December 2024.
 - The Department's service level was 98% in December 2025, compared to 95% in December 2024. The average speed to answer (ASA) was seven seconds (00:07) compared to fourteen seconds (00:14) in December 2024. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
 - The average talk time (ATT) was six minutes and thirty-eight seconds (06:38) for December 2025 compared to seven minutes and thirty-three seconds (07:33) for December 2024.
 - 100% of calls were answered within 10 minutes for December 2025 and 100% of calls were answered within 10 minutes for December 2024.
 - Outbound calls totaled 8,986 in December 2025 compared to 8,575 in December 2024.
 - The top five (5) call reasons for December 2025 were 1) Eligibility/Enrollment, 2) Change of PCP, 3) Grievances/Appeals, 4) Benefits, and 5) Provider Network Information. The top five (5) call reasons for December 2024 were: 1) Change of PCP, 2) Eligibility/Enrollment, 3) Benefits, 4) Grievances/Appeals, and 5) Provider Network Information.
 - December utilization for the member automated eligibility IVR system totaled 1,413 in December 2025 compared to 1,215 in December 2024.
 - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests, and in-person). The Department responded to 980 web-based requests in December 2025 compared to 1,065 in December 2024. The top three (3) web reason requests for December 2025 were: 1). Change of PCP, 2) ID Card Requests, and 3) Update Contact Information 51 members were assisted in-person in December 2025 compared to 28 in December 2024.

- MS Behavioral Health:
 - The Member Services Behavioral Health (MS BH) Unit received a total of 944 calls in December 2025 compared to 1,102 in December 2024.
 - The abandonment rate was 1% in December 2025 compared to 8% in December 2024.
 - The service level was 94% in December 2025 and 76% in December 2024.
 - The average speed to answer (ASA) was thirteen seconds (00:13) compared to one minute and thirty-four seconds (01:34) in December 2024.
 - Calls answered in 10 minutes were 100% in December 2025 compared to 99% in December 2024.
 - The Average Talk Time (ATT) was eight minutes and fifty-two seconds (08:52) compared to eight minutes and fifty seconds (08:50) in December 2024. The MS BH Team utilizes the DHCS age-appropriate screening tools for Medi-Cal Mental Health Services to determine the appropriate delivery system for members who are not currently receiving mental health services when they contact the plan.
 - 1,294 outbound calls were completed in December 2025 compared to 851 in December 2024.
 - 89 screenings were completed in December 2025 compared to 118 in December 2024.
 - 28 referrals were made to the County (ACCESS) in December 2025 compared to 30 December 2024.
 - 18 members were referred to Center Point for SUD services in December 2025 compared to 18 in December 2024.
- D-SNP Member Services blended:
 - The Member Services D-SNP Unit received a total of 494 calls.
 - The abandonment rate was 3%.
 - The Average Speed to Answer (ASA) was six seconds (00:06).
 - The service level was 100%.
 - The Average Talk Time (ATT) was six minutes and thirty-three seconds (06:33)
 - The top five (5) call reasons were: 1) Eligibility/Enrollment, 2) Benefits, 3) Grievances/Appeals, 4). Change PCP, and 5) ID Card Request.

Claims

- 12-Month Trend Summary:
 - The Claims Department received 320,327 claims in December 2025 compared to 332,108 in December 2024.
 - The Auto Adjudication rate was 91% in December 2025 compared to 88% in December 2024.

- Claims compliance for the 30-day turn-around time was 81.1% in December 2025 compared to 90.2% in December 2024. The 45-day turn-around time was 89.8% in December 2025 compared to 99.3% in December 2024.
- Monthly Analysis:
 - In December, we received a total of 320,327 claims in the HEALTHsuite system, which represents a 9% decrease from November 2025 with 349,052 claims received. It is also 3.7% lower than the number of claims received in December 2024 (332,108 vs 320,327).
 - 87% of claims were received via EDI and 13% of claims via paper during December.
 - 89.8% of our claims were processed within 45 working days during the month.
 - The Auto Adjudication rate was 91% for December.

Provider Dispute Resolution

- 12-Month Trend Summary:
 - In December 2025, the Provider Dispute Resolution (PDR) team received 3,121 PDRs versus 3,173 in December 2024.
 - The PDR team resolved 3,493 cases in December 2025 compared to 2,185 cases in December 2024.
 - In December 2025, the PDR team upheld 83% of cases versus 69% in December 2024.
 - The PDR team resolved 99.2% of cases within the compliance standard of 95% within 45 working days in December 2025, compared to 99.9% in December 2024.
- Monthly Analysis
 - In December 2025, the Provider Dispute Resolution (PDR) team received 3,121 PDRs versus 3,173 in December 2024. This represents a decrease of 1.6% than the number of PDRs received in December 2024, and an increase of 23% from November 2025.
 - In December 2025, 3,493 PDRs were resolved, with 2,890 upheld and 603 overturned.
 - 3,467 of 3,493 cases were resolved within 45 working days, resulting in a 99.2% compliance rate.
 - The average turnaround time for resolving PDRs in November was 42 days.
 - There were 4,600 PDRs pending resolution as of 12/31/2025, with no cases older than 45 working days.
 - The overturn rate for PDRs was 17%, which meets our goal of 25% or less.

Grievances & Appeals

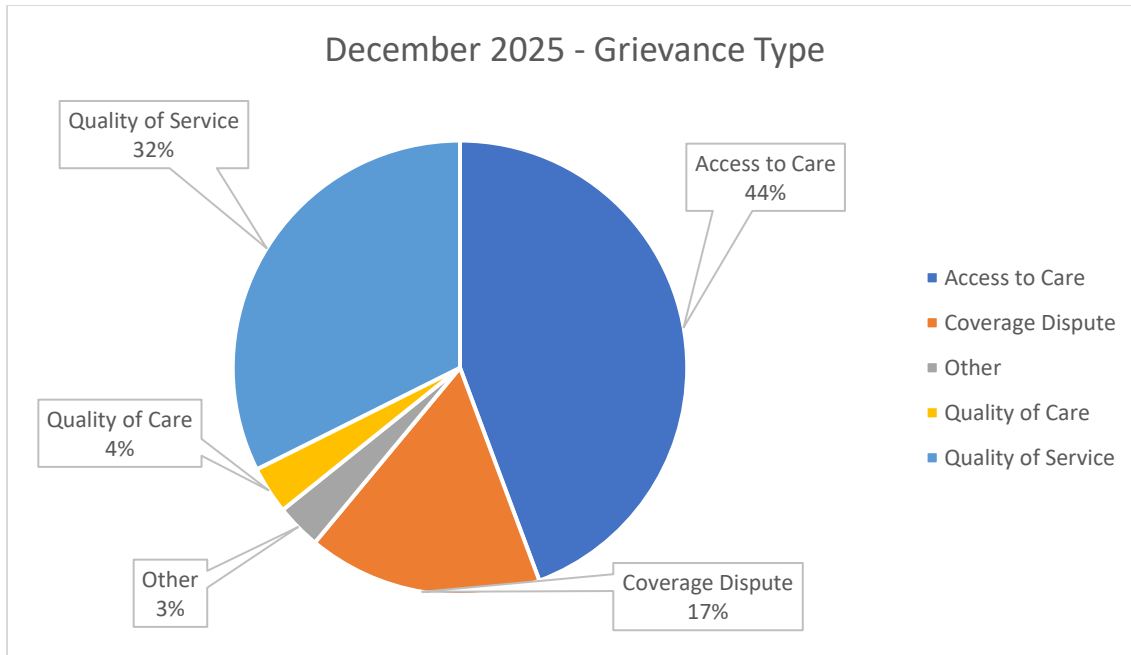
- Standard Grievance cases were not resolved within the goal of 95% of regulatory timeframes.
- Exempt Grievance cases were resolved within the goal of 95% of regulatory timeframes.
- Standard Appeal cases were resolved within the goal of 95% of regulatory timeframes.
- Total Unique grievances resolved in December were 8.42 complaints per 1,000 members.

December 2025 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,394	30 Calendar Days	95% compliance within standard	2,242	93.6%	4.88
Expedited Grievance	0	72 Hours	95% compliance within standard	0	N/A	N/A
Exempt Grievance	1,609	Next Business Day	95% compliance within standard	1,609	100.0%	3.54
Standard Appeal	73	30 Calendar Days	95% compliance within standard	73	100.0%	0.18
Expedited Appeal	0	72 Hours	95% compliance within standard	0	N/A	N/A
Total Cases:	3,904		95% compliance within standard	3,618	92.6%	8.42

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

Standard Grievances:

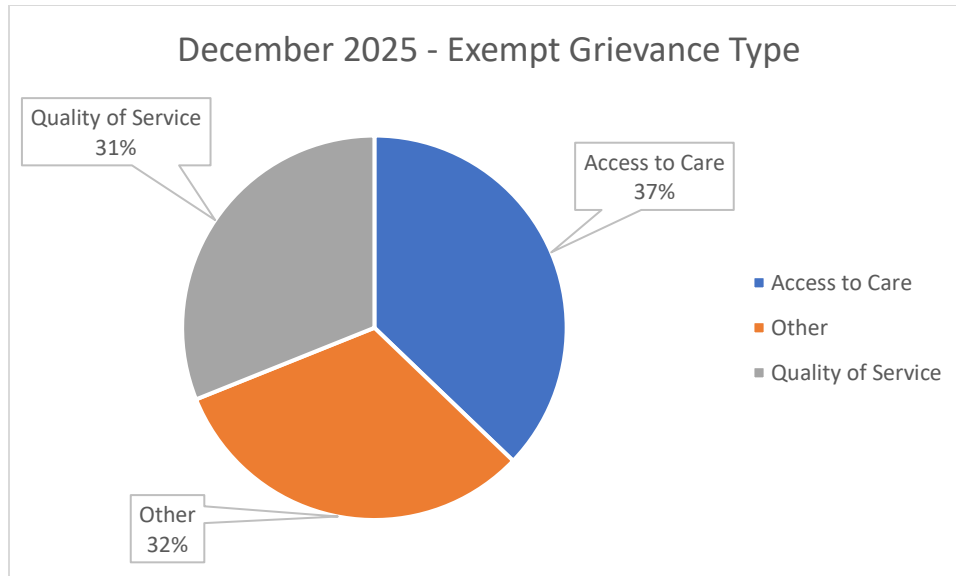
There were 1,958 unique grievance cases resolved during the reporting period, with a total of 2,394 grievances including 436 shadow cases.



- **1,061** of 2,394 (44%) cases were related to Access to Care; the following are the top four (4) categories:
 - Technology/Telephone – 343
 - Timely Access – 319
 - Provider Availability – 138
 - Authorization – 129
- **775** of 2,394 (32%) cases were related to Quality of Service; the following are the top four (4) categories:
 - Plan Customer Service – 188
 - Provider/Staff Attitude – 183
 - Referral – 124
 - Authorization – 89
 -
- **400** of 2,394 (17%) cases were related to Coverage Dispute; the following are the top two (2) categories:
 - Provider Direct Member Billing – 206
 - Provider Balance Billing – 120

Exempt Grievances:

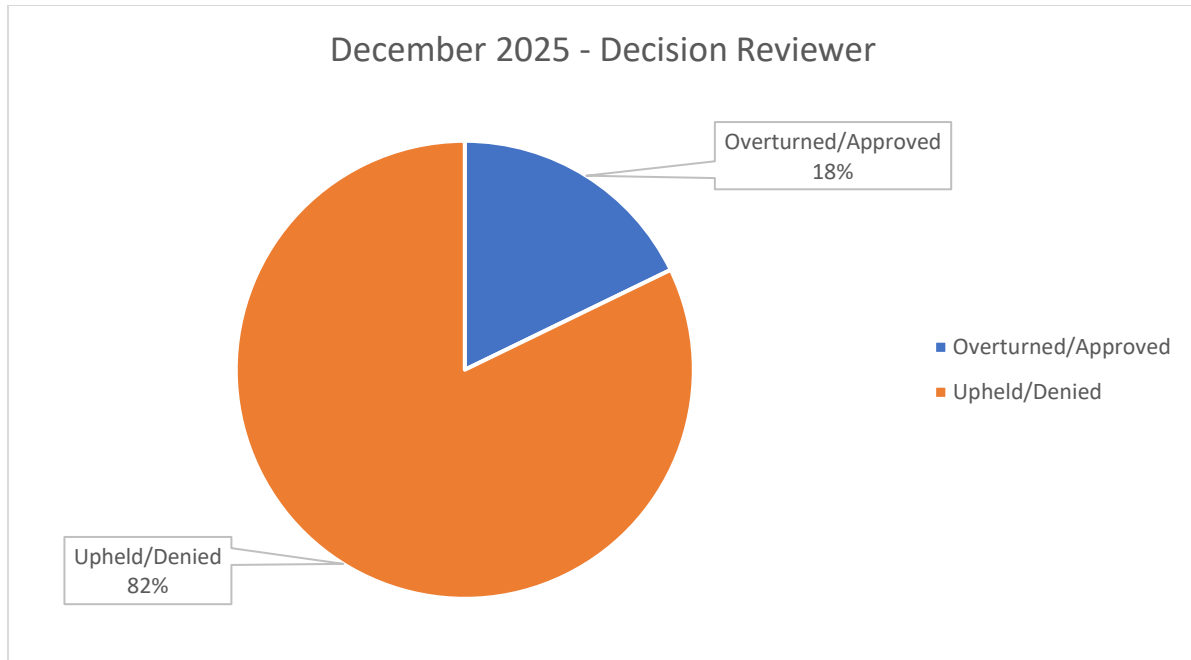
There were 1,420 unique exempt grievance cases resolved during the reporting period, with a total of 1,609 exempt grievances including 189 shadow cases.



- **598** of 1,609 (37%) cases were related to Access to Care; the following are the top three (3) categories:
 - Telephone/Technology – 352
 - Provider Availability – 123
 - Geographic Access – 72
- **511** of 1,609 (32%) cases were related to Other; the following are the top two (2) categories:
 - Enrollment – 463
 - Eligibility – 48
- **500** of 1,609 (31%) cases were related to Quality of Service; the following are the top two (2) categories:
 - Plan Customer Service – 333
 - Provider/Staff Attitude – 135

Appeals:

The Alliance's goal is to have an overturn rate of less than 25%; for the reporting period of December 2025, we met our goal with an 18% overturn rate.



- **60** out of 73 (82%) cases were upheld/denied for the month of December 2025:
 - Disputes Involving Medical Necessity – 41
 - Out of Network – 18
 - Coverage Disputes – 1
- **13** out of 73 (18%) cases were overturned for the month of December 2025:
 - Disputes Involving Medical Necessity – 16
 - Out of Network – 2

Provider Services

- 12-Month Trend Summary:
 - The Provider Services department's call volume in December 2025 was 8,547 calls compared to 7,479 calls in December 2024.
- Monthly Analysis:
 - The Provider Services department completed 399 calls/visits during December 2025.
 - The Provider Services department answered 6,388 calls for December 2025 and made 441 outbound calls.
 - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.

Credentialing

- Monthly Analysis:
 - At the Peer Review and Credentialing (PRCC) meeting held on December 16th, 2025, there were 259 initial network providers approved; 5 primary care providers, 11 specialists, 7 ancillary providers, 9 midlevel providers, and 227 behavioral health providers. Additionally, 44 providers were re-credentialed at this meeting; 6 primary care providers, 5 specialists, 0 ancillary providers, 0 midlevel providers and 33 behavioral health providers.
 - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Community Relations and Outreach

The 2025 Year-in-Review Report:

1. Alliance Member Connect Newsletter:

- In 2025, the Alliance published the Spring/Summer 2025, and Fall/Winter 2025/2026 Alliance Member Connect Newsletter in our threshold languages: English, Spanish, Chinese, Vietnamese, and Tagalog.
- An average of more than 215,000 printed copies of each publication were disseminated to member households to reach more than 400,000 members, and community outreach events and digital copies of the publications are made available on the Alliance website.
- Please see attached **Addendum A**.

2. Outreach:

- 12-Month Trend Summary:
 - The C&O Department reached 13,250 people (48% identified as Alliance members) during outreach activities.
 - The C&O Department spent a total of \$7,615.00 on donations, fees, and/or sponsorships.
 - The C&O Department reached members in more than 38 cities/unincorporated areas throughout Alameda County, the Bay Area, and the United States.
- Quarterly Analysis:
 - In Q2 FY 2026, the C&O Department completed 181 member orientations by phone, 7 community events and 12 member education events, 1 community meeting presentation, and 83 website inquiries.

- Among the 2,422 people reached, 48% identified as Alliance members.
- In Q2 FY 2026, the C&O Department reached members in 15 cities / unincorporated areas throughout Alameda County, the Bay Area, and the United States.
- Please see attached **Addendum B**.

3. Social Media and Website Engagement

- In 2025, the Alliance public website received 1,117,553 visits and 11,447,222 pages served.
- The Alliance Glassdoor Page:
 - Overall rating was 3.1 compared to 3.5 in 2024
 - Received three (3) crowdsourced reviews compared to nine (9) in 2024
- The Alliance Facebook Page:
 - Completed 264 posts compared to 276 in 2024
 - Increased page followers to 691 compared to 633 in 2024
- The Alliance Instagram Page:
 - Completed 272 posts compared to 295 in 2024
 - Increased followers to 708 compared to 595 in 2024
- The Alliance X (formerly known as Twitter) Page:
 - Completed 306 posts compared to 395 in 2024
 - Had 354 followers compared to 359 in 2024
- The Alliance LinkedIn Page:
 - Completed 219 posts compared to 232 in 2024
 - Increased followers to 7.2k compared to 6.1k in 2024
- The Alliance Yelp Page:
 - Appeared in Yelp 1,800 searches compared 1,200 in 2024
 - Received eight crowdsourced reviews compared to four in 2024
- The Alliance Google Page:
 - Received 47,582 business profile interactions compared to 54,127 in 2024
 - Received 19,571 calls made from the business profile compared to 21,239 in 2024
 - Received 9 crowdsourced reviews compared to 17 in 2024
- Please see attached **Addendum C**.

Incentives & Reporting

Current Incentive and Grant Programs

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

- The Alliance earned a total of \$9.7M (100% of eligible funds) based on submission of DHCS deliverables and achievement of milestones

- A total of \$9.1M has been paid to date to Local Education Agencies (LEAs) and SBHIP partners
- SBHIP program dollars have been reviewed, and additional payments in the amount of \$265,328 were distributed to the LEAs; these funds were not included in our initial payment methodology, which was intentionally conservative to avoid overspending in case full funding was not secured

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

- The Alliance earned \$38M out of \$44M available under this program based on submission of deliverables and achievement of DHCS-defined metrics
 - \$25.3M 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
 - Projects continue with activities taking place through 2028 related to capacity building, innovation, diversity and health equity, and housing stability
- The Alliance continues to review partner project deliverables prior to payment and meet with partners to discuss program activities and barriers

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

- 2024-25 Program highlights:
 - Launched on June 1st, 2024
 - 15 applications received totaling \$6M in funding requests
 - \$400,145 has been awarded to our PRI partners to date
 - PRI deliverable trackers, to assist with program requirements, were created and distributed to all awardees with signed MOUs
 - Approximately \$108,900 in unused funds for FY 2024-25 will not be rolled over to the FY 2025-26 program
- 2025-26 Program status:
 - PRI program was renewed for FY 2025-26 and launched July 1st, 2025
 - Reimbursement for Certified Medical Assistant training was added to the program
 - 16 organizations expressed initial interest in the program
 - The application period closed September 29th, 2025
 - Received \$2,135,375 in requests
 - 13 Applications received (only those eligible)
 - \$1,975,375 eligible for funding

- The I&R team met with the PRI Evaluation Work Group to coordinate the evaluation process of applications received and presented the recommendations to applicable Senior Leadership which approved \$1,890,375 in requests
- Applicants were notified of funding decisions, and the MOU process initiated for all awardees
- FY 2024-25 and FY 2025-26 overview of funding:

Awards Funded	FY 2024-25	FY 2025-26
MD/DO	3	8
OB/GYN	3	0
NP/PA	8	2
BH	5	4
Community Health Workers	34	127
Medical Assistants	Not applicable	4
Bilingual Positions	6	4
Housing Relocation	0	1
Total Awarded*	\$1,905,750	\$1,890,375

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

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

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

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

- Scholarships are intended to offset costs related to the following:
 - Medi-Cal Provider Application and Validation for Enrollment (PAVE)
 - Contracting and credentialing with the Alliance
 - Continued education, training, and administrative and operational support required to be a Doula
- FY 2024-25 Program highlights:
 - Scholarships of up to \$1,000 per person were available for Doulas both intending to contract with the Alliance and Doulas already contracted with the Alliance
 - MOUs for the 20 scholarship awardees were signed, including seven (7) awards to support currently contracted Doulas and 13 awards for Doulas that intend to contract with the Alliance
 - \$15,000 of the available \$20,000 in scholarships has been paid to program participants for completion of scholarship deliverables
 - One (1) awardee withdrew from the program and one (1) awardee indicated they would not complete the deliverables required for their final payment
- FY 2025-26 Program status:
 - I&R and Health Care Services launched a new funding cycle on October 31st, 2025
 - \$40,000 is available for Doulas that intend to contract with the Alliance with \$8,500 earmarked for outstanding deliverables from the FY 2024-25 program
 - \$5,000 in scholarships has been paid through December 2025 to program participants for completion of scholarship deliverables
 - 14 applications have been selected for funding to date, and the MOU process initiated
 - 33 applications are under review as of the December 31st deadline

Grant Program Updates

- The Incentives and Reporting (I&R) team implemented a grant management software system, Submittable, to support the various grant and incentive programs the Alliance participates in
 - Submittable creates an online application process for community partners, an electronic evaluation process, reporting for fund management, and awardee deliverable tracking
 - The Alliance is working with Submittable to create a dashboard to manage and track program related deliverables, including fund distribution
 - Project activities kicked off on September 24th, 2025, and the final mockup of the dashboard is under review

- California Improvement Network – the Alliance was selected, along with 24 other partners, to participate in an opportunity through the California Improvement Network (CIN), which is a learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading good ideas, and implementing improvements
 - CIN participation provides the Alliance with an opportunity to partner and connect with other organizations that are also working to improve health equity
 - The Director, Health Equity is participating in the equity focused learning network and leading project initiatives; I&R provides program management support
 - The Alliance received a \$4,500 grant to cover costs related to travel for participating in program activities; the grant award was received on September 22nd
 - Participants of the CIN project were invited to apply for an Action Project award to support implementation efforts for partners
 - An application for a \$20,000 CIN Action Project grant was submitted on behalf of the Health Equity team on August 21st, and the Alliance was notified that the application was accepted on October 1st, 2025
 - The grant agreement with the California Health Care Foundation (CHCF) was fully executed on October 30th, 2025; the project's goals are to support efforts to improve Well Child-Care visits and immunization rates and decrease maternal depression for Black members through group classes with integrated pediatric visits
 - This project will be led by Dr. Simms-Mackey at Alameda Health System (AHS) with support from Health Equity
 - An MOU that outlines expectations and program requirements for the partnership was signed November 19th; the Alliance has provided payment to AHS Foundation to support this work
- The First 5 Alameda County was awarded a grant for \$1.1M, and the MOU related to the work, was fully executed in December 2025 for activities through June 2026

Incentive and Grant Program Descriptions

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

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



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Integrated Planning

Ruth Watson

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

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

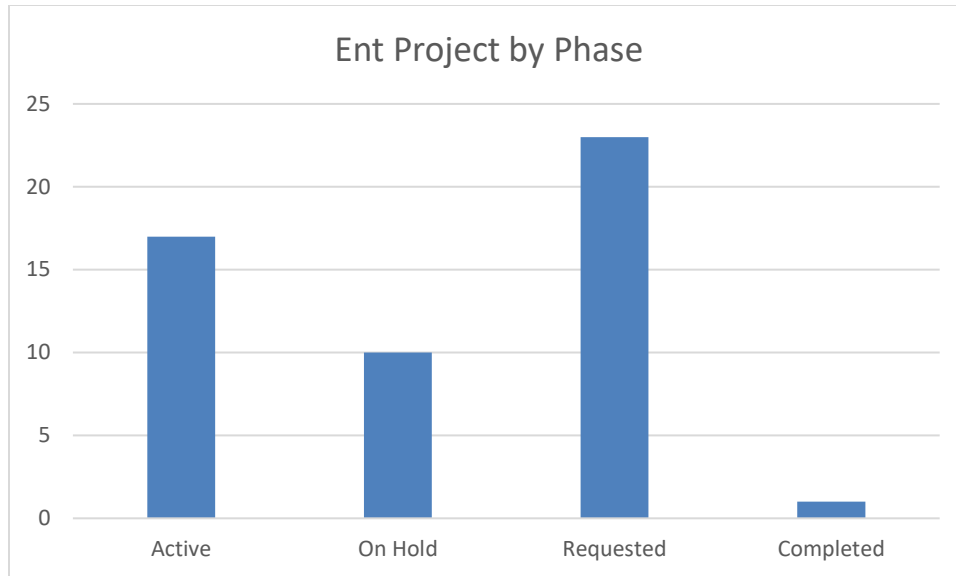
The Provider Recruitment Initiative (PRI) – program launched on June 1st, 2024, and is designed to provide grants to support the Alameda County Safety Net and community-based organizations to hire and retain healthcare professionals who serve the Alameda County Medi-Cal population. The PRI aims to grow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

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

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

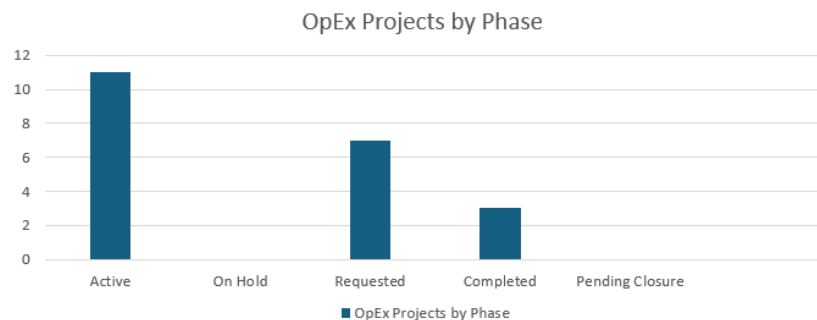
Integrated Planning

- 50 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
 - 17 Active projects (discovery, initiation, planning, execution, warranty)
 - 10 On Hold projects
 - 23 Requested and Approved Projects
 - 1 Completed Projects (Last month)



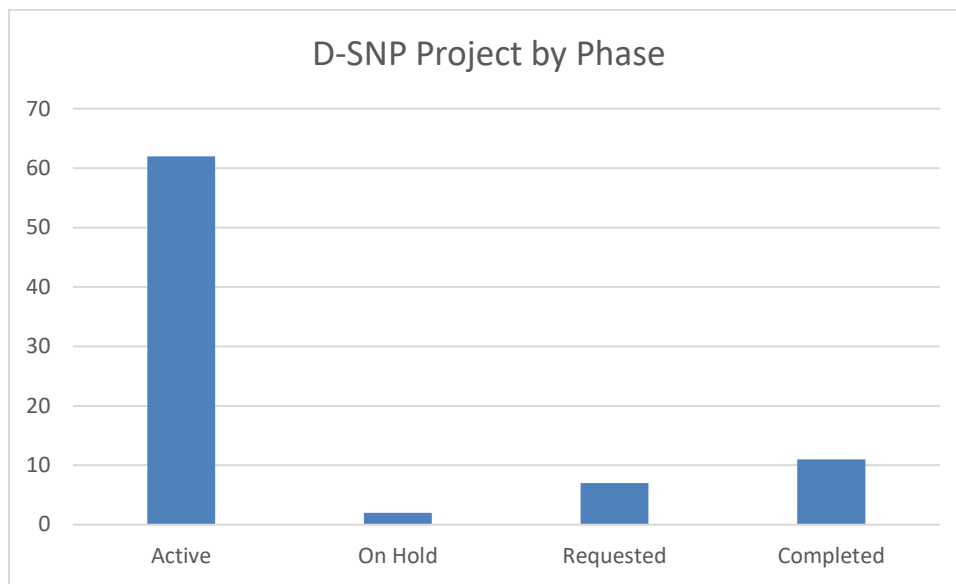
- Operational Excellence (OpEx) Portfolio

OpEx Portfolio Stats



- 17 projects currently on the Alameda Alliance for Health (AAH) OpEx portfolio
 - 11 Active projects (discovery, initiation, planning, execution, warranty)
 - 0 On Hold projects
 - 7 in Request Stage
 - 11 Approved Projects
 - 3 Completed Projects
 - 0 Pending closure

- D-SNP Portfolio
 - 71 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
 - 62 Active projects (discovery, initiation, planning, execution, warranty)
 - 2 On Hold
 - 7 Requested Projects
 - 11 Completed in Total



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

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

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

- 01 – Provider Services & Contracting:
 - Provider Contracting
 - Continued outreach to AAH provider network to complete the execution of the D-SNP Provider Amendments.
 - As of December 23rd, 306 contracts are fully executed, which equates to 88% completion.
 - The following D-SNP Hospital, IPA, and Lab amendments are fully executed.

- AHS Hospital
 - St. Rose Hospital
 - Stanford Valley Care Hospital
 - CHCN Medical Group
 - Foundation Labs
 - Central Valley Specialty Hospital
 - Kentfield Hospital
 - Sonoma Specialty Hospital
 - Valley Care (Tri Valley Stanford) Hospital
 - WHHS
 - Network adequacy increased by 5.2%, raising it to 97.1%
- Provider Services
 - On December 18th, the following D-SNP changes were deployed to production.
 - Provider Portal
 - PDF Fillable Forms (Authorization / Referral, Care Plan)
 - Provider Toolkit
 - Provider Directory
 - Printed
 - Continued refinement of pharmacy data and generation of new iterations of the printed directory.
- Provider Rates and Reimbursement
 - Continued development of the Pay4Performance (P4P) program.
- 02 – Quality:
 - Model of Care
 - MOC has been approved by both DHCS and CMS.
 - 96.25% earning three (3) year approval.
 - MOC Provider Training – Deck is completed and in Articulate – Content converted to Azure and URL developed for website. Communication and Outreach to upload to website by 12/5/2025.
 - MOC Internal Training – Has been launched to staff with completion due date of 12/19/2025.
 - Process created to incorporate changes into annual MOC updates.
 - Quality Program
 - Quality Improvement Health Equity P&Ps are completed and updates incorporated.
 - 52 policies – Completed committee reviews.
 - Quality Workplan
 - Core Metrics Dashboard for reporting created to align across multiple Quality, HCS, and Stars initiatives. All edits incorporated. Business owners are being identified.

- Developing BRDs for reporting requirements related to QI Workplan to align with above.
 - Next steps are to submit Analytics Request for reports.
- Establishing New Committees:
 - New D-SNP Utilization Management committee will align with QIHEC committee members and cadence. Awaiting final signoffs for structure.
 - Templates being developed to document meeting agenda, minutes, and attendees for D-SNP.
 - D-SNP Community Advisory Committee will be combined as a joint Medi-Cal and DSNP committee. Efforts continue to identify community members that will represent D-SNP population.
 - Charter redlines have been completed (Seven Quality Committees) and are in various stages of committee approval.
- 03 - Health Care Services (HCS) and 04 - Behavioral Health (BH):
 - All policies are complete and under committee review. (130 policies). Awaiting final AOC and in alignment to have all policies approved during this session.
 - CM policies have been revised and drafted and under committee review. Final approvals awaiting AOC.
 - UM policies moving through committee reviews. Final approvals awaiting AOC.
 - UM Committee Charter presented at UMC on 09/24/2025. Revised to include D-SNP as a new service line.
 - Finalizing reporting requirements for UM, CM, and BH. Creating analytics requests and workflows. This is part of the Core Metrics Dashboard for Reporting Project.
 - UM and CM letter inventory complete and under final review by C&O.
 - Program Descriptions for UM and CM have been rolled out to Q1 2026. MOC will act as PD until revisions are made. Prior authorization code list has been finalized. The combined PA Code List + Benefit Criteria grid includes all 3 lines of business.
 - HRA Implementation Workgroup ongoing with Cotiviti. Identifying and defining data feeds/elements and assessment administration.
 - Defining key components of how data will be exported from AAH to Cotiviti and how data will be ingested into TruCare from Cotiviti.
 - Cotiviti is in the process of configuring HRA and testing is underway for data transfer into TruCare.
 - HRA Cotiviti scripts continuing to be finalized. Adult script is final for D-SNP.
 - Future State D-SNP CM Global Workflow complete – Continuing to define structure and new net processes for California Integrated

Care Management (CICM) to include new requirements outlined in the CY2026 Program Guide.

- D-SNP CM Assessment/HRA mapping to care plan for rules generation.
 - All CM assessments are completed and mapped in TruCare. Business rules for authorizations have been configured and tested. Finalizing Tru-Care Core Feeds SRD.
 - UM customer set up requirements for configuration has been finalized and configured into TruCare.
 - BH CM – D-SNP CM program structure has been finalized and will mirror PH CM.
 - BH workflows for UM and CM are complete.
 - Workflow was established to coordinate Medicare non-covered services with Alameda County Behavioral Health (ACBH).
 - BH programs policy and procedure development and revisions complete and approved in committees.
 - BH call flows are completed to include intersections with Member Services.
 - Completed edits for D-SNP Member and Provider letters; additional letters created to support CMS and DHCS requirements.
 - Risk Stratification model alignment with Medi-Cal model. First RSS deployment will occur 1/25/2026.
 - Framework for identification of populations of focus for CICM, Palliative Care, and Most Vulnerable Populations have been completed and will deploy with RSS.
 - BH UM – additional levels of care established for D-SNP population and configured in TruCare.
 - Training continues for UM, CM and BH staff.
 - Continuing to develop SOPs.
- 05 – Finance:
 - 5C – Financial Reconciliation and Reporting
 - Continued development of required D-SNP reporting for CMS and internal reporting
- 06 – Product:
 - 6A – Bid and Benefit Design
 - Training sessions are being scheduled with supplemental benefit vendors to enhance organizational knowledge and deepen expertise.
 - 6C – Enrollment and Eligibility
 - Continued monitoring of the enrollment confirmation files (DTRR) from CMS.
 - Continued enrollment letter fulfillment monitoring following receipt of CMS's enrollment file confirmation (DTRR).
 - 6J – Liberty Dental

- Enrollment file (834) full file and delta file testing is completed.
 - AAH shared production eligibility (834) files and Liberty Dental successfully loaded files into their environment.
 - SSO integration scope identified for D-SNP AAH members to transition from AAH member portal to Liberty Dental portal to view claims. Liberty Dental and mPulse completed implementation. Validation is pending to confirm this functionality in the Production environment.
 - Member Communication Letter templates shared with Utilization Management (UM) Team and Claims Business Team – sign-off complete.
 - Training materials are in development for internal staff. Meeting will be scheduled in early January to educate AAH resources on Dental benefits offered.
 - Gap analysis underway to identify potential additions to Liberty network.
- 07 – Compliance:
 - DMHC Contract Filing – VSP (Filing # 20253841)
 - Third DMHC comment table received and responses submitted.
 - D-SNP Compliance Policies – all remaining policies were approved at AOC.
 - 08 - Operations (Claims / Member Services / Mailroom / IVR):
 - 8A – Claims
 - Continued HEALTHsuite configuration for all D-SNP provider amendments and new contracts.
 - Deployment of HEALTHsuite configuration supporting D-SNP claims processing.
 - 8B – Member Services / Call Center / IVR
 - Completed Call Center and Member Services D-SNP Training.
 - Member Portal D-SNP changes were deployed to production.
 - Member Services Call Center Phone Tree and Scripts were deployed to production.
 - 8H – Policies, SOPs, and KPIs
 - Claims SOPs in process.
 - KPI review and development for Claims and Member Services.
 - 09 – Sales:
 - 9A – Sales Implementation
 - JD approved for second sales agent, targeting hire early mid-January.

- Interview process started for Medicare Field Sales Agent (bilingual).
- Target enrollments set for each partnered FQHC (20 member enrollments per site by 1/1/2026).
- Continued development of Standard Operating Procedures, completion date set to 1/1/2026.
- Continued development of Cirrus reporting dashboards for enrollment and retention data.
- Translation of all sale scripts in threshold languages.
- Finesse “agent queue” functionality initiated.
- PerformRx enhancements requested.
- 9D – Medicare Marketing & Brand Strategy
 - CMS 1/1 Required Materials: All content is on track and scheduled to be published on the Alliance D-SNP public website for the 1/1 launch.
 - Member Materials: Welcome Kit and ID Card mailing materials have been filed with CMS, tested, programmed, and distributed to new members as of mid-December. Ongoing monthly kits and ID cards will continue to be sent to newly enrolled members.
 - Provider Resources: Provider Tool Kit materials are complete and available on the new Provider D-SNP public-facing website as of mid-December, and providers have been notified that kit is available.
- 9E – Retention
 - Continued development of retention reporting dashboard.
- 10 – Pharmacy:
 - PBM Technical and Operational workgroup meetings are in progress. Topics covered in the month of November include Part B Medical Directors scope with denial determinations, UM processes, letters, various report ingestions for the health plans and CMS reporting processes.
 - M3P program in AAH will be managed by Echo; contract amendment is complete. Program scope and project plan development has initiated.
 - CMS Part D Model materials and letters are under review with Pharmacy and C&O teams. English versions have been delivered and translations into threshold languages are complete.
 - MTM program will be implemented during the first quarter or when complete billing report is in receipt by the health plan.
 - Eligibility test files shared with both PerformRx and Outcomes to support vendor configuration activities. Revisions to test files for both vendors have been shared to correct errors in the initial test files. Currently in review with PerformRx and Outcomes.
 - AAH will delegate Part D appeals to the PBM and AAH will own Part D grievances; contract amendment is complete.

- D-SNP Policies and Procedures are complete and approved.
 - Development of standard operating procedures for D-SNP is in progress.
 - D-SNP KPIs and reporting decisions have been completed by the pharmacy team.
 - Warm transfer process for pharmacy call from member services and pharmacy team is in discussion.
 - Development and documentation of Other Health Insurance (OHI) process in progress when checking eligibility and processing determinations.
 - Development and documentation of Best Available Evidence (BAE) process are in progress as it pertains to completing a Medical Necessity process and final determinations.
- 13 – Health Equity:
- Policies approved and completed for D-SNP.
 - SOPs completed for Quality and HE initiatives.
 - Phase 2 of plan to develop monitoring processes and procedures that HE team will oversee.
 - Gaps analysis completed and reviewed with workgroup. Interventions provided for D-SNP Health Equity Launch 01/01/2026. Working with business owners to establish responsibly.
 - Health Equity Workplan for quality improvement interventions drafted and approved.
 - Oversight policy and procedure 1st draft and workgroup review complete.
- 15 - Grievance and Appeals:
- Development of Standard operating procedures and KPI reporting for D-SNP in process.
 - CMS five (5) levels of appeal are configured in QualitySuite.
 - No CTMs received during the Annual Enrollment Period (AEP).
 - The G&A team in collaboration with Analytics are currently developing reporting requirements.
- 16 – IT:
- **TruCare:** Program is 92% complete. Core feeds (Member, Provider and Network) development completed and deployed into Production environment as a part of 12/20 weekend deployment window
 - An issue was identified that “in-network” indicator is changing based on the service start date. Authorizations are being processed incorrectly based on this factor. AAH IT and Zyter (TruCare) teams are collaborating to confirm solution to this issue. There is a possibility that there is a discrepancy between Provider Repository and TruCare platform; D-SNP go-live on 1/1/26 is a priority. Post-fix

audit to be planned (after January 2026) to assess impact of incorrect data (for example, wrong approvals/denials of authorizations). This will be handled as a part of Operations as this is an existing issue in Production environment.

▪ **HEALTHsuite:**

- 415 provider contracts signed by Network Contracting Team are in the process of being loaded. IT will load completed contracts by 1/1. Any Contract changes will be updated after 1/1 go-live.
- Updates to Pre-processor to enhance the flow of authorization data from the authorization system (TrueCare) to the Claim System (HEALTHsuite). The focus is on resolving current issues with D-SNP Medicare authorizations, particularly those for noncovered services that should be processed under Medi-Cal contracts. This code is on track to be deployed into Production before 1/1 go-live.
- RAM is planning to deploy below patches in preparation for 1/1 go-live
 - 8382950: Updates to the CMS MARx Batch Submission file layout (TC 61/92).
 - 8386746: DTRR Data File Detail Record.
 - 8385914: HPMS: Online Enrollment Center (OEC) Record Layout Changes for Enrollments Received on or After January 1st, 2026.
 - 8375797: Enable HealthSuite to Pay Based on Authorized services vs. billed services.
 - 8380878: APG creating duplicate providers.
 - 8380862: Create a process to Pay Ambulance claims with modifier G or J in any position it should be paying 77% of the fee schedule.

▪ **QualitySuite:**

- Grievance module and CTM module deployment completed and validated. Actively working with Business resources to start closing out this workstream and handover to Operations for support.
- 16B – Enrollment Process & Nations Benefits / D-SNP Member Incentives Implementation.
 - Cirrus production deployment for D-SNP enrollment was completed on 9/19/25.
 - Identification of D-SNP Member Incentives scope and requirements development.
 - Mitigation decision confirmed to use KP Corp to support Farsi translation of member letters.
 - Confirmed Decision: Sales OCR will be deferred until after AEP (10/15/2025).

- 17 – Stars and Risk Adjustment:
 - Optum and Episource implementation is underway to support Risk Adjustment CMS submissions and analytics.
 - Encounter Data Submissions to CMS begin February 2026.
 - Episource Analyst go live scheduled March 2026.
 - 3 Risk Adjustment Policy & Procedures approved by AOC and 2 are in progress.
 - Phase 1 of Star strategy:
 - Identified initiatives for the HEDIS measures supported in the Medi-Cal line of business and Operational measures that will impact Star ratings on Day 1.
 - Aligning interventions to Quality Workplan.
 - Process flow documentation for the measures is underway with Quality, Health Care Services, and Analytics. We will plan to implement foundational initiatives to support Star gap closure.
 - TruCare Star gap integration in process to track Admission, Discharge, and Transfer Star measures.
 - Pay-for-Performance and Pay-for-Reporting program – Measure scope has been finalized. Confirmed with CHCN that they will not have their own P4P Program.
 - Data feeds – This is already in production and will be slightly modified to ensure support for D-SNP measures.
 - Prospective Chart Review – This is already in production and will be slightly modified to ensure support for D-SNP measures.
 - Stars Education – Internal and external training to provide a clear understanding of how Star measures impact quality ratings. Internal training with key departments has been completed. Organizational training has been drafted, and it is with the appropriate teams to prepare for launch External training and quality discovery sessions with CHCN Clinic SMES have been completed.
 - Provider facing Stars and Risk tips and best practices documentation development is in progress.
 - We plan to implement operational initiatives to support Star gap closure.
 - Concierge Care Gap Closure Program – Beginning development of a member/provider outreach program for members with 2+ care gaps. Currently documenting the internal member touchpoints we have as an organization to reduce member abrasion.

- Awareness Campaign – Development of the Welcome Postcard with a checklist of preventative screenings is in final stages.
- Preventive Physical Exam (IPPE) & Annual Wellness Visit (AWV) – Discussions continued to ensure providers are engaged in the development of the IPPE & AWV program to ensure members are seen for gap closure and accurate diagnosis capture.
- Individual sessions with each clinic have been completed. Clinics were introduced to new Star measures, discovery into clinical workflows, and HEDIS measures interventions that align with Star measures.
- Star measure tip sheets and best practice documents are being developed to support providers at the point of care.
- Member incentive program in development with Nations to promote gap closure for Star measures. This program is to be launched on January 1st, 2026.

- **CalAIM Initiatives:**

- Community Supports (CS)
 - Due to Budget Constraints, all CS enhancements and/or expansions are on hold.
- Justice-Involved (JI) Initiative:
 - CalAIM Re-entry (TDX: 1539): Project on hold pending direction from the State.
 - Correctional facilities go-live date for pre-release services is determined based on DHCS readiness assessment and will go-live with pre-release services within a 24-month phase in period (10/1/2024 – 9/30/2026).
 - Santa Rita Jail is targeting to go-live on 7/1/2026 with pre-release services; Juvenile Justice Center's go-live is TBD.
 - Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of October 1st, 2024, even if facilities in their county will go-live later.
 - JI project team is developing a contact list for the counties going live with pre-release to support coordination of referrals for any AAH members being released from these counties.
 - DHCS has indicated they intend to release a revised JI Policy Guide; impacts to project scope and schedule will be assessed once this is released.
 - DHCS JI Learning Collaboratives initiated in August 2024 and continues through January 2025. These collaborative sessions include correctional facilities, county behavioral health agencies, probation, managed care plans, and ECM providers.

- On 10/28/24, AAH SLT approved to place CalAIM JI Re-Entry project on hold until July 2025 to await final policy guide from DHCS and give Alameda County partners time to develop their internal processes and readiness.
- CYBHI Fee Schedule (TDX: 4186): Project on hold pending direction from the State.
 - Effective January 1st, 2024, the Alliance is partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule.
 - Cohort 1 is intended to be a “learning” cohort.”
 - The Alliance was not selected to participate in the permanent ASO Model and will participate in an interim solution until further notice from Carelon and DHCS.
- MOU
 - Interim Model MOU has been executed by AAH CEO 4/29/2025 and returned to Carelon.
 - AAH Finance Team shall receive Invoice File from Carelon for billing purposes via secured file transfer process and process payments manually.
 - This includes checking member eligibility internally to deliver payments when services have been rendered.
 - SFTP File Exchange template executed and resubmitted to Carelon 6/2/2025.
 - Banking information with Carelon has been established and ready for invoice payments.
 - Final stages of testing data with Carelon and DHCS.
 - Test file from Carelon via SFTP picked up successfully.
 - Project Close Activities
 - Upon completion of file transfer validation, the AAH business stakeholders propose closing this project.
 - Anticipate project close in June 2025.
 - Warranty period through end of July to monitor stabilization of potential incoming invoices.

Supporting Documents Project Descriptions

- Key projects currently in-flight:
 - California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs.
 - Enhanced Care Management (ECM) – ECM will target eight (8) specific populations of vulnerable and high-risk children and adults.
 - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022
 - Two (2) additional PoF became effective on January 1st, 2023

- One (1) PoF became effective on July 1st, 2023
 - Two (2) PoF became effective on January 1st, 2024
- Restarting in July 2025 – Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release.
 - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative.
 - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024.
 - MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by October 1st, 2024.
 - Correctional facilities will have two years from 10/1/2024-9/30/2026 to go live based on readiness.
- Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary.
- CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed and a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site. CYBHI requires commercial health plans and the Medi-Cal delivery system, as applicable, to reimburse, at or above the published rates, these school-linked providers, regardless of network provider status, for services furnished to students pursuant to the fee schedule. Effective January 1st, 2024, the Alliance is partnering with the Alameda County Office of Education (ACOE) and several Local Education Agencies (LEAs) who were selected to participate in the CYBHI Fee Schedule Cohort 1.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	December 2025
Incoming Calls (R/V)	18,094
Abandoned Rate (R/V)	1%
Answered Calls (R/V)	17,831
Average Speed to Answer (ASA)	00:07
Calls Answered in 30 Seconds (R/V)	98%
Average Talk Time (ATT)	06:38
Calls Answered in 10 minutes	100%
Outbound Calls	8,986

Top 5 Call Reasons (Medi-Cal and Group Care) December 2025

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

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) December 2025

Change PCP
ID Card Requests
Update Contact Information

Member Services Behavioral Health	December 2025
Incoming Calls (R/V)	944
Abandoned Rate (R/V)	1%
Answered Calls (R/V)	935
Average Speed to Answer (ASA)	00:13
Calls Answered in 30 Seconds (R/V)	94%
Average Talk Time (ATT)	08:52
Calls Answered in 10 minutes	100%
Outbound Calls	1,294
Screenings Completed	89
ACBH Referrals	28
SUD referrals to Center Point	18

Blended Call Results

DSNP Blended Results	December 2025
Incoming Calls (R/V)	494
Abandoned Rate (R/V)	483
Answered Calls (R/V)	3%
Average Speed to Answer (ASA)	00:06
Calls Answered in 30 Seconds (R/V)	100%
Average Talk Time (ATT)	06:33
Calls Answered in 10 minutes	100%

Top 5 Call Reasons (D-SNP) December 2025
Eligibility/Enrollment
Benefits/Org Determinations
Grievances/Appeals
Change PCP
Provider Network Information

Claims Department
November 2025 Final and December 2025 Final

METRICS

Claims Compliance	Nov-25	Dec-25
90% of clean claims processed within 30 calendar days	85.5%	81.1%
95% of all claims processed within 45 working days	99.7%	89.8%
Claims Volume (Received)	Nov-25	Dec-25
Paper claims	33,837	43,060
EDI claims	315,215	277,267
Claim Volume Total	349,052	320,327
Percentage of Claims Volume by Submission Method	Nov-25	Dec-25
% Paper	9.7%	13.4%
% EDI	90.3%	86.6%
Claims Processed	Nov-25	Dec-25
HEALTHsuite Paid (original claims)	227,993	276,032
HEALTHsuite Denied (original claims)	73,395	142,691
HEALTHsuite Original Claims Sub-Total	301,388	418,723
HEALTHsuite Adjustments	4,635	5,525
HEALTHsuite Total	306,023	424,248
Claims Expense	Nov-25	Dec-25
Medical Claims Paid	\$134,421,366	\$149,281,494
Interest Paid	\$115,290	\$173,533
Auto Adjudication	Nov-25	Dec-25
Claims Auto Adjudicated	257,501	380,455
% Auto Adjudicated	85.4%	90.9%
Average Days from Receipt to Payment	Nov-25	Dec-25
HEALTHsuite	16	50
Pended Claim Age	Nov-25	Dec-25
0-30 calendar days	35,561	37,006
HEALTHsuite		
31-61 calendar days	25,920	29,187
HEALTHsuite		
Over 62 calendar days	47,909	780
HEALTHsuite		
*Pended claims over 62 days are high due to investigation of 3 providers for FWA		
Overall Denial Rate	Nov-25	Nov-25
Claims denied in HEALTHsuite	73,395	142,691
% Denied	24.0%	33.6%

Claims Department

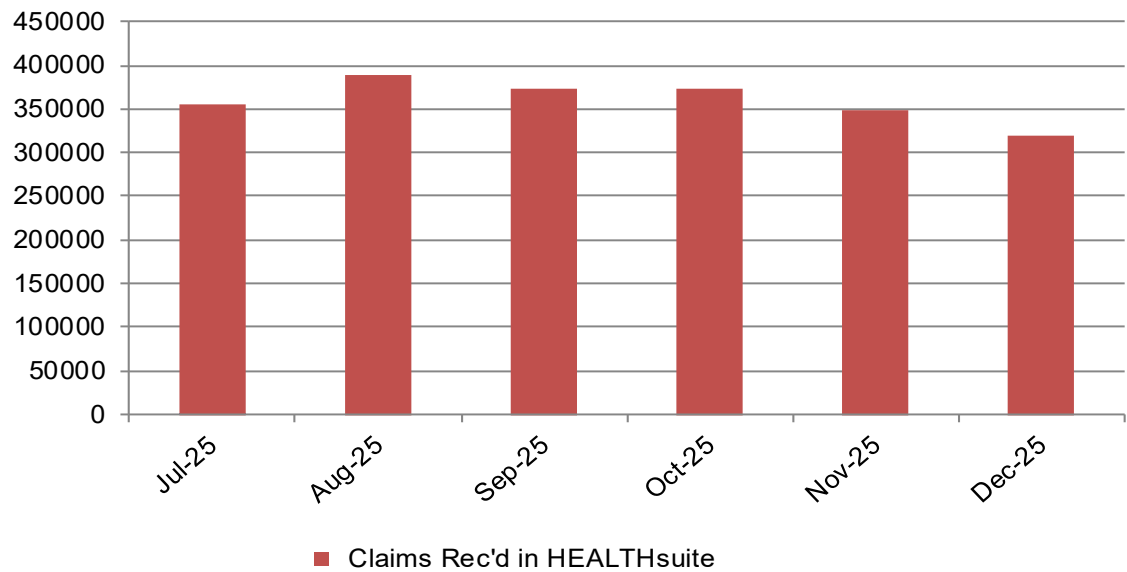
November 2025 Final and December 2025 Final

Dec-25

Top 5 HEALTHsuite Denial Reasons	% of all denials
Claim Denied- Provider Under Investigation For Potential Fraud, Waste Or Abuse	27%
Responsibility of Provider	16%
Non-Covered Benefit For This Plan	10%
Must Submit Paper Claim With Copy of Primary Payor EOB	9%
No Benefits Found For Dates Of Service	9%
% Total of all denials	71%

Claims Received By Month

	8/1/2025	9/1/2025	10/1/2025	11/1/2025	12/1/2025	1/1/2026
Claims Received Through	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Claims Rec'd in HEALTHsuite	355,255	389,082	373,025	372,246	349,052	320,327



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing December 2025 to December 2024 as follows: 30 Days - 81.1% (2025) vs 90.2% (2024) 45 Days - 89.8% (2025) vs 99.3% (2024) 90 Days - 99.9% (2025) vs 99.9% (2024)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 320,327 claims in December 2025 vs 332,108 in December 2024	N/A	N/A
EDI - the volume of EDI submissions was 87% which falls within the normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 328,733 in December 2025 (22 working days) vs 319,749 in December 2024 (20 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in December 2025 was \$149,281,494 (5 check runs) vs \$119,016,631 in December 2024 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in December 2025 was \$173,533 vs \$105,882 in December 2024	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in December 2025 was 90.9% vs 88.7% in December 2024	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in December 2025 was 50 days vs 14 days in December 2024	N/A	<= 25 days
Pended Claim Age - comparing December 2025 to December 2024 as follows: 0-30 calendar days - 37,006 (2025) vs 64,568 (2024) 31-61 calendar days - 29,187 (2025) vs 29,816 (2024) Over 62 calendar days - 780 (2025) vs 778 (2024) *Pended claims over 62 days are high due to the investigation of 3 providers for FWA	N/A	N/A
Top 5 Denial Reasons - the claim denial reasons remain consistent from month to month so there is no significant changes to report from December 2025 to December 2024	N/A	N/A

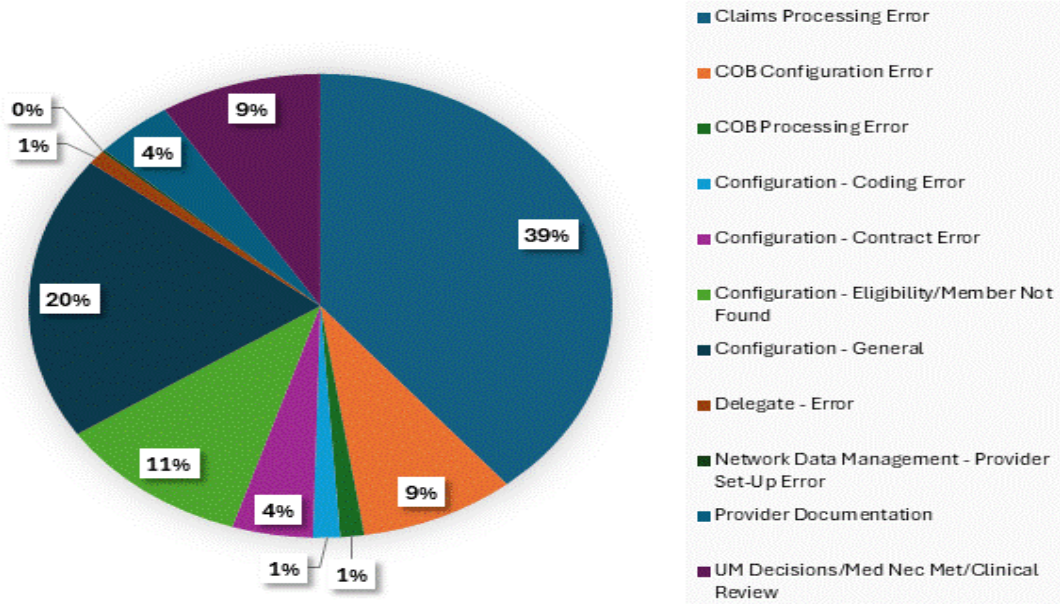
Provider Dispute Resolution		
November 2025 and December 2025		
METRICS		
PDR Compliance	Nov-25	Dec-25
# of PDRs Resolved	2,677	3,493
# Resolved Within 45 Working Days	2,666	3,467
% of PDRs Resolved Within 45 Working Days	99.6%	99.2%
PDRs Received	Nov-25	Dec-25
# of PDRs Received	2,543	3,121
PDR Volume Total	2,543	3,121
PDRs Resolved	Nov-25	Dec-25
# of PDRs Upheld	1,956	2,890
% of PDRs Upheld	73%	83%
# of PDRs Overturned	721	603
% of PDRs Overturned	27%	17%
Total # of PDRs Resolved	2,677	3,493
Average Turnaround Time	Nov-25	Dec-25
Average # of Days to Resolve PDRs	40	42
Oldest Resolved PDR in Days	240	183
Unresolved PDR Age	Nov-25	Dec-25
0-45 Working Days	5,676	4,600
Over 45 Working Days	0	0
Total # of Unresolved PDRs	5,676	4,600

Provider Dispute Resolution November 2025 and December 2025

Dec-25

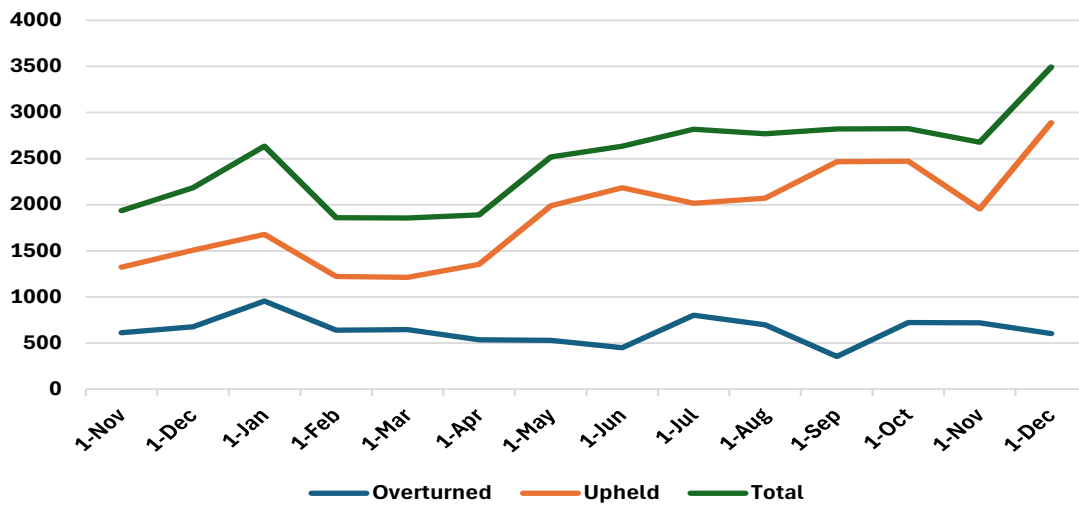
PDR Resolved Case Overturn Reasons

December 2025



Rolling 12-Month PDR Trend Line

December 2025



Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Resolved - 3,493 in December 2025 vs 2,185 in December 2024	N/A	N/A
# of PDRs Received - 3,121 in December 2025 vs 3,173 in December 2024	N/A	N/A
# of PDRs Resolved within 45 working days - 3,467 in December 2025 vs 2,182 in December 2024	N/A	N/A
% of PDRs Resolved within 45 working days - 99.2% in December 2025 vs 99.9% in December 2024	95%	95%
Average # of Days to Resolve PDRs - 42 days in December 2025 vs 42 days in December 2024	N/A	30
Oldest Resolved PDR in Days - 183 days in December 2025 vs 118 days in December 2024	N/A	N/A
# of PDRs Upheld - 2,890 in December 2025 vs 1,508 in December 2024	N/A	N/A
% of PDRs Upheld - 83% in December 2025 vs 69% in December 2024	N/A	> 75%
# of PDRs Overturned - 603 in December 2025 vs 677 in December 2024	N/A	N/A
% of PDRs Overturned - 17% in December 2025 vs 31% in December 2024	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 39% (2025) vs 36% (2024) Configuration errors - 37% (2025) vs 35% (2024) COB - 10% (2025) vs 7% (2024) Clinical Review/UM Decisions/Medical Necessity Met - 14% (2025) vs 12% (2024)	N/A	N/A

Provider Relations Call Center Dashboard December 2025

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10,977	8,885	8,303	8,709	7,861	9,214	9,330	8,838	8,883	8,307	7,019	8,547
Abandoned Calls	3,600	1,133	1,434	1,685	1,254	2,245	1,545	1,857	2,089	1,504	1,688	2,159
Answered Calls (PR)	7,377	7,752	6,869	7,024	6,607	6,969	7,785	6,981	6,794	6,803	5,331	6,388
Recordings/Voicemails	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (R/V)	2,910	2,140	13	15	12	6	14	9	5	5	10	14
Abandoned Calls (R/V)												
Answered Calls (R/V)	2,910	2,140	13	15	12	6	14	9	5	5	10	14
Outbound Calls	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Outbound Calls	868	1,162	434	602	570	520	693	650	669	382	344	441
N/A												
Outbound Calls	868	1,162	434	602	570	520	693	650	669	382	344	441
Totals	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Incoming, R/V, Outbound Calls	14,755	12,187	8,750	9,326	8,443	9,740	10,037	9,497	9,557	8,694	7,373	9,002
Abandoned Calls	3,600	1,133	1,434	1,685	1,254	2,245	1,545	1,857	2,089	1,504	1,688	2,159
Total Answered Incoming, R/V, Outbound Calls	11,155	11,054	7,316	7,641	7,189	7,495	8,492	7,640	7,468	7,190	5,685	6,843

Provider Relations Dashboard December 2025

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.1%	5.8%	5.4%	5.0%	5.2%	5.4%	5.7%	5.3%	6.3%	5.0%	4.9%	5.9%
Benefits	5.1%	3.7%	3.4%	3.9%	6.4%	3.4%	3.2%	3.3%	2.9%	3.6%	4.4%	4.2%
Claims Inquiry	39.4%	43.9%	43.7%	46.3%	47.7%	48.5%	46.8%	45.2%	42.1%	41.2%	39.7%	41.1%
Change of PCP	2.5%	2.7%	2.4%	2.9%	2.8%	2.0%	2.2%	1.9%	2.5%	2.6%	2.4%	2.3%
Check Tracer	0.7%	0.6%	1.0%	0.9%	0.7%	1.0%	0.6%	0.6%	0.6%	0.8%	0.5%	0.7%
Complaint/Grievance (includes PDRs)	5.8%	6.7%	6.8%	6.5%	7.6%	7.1%	8.6%	9.1%	9.8%	11.3%	10.2%	11.4%
Contracts/Credentialing	0.8%	0.8%	0.7%	0.8%	0.8%	0.8%	0.8%	0.8%	0.9%	1.0%	0.7%	0.6%
D-SNP Enrollment	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0%	0.0%	0.0%
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	21.0%	17.4%	17.0%	17.9%	16.5%	17.2%	16.3%	17.7%	18.8%	17.0%	21.0%	21.9%
Exempt Grievance/ G&A	0.0%	0.1%	6.8%	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	11.2%	0.2%	0.0%
General Inquiries	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%	0.5%	0.6%	0.4%	0.4%	0.4%	0.4%	0.5%	0.5%	0.5%	0.3%	0.2%
Provider Portal Assistance	3.4%	3.2%	3.9%	3.4%	3.4%	3.4%	3.6%	3.9%	3.9%	3.2%	3.7%	3.4%
Pharmacy	0.1%	0.2%	0.1%	0.0%	0.1%	0.1%	0.0%	0.2%	0.2%	0.1%	0.1%	0.0%
Prop 56	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%
Provider Information Updates/ W9	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%	0.1%	0.3%
Transportation Services	0.0%	0.2%	0.2%	0.2%	0.3%	0.1%	0.1%	0.2%	0.1%	0.2%	0.1%	0.1%
Transferred Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.2%
All Other Calls	15.5%	14.4%	7.9%	11.4%	7.9%	10.4%	11.2%	11.1%	11.2%	2.1%	11.6%	7.5%
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%

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	28	72	89	54	60	41	48	25	77	64	30	32
Contracting/Credentialing	29	41	50	59	150	66	53	51	88	61	45	49
Drop-ins	127	83	141	146	149	96	220	189	227	189	74	95
JOM's	2	2	3	2	3	1	3	1	2	4	2	0
New Provider Orientation	100	134	118	173	143	182	154	102	132	148	142	162
Quarterly Visits	0	0	0	82	0	0	0	0	0	0	24	60
UM Issues	0	0	3	1	1	5	3	0	6	3	0	1
Total Field Visits	286	332	404	517	506	391	481	368	532	469	317	399

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALIAED PRACTITIONERS - December 2025											
Practitioners		PCP 400	SPEC 778	AHP 774	BH/ABA 3,617	PCP/SPEC 12					
Direct Network vs Delegated Network Breakdown			AAH 4,292	AHS 311	CHCN 616	COMBINATION OF GROUPS 362					
Facilities	458										
VENDOR SUMMARY											
Credentialing Verification Organization, Symplr CVO											
	Number		Average Calendar Days in Process	Goal - 25 Business Days*	Goal - 98% Accuracy	Compliant					
Initial Files in Process	41		4	Y	Y	Y					
Recred Files in Process	316		0	Y	Y	Y					
Expirables updated											
Insurance, License, DEA, Board Certifications						Y					
Files currently in process	357										
* 25 business days = 35 calendar days											
December 2025 Peer Review and Credentialing Committee Approvals											
Initial Credentialing	Number										
PCP	5										
SPEC	11										
ANCILLARY	7										
MIDLEVEL/AHP	9										
BH/ABA	227										
Sub-total	259										
Recredentialing											
PCP	6										
SPEC	5										
ANCILLARY	0										
MIDLEVEL/AHP	0										
BH/ABA	33										
Sub-total	44										
TOTAL	303										
December 2025 Facility Approvals											
Initial Credentialing	8										
Recredentialing	12										
Sub-total	20										
Facility Files in Process	68										
December 2025 Employee Metrics (6 FTEs)											
	Goal	Met (Y/N)									
File Processing	Timely processing within 3 days of receipt		Y								
Credentialing Accuracy	<3% error rate		Y								
DHCS, DMHC, CMS, NCQA Compliant	98%		Y								
MBC Monitoring	Timely processing within 3 days of receipt		Y								

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RECRED	CRED DATE
Abdollahi	Beta	BH-Telehealth	INITIAL	12/16/2025
Aguilar	Cynthia	BH-Telehealth	INITIAL	12/16/2025
Almirol	Jenna	ABA-Telehealth	INITIAL	12/16/2025
Amato	Michele	ABA-Telehealth	INITIAL	12/16/2025
Anderson	Lydia	ABA-Telehealth	INITIAL	12/16/2025
Andrade Diaz	Ana	ABA-Telehealth	INITIAL	12/16/2025
Aquino	Melinda	Specialist	INITIAL	12/16/2025
Arres	Veronica	BH-Telehealth	INITIAL	12/16/2025
Asgarian	Nazgol	BH-Telehealth	INITIAL	12/16/2025
Athanasios	Amira	BH	INITIAL	12/16/2025
Avitia	Guadalupe	BH-Telehealth	INITIAL	12/16/2025
Baker	Nicholas	BH-Telehealth	INITIAL	12/16/2025
Balan	Naveen	Specialist	INITIAL	12/16/2025
Barbre	Teena	BH-Telehealth	INITIAL	12/16/2025
Barker	Alyssa	Ancillary	INITIAL	12/16/2025
Barnett	Brooke	BH	INITIAL	12/16/2025
Bauer	Julie	BH-Telehealth	INITIAL	12/16/2025
Bene	Melissa	BH-Telehealth	INITIAL	12/16/2025
Bennett	Tara	BH-Telehealth	INITIAL	12/16/2025
Boeving	Samantha	ABA-Telehealth	INITIAL	12/16/2025
Bolanos-Santillan	Ginger	BH-Telehealth	INITIAL	12/16/2025
Bonatto	Justin	ABA-Telehealth	INITIAL	12/16/2025
Bowman	Alexandra	ABA-Telehealth	INITIAL	12/16/2025
Brandon	Danielle	BH	INITIAL	12/16/2025
Broberg	Janel	BH-Telehealth	INITIAL	12/16/2025
Burke	Eric	BH-Telehealth	INITIAL	12/16/2025
Byrne	Michaela	Allied Health	INITIAL	12/16/2025
Carey	Melissa	ABA-Telehealth	INITIAL	12/16/2025
Castro Serrato	Brenda	Ancillary	INITIAL	12/16/2025
Chang	Daniel	Specialist	INITIAL	12/16/2025
Chavez	Hilda	BH	INITIAL	12/16/2025
Chernick	Sarah	BH-Telehealth	INITIAL	12/16/2025
Choo	Monica	Specialist	INITIAL	12/16/2025
Chung	Joseph	BH-Telehealth	INITIAL	12/16/2025
Clark	Kayla	ABA-Telehealth	INITIAL	12/16/2025
Covington	Merline	BH-Telehealth	INITIAL	12/16/2025
Crljenica-Moad	Tasha	BH-Telehealth	INITIAL	12/16/2025
Cruz Mendoza	Yessenia	BH-Telehealth	INITIAL	12/16/2025
Cruz-Elmassian	Celia	BH-Telehealth	INITIAL	12/16/2025
Dailey	Anna	Primary Care Physicia	INITIAL	12/16/2025
Dang	Nikki	ABA-Telehealth	INITIAL	12/16/2025
Davis	Michelle	BH	INITIAL	12/16/2025
Dean	Jacquel	BH-Telehealth	INITIAL	12/16/2025
Delfin	Mae-Ghan	BH-Telehealth	INITIAL	12/16/2025
Delgado	Brinae	BH-Telehealth	INITIAL	12/16/2025
Denis	Asheley	BH	INITIAL	12/16/2025
Dhaliwal	Jaspreet	ABA	INITIAL	12/16/2025
Dorgile	Dawenn	ABA-Telehealth	INITIAL	12/16/2025
Dowling	Kristopher	ABA-Telehealth	INITIAL	12/16/2025
Dunets	Miya	BH-Telehealth	INITIAL	12/16/2025
Dyer	LaNita	BH-Telehealth	INITIAL	12/16/2025
Egan	Patricia	ABA-Telehealth	INITIAL	12/16/2025
Eggen	Alicia	BH-Telehealth	INITIAL	12/16/2025
Ernest	Marietta Melanie	BH-Telehealth	INITIAL	12/16/2025
Facundo	Leticia	BH-Telehealth	INITIAL	12/16/2025
Farhang	Baran	BH-Telehealth	INITIAL	12/16/2025
Fischbein	Pamela	ABA-Telehealth	INITIAL	12/16/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RECRED	CRED DATE
Fitch Torres	Lindsey	BH-Telehealth	INITIAL	12/16/2025
Flores	Hugo	ABA-Telehealth	INITIAL	12/16/2025
Flores	Monica	BH-Telehealth	INITIAL	12/16/2025
Franck	Madi	BH-Telehealth	INITIAL	12/16/2025
Freemon Sowers	Rachel	BH-Telehealth	INITIAL	12/16/2025
Friedman	Howie	BH-Telehealth	INITIAL	12/16/2025
Fuentes	Dagoberto	BH-Telehealth	INITIAL	12/16/2025
Fuentes	Eunice	BH-Telehealth	INITIAL	12/16/2025
Fuerza	Diana	BH	INITIAL	12/16/2025
Fullmer	Samuel	Allied Health	INITIAL	12/16/2025
Gamez	Ana	BH-Telehealth	INITIAL	12/16/2025
Garcia	Janice	BH-Telehealth	INITIAL	12/16/2025
Garcia-Gonzalez	Itzel	BH	INITIAL	12/16/2025
Garnica Garcia	Fatima	BH-Telehealth	INITIAL	12/16/2025
Gengler	Kimberly	BH-Telehealth	INITIAL	12/16/2025
Ghamsari	Amanda	BH-Telehealth	INITIAL	12/16/2025
Giddens	Sophia	ABA-Telehealth	INITIAL	12/16/2025
Gonzalez	Alma	BH-Telehealth	INITIAL	12/16/2025
Gonzalez	Angel	ABA-Telehealth	INITIAL	12/16/2025
Gonzalez	Leticia	BH-Telehealth	INITIAL	12/16/2025
Gonzalez Avina	Mireya	ABA-Telehealth	INITIAL	12/16/2025
Gonzalez Velez	Juan	Specialist	INITIAL	12/16/2025
Gottschalk	Richard	BH-Telehealth	INITIAL	12/16/2025
Gradias	Daniel	BH	INITIAL	12/16/2025
Grail	Celia	BH-Telehealth	INITIAL	12/16/2025
Gramme	Heather	BH-Telehealth	INITIAL	12/16/2025
Griffiths-Randolph	Ursula	Primary Care Physicia	INITIAL	12/16/2025
Gritney	Kawanna	BH-Telehealth	INITIAL	12/16/2025
Grodzicki	Lindsey	BH-Telehealth	INITIAL	12/16/2025
Guadez	Jennifer	BH-Telehealth	INITIAL	12/16/2025
Gunville	Chad	BH-Telehealth	INITIAL	12/16/2025
Guzon	Wilfredo Ryan	BH-Telehealth	INITIAL	12/16/2025
Handa	Aaron	Specialist	INITIAL	12/16/2025
Hankins	Ashleigh	ABA-Telehealth	INITIAL	12/16/2025
Hayward	Katheryn	BH-Telehealth	INITIAL	12/16/2025
Henry	Briana	BH-Telehealth	INITIAL	12/16/2025
Hernandez Rodriguez	Leidy	BH-Telehealth	INITIAL	12/16/2025
Hill	Lexington	BH-Telehealth	INITIAL	12/16/2025
Hill-Avent	Charita	BH-Telehealth	INITIAL	12/16/2025
Ho	Jessica	Primary Care Physicia	INITIAL	12/16/2025
Horodezky	Rachel	BH-Telehealth	INITIAL	12/16/2025
Huang	Jiani	BH-Telehealth	INITIAL	12/16/2025
Hwang	Brenda	ABA-Telehealth	INITIAL	12/16/2025
Hylkema	Irian	BH-Telehealth	INITIAL	12/16/2025
Isetts	William	ABA-Telehealth	INITIAL	12/16/2025
Jadallah	Priscilla	BH-Telehealth	INITIAL	12/16/2025
Jasman	Teri	ABA	INITIAL	12/16/2025
Jiang	James	Specialist	INITIAL	12/16/2025
Johnson	Carly	BH-Telehealth	INITIAL	12/16/2025
Johnson	Taylor	ABA-Telehealth	INITIAL	12/16/2025
Johnston	Cristin	ABA-Telehealth	INITIAL	12/16/2025
Jones	Jessica	Ancillary	INITIAL	12/16/2025
Jones	Kayla	BH	INITIAL	12/16/2025
Joseph Baptiste Port	Amelle	BH-Telehealth	INITIAL	12/16/2025
Jung	Anna	BH-Telehealth	INITIAL	12/16/2025
Kanahele	Amanda	ABA-Telehealth	INITIAL	12/16/2025
Karamally	Aleena	BH-Telehealth	INITIAL	12/16/2025

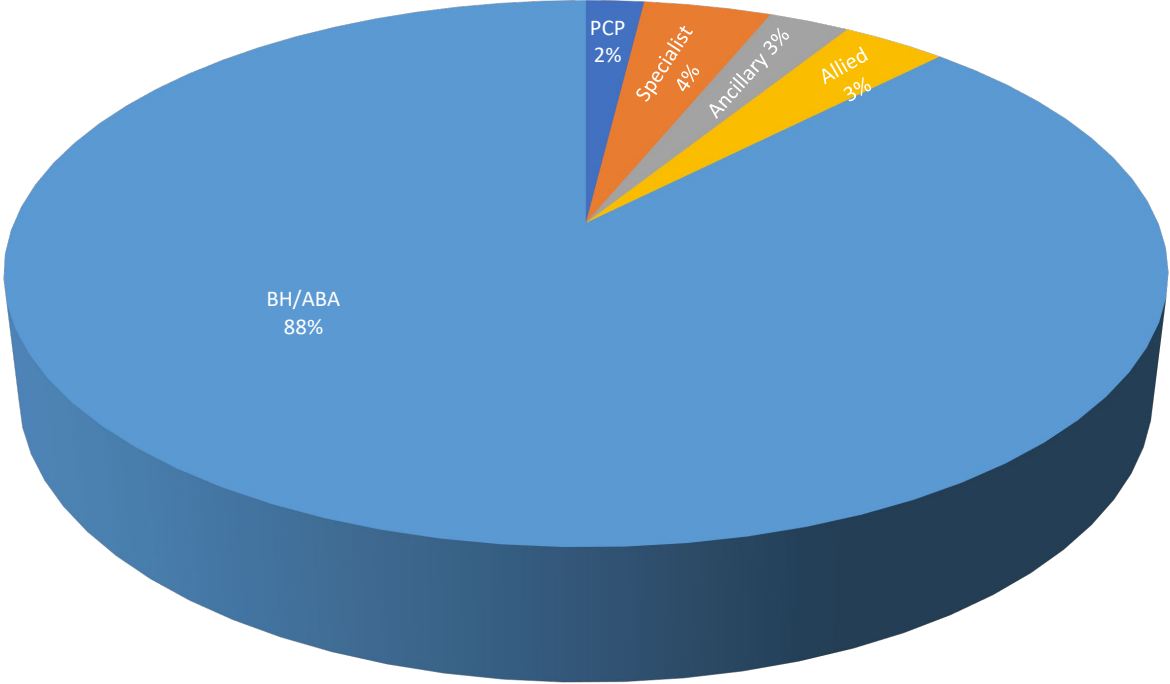
LAST NAME	FIRST NAME	CATEGORY	INITIAL / RECRED	CRED DATE
Kasle	Douglas	BH-Telehealth	INITIAL	12/16/2025
Kaur	Damanjot	ABA-Telehealth	INITIAL	12/16/2025
Khafajizadeh	Behnoush	BH-Telehealth	INITIAL	12/16/2025
Kim	Sylvia	BH-Telehealth	INITIAL	12/16/2025
Klein	Julia	Allied Health	INITIAL	12/16/2025
Kliger-Enkin	Laura	ABA	INITIAL	12/16/2025
Kosoy	Daniel	Specialist	INITIAL	12/16/2025
Kotha	Megha	Specialist	INITIAL	12/16/2025
Kozak	Melissa	ABA-Telehealth	INITIAL	12/16/2025
Lacocque	Patricia	BH	INITIAL	12/16/2025
Lang	Presj'el	BH-Telehealth	INITIAL	12/16/2025
Larios	Edith	BH-Telehealth	INITIAL	12/16/2025
Latthivongskorn	Jirayut	PCP_ECM	INITIAL	12/16/2025
Lee	Felicia	BH-Telehealth	INITIAL	12/16/2025
Lee	Urim	BH-Telehealth	INITIAL	12/16/2025
Levy	Shaked	BH-Telehealth	INITIAL	12/16/2025
Levy	Stefanie	ABA-Telehealth	INITIAL	12/16/2025
London	Brett	Primary Care Physicia	INITIAL	12/16/2025
Longan	Rachel	BH	INITIAL	12/16/2025
Lopez	Alexandra	BH-Telehealth	INITIAL	12/16/2025
Lopez	Christina	BH-Telehealth	INITIAL	12/16/2025
Lopez	Ivette	ABA-Telehealth	INITIAL	12/16/2025
Lopez	Jacinta	BH-Telehealth	INITIAL	12/16/2025
Lopez	Wendy	Ancillary	INITIAL	12/16/2025
Lujan	Brittany	ABA-Telehealth	INITIAL	12/16/2025
Luther	Shaun	BH-Telehealth	INITIAL	12/16/2025
Mace	Sarah	BH-Telehealth	INITIAL	12/16/2025
Maddox	Jonathan	BH	INITIAL	12/16/2025
Madjlessi	Bijan	BH-Telehealth	INITIAL	12/16/2025
Madlansacay	Maria	BH-Telehealth	INITIAL	12/16/2025
Mahoney	Jennifer	BH-Telehealth	INITIAL	12/16/2025
Mai	Amanda	BH-Telehealth	INITIAL	12/16/2025
Major	Jestin	BH-Telehealth	INITIAL	12/16/2025
Manners-Calderon	Fiona	ABA-Telehealth	INITIAL	12/16/2025
Maravilla	Irisbelle	ABA-Telehealth	INITIAL	12/16/2025
Martin	Jocelyn	BH-Telehealth	INITIAL	12/16/2025
Matroni	Kimberly	BH-Telehealth	INITIAL	12/16/2025
Matthew	Emily	BH-Telehealth	INITIAL	12/16/2025
Matulich	Mary	BH-Telehealth	INITIAL	12/16/2025
McKenzie	Callie	BH-Telehealth	INITIAL	12/16/2025
McKnight	Ruth	BH-Telehealth	INITIAL	12/16/2025
Mehrok	Retika	BH	INITIAL	12/16/2025
Mekis	Dominique	BH-Telehealth	INITIAL	12/16/2025
Mendoza	Jasmine	ABA-Telehealth	INITIAL	12/16/2025
Mercy	Helena	BH-Telehealth	INITIAL	12/16/2025
Merkel	Ann	BH-Telehealth	INITIAL	12/16/2025
Mey	Samantha	ABA	INITIAL	12/16/2025
Miller	Nancy	BH-Telehealth	INITIAL	12/16/2025
Min	Kristine	BH-Telehealth	INITIAL	12/16/2025
Miranda	Ana	ABA-Telehealth	INITIAL	12/16/2025
Montigny	Monique	BH-Telehealth	INITIAL	12/16/2025
Moore	LaQuisha	ABA-Telehealth	INITIAL	12/16/2025
Morris	Lacey	BH-Telehealth	INITIAL	12/16/2025
Nevel	Cylystina	BH-Telehealth	INITIAL	12/16/2025
Newman	Mary	BH-Telehealth	INITIAL	12/16/2025
Ngo-Agard	Alexus	BH-Telehealth	INITIAL	12/16/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RECRED	CRED DATE
Nguyen	Toan	ABA-Telehealth	INITIAL	12/16/2025
Nicolai	Alexandria	BH-Telehealth	INITIAL	12/16/2025
No	Eunice	BH-Telehealth	INITIAL	12/16/2025
Nocera	Vincent	BH	INITIAL	12/16/2025
Okamoto	Mia Angela	ABA-Telehealth	INITIAL	12/16/2025
O'Keefe	Galina	ABA	INITIAL	12/16/2025
Okendo	Esmeralda	BH-Telehealth	INITIAL	12/16/2025
Olivo Read	Chanelle	ABA	INITIAL	12/16/2025
Omega	Nicole	ABA-Telehealth	INITIAL	12/16/2025
Ortega	Kimberly	BH-Telehealth	INITIAL	12/16/2025
Ortez	Joseph	ABA-Telehealth	INITIAL	12/16/2025
Ortiz	Crystal	BH	INITIAL	12/16/2025
Ortiz	Renee	BH-Telehealth	INITIAL	12/16/2025
Padilla	Elissa	BH-Telehealth	INITIAL	12/16/2025
Paglinawan	Adrienne	ABA-Telehealth	INITIAL	12/16/2025
Palafox	Adbni	NP_ECM	INITIAL	12/16/2025
Palmer	Owen	Specialist	INITIAL	12/16/2025
Parry	Angela	BH-Telehealth	INITIAL	12/16/2025
Patel	Trisha	BH-Telehealth	INITIAL	12/16/2025
Peklo	Sarah	BH-Telehealth	INITIAL	12/16/2025
Peoples	Sandy	BH-Telehealth	INITIAL	12/16/2025
Pham	Cassidy	BH-Telehealth	INITIAL	12/16/2025
Phan	Tina	ABA-Telehealth	INITIAL	12/16/2025
Phillips	Katherine	BH-Telehealth	INITIAL	12/16/2025
Phillips	Shauntie	Allied Health	INITIAL	12/16/2025
Pierre-Paul	Lyse	ABA-Telehealth	INITIAL	12/16/2025
Ponio	Reginald	ABA	INITIAL	12/16/2025
Powell	Daniel	ABA-Telehealth	INITIAL	12/16/2025
Powell-Bulutoglu	Angela	BH-Telehealth	INITIAL	12/16/2025
Procks	Monica	BH-Telehealth	INITIAL	12/16/2025
Pytel	Devon	BH-Telehealth	INITIAL	12/16/2025
Rahmany	Saema	BH-Telehealth	INITIAL	12/16/2025
Raina	Amir	BH-Telehealth	INITIAL	12/16/2025
Ramanathan	Anita	BH-Telehealth	INITIAL	12/16/2025
Randhawa	Navdeep	ABA-Telehealth	INITIAL	12/16/2025
Rashid	Saad	Specialist	INITIAL	12/16/2025
Rector	Eli	ABA-Telehealth	INITIAL	12/16/2025
Rednikov	Vladimir	BH-Telehealth	INITIAL	12/16/2025
Reyes	Jessica Lourdes	BH-Telehealth	INITIAL	12/16/2025
Richardson	Kimberly	BH-Telehealth	INITIAL	12/16/2025
Richmond	Gayleah	BH-Telehealth	INITIAL	12/16/2025
Rivas	Michelle	ABA-Telehealth	INITIAL	12/16/2025
Rivera	Ma Angela Rica Ma	ABA-Telehealth	INITIAL	12/16/2025
Roper	Hollie	BH-Telehealth	INITIAL	12/16/2025
Russell	Brandy	ABA-Telehealth	INITIAL	12/16/2025
Sable	Suzette	BH-Telehealth	INITIAL	12/16/2025
San Mateo Virgen	Kristine	BH-Telehealth	INITIAL	12/16/2025
Sanchez	Claudine	ABA-Telehealth	INITIAL	12/16/2025
Sawyer	Tesia	ABA-Telehealth	INITIAL	12/16/2025
Schmitto	Coleton	Allied Health	INITIAL	12/16/2025
Schubert	Amara	ABA-Telehealth	INITIAL	12/16/2025
Schultz-Alarcon	Talia	Doula	INITIAL	12/16/2025
Scolini	Gianna	BH-Telehealth	INITIAL	12/16/2025
Seawell	Robert	BH-Telehealth	INITIAL	12/16/2025
Sellers	Caitlin	BH-Telehealth	INITIAL	12/16/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RECRED	CRED DATE
Shanker	Arpana	ABA-Telehealth	INITIAL	12/16/2025
Sheldon	Nicholas	BH	INITIAL	12/16/2025
Silva	Alexee	BH-Telehealth	INITIAL	12/16/2025
Sims-Morales	Lakeitha	ABA-Telehealth	INITIAL	12/16/2025
Small	Amanda	ABA-Telehealth	INITIAL	12/16/2025
Sniado	Susan	BH-Telehealth	INITIAL	12/16/2025
Sorenson	Kristen	ABA-Telehealth	INITIAL	12/16/2025
Sosa-Williams	Tanyana	BH-Telehealth	INITIAL	12/16/2025
Starks	Jennifer	BH-Telehealth	INITIAL	12/16/2025
Strong	Morgan	BH-Telehealth	INITIAL	12/16/2025
Subijano	Rolando	Allied Health	INITIAL	12/16/2025
Such	Julie	BH-Telehealth	INITIAL	12/16/2025
Sulek	Bridget	ABA-Telehealth	INITIAL	12/16/2025
Takagi	Laura	ABA-Telehealth	INITIAL	12/16/2025
Tanis	Richard	ABA-Telehealth	INITIAL	12/16/2025
Taylor	Madelynn	Primary Care Physicia	INITIAL	12/16/2025
Taylor	Melanie	BH-Telehealth	INITIAL	12/16/2025
Teal	Mariana	BH-Telehealth	INITIAL	12/16/2025
Torres	Gabriela	ABA-Telehealth	INITIAL	12/16/2025
Tougas	Ana	BH-Telehealth	INITIAL	12/16/2025
Varrell	James	BH-Telehealth	INITIAL	12/16/2025
Vartak	Shirin	BH-Telehealth	INITIAL	12/16/2025
Ventura	Barbara	ABA-Telehealth	INITIAL	12/16/2025
Victoria	Michelle	ABA-Telehealth	INITIAL	12/16/2025
Waldron	Vincent	Allied Health	INITIAL	12/16/2025
Wang	Kara	BH	INITIAL	12/16/2025
Werblun	Arielle	BH-Telehealth	INITIAL	12/16/2025
Williams	Sophia	BH-Telehealth	INITIAL	12/16/2025
Wood	Sam	BH-Telehealth	INITIAL	12/16/2025
Wormley	Ashley	BH-Telehealth	INITIAL	12/16/2025
Yglecias	Loren	Allied Health	INITIAL	12/16/2025
York	Glenda	BH-Telehealth	INITIAL	12/16/2025
Zadra	Collin	ABA-Telehealth	INITIAL	12/16/2025
Zaiduni Nunez	Ana	Allied Health	INITIAL	12/16/2025
Aguirre-Sullivan	Mercedes	BH/ABA	RECRED	12/16/2025
Al-Naqbi	Abeer	Specialist	RECRED	12/16/2025
Badoni	Parvati	BH/ABA-Telehealth	RECRED	12/16/2025
Banerjee	Madhumita	BH/ABA	RECRED	12/16/2025
Boisvert	Alexandria	BH/ABA-Telehealth	RECRED	12/16/2025
Franklin	Lesleigh	BH/ABA	RECRED	12/16/2025
Hillas-Buck	Summer	BH/ABA-Telehealth	RECRED	12/16/2025
Jain	Ashit	Primary Care Physicia	RECRED	12/16/2025
Jones	Margaret	BH/ABA	RECRED	12/16/2025
Kashlinskaya	Olga	Primary Care Physicia	RECRED	12/16/2025
Kastner	Mary	BH/ABA	RECRED	12/16/2025
Ketcham	Adryon	BH/ABA	RECRED	12/16/2025
Kim	Angela	BH/ABA	RECRED	12/16/2025
Lachini	Sohi	BH/ABA	RECRED	12/16/2025
Lay	Cho Cho	Primary Care Physicia	RECRED	12/16/2025
Leon Guerrero	Shanti	Primary Care Physicia	RECRED	12/16/2025
Liang	Mark	Primary Care Physicia	RECRED	12/16/2025
Lipson	Brian	Specialist	RECRED	12/16/2025
Manjunath	Sudha	BH/ABA	RECRED	12/16/2025
Mohaghegh	Sara	BH/ABA	RECRED	12/16/2025
Moreno	Adrianna	BH/ABA	RECRED	12/16/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RECRED	CRED DATE
Rivas	Daniel	BH/ABA-Telehealth	RECRED	12/16/2025
Rutsch	Victoria	BH/ABA	RECRED	12/16/2025
Sadiq	Ahmed	Specialist	RECRED	12/16/2025
Sagewood	Anne	BH/ABA	RECRED	12/16/2025
San Jose	Michelle	BH/ABA	RECRED	12/16/2025
Sanchez	Jennifer	BH/ABA	RECRED	12/16/2025
Sanchez	Jessica	BH/ABA	RECRED	12/16/2025
Schiffirin	Elizabeth	BH/ABA	RECRED	12/16/2025
Schramm	Emily	BH/ABA	RECRED	12/16/2025
Snow	Alexander	BH/ABA-Telehealth	RECRED	12/16/2025
Stewart	Tanisha	BH/ABA	RECRED	12/16/2025
Strickland-Ramsay	Marcella	BH/ABA	RECRED	12/16/2025
Stublefield	Mila	BH/ABA	RECRED	12/16/2025
Titcher	Randall	BH/ABA-Telehealth	RECRED	12/16/2025
Tran	Nhi	Primary Care Physicia	RECRED	12/16/2025
Tsai	Wilson	Specialist	RECRED	12/16/2025
Turner	Candice	BH/ABA	RECRED	12/16/2025
Vartivarian	Mher	Specialist	RECRED	12/16/2025
Vazquez	Akilah	BH/ABA	RECRED	12/16/2025
Venkatachalam	Sukanya	BH/ABA	RECRED	12/16/2025
Vidal-Zavala	Grecya Nadir Odett	BH/ABA	RECRED	12/16/2025
Vigil-Toledo	Jessica	BH/ABA-Telehealth	RECRED	12/16/2025
Wei	Hui	BH/ABA	RECRED	12/16/2025

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



PCP	5
SPECIALIST	11
ANCILLARY	7
ALLIED	9
BH/ABA	227
TOTAL	259

MEMBER CONNECT

Spring/Summer 2025

ALAMEDA
Alliance
FOR HEALTH

we are

ALAMEDA COUNTY

Helping People in Our Community Since 1996



PROVIDER SPOTLIGHT: ENCOURAGING MENTAL HEALTH CARE – DR. ALEXIS HAMILL'S STORY

Dr. Alexis Hamill develops the psychology training program at the Native American Health Center (NAHC) in Oakland. Dr. Hamill enjoys working at NAHC and seeing how culture can be empowering for the community they serve.

www.alamedaalliance.org

PO Box 3789
San Leandro, California 94578

ALAMEDA
Alliance
FOR HEALTH



(Continued on page 2)

PRSR STD
US POSTAGE
PAID
Alliance for Health

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MENTAL HEALTH, AUTISM SPECTRUM SERVICES, AND THE NO WRONG DOOR TO MENTAL HEALTH SERVICES



The Alliance offers No Wrong Door (NWD) to all members to make it easy to connect to mental health services. No matter where you first seek care, you can receive services without delay.

The NWD model connects access to services and treatment. Before, Medi-Cal members would go to Alameda County Behavioral Health for specialty mental health services like hospital care and Alameda Alliance for non-specialty services like therapy.

Now, you can seek care from either Alameda County Behavioral Health or the Alliance and maintain relationships with trusted providers even when your care needs change. NWD will improve access to mental health and autism spectrum services, and offer higher-quality care for all our members.

Partnering to improve the mental health of our youngest members

The COVID-19 pandemic had a big impact on our lives, and many of us have experienced increased stress. It has also greatly impacted the mental health of young people. In response, the state invested over \$4 billion to improve mental health care for the state's children and youth. These funds go to public schools so that they can detect mental health concerns among students early and offer them needed services.

The Alliance supports this effort! We are partnering with the Alameda County Office of Education and the Alameda County Health Care Services Agency to support this work. With our partners, we are committed to ensuring the children and families who we serve have access to mental health services, so they can have the best possible health and well-being and reach their greatest potential.

PROVIDER SPOTLIGHT: ENCOURAGING MENTAL HEALTH CARE – DR. ALEXIS HAMILL’S STORY

(CONTINUED FROM PAGE 1)

Born in San Francisco and growing up in the East Bay, Alexis became a good listener at a very young age. She majored in psychology at the University of California Santa Cruz. She then focused on learning about the deaf culture working in a deaf and disabled telecommunications program in Oakland. After graduate school at Bowling Green State University, she interned at the Veteran Affairs (VA) Hospital in both San Francisco and Los Angeles.

Managing and supporting the therapists, care coordinators, and peer specialists at NAHC, she helps foster their interests and supports them in their development and growth. She is honored to hear patients’ stories, help them find their strength from culture and community, and see them thrive and heal in new ways.

She knows the importance of having mental health coverage because it gives access to needed services and maintains the continuity (flow) of care, which is vital in behavioral health.

Dr. Hamill has seen a drop in stigma around mental health care over time and hopes this continues.

She encourages people to reach out for mental health support as everyone faces struggles and can benefit from supportive, non-judgmental care.



The Alliance is honored to have Dr. Hamill as a provider partner. 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 continue working with Dr. Hamill and NAHC.

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



Alliance members can choose NAHC 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**

If you cannot hear or speak well (CRS/TTY):

711/1.800.735.2929



facebook.com/alamedaallianceforhealth



[@alamedaallianceforhealth](https://alamedaallianceforhealth)



[@alamedaalliance](https://alamedaalliance)

Native American Health Center

2920 International Blvd.

Oakland, CA 94601

Monday – Friday, 8:30 am – 5 pm

2950 International Blvd.

Oakland, CA 94601

Monday – Friday, 8:30 am – 5 pm (and 2nd and 4th Saturdays of each month)

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**.

HIDDEN IN PLAIN SIGHT: THE TRUTH ABOUT E-CIGARETTES

Vapes contain toxic chemicals, like some found in antifreeze, that are linked to cancer and lung disease. Most vapes contain nicotine. Nicotine alters how the brain works and harms its development. Since the brain continues to develop into the mid-20s, younger people are more likely to become addicted. Nicotine also makes it harder for kids to stay focused and can cause mood swings and increase anxiety.

Parents: Learn how to talk to your kids about vaping at **flavorshookkids.org**.

Teens: Find out the facts and take action at **thetruth.com**.

Help to quit

Here are some helpful resources if you, or someone you know, need help quitting e-cigarettes:

Asian Smokers' Quitline (Toll-Free):

Chinese: **1.800.838.8917**

Vietnamese: **1.800.778.8440**

Korean: **1.800.556.5564**

asiansmokersquitline.org

Kick It California (Toll-Free):

English: **1.800.300.8086**

(Interpreters offered)

Spanish: **1.800.600.8191**

kickitca.org



KNOW WHERE TO GO: THE RIGHT PLACE FOR THE RIGHT CARE

When you are feeling sick or have a minor injury, it is important to know where to go for care. Many people head straight to the emergency room (ER), but did you know the ER is meant for life-threatening emergencies only? There may be better options that can save you time, and help you feel better faster.

The next three (3) articles can help you choose and learn more about the right care options. These options are a part of the health care and service benefits that are no cost to Alliance members.

Advice Nurse Line

Not sure if you need to see a doctor? Call the **Alliance Advice Nurse Line**. Nurses can help you decide whether you need emergency or urgent care – or if a regular doctor's visit is best.

Call toll-free at:

- Medi-Cal Members: **1.888.433.1876**
- Group Care Members: **1.855.383.7873**

Teladoc®: 24/7 doctor access by phone or video

If you cannot reach your doctor or can't leave home and need to talk to a health care professional, Teladoc® offers 24/7 phone or video chat services.

To use Teladoc®, call toll-free at **1.800.835.2362** or download the Teladoc® app. First-time users need to set up an account using their Alliance Member ID.

If you need help with Teladoc®, call the Alliance Member Services Department at **1.510.747.4567**.

To learn more about the Teladoc® benefit for Alliance members, please see the article called "Talk To A Doctor in Minutes With Teladoc®" on page **9**.



KNOW WHERE TO GO: THE RIGHT PLACE FOR THE RIGHT CARE

(CONTINUED FROM PAGE 7)



Urgent Care: When you need care right away

Urgent care centers are a great choice instead of the ER for non-life-threatening conditions. They offer same-day care with shorter waiting times.

This service is perfect for concerns like:

- Allergies
- Cough
- Flu
- Pink eye
- Rashes
- Sinus infections
- Sore throats
- Stomach bugs
- And more

Search the Alliance Provider Directory to find an Urgent Care Center near you. Search under **“Facility”** and select **Urgent Care** as facility type.

To learn more about the Urgent Care benefit for Alliance Members, please see the article called “Get The Care You Need Even After Hours With Urgent Care” on page **10**.

Emergency? Call 9-1-1

For serious, life-threatening conditions – such as chest pain, difficulty breathing, severe injuries, or sudden weakness – call **9-1-1** or go to the nearest emergency room.

Make the right choice

Choosing the right place for care helps you get the treatment you need quickly while keeping the ER free for emergencies. Keep this information handy and stay healthy.

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 the Alliance member service benefit – Teladoc®.

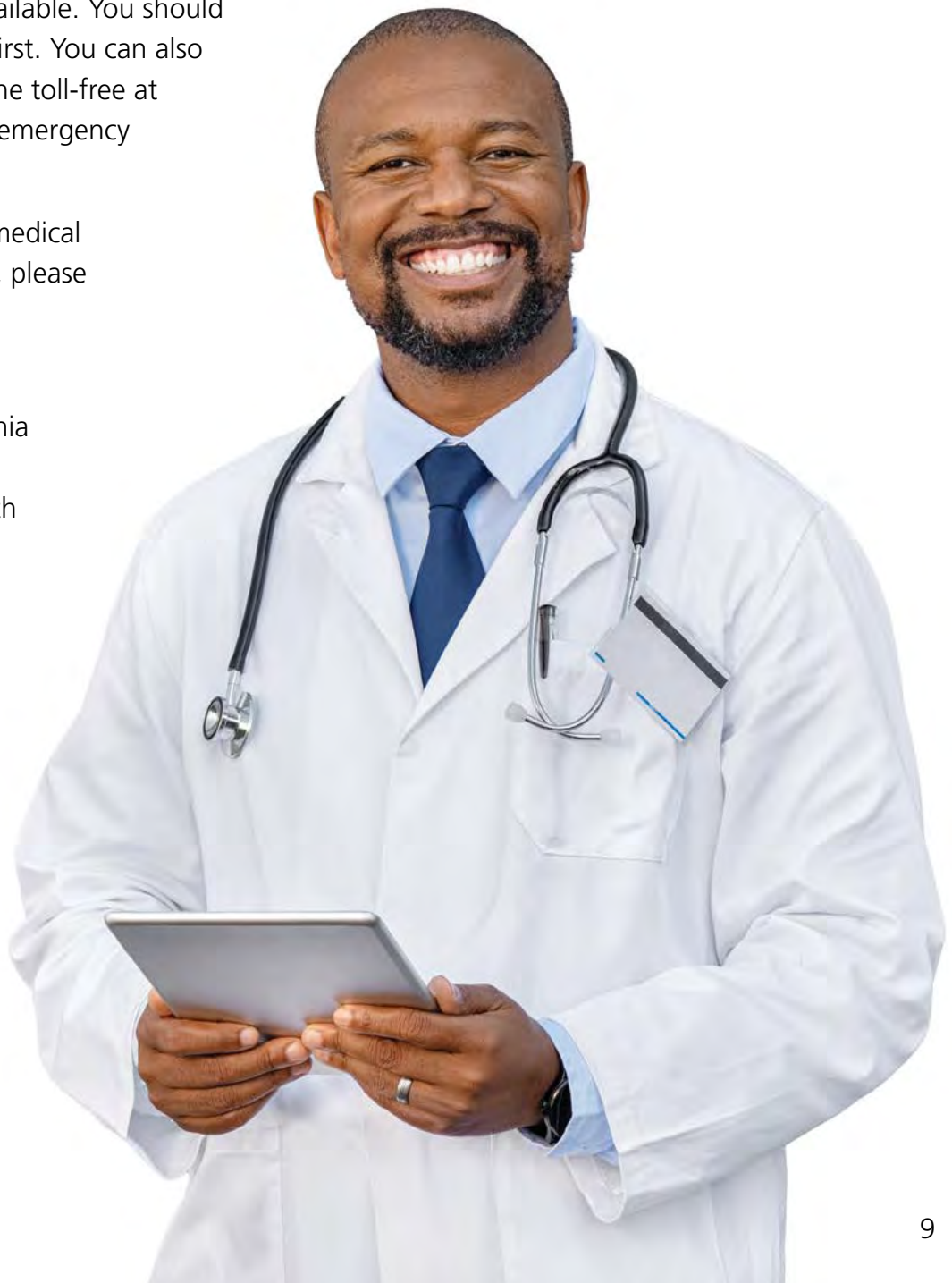
Alliance members can use Teladoc® to talk to a doctor anytime, day or night. You can get care when you need it from the comfort of your own home. You can talk to a doctor in the language you need.

The Alliance works with Teladoc® to give you access to care when your 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 non-emergency health questions.

Teladoc® is for non-emergency medical issues. 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.



GET THE CARE YOU NEED, EVEN AFTER HOURS, WITH URGENT CARE

Urgent care is for services like a sudden illness, injury, or complication (issue) of a condition you already have. Most urgent care appointments are given within 48 hours. If your urgent care visit needs 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 any time 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**.

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.



INFANT FEEDING DURING EMERGENCIES: WHAT PARENTS NEED TO KNOW

Natural disaster emergencies can make it hard for parents and caregivers to safely feed their infants and young children. A crisis can impact food, clean water, and electricity. It is important to have a plan to make sure your baby gets the nutrition they need.



Why planning ahead matters

During a crisis, stress levels are high and supplies may be limited. Thinking ahead of time can help ease some of the stress.

If you are breastfeeding (also known as chestfeeding): Breast milk is a safe food source. You do not need clean water or electricity to make it. It also contains antibodies that can help your baby from getting sick during an emergency. Illness can be more common in emergency situations.

If you use infant formula: You need a safe water source and supplies to make and store it. Ready-to-feed infant formulas are the safest option when you do not have access to clean water.

Ways to prepare

No matter how you feed your baby, these steps can help you feel more prepared for an emergency:

- **Make a feeding plan:** Consider what resources you have and how you will continue feeding your baby if you lose power or water.
- **Learn to express milk with hands:** Knowing how to express milk by hand can help if you lose power and cannot use your breast pump.
- **Stock up on formula and supplies:** If you use formula, keep extra ready-to-feed bottles on hand. If you use a powdered formula, make sure you have a safe way to boil and store water.
- **Keep feeding items clean:** In emergencies, washing bottles and nipples can be hard. Cup feeding may be a safer choice if you don't have access to clean water.

INFANT FEEDING DURING EMERGENCIES: WHAT PARENTS NEED TO KNOW

(CONTINUED FROM PAGE 11)



Help is available!

Did you know that the Alliance offers lactation (breastfeeding or chestfeeding) support with Alta Bates Summit Medical Center? Members can call to schedule an appointment (in-person at the hospital, online, or over the phone) with a lactation consultant (breastfeeding expert).

To schedule an appointment, please call:

Alta Bates Summit Medical Center

Monday - Friday, 9 am - 4 pm

Phone number: **1.510.204.6546**

**Please note: you must be a patient at Alta Bates to schedule an appointment.*

Members can also get support with infant feeding and food at WIC (Women, Infants, and Children). Medi-Cal members are eligible for WIC. To learn more about WIC and search for an office, please visit **myfamily.wic.ca.gov**.

Other Resources:

Center for Disease Prevention and Control (CDC) – Feeding Your Child Safely During a Disaster

www.cdc.gov/breastfeeding/php/guidelines-recommendations/feeding-your-child-safely-during-a-disaster.html

Administration for Children and Families

https://acf.gov/sites/default/files/styles/full_screen/public/images/ohsepr/infant_feeding_edits.png

Disaster Distress Helpline

www.samhsa.gov/find-help/helplines/disaster-distress-helpline

Emergencies are stressful, but with planning, you can make sure your family's needs are met in the safest way possible.

YOUR VOICE MATTERS!

Alliance members, we value your input and feedback. We invite you to join our Community Advisory Committee (CAC). Learn more about the Alliance and share your ideas to help us improve our services and programs. You will also get a stipend (fixed payment) for each meeting you attend.

What does the CAC do?

The CAC provides a link between the Alliance and the community. It is made up of Alliance members, community advocates, and providers. CAC members can share the needs and concerns of Alliance members of all ages and backgrounds.

When are the CAC meetings held?

The CAC meets four (4) times a year and each meeting is two (2) hours long. The Alliance can provide help with transportation, interpreter services, and childcare.

Who can join the CAC?

We want to expand our CAC membership. All Alliance members are welcome to join.

We are looking for CAC members from these groups, but not limited to:

- Members who speak a language other than English
- Men
- Members aged 19-44
- Foster youth and/or a parent or caregiver of current or former foster youth.

If you are interested or would like to learn more about the CAC, please email us at livehealthy@alamedaalliance.org or call **1.510.747.4577**. If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**.



BLOOD PRESSURE MATTERS

Blood pressure is the force put on the walls of the blood vessels with each heartbeat. These vessels carry blood from your heart to other parts of your body. When your blood pressure stays high, your risk increases for problems like heart disease and stroke. The good news is that you can work to manage your blood pressure.

To help keep your blood pressure in a healthy range, follow these healthy habits:



Know your numbers. Ask your doctor what your blood pressure numbers are and what that means for you. If your blood pressure is too high, follow your doctor's treatment plan.



Get moving. Try walking, dancing, or your favorite activity. All you need is 30 minutes a day, five (5) days a week. Remember, you do not have to do it all at once.



Eat healthy. Add more fruits and vegetables to your meals. Limit foods with salt, fat, and sugar.



Limit alcohol. For men, no more than two (2) drinks per day are recommended. For women, no more than one (1) drink per day is recommended.



Don't smoke. If you smoke, work with your doctor to make a quit plan or call the Kick It California Helpline toll-free at **1.800.300.8086**.



Manage stress. Find healthy ways to help you relax. You can try deep breathing, stretching, or meditation.

GET HELP MANAGING YOUR HEALTH



Living with a health concern can be hard. The Alliance is here to help by offering disease management programs for members. These programs help give you support to take care of your health.

What is disease management?

Disease management programs help people with certain health concerns get the care and support they need.

This can include:

- **Talking to a nurse case manager** (a nurse who helps with your care)
- **Learning about your medicines** (how to take them and why)
- **Getting health education and coaching** (tips to stay healthy)
- **Help from a social worker** (support for personal and family needs)

Who can join?

If you have one (1) or more of these conditions, you may qualify:



Asthma



Depression



Diabetes



Hypertension
(high blood pressure)

Extra help for high-risk members

If you are at a higher risk for health concerns, you may also get:

- **Help with housing, food, and transportation** (rides to your medical appointments)
- **Tailored health education** (information made just for you)
- **Asthma support** (help to make your home safe from asthma triggers)
- **More personalized care and in-home visits** (special nurses and social workers to help you)
 - This may include Enhanced Case Management (ECM) or Complex Case Management (CCM).

Want to learn more?

If you think you may qualify, call the Alliance Case and Disease Management (CMDM) Department at **1.510.747.4512**.

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 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.



3-5
DAYS

1
MONTH

2
MONTHS

4
MONTHS

6
MONTHS

9
MONTHS

12
MONTHS

15
MONTHS

18
MONTHS

24
MONTHS

30
MONTHS



DEPRESSION – KNOW THE SIGNS AND WHEN TO GET HELP



Depression is a common illness that affects millions of people every year.

You may feel down once in a while or struggle with your emotions when life becomes stressful. This is normal but if you feel sad or down on most days or for more than two (2) weeks at a time, you may be depressed.

What is depression?

Depression is an illness that involves the brain. It can affect your thoughts, mood, and daily activities — and make you feel sad or down.

Depression can be mild, moderate, or severe. Mild depression may become more serious if it's not treated.

The good news is that you can get treatment for depression. Getting help is the best thing you can do for yourself and your loved ones. You can feel better.

How is depression treated?

Depression can be treated with talk therapy, medicines (called antidepressants), or both. Your doctor may refer you to a mental health professional for talk therapy or medicine.

If you start taking medicine and it's not working well enough, your doctor may have you try a different type of antidepressant.

See a doctor

Depression is a real illness. People with depression need treatment like people with any other illness. If you think you might be depressed, it is important to see your doctor or nurse and get treatment right away.

Talk to a doctor about how you are feeling. Ask to see a doctor or nurse who can screen you for depression.

The doctor or nurse can check to see if you are taking medicines that can cause depression or make it worse.

Alliance members can see a doctor about depression at no cost to you.

If you think you need help, please see your doctor soon. You can also visit our website to find a behavioral health care provider.

Other resources:

<https://odphp.health.gov>

www.calhope.org

BE YOUR BEST BY EATING WELL AND BEING ACTIVE

At the Alliance, we want you to live well and make healthy habits part of your lifestyle so you can feel better and stronger every day.

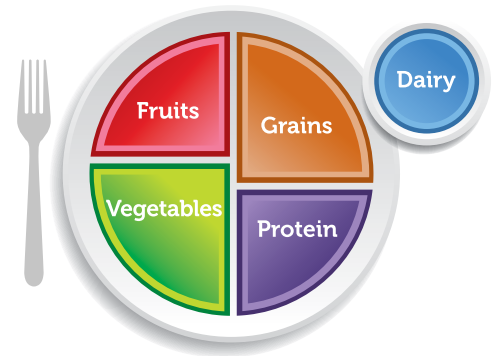
Eating well nourishes your body and gives you energy.

Eating well can also prevent and manage health problems like diabetes and heart disease. Start by building balanced meals and choosing healthy options. Make sure you eat the right number of calories for you.

Building balanced meals

Choose fruits, vegetables, grains, dairy, and protein foods. MyPlate shows how you can balance these food groups to build healthy meals.

- Make half your plate **fruits and vegetables**.
- Make half your grains **whole grains**.
- Vary your **lean proteins**.
- Get calcium from **dairy** and other non-dairy foods such as greens, canned fish, beans, and tofu.



How to choose healthy options and eat the right number of calories

Drink and eat less sodium, saturated fat, and added sugar. Read food labels. Try to grill, broil, bake, or steam food instead of frying it.

Use healthy oils for cooking. Limit butter. Choose water, tea without sugar, or 1% or nonfat milk over sweetened drinks.

Taking in more calories than your body uses can cause weight gain. Plan your meals and snacks ahead of time. Eat slowly so you know when you have had enough to eat. When eating, focus on your food instead of doing other things.

Learn more about balanced meals and calories at www.choosemyplate.gov/myplateplan.





Be active

Exercise makes you stronger and burns calories. Being active improves the health of both your mind and body.

Exercise can help:

- Improve your balance, muscle tone, and joint movement.
- Improve how well your heart and lungs work. Maintain a healthy weight or lose weight.
- Reduce the risk of heart disease, high blood pressure, osteoporosis (bone weakness), and diabetes.
- Relieve stress and improve your mood.

The goal is to exercise most days each week. Aim for a total of 30 minutes per day. You don't have to be active for 30 minutes all at once. Ten minutes at a time works too!

To prevent injury, slowly increase the amount of time and the number of days you spend exercising.

Choose an exercise you like to do. Try to vary the type of exercise you do to increase the health benefits and prevent boredom and injury.

Talk to your doctor or nurse about how much you should eat, and how much you should exercise, and any other questions or concerns you may have.

HOW TO MAKE THE MOST OF YOUR DOCTOR'S VISIT

At the Alliance, we are here to help you. As your partner in health, we are sharing some best practices to help you get the most out of your doctor's visit.

Before your doctor visit:

- ☐ Make appointments ahead of time with your assigned doctor, when you can. Non-urgent visits can take **two (2) – three (3) weeks** to schedule. If you are not sure who your assigned doctor is, please call the Member Services Department toll-free at **1.877.932.2738**. You can also ask to switch to another doctor if you prefer.
- ☐ Schedule a wellness check-up if you are new to the Alliance.
- ☐ See your doctor before a health concern becomes a problem. Wellness checkups are no cost to Alliance members.
- ☐ Find out your doctor's after-hours phone number.
- ☐ Get advice from a doctor or nurse by phone. This may help you avoid an emergency room (ER) visit.

Do you need help during your doctor visit?

Tell your doctor's office ahead of time if you have a disability or need an interpreter or transportation services.

- ☐ To schedule a language interpreter, please call the Alliance Member Services Department toll-free at **1.877.932.2738** at least **five (5) days** before your doctor's visit. If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**.
- ☐ **Alliance Medi-Cal Members:** Request a ride at least **three (3) business days** before the appointment by calling toll-free at **1.866.791.4158**. Please have your Alliance member ID card ready when you call.



Along with your checklist, please bring these with you:

- ☐ Alliance member ID card.
- ☐ Photo ID.
- ☐ All drugs, vitamins, herbs, and over-the-counter medication you are taking.
- ☐ A list of your health questions and concerns.
- ☐ Information about your medical history.
- ☐ Pen and paper to write down your doctor's advice.

Be sure to arrive early. You may have forms to fill out.

Can't get to your appointment? Please call your doctor's office to cancel.

IMPROVE YOUR BALANCE TO PREVENT FALLS



Can you name the four (4) types of exercise?

They are endurance (also known as aerobics or cardio), strength, balance, and flexibility. It's important to work on all four (4) because each helps your body in different ways.

Exercises that improve balance and make your legs and hip muscles stronger can lower your chances of falling. They also help you feel better and more confident. Balance exercises can be done every day or as often as you would like. Talk to your doctor if you feel unsure about an exercise.

To improve your balance, you can try exercises such as:

- Marching in place
- Standing from a seated position
- Standing on one (1) foot
- Walking heel-to-toe
- Walking in a straight line
- Tai Chi
- Yoga

Start slowly and have a wall, sturdy chair, or person nearby. Over time, you may be able to do the exercises for longer or with less support.

To learn about programs and services for older adults in Alameda County that can help prevent falls, please call the California Aging and Adult Information Line toll-free at **1.800.510.2020**.

To download their "Fall Prevention Resource Guide for Older Adults," please visit **seniorinfo.acgov.org**.

For more fall prevention tips, please visit **www.alamedaalliance.org/live-healthy-library** and click "**Safety**." You can also request materials to be mailed to you using the Alliance Wellness Programs & Materials Request Form found on page **28**.

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.

NONDISCRIMINATION NOTICE AND NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

NONDISCRIMINATION NOTICE

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, and/or sexual orientation.

NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND 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 free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بالرقم **1.877.932.2738** (TTY: **1.800.735.2929**). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريـل والخط الكبير. اتصل بالرقم **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:

ភាសាខ្មែរ (Cambodian)

ចំណាំ: បើអ្នក ត្រូវ ការជំនួយ ជាភាសា ខ្មែរ ឬ មិន អាច អាន ឬ ឆ្លើយ បាន លើ អត្ថបទ ដែល ជាប់ ពាក់ ព័ន្ធ ជាមួយ ការ ថែទាំ ឬ ការ ព្យាបាល របស់ យើង ទេ ទូរស័ព្ទ ទៅ លេខ **1.877.932.2738** (TTY: **1.800.735.2929**)។ ជំនួយ និង សេវា ភាសា ខ្មែរ ផ្តល់ ជូន ដល់ អ្នក ដែល មាន ការ ពិការ ភាព ក្នុង ការ អាន ឬ ការ ឆ្លើយ បាន លើ អត្ថបទ ដែល ជាប់ ពាក់ ព័ន្ធ ជាមួយ ការ ថែទាំ ឬ ការ ព្យាបាល របស់ យើង ទេ ឥត គិត ថ្លៃ ឡើយ។ ទូរស័ព្ទ ទៅ លេខ **1.877.932.2738** (TTY: **1.800.735.2929**)។ សេវា ភាសា ខ្មែរ នេះ មិន គិត ថ្លៃ ឡើយ។

简体中文标语 (Chinese – Simplified)

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。

繁体中文标语 (Chinese – Traditional)

請注意:如果您需要以您的母語獲得幫助,請撥打 **1.877.932.2738** (TTY: **1.800.735.2929**)。另外我們也提供面向殘障人士的幫助和服務,例如點字和大字版文件。請撥打 **1.877.932.2738** (TTY: **1.800.735.2929**)。這些服務均免費提供。

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। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में दस्तावेज़, भी 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.

NONDISCRIMINATION NOTICE AND NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES (CONTINUED FROM PAGE 23)

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。

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. (TTY: **1.800.735.2929**) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແຫນ້າໂລພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໄດ້ທັນທີ **1.877.932.2738** (TTY: **1.800.735.2929**). ຍັງມີຄວາມຊ່ວຍເຫຼືອ ແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໄດ້ທັນທີ **1.877.932.2738** (TTY: **1.800.735.2929**). ການບໍລິການເຫຼົ່ານີ້ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໄດ້.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiexmx 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 hlou 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)

ਬਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ **1.877.932.2738** (TTY: **1.800.735.2929**). 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। **1.877.932.2738** (TTY: **1.800.735.2929**). 'ਤੇ ਕਾਲ ਕਰੋ। 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 serbisyonang 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 **28**, 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](https://twitter.com/alamedaalliance)



[@alamedaallianceforhealth](https://instagram.com/alamedaallianceforhealth)



[@alameda-alliance-for-health](https://linkedin.com/company/alameda-alliance-for-health)



[@alamedaalliance](https://youtube.com/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 for 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

Member Connect

Fall/Winter 2025 – 2026



Here's to 30 Years! A Fresh Look for a Bright Future



We are turning 30, and we could not be more excited. For three decades, the Alliance has been making sure our community has the care and services everyone deserves. As we celebrate this milestone, we're unveiling: **our refreshed logo!**

Our new look is bold, bright, and full of energy, just like the future we're building together. While our logo has changed, our promise has not. We're still here to provide **great service and access to care** because your health matters.

This anniversary is a celebration of **30 years of care and impact**. We'll keep **building a healthier community, one block at a time**. Our mission-driven work is our greatest reward.

Thank you for being part of our story. Together, we make health happen!



Celebrating 30 Years of Community Health in Alameda County

Reflections from Matthew Woodruff, CEO

30 years of Strengthening and Uplifting our Community

On our 30th anniversary, I am humbled by the progress we have made in delivering access to health care for the residents of Alameda County. We take great pride in our role as a trusted partner in the health care safety net.

The Alliance staff and partners are committed to our vision that all residents of Alameda County will achieve optimal health and well-being at every stage of life. It is deeply rewarding to see how a healthy community contributes to a thriving community.

This is our passion and our reward.

Exciting Growth

In 30 years, our membership has grown from our first member to now serving over 400,000 individuals—providing health care coverage for one (1) out of every four (4) Alameda County residents.

Our 30th year also brings exciting new opportunities as we roll out our third program, Medicare Advantage Dual Eligible Special Needs Plan (D-SNP), which we call Alameda Alliance Wellness. Now, Alameda County residents who have both Medicare and Medi-Cal benefits can have these health care programs combine their services. This will provide a higher level of care in an even more timely manner.

The Road Ahead

The Alliance and many of our health partners will face major challenges in the next decade. The recent Federal funding cuts to the health care safety net system and State Budget deficit are a hard reality. We will approach these challenges with the same resilience and dedication that has brought us through our first 30 years.

We are working with our providers, community partners, and local and state healthcare leaders to minimize the impact of cuts to healthcare spending and continue to remove the barriers to healthcare.

Our dedication and mission remain firm. We have much to be grateful for and look forward to continually provide access to the care and services people deserve.



Board of Governors

The Board of Governors has 19 members. Each one represents specific stakeholder groups. The Board works with and makes major decisions for the Alliance.

- Rebecca Gebhart (Chair)
- Noha M. Aboelata, MD (Vice Chair)
- Matthew Woodruff (ex officio Board member and Secretary/Treasurer)
- Aarondeep Basrai
- Toritsesan Boyo
- Kathleen Clanon, MD
- Rollington Ferguson, MD
- Andrea Ford
- James Jackson
- Byron Lopez
- Marty Lynch
- Kelley Meade, MD
- Jody Moore
- Yeon Park
- Andie Martinez Patterson
- Wendy Peterson
- Andrea Schwab-Galindo
- Evan Seevak, MD
- Supervisor Lena Tam
- Natalie Williams

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Alliance 2026

Holiday Calendar

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

2026

New Year's Day

Thursday, January 1st

Martin Luther King Jr. Day

Monday, January 19th

Presidents' Day

Monday, February 16th

Cesar Chavez Day

Tuesday, March 31st

Memorial Day

Monday, May 25th

Juneteenth Holiday

Friday, June 19th

Independence Day

Friday, July 3rd

Labor Day

Monday, September 7th

Veterans Day

Wednesday, November 11th

Thanksgiving Day

Thursday, November 26th

Day After Thanksgiving

Friday, November 27th

Christmas Eve

Thursday, December 24th

Christmas Day

Friday, December 25th

Celebrating 30 Years of Community Health in Alameda County

Alliance Mission, Vision, and Values

Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of life.

Values

- **Teamwork:** We actively participate, support each other, develop local talent, and interact as one team.
- **Respect:** We put people first, embracing diversity and equity, striving to create a positive work environment, excellent customer service, and value all people's health and well-being.
- **Accountability:** We work to create and maintain efficient processes and systems that minimize barriers, maximize access, and sustain high quality.
- **Commitment & Compassion:** We are empathic and care for the communities we serve including our members, providers, community partners and staff.
- **Knowledge & Innovation:** We collaborate to find better ways to address the needs of our members and providers by proactively focusing innovative resources on population health and clinical quality.



Financial and Operational Efficiency



Health Care Services First

Of our total \$2.1 billion of revenue, 99.9% was spent on health care services.



Engaging our Provider Network

One million doctor office visits, provided in partnership with a dedicated network of more than 12,000 physicians and specialists.



Removing Language Barriers

Provided access to care and services in more than 134 languages processing more than 100,000 interpreter requests.



Member Services

Answers more than 9 out of 10 calls within 13 seconds.

Nearly 30% of all babies born in Alameda County were covered by the Alliance

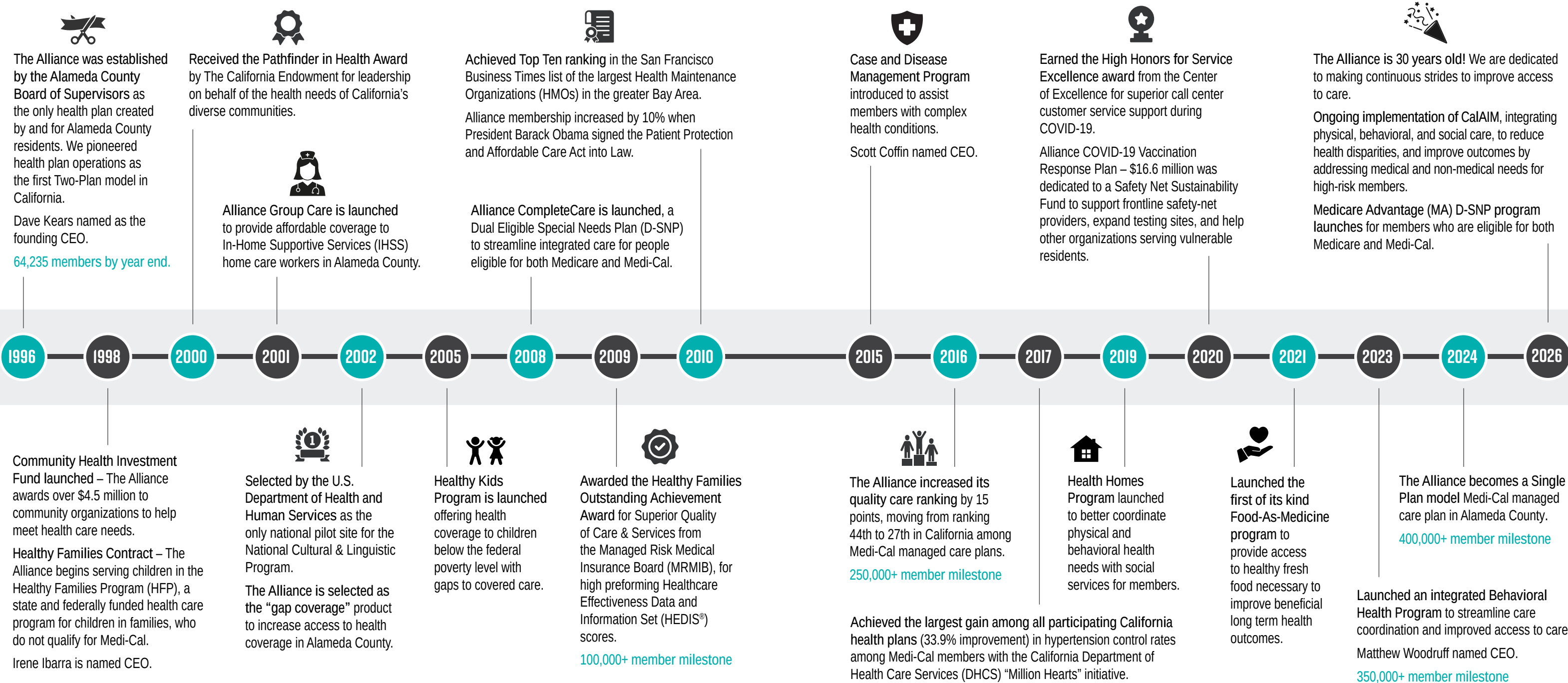
Celebrating 30 Years of Community Health in Alameda County

Created by and for Alameda County residents, the Alliance helps meet an important need: accessible and affordable healthcare for Alameda County residents with limited resources.

Thirty years later, the Alliance grew to serve more than 400,000 members.

We did not do it alone. Our progress has been made possible by the support of healthcare providers, dedicated staff, and community partners who have worked with us every step of the way. Together, we have built a stronger foundation for health security and invested in local programs that help our communities thrive.

We are proud of how far we have come – and the lives we have helped improve – but we know the work is far from over. As we celebrate this 30-year milestone, we are recommitted to our mission and look ahead with renewed determination. The next chapter begins now, and we’re just getting started.



Commitment to Quality Care

Quality Care → Successful Outcomes → Healthier Communities

The National Committee for Quality Assurance (NCQA) sets the national healthcare quality standards. These standards create the baseline for safe, effective, patient-centered, and fair care by healthcare systems.

Our commitment to our members extends beyond these standards to get even better health outcomes for our members.

Strong preventive care is the foundation of raising quality care standards. Detecting and treating conditions early helps avoid potentially serious and costly health outcomes.

Of the top 18 healthcare measure standards set by the NCQA, the Alliance scored double-digit percentage points above the benchmark standards, in the very top 90th percentile.*

A partial list:

Healthcare Measure	Alliance 90 th Percentile Above Benchmark
Breast Cancer Screening Rates	10.80% above industry benchmark
Cervical Cancer Screening Rates	11.66% above industry benchmark
Asthma Medication Ratio	10.41% above industry benchmark
Lead Screening in Children	15.67% above industry benchmark
Well-Child Visits	10.51% above industry benchmark



Of all 27 managed care providers in California, we rate in the **top 25th** percentile for overall top-quality care.

**Based on national quality performance measures established by the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set.*

Celebrating 30 Years of Community Health in Alameda County



Our Commitment to Our Members

Finding the right care at the right time can be hard. Our Alliance member services team is available to help. They work to provide support and guide our members to the right care and resources. They strive to create a positive experience.

Annual survey results from our members reaffirm our commitment to delivering quality service in the areas most critical to positive health outcomes.*

Having a team ready to answer our members' calls helps reduce the barriers to healthcare and improves health outcomes. This is one of the many ways we are committed to our members' well-being.*

Key Drivers of Health Plan Satisfaction Ratings Plan*

Alliance scores have remained strong, with many showing year-over-year increases that consistently exceed industry benchmarks in core healthcare plan satisfaction ratings.**



9 out of 10 doctors would recommend working with the Alliance to other doctors.



Positive rating of personal doctor
83.5%



Positive rating of health care
81.6%



Happy with our customer service
87.3%



Overall satisfaction with the Alliance
80.7%

Alliance Performance Far Above Industry Benchmarks

In-office wait time (within 60 minutes) **90.5%** (compared to industry benchmark of 80%)

Call return time (within 1 business day) **85.9%** (compared to industry benchmark of 80%)

Time to answer call (within 10 minutes) **80%** (compared to industry benchmark of 70%)

* As per national quality performance measures established by the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set.

** Data set measuring of all adults who ranked 8 out of 10.

Celebrating 30 Years of Community Health in Alameda County

Whole Health – Investing in a Healthier Community

We are a community partner focused on building a healthier, stronger community. We've created and operate many Community Enrichment Programs that improve members' health and well-being by providing hands-on support and education.

These programs directly invest our funds into local organizations and community initiatives that address and help drive long-term changes for health stability. This includes housing and food programs.

These efforts strengthen the safety net and address critical needs. This past year, the Alliance directly invested almost \$15 million to support the health and well-being of our community.



Housing & Homelessness Incentive Program

Through the Housing & Homelessness Incentive Program (HHIP), the Alliance earned \$38 million in incentive funds, which we invest into community partnerships to support members at risk of, or experiencing homelessness, by connecting them with resources necessary to achieve housing stability.



Student Behavioral Health Incentive Program

The Alliance earned \$9.7 million to develop partnerships focused on increasing access to behavioral health services in schools. This includes early intervention and suicide-awareness training for school staff. By providing access to resources before challenges escalate, the program reduces crisis-level interventions, creating a stable foundation for children.



Provider Recruitment Initiative

The Provider Recruitment Initiative supports the Alameda County Safety Net to hire and retain healthcare professionals who serve the Medi-Cal population. This year, the Alliance committed \$2 million in grants to 13 practices to increase accessibility, provide training opportunities for staff, and promote culturally inclusive care.



Community Health Assessment and Improvement

The Alliance invested \$100,000 in city and county public health entities that identify and assess community health gaps and areas of need, and then develop strategies and action plans that will focus program needs to ultimately better support and improve health outcomes.



Diabetes Prevention Program

Our diabetes prevention program as an easy-to-enroll, easy-to-participate online program was created to help at-risk adults recognize their risk, provide individual coaching, group support and online tools that focused on how to make sustainable lifestyle changes to help participants lose weight and reduce the risk of developing diabetes.



Doula Program Expansion

Recognized for their role in addressing rising maternal mortality, doulas provide critical physical, emotional, and informational support before, during, and after childbirth. We grew our network from 12 to 73 doulas with \$20,000 in scholarships and additional funding for mentorship services, improving access to skilled birth support.

Looking Ahead

This past year, the federal government voted to cut nearly \$800 billion in Medicaid funding. This puts nearly half a million Alameda County residents at risk of losing access to the lifesaving care they rely on for their well-being. These cuts will have devastating effect on the healthcare system that serves them.

The Alliance is more committed than ever to address this impact and preserve access to care for our members. We are exploring a variety of ideas, working with community-based organizations, and strengthening community programs to help fill critical gaps. We continue to collaborate with local, state, and federal partners to support policies that protect and expand health care access for our community..



Don't lose your Health Coverage. Renew Your Medi-Cal Today.



Keep yourself and your family covered.

It's important to renew your Medi-Cal on time.

Alameda Alliance for Health (Alliance) is here to help you and your family keep your Medi-Cal coverage, so you can get the care you need to stay healthy. It's very important to renew your Medi-Cal so you don't lose access to your health care.

You can renew by mail, or through one (1) of the three (3) easy ways.

- 1 Go to BenefitsCal.com**
Visiting BenefitsCal.com is the best way to update your information and renew your coverage. If you don't have an account yet, it's fast and easy to make one. To watch a video and learn more, please visit, bit.ly/4qSpdNB.
- 2 Visit one of the many Alliance partners at a location near you.**
To learn more, please call Alliance Member Services Department toll-free at **1.877.932.2738**, Monday – Friday, 8 am – 5 pm, or visit www.alamedaalliance.org.
- 3 Call & Get Support to Renew**
If you need help, you can also call the Alameda County Social Services Agency toll-free at **1.888.999.4772**, Monday – Friday, 8 am – 5 pm, or visit www.alamedacountysocialservices.org. You can also contact your health care provider or clinic, or your trusted outreach enrollment team.



To learn more and sign up for general updates, please visit www.keepmedicalcoverage.org.

Don't lose your Health Coverage. Renew Your Medi-Cal Today.

If you need help to complete your renewal form, please call for an appointment at a location near you.

Alameda County Health – HealthPAC Health Insurance Technicians
1.800.422.9495

Asian Health Services
818 Webster St.
Oakland, CA 94607
1.510.986.6880

Asian Health Services – Rolland & Kathryn Lowe Medical Center
835 Webster St.
Oakland, CA 94607
1.510.318.5800

Axis Community Health – Pleasanton
5925 W. Las Positas Blvd.
Suite 100
Pleasanton, CA 94588
1.925.462.1755

Axis Community Health – Livermore
3311 Pacific Ave.
Livermore, CA 94550
1.925.462.1755

Bay Area Community Health – Liberty
39500 Liberty St.
Fremont, CA 94538
1.510.252.5860

Bay Area Community Health – Mowry I
2299 Mowry Ave.
Suite 3B
Fremont, CA 94538
1.510.252.5860

Bay Area Community Health – Mowry II
1999 Mowry Ave.
Suite F
Fremont, CA 94538
1.510.252.5860

Bay Area Community Health – Main Street Village Clinic
3607 Main St.
Suite B
Fremont, CA 94538
1.510.252.5860

Bay Area Community Health – Irvington
40910 Fremont Blvd.
Fremont, CA 94538
1.510.252.5860

Baywell Health
7450 International Blvd.
Oakland, CA 94621
1.510.835.9610 ext. 2012

Baywell Health
700 Adeline St.
Oakland, CA 94607
1.510.835.9610 ext. 2012

Korean Community Center of the East Bay
97 Callen Ave.
San Leandro, CA 94577
1.844.828.2254

La Clínica de la Raza – Transit Village
3451 East 12th St.
Oakland, CA 94601
1.510.535.36502

La Familia
22366 Fuller Ave.
Hayward, CA 94541
1.510.244.4175

LifeLong Medical Care
837 Addison St.
Berkeley, CA 94710
1.510.981.3250

LifeLong Medical Care
2344 Sixth Street
Berkeley, CA 94710
1.510.981.3250

Native American Health Center
2950 International Blvd.
Oakland, CA 94601
1.510.535.4406, press 1

Roots Community Health Center
9925 International Blvd.
Oakland, CA 94603
1.510.777.1177

Tiburcio Vasquez Health Center – Hayward
22331 Mission Blvd.
Hayward, CA 94541
1.510.288.3505

Tiburcio Vasquez Health Center – San Leandro
16110 E. 14th St.
San Leandro, CA 94578
1.510.288.3505

Tiburcio Vasquez Health Center – Union City
33255 9th St.
Union City, CA 94587
1.510.288.3505

Tiburcio Vasquez Health Center – Silva Clinic
680 W. Tennyson Rd.
Hayward, CA 94544
1.510.288.3505



Important Update: New Vision Service Provider for Alliance Medi-Cal Members

We are excited to announce that starting Thursday, January 1, 2026, Vision Service Plan (VSP) will be our new vision care provider for all Alliance Medi-Cal members. VSP will now manage your vision benefits, replacing March Vision.

- There are no changes to your vision benefits: You'll continue to enjoy easy access to doctors, routine eye exams, eyeglasses, low vision devices, and more.
- No prior authorization is required: You can visit a vision care doctor without needing approval first.
- There's a toll-free line for assistance, and referrals are available to your doctor if a medical issue is found during your eye exam.



To get vision care services, simply contact a VSP network provider. For a list of VSP providers, call VSP toll-free at **1.855.492.9028**. If you cannot hear or speak well, please use TTY: **711**. You can also visit **www.vsp.com** for more information.

If you have questions about this transition or need help, please contact the Alliance Member Services Department toll-free at **1.877.932.2738**, Monday through Friday, from 8 am – 5 pm. For TTY services, dial **711**.

If at this time you receive certain kinds of care, you may have the right to keep your current March Vision provider during your treatment. The kinds of care may include follow up care related to medically necessary contact lenses and after eye surgery. After this time of treatment, you may need to change to a new specialist.

If you are worried about this change, you may contact the California Department of Health Services Ombudsman's Office at **1.888.452.8609**. You can also contact the Department of Managed Health Care (DMHC) at **1.888.466.2219** or TDD for the hearing impaired at **1.877.688.9891**. You may also go online at **www.hmohelp.ca.gov**.

If you have any questions, please call us. We can assist you in your language. We can also help you learn more about what your health plan offers.

Alliance Member Services Department

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4567**

Toll-Free: **1.877.932.2738**

If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

Flu Shot and COVID-19 Vaccine

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

It is important to get your flu shot every year. It will help you stay healthy, safe, and strong during the 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 shot and COVID-19 vaccine or booster during the same visit.*

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



Vaccines: Protecting You and Your Family



Vaccines (also called shots, immunizations, or boosters) protect children and adults against many serious diseases. Some of these diseases used to be common, but now they are rare thanks to vaccines. That's why staying up to date on your vaccines is so important — for both kids and adults.

Why Kids Need Vaccines

Babies and young children need several vaccines in their first few years of life. This helps protect them from illnesses that can be serious or even life-threatening. Some key vaccines for children include:

- **Hepatitis B** – Protects against a serious liver infection.
- **Influenza (Flu)** – Protects against seasonal flu.
- **Rotavirus** – Protects against severe diarrhea and dehydration in infants.
- **Pneumococcal** – Protects against ear infections, pneumonia, and meningitis.

Most vaccines are given in a series, which means your child will need more than one dose over time to build strong protection. Your child's doctor or clinic will track their vaccine schedule and remind you when it's time for the next visit.

Adults Need Vaccines Too

Vaccines also protect adults from certain vaccines. Most adults get a yearly flu shot to help prevent illness and protect those around them. You can talk to your doctor about which other vaccines you might need to stay healthy.

Stay on Track

Not sure if you or your child is up to date on vaccines? Call your doctor or clinic to ask. They can check the California Immunization Registry (CAIR). This is a secure system that keeps track of the shots you and your family get from doctors, clinics, and health centers.

To learn more about the California Immunization Registry, visit www.cdph.ca.gov.

Know Your Numbers: Protecting Your Heart as You Age

High blood pressure (also called hypertension) becomes more common as we age. For older adults, uncontrolled blood pressure can lead to serious problems such as heart disease, stroke, kidney damage, vision loss, and memory decline (dementia). High blood pressure often has no signs or symptoms. The only way to know if your blood pressure is too high is to check it regularly.

How Can I Control My Blood Pressure?

You can often lower your blood pressure by changing your daily habits and by taking medication if needed. Try these tips:

- **Aim for a healthy weight.** Being overweight adds to your risk of high blood pressure.
- **Exercise.** Moderate (medium) activity, such as brisk walking or swimming, can lower high blood pressure. Check with your doctor about exercise that is safe for you.
- **Eat a heart-healthy diet.** Eat a variety of vegetables, fruits, grains, protein, dairy, and oils.
- **Cut down on salt.** As you get older, the body and blood pressure become more sensitive to salt.
- **Limit alcohol and quit smoking.** Drinking too much alcohol and smoking both raise your risk for high blood pressure, heart disease, and stroke.
- **Get enough sleep.** Tell your doctor if you've been told you snore or sound like you stop breathing for moments when you sleep.
- **Manage stress.** Reducing stress can help lower high blood pressure.



Blood Pressure Cuff – Covered by the Alliance

A home blood pressure cuff (also called a monitor) is a covered benefit for Alliance members. Checking your blood pressure at home is a simple and powerful way to protect your health as you age. You can talk to your doctor about getting one. Many cuffs are easy to use, and your care team can show you how to take readings the right way.

Need help getting a blood pressure cuff? Call your doctor for more information.

Urgent Call to Action: Fight the Silent Killer – Fatty Liver Disease

Fatty liver disease is a pressing health crisis affecting more than 25% of Americans, yet 90% remain unaware of their condition due to it not showing any symptoms. This “silent killer” can progress to cirrhosis and is already the leading cause of liver transplants in women, with men expected to follow by 2030.

Understanding the Threat

Today's Silent Killer is a nonalcoholic fatty liver disease which is characterized by the buildup of excess fat in the liver like the damage seen in alcohol-related liver disease, but it occurs in people who do not consume alcohol very much. It involves liver inflammation and damage.

Located on the upper right side of the abdomen just below the diaphragm, the liver is the body's largest internal organ and performs many important functions. It helps you process food by changing carbohydrates into glucose for energy. It also removes poisons, also called toxins, from your body. The liver also helps with your immune system. It even produces proteins which provide essential nutrients for the body.

Common risk factors for developing fatty liver disease are obesity, overweight, family history of fatty liver, high cholesterol, high levels of triglycerides in the blood, diabetes, prediabetic, obstructive sleep apnea, underactive thyroid or hypothyroidism, underactive pituitary gland, or hypopituitarism, people older than 50, metabolic syndrome such as high blood pressure, high triglycerides and large waist size, Genetic risk such as patatin-like phospholipase domain-containing 3 (PNPLA3) seen in people with Mexican descent.

Why You Should Care

Beyond the liver damage that fatty liver causes, it heightens risk for heart attacks, stroke, diabetes, various cancers, chronic kidney disease, and other related health concerns.



Take Action Now

- **Lifestyle Changes:** Adopt a balanced diet and regular exercise to reduce liver fat.
- **Regular Monitoring:** Check liver health through medical screenings.
- **Risk Management:** Control related conditions like obesity and diabetes.

Don't wait – take steps today to help your liver health and prevent this silent epidemic from advancing.

Written By: **Ralph L. Peterson MD**

Gastroenterologist

MacArthur Gastroenterology, Oakland CA

**Edited by the Alliance for reading ease*

Why Dental Care is Important – Especially for Teens!



Taking care of your teeth is just as important as taking care of the rest of your body. Even if your teeth look fine, you still need regular checkups. Dentists can catch problems early, like tiny cavities, before they become big (and painful) problems.

This is especially true during the teen years. Between ages 13 and 19, a lot is changing — including in your mouth. This is the time when you get your last permanent teeth. Wearing braces, playing sports, and enjoying sweet drinks and snacks are all things that can affect your dental health.

Why Teens Skip the Dentist

Some teens don't go to the dentist because they feel too busy, nervous, or think they don't need it. But these years are a key time to build healthy habits and protect your smile for the future. Going to the dentist every 6 months for a cleaning and exam helps keep your teeth and gums healthy.

What Is Fluoride Varnish?

One easy and helpful treatment your dentist might offer is fluoride varnish. It's a sticky liquid that helps make your teeth stronger and fights cavities. Here's what you should know:

- **It's quick.** It only takes a few minutes to apply. You can get it during your dental checkup.
- **It's safe.** It can be used for kids, teens, and adults.
- **It doesn't hurt.** There are no shots or drills.
- **You can eat and drink shortly after.** Just wait about 30 minutes.



Fluoride varnish is especially helpful if you get cavities easily or eat a lot of snacks and sugary drinks (like soda or sports drinks).

Make a Plan

Teens: Ask your parents or caregiver to help you make an appointment. Most dental visits are covered by Medi-Cal, including fluoride treatments.

Parents: Help your teens build strong habits now. A visit every 6 months helps your child stay healthy and avoid bigger problems in the future.

If you have questions or want to learn more about dental services, call Medi-Cal Dental at **1.800.322.6384** (TTY **1.800.735.2922** or **711**). You can also visit the Medi-Cal Dental website at: **www.dental.dhcs.ca.gov**.

Doctors, Midwives, and Doulas: Find the Right Team for Your Pregnancy

Are you thinking of becoming pregnant? Or did you just find out that you are pregnant?

It's a good idea to choose your care team early in your journey—from pregnancy through birth and the months after. The right team helps you feel safe, supported, and cared for. The Alliance can help you find doctors, midwives, and doulas to support you and your baby. See the table below to learn what each provider does.

Provider Care Team

Provider Type	What they do
Doctors (like OB-GYNs or some family doctors)	• Give medical checks and tests • Manage high-risk pregnancies • Deliver babies in hospitals • Can do surgeries like C-sections
Midwives	• Help with healthy, low-risk pregnancies • Offer medical care at prenatal visits • Provide emotional support and advice • May deliver babies in hospitals, birth centers, or at home • Do not perform surgeries
Doulas	• Support you physically and emotionally (before, during, and after birth) • Teach you about pregnancy and caring for your baby • Help you feel strong and speak up for what you want • Offer comfort techniques like breathing and relaxation • Do not give medical care or deliver babies

The Alliance is Here for You!

Each provider offers different help, and you can have more than one on your team. Having a healthy baby is a big job, but you are not alone. The right team—whether it's a doctor, midwife, doula, or all three – can help you feel safe, supported, and ready.

To find a care provider, members can:

- Call the Alliance Member Services Department at **1.510.747.4567**
- Search **www.alamedaalliance.org/help/find-a-doctor** to contact a provider directly
 - o Choose: Location, or No Preference
 - o Choose Alliance Plan: Medi-Cal or Group Care
 - o Choose Specialty: Doula, Doctor (OB-GYN), etc.

Safe Sleep for Your Baby



At Alameda Alliance for Health (Alliance), we are here to help your children stay healthy and safe. Keeping your baby safe while they sleep is very important. The way your baby sleeps can help prevent sudden infant death syndrome (SIDS) and other dangers.

Follow these simple steps every time your baby sleeps to help keep them safe:

1. Put Baby on Their Back

Always place your baby on their back to sleep (at night and for naps). This is the safest position for breathing.

2. Use a Safe Sleep Space

- Baby should sleep in a crib, bassinet, or play yard that meets safety standards.
- Use a firm, flat mattress with a fitted sheet.
- No pillows, blankets, stuffed animals, or bumper pads. These can cause suffocation (choking).

3. Share a Room, not a Bed

Keep the baby's sleep space in your room, close to your bed, for at least the first six (6) months. Do not sleep in the same bed as your baby. This can increase the risk of suffocation.

4. Keep Baby Comfortable and Safe

- Dress your baby in a wearable blanket or sleep sack instead of loose blankets.
- Keep the room at a comfortable temperature, not too hot

Your baby's safety is the most important thing.

Following these steps every time your baby sleeps will help keep them safe and give you peace of mind.

Contact Alliance Health Programs for more safety information for children and adults. You can also submit the Wellness Program & Materials Request Form found on page **28**.

Alliance Health Programs

Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4577**

Toll-Free: **1.855.891.9169**

If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

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.

Nondiscrimination Notice and Notice of the Availability of Language Assistance Services and Auxiliary Aids and Services

NONDISCRIMINATION NOTICE

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, and/or sexual orientation.

NOTICE OF THE AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND 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 free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بالرقم **1.877.932.2738** (TTY: **1.800.735.2929**). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريـل والخط الكبير. اتصل بالرقم **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:

ភាសាខ្មែរ (Cambodian)

ចំណាំ: បើអ្នក ត្រូវ ការជំនួយ ជាភាសា ខ្មែរ ឬ មិន ច្បាស់ អំពី ការបំពេញ ប្រព័ន្ធ ឬ ឯកសារ ណាមួយ ក៏សូម ទូរស័ព្ទ ទៅលេខ **1.877.932.2738** (TTY: **1.800.735.2929**)។ ជំនួយ និងសេវាកម្ម សម្រាប់ ជនមាន ឥទ្ធិពល កាត់បន្ថយ ឬ មាន ការរារាំង ផ្លូវចិត្ត ឬ ឯកសារ ណាមួយ ក៏អាច ទទួលបាន ផងដែរ។ ទូរស័ព្ទ ទៅលេខ **1.877.932.2738** (TTY: **1.800.735.2929**)។ សេវាកម្មទាំងនេះ មិន គិត ថ្លៃ ឡើយ។

简体中文标语 (Chinese – Simplified)

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。

繁体中文标语 (Chinese – Traditional)

請注意:如果您需要以您的母語獲得幫助,請撥打 **1.877.932.2738** (TTY: **1.800.735.2929**)。另外我們也提供面向殘障人士的幫助和服務,例如點字和大字版文件。請撥打 **1.877.932.2738** (TTY: **1.800.735.2929**)。這些服務均免費提供。

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। विकलांग लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में दस्तावेज़, भी 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.

Nondiscrimination Notice and Notice of the Availability of Language Assistance Services and Auxiliary Aids and Services

Continued from page 23

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。

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. (TTY: **1.800.735.2929**) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແຫນ້າໂພສາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂຕເທິງ **1.877.932.2738** (TTY: **1.800.735.2929**). ຍັງມີຄວາມຊ່ວຍເຫຼືອ ແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂຕເທິງ **1.877.932.2738** (TTY: **1.800.735.2929**). ການບໍລິການເຫຼົ່ານີ້ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໄດ້.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiex 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 hlou 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)

ਬਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ **1.877.932.2738** (TTY: **1.800.735.2929**). 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਫੁੱਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। **1.877.932.2738** (TTY: **1.800.735.2929**). 'ਤੇ ਕਾਲ ਕਰੋ। 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 serbisyon ng 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 **28**, 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**.



Nondiscrimination Notice and Notice of the Availability of Language Assistance Services and Auxiliary Aids and Services

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
If you cannot hear or speak well (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: VSP	1.855.492.9028
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](https://twitter.com/alamedaalliance)



[@alamedaallianceforhealth](https://instagram.com/alamedaallianceforhealth)



[@alameda-alliance-for-health](https://linkedin.com/company/alameda-alliance-for-health)



[@alamedaalliance](https://youtube.com/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
- ☐ Diabetes **(type 1 or type 2)**
- ☐ 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)
- ☐ Cookbook (Multicultural Flavors)
- ☐ 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: _____

Requested materials will be mailed to you. What other ways can the Alliance contact you? (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



HE_MBR_WPM REQ FORM 09/2024
HED W-1 09/2025

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

2025 | ANNUAL OUTREACH REPORT

ALLIANCE IN THE COMMUNITY

2025 | ANNUAL OUTREACH REPORT

Alliance in the Community Events and Activities:

Between **January 2025** and **December 2025**, the Alliance initiated and/or was invited to participate in **114** events throughout Alameda County. The Alliance completed **31** community events, **47** member education events, **6** community meeting/presentation, more than **9,546** live member orientation outreach calls among net new members and non-utilizers and completed **956** member orientations by phone. The Alliance reached a total of **13,250** people and spent **\$7,615.00*** on donations, fees, and/or sponsorships in 2025. In addition, during 2025, the Outreach team completed **501** Alliance website inquiries, and **69** service requests.

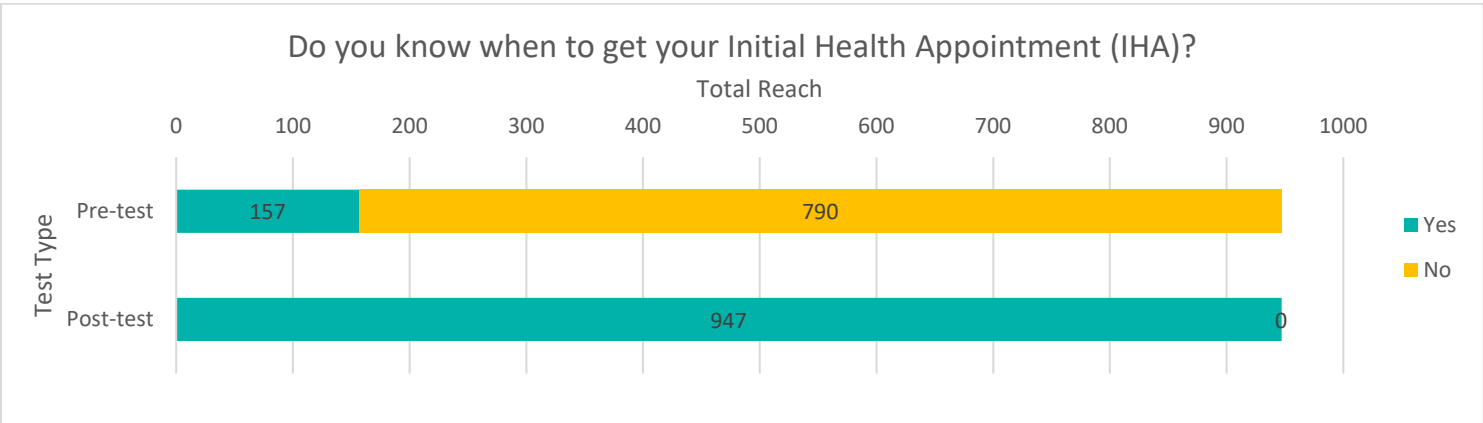
Since July 2018, **43,597** self-identified Alliance members were reached during outreach activities.

Alliance Member Orientation Program:

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

On **Wednesday, March 18, 2020**, the Alliance began conducting member orientations by phone. As of December 31, 2025, the Outreach Team completed **54,613** member orientation outreach calls and non-utilizer calls and conducted **10,235** member orientations (**19%** member participation rate).

Between March 18, 2020, through December 31, 2025 – **10,235** members completed our MO program by phone. After completing a MO **100%** of members who completed the post-test survey in 2025 reported knowing when to get their IHA, compared to only **16.6%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 25-26\Q2\December 2025**

ALLIANCE IN THE COMMUNITY
2025 | ANNUAL OUTREACH REPORT

2025 TOTALS



31 COMMUNITY EVENTS

47 MEMBER EDUCATION
EVENTS

956 MEMBER
ORIENTATIONS

6 MEETINGS/
PRESENTATIONS

114 TOTAL INITIATED /
INVITED EVENTS

1040 TOTAL EVENTS



7,017 TOTAL REACHED AT
COMMUNITY EVENTS

5,700 TOTAL REACHED AT MEMBER
EDUCATION EVENTS

956 TOTAL REACHED AT MEMBER
ORIENTATIONS

533 TOTAL REACHED AT
MEETINGS/PRESENTATIONS

6,806 TOTAL MEMBERS REACHED AT
EVENTS

14,176 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 38 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.*



\$7,615.00

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*



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

Compliance

Richard Golfin III

To: Alameda Alliance for Health Board of Governors

From: Richard Golfin III, Chief Compliance & Privacy Officer

Date: January 9th, 2026

Subject: Compliance Division Report

Enterprise Audit Updates

- 2023 Department of Managed Health Care (DMHC) Health Equity and Quality Performance CAP
 - The Plan received the 2023 Health Equity and Quality Performance Findings Report from the Department of Managed Health Care (DMHC) on September 2nd, 2025. The Plan submitted its CAP response timely on December 1st, 2025. The Plan is awaiting DMHC's guidance.
- 2025 Department of Managed Health Care (DMHC) Routine Full Medical Survey
 - The Plan received its preliminary report from the department on December 31st, 2025. There were sixteen (16) findings which included two (2) repeat findings across the following review areas:
 - Quality Assurance
 - Grievances and Appeals (*Repeat Finding*)
 - Access and Availability of Services
 - Utilization Management
 - Prescription Drug Coverage (*Repeat Finding*)
 - Behavioral Health – SB 855
 - The Plan's CAP response is due to the department on February 14th, 2026.
- 2025 Department of Managed Health Care (DMHC) Financial Examination
 - The DMHC conducted its fiscal survey of the Plan on August 4th, 2025. The Plan received the Department's final report on December 17th, 2025, following its CAP submission, which included one (1) unresolved deficiency regarding the oversight of forwarded claims.
 - The Plan is expected to provide its CAP response by January 16th, 2026. The Department requires the Plan to provide the revised policies and procedures, dates implemented as well as the implementation dates of the new audit procedures.

- 2026 Department of Health Care Services (DHCS) Routine Survey
 - The Plan received audit notification from the DHCS on December 8th, 2025. The audit will take place on March 2nd, 2026, through March 13th, 2026, and will be conducted virtually. The review period will cover March 1st, 2025, through December 31st, 2025.
 - The Plan will be evaluated in the following areas:
 - Utilization Management
 - Population Health Management & Coordination of Care
 - Network and Access to Care
 - Grievance, Appeals, & Member's Rights
 - Quality Improvement & Health Equity Transformation
 - Plan Organization and Administration
 - The Plan is expected to provide documentation in response to the Pre-Audit Information Request by January 22nd, 2026.

Compliance Program Activity

- Alameda Alliance Wellness (HMO D-SNP)
 - On January 1st, 2026, the Plan launched its California D-SNP plan in Alameda County. The Compliance Division provides regulatory support across the enterprise for all lines of business, to include, post-launch metric reporting to regulators for the Alameda Alliance Wellness line of business, and if necessary, real-time escalation of any issues to federal regulators.
 - The Plan selected Knox Keene licensed specialty health plan, Vision Service Plan (VSP), as its vision services provider for both D-SNP and Medi-Cal lines of business. This required both the Alliance and VSP to submit a Material modification e-Filing for the DMHC's review and approval. On Monday, December 29th, 2025, although the agency continues to review documents in furtherance of full approval, the Plan was granted preliminary and conditional approval. This enables the Plan to implement the provisions of its agreement with VSP while the DMHC concludes its review in the upcoming months.
- Legislative & Regulatory Implementation (End of Year Initiatives)
 - On March 21st, 2025, the Plan provided its initial submission in response to the DMHC's 2024 Annual release of Newly Enacted Statutes – All Plan Letter (APL 24-023) filing. This APL includes seventeen (17) newly enacted statutes that impact the Plan's Medi-Cal and/or Group Care lines of business. As of January 2nd, 2026, the Plan has received five (5) rounds of comments, the latest due on January 16th, 2026. Only three (3) of the seventeen (17) newly enacted statutes remain open.

- On April 1st, 2025, the DMHC published APL 25-007 which provides guidance and outlines compliance requirements related to AB 3275 – Timely Payment of Claims. This bill, effective January 1st, 2026, adjusts the claims reimbursement timeframe from forty-five (45) working days to thirty (30) calendar days. The filing was closed by the Department on December 12th, 2025.
- On December 19th, 2025, DMHC published APL 25-020 which provides guidance and outlines compliance requirements related to twelve (12) newly enacted statutes. The Compliance filing is due to DMHC on March 19th, 2026.
- On December 30th, 2025, DMHC published APL 25-021 which provides guidance and outlines compliance requirements related to SB 729 – Treatment for Infertility and Fertility Services. The Compliance filing is due to DMHC on March 19th, 2026.

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

- Privacy Workflow Oversight and Tracking Enhancements
 - The Privacy Office has completed implementation of standardized and expanded tracking models across all major privacy-related workflows to strengthen oversight, improve operational management, and enable enterprise-level trend analysis. These enhancements establish consistent logging and documentation for legal document reviews, medical record requests, HIPAA incident intake, Email HIPAA review, and Grievance & Appeals responses. This centralized tracking will also provide leadership with improved visibility into workload volume, complexity, and emerging risk patterns, moving Privacy into a unified data-driven oversight model. The enhanced tracking framework supports more effective resource planning, risk identification, and decision-making.
- CMP – 213: Remote Access
 - The policy was refined to clearly define its role within Alameda Alliance for Health's enterprise privacy, security, and compliance framework. The update establishes a clear governance structure, positioning this policy as the primary compliance authority, while relying on existing specialized policies to address detailed operational and technical requirements, and by formally incorporating related policies by reference, this approach reduces duplication, improves consistency across the policy ecosystem, and clarifies accountability for ownership and enforcement. Refinement minimizes the risk of conflicting requirements and strengthens organizational alignment across privacy, security, and IT functions.
 - The updated policy enhances audit readiness by serving as the central compliance anchor for HIPAA remote access expectations. This approach helps ensure better oversight and ongoing regulatory preparedness throughout every area of the business.

- Annual Corporate Compliance Training (Update)
 - On September 8th, 2025, the Plan launched the Annual Compliance Training for all staff, contractors, and temporary employees.
 - This year's program includes three (3) required Corporate Compliance training courses, covering the following topics:
 - HIPAA,
 - Fraud, Waste & Abuse (FWA), and
 - Cultural Sensitivity
 - The Compliance Division partnered with the IT Department to roll out six (6) additional Security Awareness modules. The modules are designed to equip staff with the knowledge to identify, prevent, and respond to compliance and security risks.
 - The annual training cycle is a key pillar of the Corporate Compliance Program. Policy CMP-026: Compliance Training and Education governs the annual enterprise training exercise. As of this report, approximately seven hundred thirty-five (735) individuals were assigned to participate in the annual training, and the following completion rates are recorded in the corporate record:
 - 100% of active assignees have completed the HIPAA & FWA Trainings.
 - 100% of active assignees have completed the Cultural Sensitivity Training.
 - 100% of active assignees have completed the Security Trainings.
- Department-Specific Privacy Training Initiative
 - The Privacy Office has initiated a structured, department-specific privacy training program to strengthen workforce awareness, operational compliance, and risk mitigation across key functional areas in the topic of information security practices. Quarterly trainings are scheduled and underway for Member Services, Grievance & Appeals, and UM – Case Management. This targeted approach to training is designed to align privacy requirements with department-specific workflows and risk profiles, reinforcing practical application of privacy obligations in day-to-day operations. The initiative supports improved compliance consistency, incident prevention, and audit readiness. The Privacy Office will continue to expand this quarterly, role-based training model, across the enterprise in the coming months as part of its broader privacy education and governance strategy.

- Corporate Annual D-SNP Training (Status)
 - In anticipation of the January 1, 2026 D-SNP product launch, the Plan launched a comprehensive Medicare training program in Q4 2025 to ensure readiness for D-SNP operations and compliance with CMS and DHCS requirements. The program included core modules such as General Medicare Training, Model of Care (MOC), Medicare STARS, Marketing & Communications, Behavioral Health, and specialized sessions for Claims, Pharmacy, and LTSS.
 - 100% of active assignees have completed the General Medicare Training.
 - 100% of active assignees have completed the Model of Care Training.
 - 100% of active assignees have completed Medicare STARS Training.
 - 100% of active assignees have completed Behavioral Health Training.
 - 100% of active assignees have completed the Marketing Training.

Alameda Alliance Special Investigations Unit: Operational Updates

- 2025 Fraud, Waste, and Abuse Program Overview and Performance
 - The Alliance Special Investigations Unit (SIU) investigates fraud, waste and abuse (FWA) incidents through claims and medical data review, medical record review, and interviews with providers, members, and staff.
 - The Alliance SIU contracts with Healthcare Fraud Shield to review claims data, regulations, and contract information to detect potential FWA cases and enhance the fraud, waste, and abuse program.
 - Timely reporting of FWA incidents is supported through an automated referral process across six (6) points of entry: Member Services, Grievance & Appeals, Quality, Case Management, Facilities, and the Compliance Hotline. This process is reinforced by training and follow-up and has improved the timeliness of referrals.
- Fraud, Waste, and Abuse Incident Summary for 2025
 - In 2025 the Alliance SIU received three hundred and fifty-nine (359) potential FWA referrals for review:
 - Sixty-one (61) from Healthcare Fraud Shield
 - One hundred and seven (107) from the Compliance Hotline
 - One hundred and ninety-one (191) from internal sources (Member Services, Grievance & Appeals, Quality, Case Management, and Facilities)
 - After initial screening, eighty-six (86) cases were determined to be potentially FWA related, and were reported to DHCS:
 - Eighty-one (81) Provider Billing Issues
 - Four (4) Member Identity Theft/Fraud Issues
 - One (1) Other (Non-FWA) Issue

- Of these, fifteen (15) cases have been closed, and seventy-one (71) investigations remain active and will continue into 2026.

Enterprise Risk Management (ERM) and Operational Oversight Updates

- In 2025, the Plan advanced governance and risk management capabilities and developed the Enterprise Risk Management (ERM) taxonomy, finalized the annual risk policy, and drafted the Governance Risk Committee (GRC) charter, incorporating feedback from officers and senior leaders.
- The Internal Audit Department streamlined its core processes by standardizing communication, planning, fieldwork, and close-out phases, and updated tracking tools to enhance reporting and monitoring metrics. Additionally, audit approaches were enhanced to expand scope to include all enterprise risks.
- In 2026, Enterprise Risk Management (ERM) and Internal Audit (IA) Departments will formalize governance structures by launching quarterly Governance, Risk & Compliance (GRC) meetings. The focus will include finalizing the corporate ERM framework and taxonomy, delivering the first enterprise risk heatmap, and implementing dashboards for improved proactive oversight and reporting. IA will continue its transformation with a risk-informed audit plan and enhanced monitoring of corrective actions and mitigation plans. The ERM & IA Departments will evaluate technological solutions and vendors to support ERM workflows and reporting, ensuring alignment with organizational priorities and strengthening the Plan's ability to manage risk, proactively.

Compliance

Supporting Documents

2025 APL IMPLEMENTATION TRACKING LIST						
#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
1	1/9/2025	DMHC	25-001	Southern California Fires and Enrollees' Continued Access to Health Care Services	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) 25-001, which provides information regarding Health and Safety Code section 1368.7.
2	1/17/2025	DHCS	25-001	2024-2025 Medi-Cal Managed Care Health Plan Meds/834 Cutoff and Processing Scheduling	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with the 2024-2025 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.
3	1/13/2025	DHCS	25-002	Skilled Nursing Facility Workforce Quality Incentive Program	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with instructions on the payment and data sharing process required for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for Rating Periods between January 1, 2023, and December 31, 2026. The Calendar Year (CY) 2023 Rating Period is referred to as Program Year (PY) 1, CY 2024 Rating Period as PY 2, and so forth.
4	1/15/2025	DHCS	25-003	Establishing D-SNPs by 2026	DSNP	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with information regarding the Department of Health Care Services' (DHCS) enforcement of California Welfare and Institutions Code (W&I) section 14184.208, related to the requirement for MCPs to operate or be affiliated with a Dual Eligible Special Needs Plan (D-SNP) by 2026, to provide integrated care through affiliated MCPs and D-SNPs for dually eligible Medicare and Medi-Cal Members.
5	1/28/2025	DMHC	25-002	Plan Year 2026 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 25-002 to assist in the preparation of Plan Year 2026 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules).
6	2/5/2025	DMHC	25-003	Large Group Renewal Notice Requirements	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 25-003 to provide guidance to plans on the timing and content requirements for renewal notices to large group contractholders under HSC section 1374.21 and HSC section 1385.046.
7	2/7/2025	DHCS	25-004	Community Reinvestments Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the MCP Contract's requirement that MCPs reinvest a minimum level of their net income into their local communities.
8	2/12/2025	DHCS	25-005	Standards For Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, And Alternative Formats	MEDI-CAL	This All Plan Letter (APL) serves to inform all Medi-Cal managed care plans (MCPs) of the dataset for threshold and concentration languages and clarifies the threshold and concentration standards specified in state and federal law and the MCP Contract. This dataset identifies the threshold and concentration languages in which, at a minimum, MCPs must provide written translated Member information. This APL also provides guidance on federal and state requirements regarding nondiscrimination, discrimination grievance procedures, language assistance, and communications with individuals with disabilities as set forth in the federal regulations implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA), Title 42 of the Code of Federal Regulations (CFR) Part 438, Senate Bill (SB) 223 (Atkins, Chapter 771, Statutes of 2017), and SB 1423 (Hernandez, Chapter 568, Statutes of 2018)
9	3/12/2025	DMHC	25-004	AB 118: Part 1 - Compliance with Large Group Standardized Evidence of Coverage/Disclosure Form	GROUP CARE	Assembly Bill (AB) 118 (Ting, Chapter 42, Statutes of 2023) added Health and Safety Code section 1363.3 and revised Sections 1352.1, 1363, 1367.041, and 1367.24, effective January 1, 2025. These statutory changes apply to all commercial full-service health care service plans (plans), and require the Department of Managed Health Care (DMHC) to develop standardized templates for various documents describing health plan member benefits, such as the Evidence of Coverage (EOC), Disclosure Form (DF), Schedule of Benefits (SOB), Explanation of Benefits (EOB), and Cost-Share Summary (CSS). The DMHC's work to implement AB 118's requirement to develop standardized templates will be an iterative process. The first part of the standardized EOC/DF will be the following template components: (1) Exclusions and Limitations, (2) Members' Rights and Responsibilities, and (3) Definitions, for use in large group health care service plan contracts issued, amended, or renewed on or after January 1, 2026. This All Plan Letter (APL) and its accompanying attachments set out the filing requirements needed to demonstrate compliance with each template component.
10	3/19/2025	DMHC	25-005	Southern California Fires and Flexibilities to Impacted Providers	GROUP CARE & MEDI-CAL	On January 7, 2025, California Governor Gavin Newsom declared a State of Emergency in Los Angeles and Ventura Counties due to wildfires. The fires destroyed homes and businesses and displaced enrollees and health care providers. After the Governor declares a state of emergency, Health and Safety Code section 1368.7 allows the DMHC to take actions to help mitigate the impact to enrollees and providers.
11	3/21/2025	DMHC	25-006	Health Plan Coverage of Mobile Crisis Services	GROUP CARE	This APL provides guidance regarding the obligations of health plans related to behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team.
12	4/1/2025	DMHC	25-007	Assembly Bill 3275 Guidance (Claim Reimbursement)	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) under the Knox-Keene Health Care Service Plan Act of 1975, as amended, to provide guidance to health care service plans (plans) on requirements for the processing and reimbursement of claims for health care services with a date of receipt on or after January 1, 2026. Assembly Bill 3275 (Soria, 2024) amended Health and Safety Code sections 1371 and 1371.35 relating to reimbursement of claims for health care services, and enacted Health and Safety Code section 1371.34 enhancing consumer protections relating to grievances about claims for health care services.
13	4/9/2025	DMHC	25-008	Provider Directory Annual Filing Requirements	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (the Department) issues this All Plan Letter (APL) to remind health care service plans (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. In addition, the Department reminds plans to submit the changes to their provider directory policies and procedures as instructed in APL 24-018 – Compliance with Senate Bill 923.
14	4/15/2025	DMHC	25-009	2025 Health Plan Annual Assessments	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide information to health care service plans (health plans) pertaining to the DMHC's fiscal year (FY) 2025-26 annual assessment.

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
15	4/25/2025	DHCS	25-006	Timely Access Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the ongoing requirement to meet timely access standards as outlined in Health and Safety Code (H&S) section 1367.03, as set forth by Senate Bill (SB) 221 (Chapter 724, Statutes of 2021) and SB 225 (Chapter 601, Statutes of 2022). MCPs are required to comply with these requirements pursuant to Welfare and Institutions Code (W&I) section 14197(d)(1)(a).1 Additionally, this APL outlines the required minimum performance levels (MPLs) as set by the Department of Health Care Services (DHCS) which go into effect Measurement Year (MY) 2025 for the Timely Access Survey.
16	4/25/2025	DHCS	25-007	Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care plans (MCPs) of the Department of Health Care Services' (DHCS) policy regarding the imposition of enforcement actions, including corrective action plans, and administrative and monetary sanctions, which are among the enforcement actions DHCS may take to enforce compliance with MCP contractual provisions and applicable state and federal laws.
17	5/5/2025	DHCS	25-008	Hospice Services and Medi-Cal Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to highlight contractual, regulatory, and statutory requirements applicable to Medi-Cal managed care plans (MCPs) with respect to their responsibilities to provide Medically Necessary hospice services to their MCP Members.
18	5/12/2025	DHCS	25-009	Commyunity Advisory Committee	MEDI-CAL	The purpose of this All Plan Letter (APL) is to summarize the Community Advisory Committee (CAC) requirements and provide Medi-Cal managed care plans (MCP) with information and guidance regarding their responsibility to implement, maintain, and maximize Member, family, and community engagement through the CAC.
19	5/20/2025	DMHC	25-010	Sections 1357.503 and 1357.505 MEWA Registration and Annual Compliance Requirements	N/A	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to inform health care service plans (Plans) and association of employers defined as multiple employer welfare arrangements (MEWAs) of the requirements of AB 2072 (Weber, Ch. 374, Stats. 2024) and AB 2434 (Grayson, Ch. 398, Stats. 2024). This APL discusses the requirements on Plans and MEWAs for the initial MEWA registration pursuant to Section 1357.505. This APL also discusses the ongoing compliance requirements for Plans and registered MEWAs pursuant to Section 1357.503. Plans are asked to disseminate this information to their contracted MEWAs.
20	5/23/2025	DMHC	25-011	Health Plan Coverage of HIV Preexposure Prophylaxis (PrEP)	GROUP CARE & MEDI-CAL	On July 8, 2020 and July 6, 2021, the Department of Managed Health Care (DMHC) issued All Plan Letter (APL) 20-026 and 21-018 regarding health plans' obligations to cover Human Immunodeficiency Virus (HIV) antiretroviral drugs and preexposure prophylaxis (PrEP). This APL supplements the two prior APLs and gives further guidance to ensure health plans meet their obligations to cover PrEP with no prior authorization or cost-sharing.
21	6/3/2025	DHCS	25-010	Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services	MEDI-CAL	This All Plan Letter (APL) provides guidance to Medi-Cal managed care plans (MCP) on standardized, statewide Adult and Youth Screening and Transition of Care Tools to guide referrals of adult and youth Members to the appropriate Medi-Cal mental health delivery system and guide timely care coordination for Members requiring transition between delivery systems.
22	6/9/2025	DMHC	25-012	Closure of Rite Aid Pharmacies	GROUP CARE	In May 2025, Rite Aid announced it would be closing numerous pharmacies across multiple states as it moves through bankruptcy proceedings. This APL reminds health plans that they have an ongoing obligation to ensure their enrollees have timely access to prescription drugs. The APL also requires health plans to file with the DMHC a description of how the plans will ensure on-going access to prescription drugs within the access standards required by the Knox-Keene Health Care Service Plan Act (KnoxKeene Act).
21	7/3/2025	DHCS	25-011	H.R.1 -- Federal Payments to Prohibited Entities	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on handling of payments to Medi-Cal and Family Planning, Access, Care, and Treatment Program (Family PACT) Providers who may be impacted by H.R. 1 that was enacted on July 4, 2025 (Public Law No: 119-21). This APL also provides guidance pertaining to a recent Temporary Restraining Order (TRO) blocking immediate implementation of Section 71113 in H.R. 1, which will expire in 14 days of issuance, unless modified, extended, or stayed.
22	8/19/2025	DHCS	25-012	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 eligible Network Provider ^{1,2} payment requirements applicable to Medi-Cal Targeted Rate Increases (TRI), as defined herein, effective for dates of service on or after January 1, 2024. Provisions of this APL regarding augmented reimbursement rates for comprehensive family planning services enacted through Senate Bill (SB) 94 (Chapter 636, Statutes of 2007) supersede APLs 10-003 and 10- 014 with retroactive effect for dates of service not included in TRI. Furthermore, provisions of this APL apply to out-of-Network providers outlined in Exhibit A, Attachment III, Subsection 3.3 (Provider Compensation Agreements) of the MCP Contract (including, but not limited to, family planning services, sexually transmitted diseases services, human immunodeficiency virus testing and counseling, and Minor Consent Services).
23	9/3/2025	DMHC	25-013	Amendments to Rules 1300.51, 1300.52, 1300.52.4, 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2026 and Continuing Thereafter	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to notice new amendments to 28 CCR §§ 1300.51, 1300.52, 1300.52.4, 1300.67.2.2, and the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for the reporting year (RY) 2026 Annual Network Report submission and continuing thereafter.
24	9/4/2025	DMHC	25-014	Provider Appointment Availability Survey Manual and Report Form Amendments Beginning RY 2027/MY 2026 and Continuing Thereafter	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 Timely Access Compliance Report documents: Provider Appointment Availability Survey (PAAS) Manual, PAAS Report Forms and the Timely Access Submission Instruction Manual (TA Instruction Manual).

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
25	9/18/2025	DHCS	25-013	Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on the oversight and administration of the Medi-Cal pharmacy benefit. Effective January 1, 2022, Governor Gavin Newsom's Executive Order N-01-19, required the Department of Health Care Services (DHCS) to transition Medi-Cal pharmacy services from the managed care delivery system to the Fee-For-Service (FFS) delivery system, which is collectively known as "Medi-Cal Rx".
26	9/18/2025	DMHC	25-015	Assembly Bill 144 and Coverage of Preventive Care Services	GROUP CARE & MEDI-CAL	This APL outlines the obligations of health plans to cover preventive care items and services prior to enactment of AB 144 and summarizes AB 144's new requirements regarding coverage of preventive care items and services. The APL also highlights recent recommendations by CDPH regarding immunizations to protect against COVID19, RSV, and influenza.
27	9/26/2025	DHCS	25-014	Update to Provider Directory Requirements	MEDI-CAL	This All Plan Letter (APL) provides Medi-Cal managed care plans (MCPs) with guidance on updated Provider Directory requirements pursuant to the Consolidated Appropriations Act, 2023 (Pub.L. No. 117-328, section 5123 (Dec. 29, 2022) 136 Stat. 4459, 5944) (CAA, 2023); State Health Official Letter (SHO) 24-003, pages 4-5; and 42 Code of Federal Regulations (CFR) section 438.10(h)(1).
28	10/2/2025	DHCS	25-015	Data Sharing and Quality Rate Production for Directed Payment Initiatives and Alternative Payment Methodology Programs	MEDI-CAL	The purpose of this All-Plan Letter (APL) is to provide details on Medi-Cal managed care plans' (MCPs') obligations surrounding data sharing and quality measures in Department of Health Care Services' (DHCS) Directed Payment Initiatives or DHCS administered Alternative Payment Methodology (APM) programs as described in the following sections of the MCP Contract 2: Exhibit A, Attachment III, Subsection 3.3.19; Exhibit B Subsection 1.1.14.B; and Exhibit B, Subsection 1.1.14.B.16. In these programs, payment to and/or participation of Providers are tied to specific quality measures.
29	10/31/2025	DMHC	25-016	Request for Health Plan Information Revisions	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (Department) issues this All-Plan Letter (APL) to notify health care service plans the Department has revised the Request for Health Plan Information (RHPI) form.
30	11/13/2025	DHCS	25-016	Alternative Format Selection For Members With Visual Impairments	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide information about the Department of Health Care Services' (DHCS) processes to ensure effective communication with Members with visual impairments or other disabilities requiring the provision of written materials in alternative formats, by tracking Members' Alternative Format Selections (AFS).
31	12/5/2025	DMHC	25-017	Introduction of a New Independent Medical Review Organization	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) to inform licensed health plans under the Department's jurisdiction and subject to independent medical reviews (IMR) set forth in Health and Safety Code section 1370.4 and 1374.29 et seq., and Title 28 of the California Code of Regulations section 1300.74.30, of the addition of Managed Medical Review Organization, Inc. (MMRO) to perform contracted IMRs for the Department.
32	12/5/2025	DMHC	25-018	Notice of Rate Changes for Independent Medical Reviews	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) to inform licensed health plans under the Department's jurisdiction and subject to independent medical reviews (IMR) set forth in Health and Safety Code section 1370.4 and 1374.29 et seq., and Title 28 of the California Code of Regulations section 1300.74.30 of an upcoming rate increase by MAXIMUS Federal Services, Inc. (Maximus) to complete IMRs for the Department.
33	12/12/2025	DMHC	25-019	As of January 2nd, , 2026, the Plan has received five (5) rounds of comments, the latest due on January 16th, 2026. for three (3) of the seventeen (17) newly enacted laws.	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to notice network adequacy amendments to 28 CCR Section 1300.51, 1300.67.1.3, and 1300.67.2, and documents incorporated by reference. These amendments are noticed pursuant to Health and Safety Code section 1367.03(f)(5).
34	12/19/2025	DMHC	25-020	Newly Enacted Statutes Impacting Health Plans (2025 Legislative Session)	GROUP CARE & MEDI-CAL	This All Plan Letter (APL) outlines the newly enacted statutory requirements for health care service plans (plans) regulated by the Department of Managed Health Care (DMHC).
35	12/30/2025	DMHC	25-021	Implementation of Senate Bill 729 (2024)	GROUP CARE	Senate Bill 729 (Menjivar, 2024) amended Health and Safety Code section 1374.55 of the Knox-Keene Act. SB 729 as enacted required large group health contracts issued, amended, or renewed on or after July 1, 2025, to cover the diagnosis and treatment of infertility and fertility services. Likewise, SB 729 as enacted, required small group health plan contracts issued, amended, or renewed on or after July 1, 2025 to offer coverage for the diagnosis and treatment of infertility and fertility services. However, Assembly Bill 116 (Committee on Budget, 2025) delayed the effective date from July 1, 2025, to January 1, 2026. AB 116 also specified that the Department of Managed Health Care (DMHC) may issue guidance regarding compliance with section 1374.55 and such guidance shall not be subject to the Administrative Procedure Act. Per that authority, the DMHC issues the following guidance to health plans.

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

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

Compliance Dashboard Summary

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

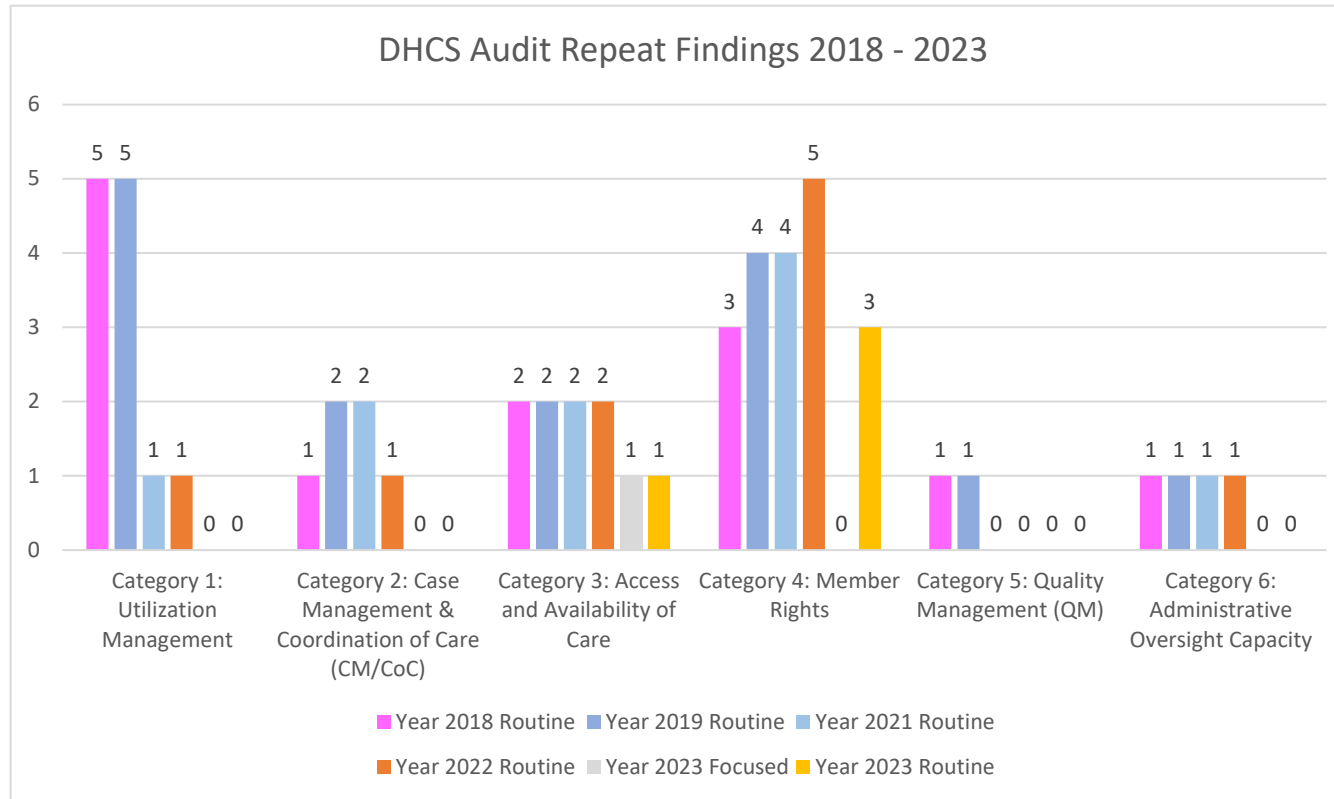
2018 DHCS Medical Services Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	38	76%
	Total Self-Identified Issues	12	24%
	Total Findings	50	
	Total In Progress	0	0%
	Total Completed	50	100%
	Total Findings	50	

Compliance Dashboard Summary

DHCS Audit Repeat Findings 2018 - 2023

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

Compliance Dashboard Summary

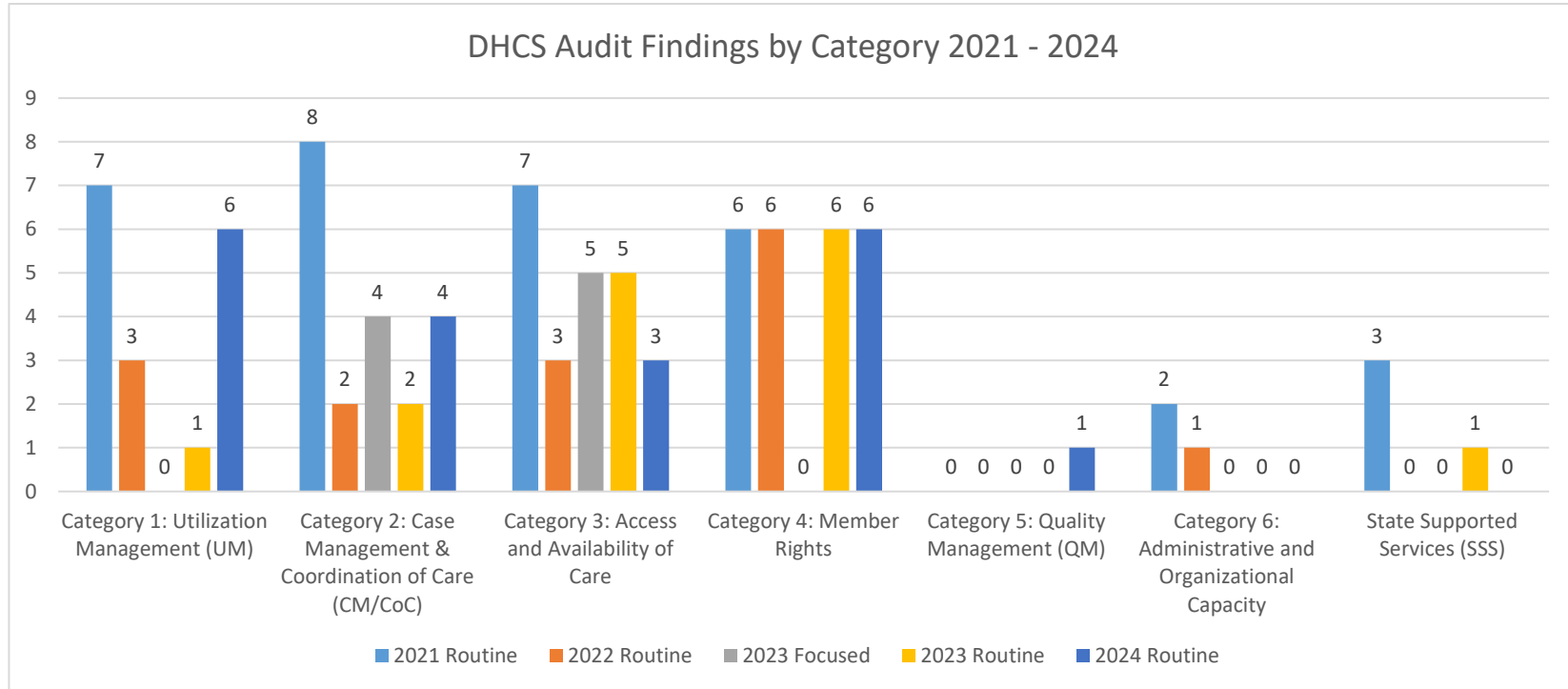


Compliance Dashboard Summary

DHCS Audit Findings by Category 2021 - 2024

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

Compliance Dashboard Summary



DHCS Repeat Findings by Year 2018 - 2023

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

**ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD**

KEY

Yellow = Plan Observations

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

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

R = Repeat Findings

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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R = Repeat Findings

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
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White = State Finding in the final report that was not a Plan Observation
<u>R</u> = Repeat Findings

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

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

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

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

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

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

2021 DMHC JOINT AUDIT FINDINGS : <i>Audit Review Period 11/1/2018 - 10/31/2020</i>							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Grievances & Appeals	When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform complainants of their right to contact the Department.	The Plan updated the process to state when a call is received by the Member Services Department and it is categorized as a potential expedite, the call is transferred to the Grievance & Appeals Department queue and the Clerk will provide the member with their DMHC rights.	5/3/2022	Completed	G&A		State	DMHC	2021
2	Grievances & Appeals	The Plan's online grievance submission procedure is not accessible through a hyperlink clearly identified as "GRIEVANCE FORM," does not allow a member to preview and edit the form before submission, and does not include the required disclosure.	The Plan has worked with our internal Information Technology (IT) Department to have the updates made to the website to include the GRIEVANCE FORM hyperlink, the edit/preview functionality and to update the disclosure statement. Exhibit 2A_Preview_Edit_Disclosure shows the updates on the testing site. Regarding the disclosure statement, the Plan identified an outdated version of the statement. The Plan has updated the disclosure statement so that it is in alignment with the verbiage from Knox-Keene (see attached Exhibit 2B_Knox-Keene).	8/11/2022	Completed	G&A		State	DMHC	2021
3	Grievances & Appeals	The Plan does not correctly display the statement required by Section 1368.02(b) in all required enrollee communications.	The Plan identified an outdated version of the statement. The Plan has updated the disclosure statement so that it is in alignment with the verbiage from Knox-Keene (see attached Exhibit 3A_Knox-Keene). Exhibit 3F will apply to both the appeals and grievance letters. The Plan's UM materials were likewise updated to reflect compliance with the verbiage. Revised Your Rights attachments for NOAs and NARs were implemented in TruCare on 1/18/2022. The Plan's Pharmacy templates are being drafted and copies will be provided on 12/30/2022 for the following: •~~4~~A_GroupCare NOA template •~~5~~A_GroupCare NOA template •~~6~~A_Full Group Care Formulary/Template <u>12/30/2022</u>:Template letters completed and submitted to DMHC	12/30/2022	Completed	G&A Member Services UM Rx		State	DMHC	2021
4	Prescription (Rx) Drug Coverage	The Plan's prescription drug denial and modification letters to enrollees do not include accurate information about their grievance rights.	The plan will update/ensure prescription drug denial and modification letters to the enrollees include accurate information about their grievance rights. Templates are being drafted and copies will be provided on December 30, 2022. <u>12/30/2022</u> :Template letters completed and submitted to DMHC	12/30/2022	Completed	Rx		State	DMHC	2021
5	Prescription (Rx) Drug Coverage	The Plan does not inform enrollees of their right to seek an external exception request review in formulary exception request denial letters.	The plan will insert external exception request review in formulary exception request denial letters as seen below: "EXTERNAL REVIEWS You have the right to request an external review when the Alliance denies a prior authorization request for a drug that is not covered by the plan or for an investigational drug or therapy. A request for an external review will not prevent you from filing a Grievance or Independent Medical Review (IMR) with the California Department of Managed Health Care. You may request an external review through the Alliance contact information listed above." •~~7~~Templates are being drafted and copies will be provided on December 30, 2022. <u>12/30/2022</u>:Template letters completed and submitted to DMHC	12/30/2022	Completed	Rx		State	DMHC	2021
6	Prescription (Rx) Drug Coverage	The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.	The Plan will update formularies in a manner consistent with the Department's standard formulary template. <u>12/30/2022</u> : The formulary template has been updated.	12/30/2022	Completed	Rx		State	DMHC	2021

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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

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

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

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

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

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

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

2021 DHCS JOINT AUDIT FINDINGS: Audit Review Period 6/1/2019 - 3/31/2021								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
27	Member Rights	R (4.1.5) The Plan did not consistently resolve grievances prior to sending resolution letters.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description. The staff attested that they understood the requirements and will ensure that grievances are fully resolved prior to sending resolution letters.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
28	Member Rights	(4.3.1) The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery, did not provide an updated investigation report within 72 hours, and did not submit a complete report of the investigation within 10 working days.	1. To address staffing needs, the Plan has streamlined its Compliance Department and now has a dedicated staff member who focuses on Privacy. This FTE was hired on February 22, 2021. 2. The Plan reviewed and updated CMP-013 HIPAA Privacy Reporting to reflect the 24hr, 72hr and 10-day reporting requirements. This policy is scheduled to be reviewed and approved at the Compliance Committee on November 23, 2021. <u>Update 12/10/2021:</u> CMP-013 was approved at Compliance Committee on 11/23/2021	Low	11/30/2021	Completed	Compliance		State	DHCS	2021
29	Compliance	R (6.2.1) The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within ten working days.	1. The Plan has a dedicated staff member in the Special Investigations Unit (SIU) to focus on Fraud, Waste and Abuse FWA cases. This FTE was hired on 6/25/2021. 2. The plan updated CMP-002 to reflect reporting requirements. This policy is scheduled to be re-approved at the Compliance Committee on Nov 23, 2021. <u>Update 12/10/2021:</u> CMP-002 was approved at the 11/23/2021 Compliance Committee	Low	12/1/2021	Completed	Compliance		State	DHCS	2021
30	Compliance	(6.2.2) The Plan did not report recoveries of overpayments to DHCS annually.	After internal review, the Plan found that an update to CMP-002 was not necessary as the reporting of overpayments is addressed in CLM-008: Overpayment Recovery. The Plan has validated that reports were submitted appropriately to the Department.	Low	2/11/2022	Completed	Compliance		State	DHCS	2021
31	Claims	(SSS.1) The Plan did not distribute payments for state supported services claims within 90 calendar days as described in APL 19-013.	1. The Plan made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate.	Low	2/17/2021	Completed	Claims		State	DHCS	2021
32	Claims	(SSS.2) The Plan did not pay interest for state supported services claims processed beyond the 90-calendar day timeframe specified in APL 19-013.	1. The Plan made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate. The claim system was also updated to pay interest at the normal timeline of claims adjudicated after 45 work days from the received date.	Low	2/17/2021	Completed	Claims		State	DHCS	2021
33	Claims	(SSS.3) The Plan improperly denied state supported services claims.	1. As of 8/7/2020 the Plan reconfigured the system to no longer re-suspend the delegate's Non-Emergency Out of Area processed claims. In addition, the Claims workflow has been updated to accommodate the system change.	Low	8/7/2020	Completed	Claims		State	DHCS	2021
34	Compliance	The Plan should have a policy and workflow for tracking discrimination grievances	1. The Plan has created the Special Cases Incident Log for tracking discrimination grievances 2. The Plan will update the policy and create a workflow regarding tracking of discrimination grievances. <u>Update 12/1/2021:</u> The policy has been created and was approved at the Compliance Committee on 11/23/2021	Medium	12/1/2021	Completed	Compliance		Self Identified	AAH	2021
35	Quality Management	The Plan should ensure that PQIs are appropriately classified (as QOS / QOA / QOC)	1. Sr. Dir. Of Quality and the QI Supervisor conduct quarterly audits of QOA and QOS case files 2. QOC files are reviewed and leveled by Quality Medical Director weekly	Low	2/28/2021	Completed	QM		Self Identified	AAH	2021

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

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

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

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

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

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2019 DMHC AUDIT FINDINGS - <i>Audit Review Period: 10/1/2017-9/30/2019</i>						INTERNAL AUDITS					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Payment Accuracy	Three out of 50 late paid claims (a compliance rate of 94 percent). This deficiency was caused by the Plan using the incorrect date to calculate interest on improperly denied and reprocessed claims. Three out of 30 high dollar claims. The deficiency was caused by the Plan not paying interest on a claim improperly denied for missing authorization when the independent practice association (IPA) authorized services but did not forward the authorization to the Plan, and underpaying claims due to processor error.	Late Claims – processing errors identified in this finding are attributable to human error by one specific individual. The incorrect handling was addressed verbally with the employee at the time of the audit. Refresher training on CLM-001 Claims Processing, CLM-003 Emergency Services Claims Processing and Claims Change Alert Clean Claim Interest Workflow was completed on March 13, 2020 to ensure that all staff who handles adjustments are using the appropriate received date for adjusted claims. <u>Update 5/1/2020:</u> At the Department’s request, the Plan created a report to identify claims where the incorrect received date was used on an adjusted claim. The report was provided to the Department on 4/21/2020. The identified claims have been adjusted and the report has been updated to add the check date, check # and the amount of interest and penalties paid. Current policies and procedures do not require changes and meet compliance requirements. High Dollar Claims – processing errors identified in this finding are attributable to human error. Refresher training on CLM-001 Claims Processing and Claims Change Alert - Clean Claim Interest Workflow was completed on 3/13/2020 to ensure that all staff who handles adjustments are using the appropriate received date for adjusted claims.	4/29/2020	Completed	Claims	✓	State	DMHC	2019	Completed
2	Incorrect Claim Denials	Claims were improperly denied and should have been paid in three out of 50 denied claims (a compliance rate of 94 percent). The deficiency was caused by the Plan not re-processing retro enrollment, incorrectly denying a claim as duplicate and a system configuration issue that incorrectly denied claims as not the financial responsibility of the Plan.	Retro Eligibility Denial – The Plan’s Claims management is working with its Information Technology/Analytics Department to create a retroactive eligibility report to identify claims that were denied correctly at the time of processing, but may be impacted due to the retroactive reinstatement of eligibility. Once the report is completed, the Plan will make sure to adjudicate any claims found to be improperly denied since 5/29/2018, and provide evidence that the claims were adjudicated appropriately. <u>Update 5/1/2020:</u> Report was put into production on 5/1/2020 and will be run weekly. Claims is working with IT to identify impacted claims from 5/29/2018-9/30/2019 and will adjust impacted claims and provide the final spreadsheet to the Department by 5/15/2020. Division Of Financial Responsibility (DOFR) Denial - this issue was identified as a configuration error for one specific service, and corrected in October 2019 prior to the audit. <u>Update 5/1/2020:</u> At the Department’s request, the Plan created a report to identify claims where the service had been denied incorrectly. The report was provided to the Department on 4/21/2020. The identified claims are being adjusted and should be complete by 5/15/2020. The report will then be updated to add the check date, check # and the amount of interest paid. Duplicate Denial - duplicate claims refresher training on HS-004 Duplicate Claims was completed on 3/13/2020 for all staff that handles adjustments. Due to the unique cause of this non-system related error, a <u>remediation report cannot be run.</u>	4/15/2020 5/15/2020	Completed	Claims	✓	State	DMHC	2019	Completed
3	Clear & Accurate Denial Explanation	Plan provided an incorrect denial explanation in three out of 50 denied claims (a compliance rate of 94 percent).	The Plan reviewed the deficient cases and found that the three denial errors identified in the audit were related to Division of Financial Responsibility (DOFR) issues. The Plan will review the services where there are DOFR conflicts, come to agreement with the delegates, and make any required configuration changes to the system. <u>Update 5/1/2020:</u> System changes for the delegate were completed and put into production on 4/16/2020. The claims were originally denied correctly as the responsibility of another delegate but contained an additional incorrect message that they were forwarded to delegate. These claims do not need to be re-adjudicated and re-denied again. Due to the Coronavirus Pandemic, meetings with delegate have been put on hold. The Plan has updated the system to correct the configuration with out of area office visits that was identified during the audit. At the Department’s request, the Plan created a report to identify claims where these services had been denied incorrectly. The report was provided to the Department on 4/21/2020. The identified claims are being adjusted and should be complete by 5/15/2020. The report will then be updated to add the check date, check # and the amount of interest paid.	6/30/2020 5/15/2020	Completed	Claims	✓	State	DMHC	2019	Completed
4	Change in Plan Personnel	Plan shall within five days, file an amendment when there are changes in personnel of the plan. Plan did not file the Board of Governors changes for three members.	The Plan has updated its internal procedures to ensure key personnel requirements are met. The Plan implemented a monthly quality check capturing any changes with the Plan’s Board of Governor member seats. The Plan’s Compliance team staff completed updated training for key personnel filing procedures on March 30, 2020. As of 3/31/2020, the Plan has also completed updates to the filings for three Board members as requested: Member 1: DMHC Filing #20201241 Member 2: DMHC Filing #20200184/#20201243 Member 3: DMHC Filing #20200644	4/1/2020	Completed	Compliance	✓	State	DMHC	2019	Completed

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

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2019 DHCS AUDIT FINDINGS - Audit Review Period: 6/1/2018-5/31/2019						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required PA for an initial visit with a mental health provider to determine if the member had mild-to-moderate mental health issues, which the contract does not allow.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. <u>Update as of 12/5/2019:</u> The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. <u>Update as of 1/8/2020:</u> Plan reviewed documents and agree with the changes for member self-referral process. Discussing with DHCS prior to final CAP submission.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
2	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required a two-step prior authorization (PA) process for BHT services, which is allowed, but did not send written notification when it denied services at the first step. The delegate did not consistently apply criteria for approving BHT.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. <u>Update as of 12/5/2019:</u> The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. <u>Update as of 1/8/2020:</u> Plan reviewed documents and still have open items not documented. Plan will be meeting with the delegate to discuss criteria and procedures for further documentation needed. <u>Update as of 2/7/2020:</u> Met with the delegate to review their criteria and approval process. Requested policy language changes to meet the regulatory requirements. Policy was approved by Committee on 1/27/20. Updated CAP response submitted to DHCS on 2/7/2020.	No	2/7/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
3	UM Delegation	(1.1.3) R The Plan did not review ownership and control disclosure information for their Utilization Management (UM) delegates	The Plan will ensure that its delegated providers complete the Ownership and Control disclosure forms. The Plan will create a tracking log and document any follow up attempts made with the delegate to ensure accuracy. <u>Update as of 12/2/2019:</u> PR has created a tracking log and is working on a desktop procedure.	Yes	1/1/2020	Completed	Provider Services	✓	State	DHCS	2019	Completed
4	UM Delegation	(1.1.4) R The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan will conduct staff retraining of delegation reporting procedures to ensure all are tracked and monitored for receipt and review. <u>Update as of 12/5/2019:</u> Staff training was conducted on 12/3/2019.	Yes	12/1/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
5	UM Delegation	The Plan's oversight of its delegate did not identify unclear NOA letters, and incorrect appeal and SFH information	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. <u>Update as of 12/5/2019:</u> The delegate has developed on a new process regarding NOA letters, appeal rights and SFH information. The Alliance will review and discuss changes with the delegate on the next Operations call. <u>Update as of 1/8/2020:</u> Plan reviewed documents and agreed with changes of procedure checklist and training materials.	No	1/15/2020	Completed	Utilization Management		State	DHCS	2019	Completed
6	Referral Tracking process	(1.1.6) R The Plan did not track all approved PAs; the specialty referral tracking process did not include modified PAs and in-network approved services.	The UM Department is working with analytics to expand the routine referral tracking report to include all approved authorizations. <u>Update as of 12/5/19:</u> Clarity is being sought from DHCS on the scope of specialty referral tracking. <u>Update as of 1/8/20:</u> An updated referral tracking report is being developed to include all decision types and specialty services that require authorization. <u>Update as of 2/7/20:</u> Updated report sample generated and submitted to DHCS. Working with Analytics to create routine report that captures all needed data elements. <u>Update as of 3/5/2020</u> UM met with Analytics to create the routine report capturing all needed elements. Report is in development. <u>Update as of 5/8/20</u> Specialty Tracking Report has been created by Analytics, including all required elements, and will now be routinely reported quarterly through UMC and HCQC. Reported at HCQC on 5/21/20. <u>Update as of 6/12/20:</u> Report sent to HCQC on 5/21/20 and reviewed at UMC at 5/29/20.	Yes	5/21/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
7	Prior Authorizations	(1.2.1) R A review of PA data showed non-qualified Plan staff denied retrospective cases for administrative reasons other than non-eligibility for membership. The Plan denied retrospective service requests without review by a medical director if the provider submitted the request more than 30 days after the service delivery date, or if requests did not meet Plan-imposed conditions. The Plan's contract did not specify submission timeframes or other conditions that, if not met, allowed eliminating medical necessity review of retrospective requests for covered services.	Policy and procedure UM-001 Utilization Management will be updated to comply with the contractual requirements. Workflows will be updated to have all retrospective requests reviewed by a medical director. Workflows have been updated to have all retrospective requests reviewed by a medical director. <u>Update as of 12/5/2019:</u> Clarity is being sought from DHCS on allowing a time limit of 30 days. <u>Update as of 1/8/2020:</u> Plan received clarity from DHCS and is updating internal procedures. <u>Update as of 2/7/2020:</u> P&Ps updated to reflect that only an MD can deny retro PA requests. P&Ps approved at HCQC on 1/16/2020.	Yes	1/16/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
8	Prior Authorizations	(1.2.2) The Plan did not ensure it used appropriate processes to review and approve medically necessary covered services when it did not ensure that qualified medical personnel rendered medical decisions. Dependent practitioners reviewed, assessed and approved requests for continued hospital stays	The process for ensuring LVNs perform only within their scope of practice was updated and implemented on 10/2/2019. Additional changes to the UM systems to better track the change in process are being developed. <u>Update as of 12/5/2019:</u> Changes to the UM systems to better track the RN oversight role with the LVNs completed. Other Managed Medi-Cal plans have LVNs performing UM. Clarity is being sought from DHCS on the use of LVNs in UM. Policies and procedures and job descriptions are being reviewed to be aligned with the updated oversight process. <u>Update as of 1/8/2020:</u> Plan received clarity from DHCS and updated procedures for RN oversight.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
9	Prior Authorizations (UM and Rx)	(1.2.3) R The Plan's notice of action (NOA) letters did not follow specifications in Health and Safety Code Section 1367.01. Provider letters in medical cases did not include the decision makers' direct phone number or contained the incorrect number. Letters did not explain the reasons for the denial. Pharmacy NOAs were not concise.	Accurate phone numbers for the decision makers are on the NOA, monitoring will be conducted through internal audits. UM NOA template letters were updated and implemented on 11/4/2019, internal auditing will be conducted monthly to ensure that the letters are clear and concise and explain the reasons for denial. Pharmacy NOA template letters were updated and implemented in April 2019, internal auditing will be conducted at least monthly to ensure that the letters are clear and concise and explain the reasons for denial. The pharmacy team also meets with the PBM on a weekly basis to optimize PA review process, NOA letter language and reasons for denial.	Yes	11/4/2019	Completed	Utilization Management /Pharmacy		State	DHCS	2019	Completed
10	Prior Authorizations	The Plan did not ensure that all contracting practitioners were aware of the procedures for orthotic items; the Plan provided inaccurate information about authorization requirements for orthotic items	The Alliance's Authorization Grid will be updated to include the accurate information about authorization requirements for orthotics. The updated grid will be uploaded on the website. <u>Update as of 12/5/2019:</u> A meeting will be scheduled the week of 12/9 to discuss changes. <u>Update as of 1/8/2020:</u> Meeting was conducted and PA grid will be updated to reflect corrections. <u>Update as of 2/7/2020:</u> PA grid is being updated for all services requiring PA, so that MDs do not receive repeat communication about changes to the PA grid. Orthotics will be included in the comprehensive update. <u>Update as of 3/5/2020:</u> Prior Auth requirement for Orthotics was added to the PA grid on the Provider Portal	No	3/2/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed

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

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2019 DHCS AUDIT FINDINGS - Audit Review Period: 6/1/2018-5/31/2019						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
26	Fraud, Waste, and Abuse (FWA)	The Plan did not investigate all suspected fraud and abuse incidents promptly. The Plan did not conduct a preliminary or follow-up investigation of 4 of 12 suspected fraud and abuse cases until two to six months after it became aware of the incidents.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. All cases will be resolved and closed within 90 days of receipt. Staff training of the revised procedure will be completed by 12/01/2019. <u>Update as of 12/5/2019:</u> Staff training will be conducted on 12/11/2019 to review the updated procedure. <u>Update as of 1/8/2020:</u> Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
27	Fraud, Waste, and Abuse (FWA)	The Plan's compliance officer did not develop and implement fraud, waste, and abuse policies and procedures	The Plan's designated compliance officer will develop and attest to all new and updated policies and procedures prior to committee review.	No	12/13/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
28	State Supportive Services Claims	The Plan did not forward all misdirected claims within 10 working days.	The post-adjudication script that adds the forwarding action was corrected and deployed.	No	7/11/2019	Completed	IT/ Claims	✓	State	DHCS	2019	Completed

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

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

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23	Emergency & Family Planning Claims	3.5.3 The Plan improperly denied family planning claims for out of network, non-contracted providers. These claims were denied based on edits in the Plan's claims system and subsequent review by claims analysts.	The Plan provided staff training on 6/11/2018 to ensure FP claims edits for out of network claims are reviewed and not inappropriately denied. Monitoring reports have been implemented to review any claims denied incorrectly. Any claims identified as denied incorrectly are adjusted the following week manually.	12/31/2018	Completed	Claims	✓	State	DHCS	2018	Completed
24	Emergency & Family Planning Claims	3.5.4 The Plan did not disclose the specific rationale used in determining why claims are rejected.	<u>Update as of 3/6/2019:</u> The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by May 31, 2019. <u>Update 4/8/2019:</u> The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
25	Emergency Pharmacy Provisions	3.6.1 The Plan did not ensure the provision of sufficient amounts of drugs prescribed in emergency situations.	The Plan updated its policy and procedure to ensure emergency provisions of drugs are prescribed in emergency situations. The monitoring report was updated to include all supply claims to ensure members have access to medically necessary drugs.	12/11/2018	Completed	Pharmacy	✓	State	DHCS	2018	Completed
26	Grievances	4.1.1 The Plan's process omitted medical director review of QOC grievances prior to sending resolution letters.	The Plan updated its grievance procedures and letters to include MD review for quality of care grievances. <u>Update as of 1/7/2019:</u> Implementation will be completed by 3/31/2019 once RN staff are on board and trained on the updated process. <u>Update as of 3/5/2019:</u> Health Care Services has successfully recruited one nurse, and is in the process of filling the remaining vacancy. <u>Update as of 4/10/2019:</u> Training is to be completed by 4/11/2019. The checklist for standard and expedited grievances has been updated. <u>Update as of 5/8/2019:</u> The review process for QOC grievances was implemented on 4/15/2019.	4/15/2019	Completed	Health Care Services	✓	State	DHCS	2018	Completed
27	Grievances	4.1.2 The Plan sent member resolution letters without completely resolving all complaints.	The Plan updated its grievance procedure to include a process for resolving all complaints and resolutions resolved outside the 30 day timeframe. Staff training was conducted on 7/17/2018.	7/17/2018	Completed	Grievance & Appeals		State	DHCS	2018	Completed
28	Grievances	4.1.3 The Plan did not update its provider manual to include the new timeframes for filing grievances that became effective July 1, 2017.	The Plan updated its Provider Manual on 12/25/2018 to include the correct new grievance filing timeframes. <u>Update as of 1/07/19:</u> The Manual is scheduled to be uploaded on our website on 1/25/2019. <u>Update as of 1/25/2019:</u> The Plan has posted the updated Provider Manual to its website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
29	Grievances	4.1.4 The Plan's grievance system did not capture and process all complaints and expressions of dissatisfaction	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. New provider orientation materials and the provider manual will include education materials of the Plan's grievance process for new and existing providers. <u>Update as of 1/7/2019:</u> The Plan will be uploading the provider manual to the website by 1/25/19. <u>Update as of 1/25/2019:</u> The Plan has posted the updated Provider Manual to its website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
30	HIPAA	4.3.1 The Plan did not report the discovery of PHI breaches to the DHCS Information Security Officer.	The Plan updated its procedures to ensure reporting of PHI incidents are reported to all DHCS contacts including the DHCS Information Security Officer. Staff training on updated procedures was conducted on 8/22/2018 and 10/3/2018.	10/3/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
31	HIPAA	4.3.2 The Plan did not report all suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery.	The Plan updated its procedures and tracking log to ensure monitoring of reporting to DHCS occurs timely. Staff training on updated procedures was conducted on 8/22/2018 and 10/3/2018.	10/3/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
32	Provider Training	5.2.1 The Plan did not ensure provider training was conducted within 10 working days.	The Plan monitors its tracking log to ensure provider training is conducted within 10 working days. Staff training of the required timeframe was conducted on 12/17/2018.	12/31/2018	Completed	Provider Services	✓	State	DHCS	2018	Completed
33	Provider Training	5.2.2 The Plan did not specify in its written agreement provider training responsibilities for two delegated entities.	The Plan updated its contract with the two delegated entities to ensure provider training requirements. <u>Update 12/31/2018:</u> The Plan has updated its contract with one of the delegates to include delegation of provider training requirements. The other delegate's contract is in progress to be finalized. Estimated time for contract to be completed is 2/28/2019. <u>Update as of 3/4/2019:</u> The remaining delegate has agreed to the provider training responsibilities; the final contract will be signed once the delegate agrees to terms for non-related items. <u>Update as of 8/5/2019:</u> Both delegates involved in the finding delegation agreements were updated. Another delegate's contract still needs to be finalized.	6/30/2019	Completed	Provider Services	✓	State	DHCS	2018	Completed
34	Provider Training	5.2.3 The Plan did not ensure training materials provided by two delegated entities included information on Plan policies, procedures, services, and member rights and responsibilities.	The Plan's delegated entities have updated their training materials to include the required information. <u>Update 12/31/2018:</u> The Plan is currently working with the delegate to incorporate this information. Target date for materials to be updated is 1/31/19. <u>Update as of 1/30/2019:</u> Both delegates have revised their training materials to include member rights and responsibilities, grievances and services.	1/31/2019	Completed	Provider Services	✓	State	DHCS	2018	Completed
35	Fraud, Waste, and Abuse (FWA)	6.3.1 The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10-working days.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to ensure timely reporting of incidents to DHCS. Staff training on updated procedures was conducted on 7/17/2018. The Plan updated its monitoring tracking log to monitor the reporting timeframe requirement.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed

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

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12	Utilization Management	The Plan did not have a clear process for peer-to-peer clinician discussions concerning denied services.	Steps Plan took or will take to correct deficiency: 1.Plan develop a desktop procedure on peer to peer discussion by 9/14/2018. 2. Plan to train physicians and pharmacists of desktop procedure and when and how to document peer-to-peer clinician discussions by 9/26/2018. 3.Plan has started a weekly meeting with physicians and pharmacist for peer to peer discussions as of 7/17/2018.	9/26/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed

DASHBOARD KEY

Internal CAP Status Performance Measures

Indicator

Criteria

Green

CAP responses have been completed and fully address the findings

Notes

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



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

Health Care Services

Donna Carey, MD

To: Alameda Alliance for Health Board of Governors
From: Dr. Donna White Carey, Chief Medical Officer
Date: January 9th, 2026
Subject: Health Care Services (HCS) Report

P&T Committee

- P&T Committee meeting – December 16, 2025
 - Reviewed 6 Therapeutic categories and drug monographs
 - Reviewed 1 Group Care policy
 - Reviewed 2 DSNP policies
 - Reviewed 4 New Group Care guidelines
 - Reviewed 2 New PAD guidelines
 - 17 formulary modifications
 - Added 12 medications to Formulary w/PA (prior authorization) requirement
 - Added 2 to F with Quantity Limit (QL) 2 ML per 28 days
 - Added 3 to F with Quantity Limit (QL) 6 ML per 28 days
 - Updated 24 Group Care PA guidelines
 - Reviewed 28 Group Care PA guidelines with no updates
 - Updated 6 PAD guidelines
 - Reviewed 8 PAD guidelines with no updates

Credentialing Committee

December 16, 2025. Please see the summary below.

At the Peer Review and Credentialing (PRCC) meetings held on December 16, 2025, there were one hundred and two hundred and fifty-nine (259) initial network providers approved; five (5) primary care providers, eleven (11) specialists, seven (7) ancillary providers, nine (9) midlevel providers, and two hundred and twenty-seven (227) behavioral health providers.

Additionally, forty-four (44) providers were re-credentialed at this meeting; six (6) primary care providers, five (5) specialists, zero (0) ancillary providers, zero (0) midlevel providers, and thirty- three (33) behavioral health providers.

One provider was reviewed in the Peer Review Committee with pending action items. The provider will be re-reviewed in the January 2026 Peer Review Committee.

- Utilization Management, Case Management, and Long-Term Care Updates

- Utilization Management

- Admits per thousand increased slightly in 2025, with the highest rates among SPD LTC full duals; CFMG had the lowest rates.
 - Average length of stay is stable, but some months showed spikes; Alliance and UCSF have the highest lengths of stay.
 - Readmission rates remain above the 18% goal (21.4% in 2025), with SPD LTC and duals having the highest rates. CFMG consistently performs below the readmission benchmark.
 - Out-of-network ED visits are high, especially at non-AHN facilities and Washington Hospital.

- Case Management

- Physician Certification Statement (PCS) form compliance with transportation remains high; delays are usually due to late submissions.
 - Referral volume to case management spiked in Q3 2024 and remains elevated.
 - Connection rates are highest for complex cases; transitions of care and care coordination have higher rates of unsuccessful outreach, often due to lack of member awareness.
 - ECM membership is steadily increasing, with ongoing efforts to improve data accuracy for program completion and transitions to lower levels of care.

- Long-Term Care

- LTC membership was stable in 2025, with a drop early in the year and a rise in June.
 - Admissions and average length of stay decreased compared to 2024, but admits increased in 2025.
 - Discharges to lower levels of care are occurring, supported by community supports and waiver services.
 - Community support utilization is rising, especially in Q3 and Q4, except for assisted living transitions, which are limited by member financial eligibility.

- Recommendations

- Analyze interventions during periods of lower readmissions (e.g., April) and assess if shorter lengths of stay are contributing to higher readmissions.
- Focus on follow-up within seven days post-discharge, especially for high-risk diagnoses (e.g., CHF), to reduce readmissions.
- Continue outreach and education to improve member engagement and connection rates, especially for care coordination and transitions of care.
- Refine data tracking for ECM program completion and transitions to ensure accurate reporting and support for members.
- Continue promoting community supports and waiver services to facilitate transitions out of LTC.
- Monitor trends in admissions, length of stay, and readmissions to identify areas for further intervention.

Utilization Management (UM)

(Summary of 2024 UM Program Evaluation)

- Denial Rates
 - Overall, 2.31% *(0.04% decrease from 2023)*
- Authorization Turn-Around Times (goal = 95%)
 - Inpatient/outpatient: overall 99%, above goal
 - LTC: overall 96%, above goal
 - BH: overall 96%, above goal
- Pharmacy:
 - Outpatient RX: overall 99.8%, above goal
 - Physician Administered Medications/Injections: overall 99.4%, above goal
- Over/Under Utilization Measures
 - ER visits: average 491.6 visits/K *(-33.4 visits/K compared to 2023)*
 - Acute Inpatient Hospitalization Readmission Rate: 21.1% *(+1.1% compared to 2023)*
- Opportunities incorporated into 2025 Program/Workplan:
 - Explore Community Health Workers and Bridge Programs embedded in Emergency Departments to decrease Emergency Department Utilization
 - Continue referral processes for Enhanced Care Management, Complex Case Management and Community Supports to link members to appropriate resources for next level of care
 - Streamline and improve accessibility of prior authorization information to providers, including increase visibility of authorization details online

- Provide regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services

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

- Total authorization volume increased month-over-month from November to December 2025

Total Authorization Volume (Medical Services)			
Authorization Type	October 2025	November 2025	December 2025
Inpatient	3,311	2,848	3,660
Outpatient	5,118	4,029	4,791
Long-Term Care	773	705	910
Total	9,202	7,582	9,361

Source: #02569_AuthTAT_Summary

Utilization Management: Outpatient

- Foster care CoC cases continue to average 3-5/day. We are reviewing pended claims each week to identify CoC services and ensure there are no delays in the care for this population. With each case, we are reviewing for any potential care coordination or case management needs and referring to CM as needed.
- Revision of prior authorization and benefits grid is in progress, to create a more provider-friendly reference document to delineate code-specific authorization rules. Development of an online searchable code database is also under development, with anticipated release in Q4 2025.
- OP processed a total of 4,791 cases for the month of December. We also processed 405 CCS referrals, of which 87 cases were submitted to our regional CCS office for review - 37 cases were approved; 8 denied, 17 pending.
- OP Turnaround times exceeded the threshold of 95% for the month of November 2025, despite staffing challenges and higher auth volumes. The OP UM team, in collaboration with the MDs, continue to explore process improvements to streamline efficiency and reduce missed TATs.
- The top 5 categories remain unchanged Radiology, OP Rehab, TQ, Home Health and Outpatient facility. Radiology and Rehab represent >70% of this volume.

- The Home Health pilot launched in July continues to be effective, reducing the number of manual reviews for selected HH services and diagnoses. There has been a slow increase in providers now using the portal (now up to 5 providers from 2). The pilot is being monitored and will be expanded in the future.
- DSNP staff training has begun and will continue weekly until go-live on 1/1/2026.

Total Outpatient Authorization Volume			
Authorization Status	October 2025	November 2025	December 2025
Approvals	3,363	2,639	3,034
Partial Approvals	0	0	0
Denials	65	57	101
Total	3,428	2,696	3,135

Source: #02569_AuthTAT_Summary

Outpatient Authorization Denial Rates			
Denial Rate Type	October 2025	November 2025	December 2025
Overall Denial Rate	3.7%	4.0%	3.7%
Denial Rate Excluding Partial Denials	3.5%	3.8%	3.4%
Partial Denial Rate	0.3%	0.2%	0.4%

Source: #03690_Executive_Dashboard

Outpatient Turn Around Time Compliance (benchmark: 95%)			
Line of Business	October 2025	November 2025	December 2025
Overall	99.5%	99.5%	99.0%
Medi-Cal	99.5%	99.5%	99.0%
IHSS	100%	100%	99.1%

Source: #02569_AuthTAT_Summary

Utilization Management: Inpatient

- Total inpatient auth volume (including all IP authorization types processed by department: Acute, LTACH, Skilled SNF, and OP auths related to discharge) increased from 2831 in November to 3647 authorizations processed in December.
- Inpatient overall average LOS decreased from 5.2 in October to 4.8 in November. Admits per thousand also decreased from 50.1 in October to 48.9 in November. Days per thousand decreased from 258.8 in October to 233.5 in November. The trend is consistent among Child, Adult, ACA and SPD categories.
- IP overall denial rate decreased from 4.3% in November to 2.8% in December.
- IP Auth TAT compliance surpassed 95% benchmark across all lines of business in November, at 98.7% and December, 97.7%

- IP UM completed trainings related to preparation for D-SNP including MCG Medicare Compliance training, along with internal staff trainings developed by leadership staff. The trainings cover key components of the UM review process along with operational differences for DSNP.
- External hospital rounds are ongoing with UCSF, Stanford, Alameda Health System, Kindred LTACH, Kentfield LTACH, Washington, Eden, Alta Bates, and Summit, to review members' current active admissions discuss UM issues, address discharge barriers, offer other opportunities for supporting throughput and appropriate discharge.
- IP UM RN onsite nurse at Washington Hospital has clearance to go onsite; anticipate implementation once final administrative steps are taken.

Total Inpatient Authorization Volume			
Authorization Status	October 2025	November 2025	December 2025
Approvals	3,305	2,831	3,647
Partial Approvals	0	0	0
Denials	6	17	13
Total	3,311	2,848	3,660

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	September 2025	October 2025	November 2025*
Authorized LOS	5.1	5.2	4.8
Admits/1,000	48.8	50.1	48.9
Days/1,000	250.0	258.8	233.5

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

Inpatient Authorization Denial Rates			
Denial Rate Type	October 2025	November 2025	December 2025
Full Denials Rate	1.6%	1.8%	1.0%
Partial Denials	2.2%	2.5%	1.8%
All Types of Denials	3.8%	4.3%	2.8%

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance (benchmark: 95%)			
Line of Business	October 2025	November 2025	December 2025
Overall	98.9%	98.7%	97.7%
Medi-Cal	98.8%	98.7%	97.7%
IHSS	100%	100%	97.7%

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during December 2025 was 2,319 members. This is an increase of 0.43% (10 members) from November 2025.
- Month to Month, the admissions, days and readmissions are decreasing. From September to November the admissions decreased by 49.22%, the days decreased by 70.39% and the readmissions also decreased by 38.71%. Some of this could be due to a lag in claims data being available

Totals	September 2025	October 2025	November 2025
Admissions	128	129	65
Days	932	749	276
Readmissions	31	22	19

*Source: #14236_LTC_Dashboard

- LTC Staff continue to participate in SNF collaboratives around the county to ensure that our facility partners are updated with processes and program enhancements.
- Having virtual rounds with AHS, San Leandro, Kyakameena, Elmwood, Jones Convalescent and Eden LTC facilities to coordinate on complex cases
- LTC Team continues to meet individually with multiple facilities to discuss collaboration with discharge planning and submitting proper documentation for requests.
- Quarterly rounds with Regional Center of Easy Bay to discuss any ICF/DD members.
- Continued internal Long Term Care rounds to discuss members coming into and leaving a long-term care setting.
- Social Workers continue visiting LTC facilities in person, on a monthly and quarterly basis depending on census, to assist with discharge planning and access to other resources. The team continues referrals to TCS and other internal/external programs to provide wraparound support to members preparing to discharge from an LTC custodial facility.
- LTSS Liaison is visiting and meeting with facilities to discuss any claims issues and educating on processes.

- Dedicated RN continue to assist with TCS for members coming back from an acute stay or transitioning from acute into long-term care. Currently, the Health Navigator position is vacant, awaiting approval to backfill the position.
- Authorization processing turn-around time (TAT) has remained between 97%- 99%, which is exceeding the threshold of 95%.

Total LTC Authorization Volume			
Authorization Status	October 2025	November 2025	December 2025
Approvals	734	655	860
Partial Approvals	0	0	0
Denials	39	40	50
Total	773	705	910

Source: #02569_AuthTAT_Summary

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

LTC Turn Around Time Compliance (benchmark: 95%)			
Line of Business	October 2025	November 2025	December 2025
Medi-Cal	97%	99%	99%

Source: #02569_AuthTAT_Summary

Behavioral Health

In December, the Behavioral Health Department processed 597 authorizations, 454 Care Coordination referrals, and 255 mental health screenings and transition of care tools.

Total BH Authorization Volume			
	25-Oct	25-Nov	25-Dec
Approvals	536	502	584
Partial Approval	0	0	0
Denials	14	5	18
Total	550	507	597

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

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

Behavioral Health Therapies (BHT/ABA) Turnaround Times

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

Behavioral Health Denial Rates

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

Source: 14939_BH_AuthTAT

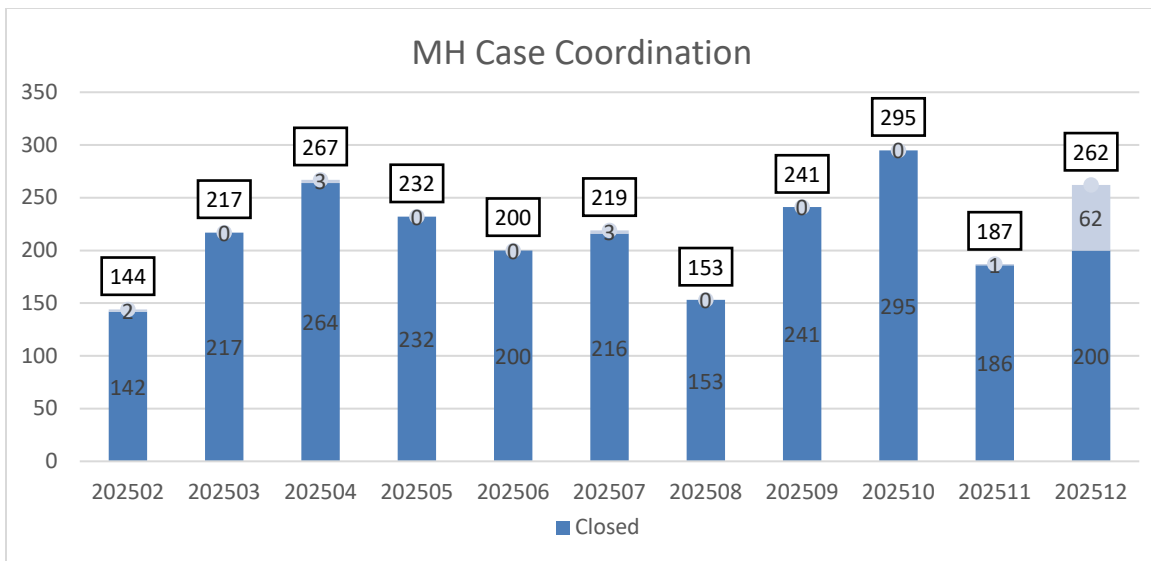
Mental Health Care Coordination

- 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 ACBHD for Specialty Mental Health Services.

Total # Medi-Cal Screenings & TOC Tools			
	25-Oct	25-Nov	25-Dec
Youth Screenings	63	39	47
Adult Screenings	116	77	108
Incoming ACBH Referrals	110	138	178
Outgoing Referrals to ACBH	47	25	39
Transition of Care Tools to ACBH	6	2	0

Source: 16015_MH_Assessments, 16093_BH Referral Report

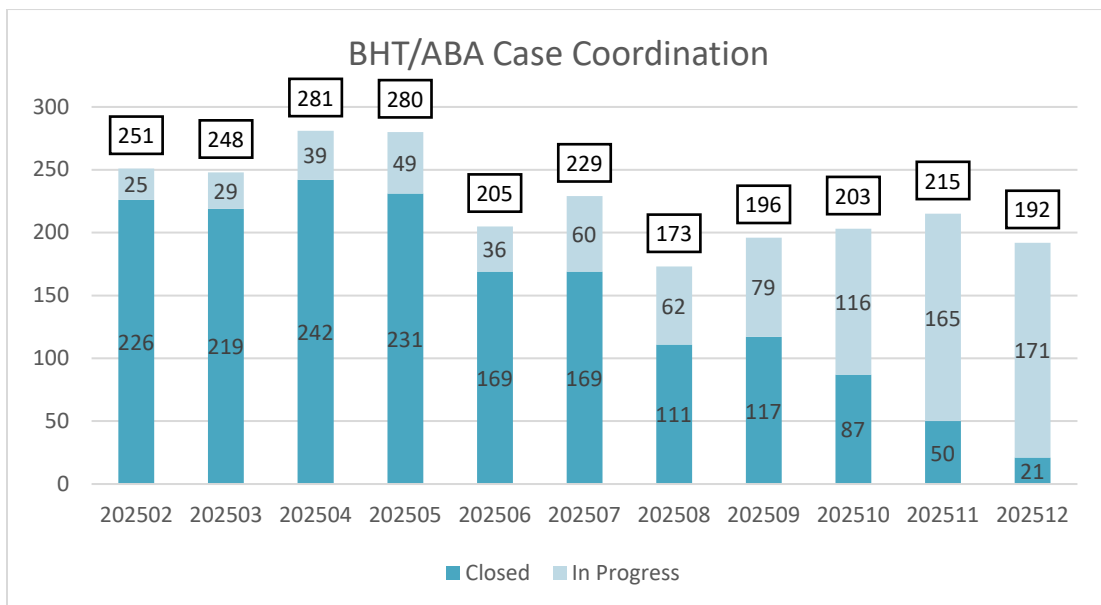
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA)

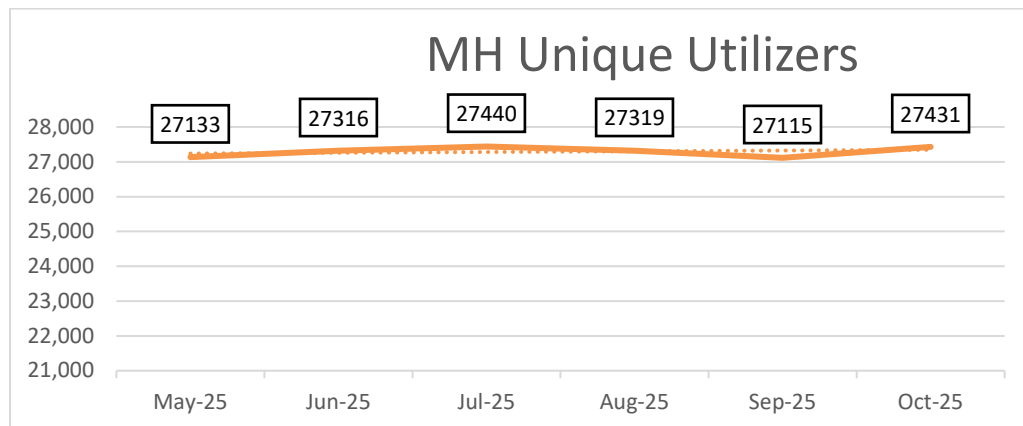
- Children and youth referred for BHT/ABA services, including Applied Behavioral Analysis (ABA) and Comprehensive Diagnostic Evaluations (CDE), require Care Coordination to access the services needed. The Alliance manages each child's unique needs and follows up with parents and caregivers to resolve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



Source: 14665_BH_Cases

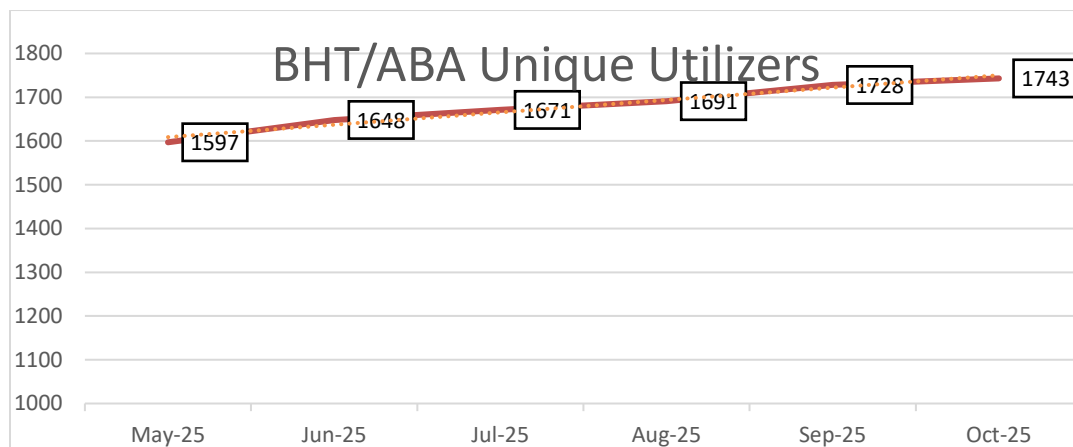
Behavioral Health Unique Utilizers

- Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.
- The number of unique utilizers of mental health services has decreased by 1.2% compared to the previous month.



Source: PBI 14637 BH12M Report

- We observed a continuing rise in unique utilizers of BHT/ABA services, reflecting a 0.9% increase compared to the previous month.



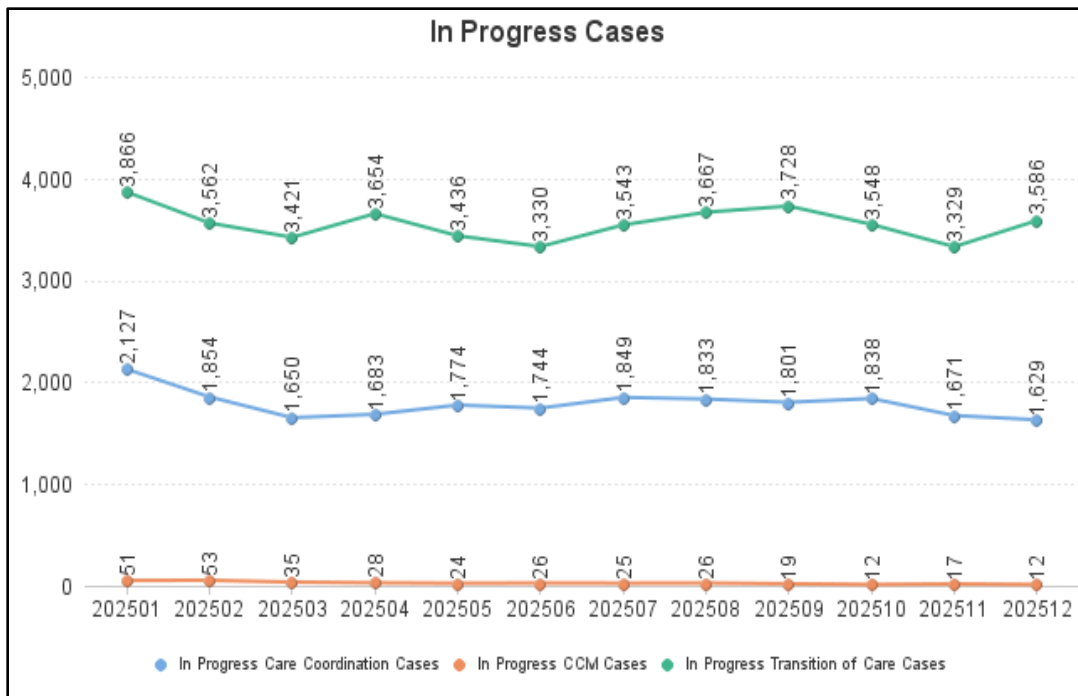
Source: PBI 14621 BHT Utilization Report

Pharmacy

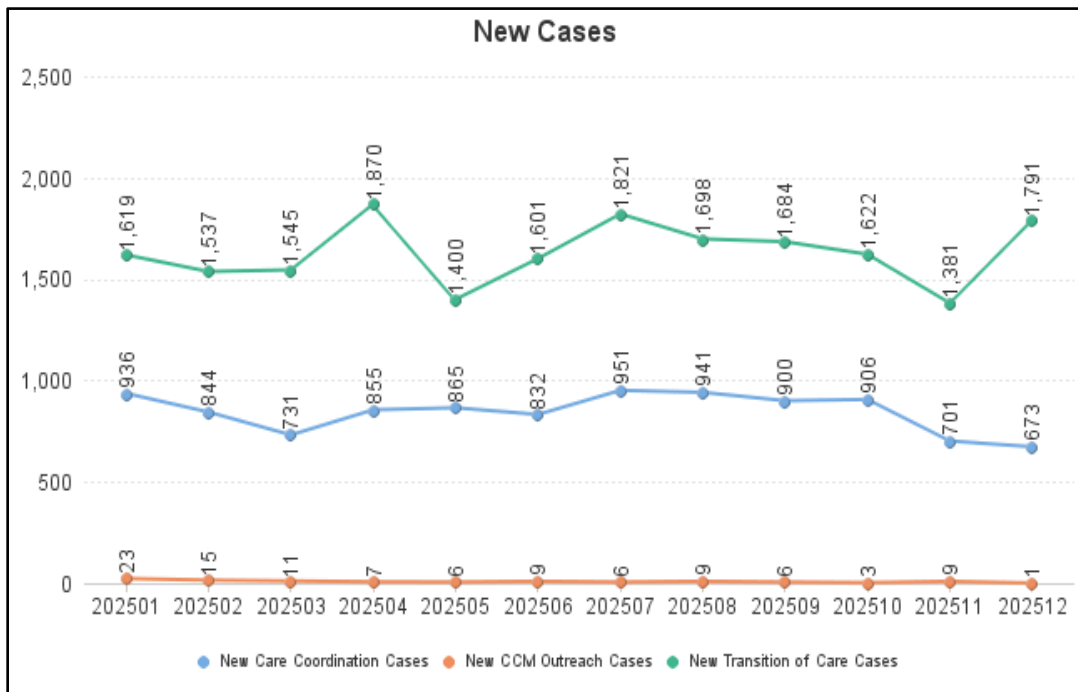
- The Pharmacy Transitional Care Services (TCS) program has screened 11 Heart Failure cases, 30 Sepsis cases, and received 1 direct referral for the month of December 2025.

Case and Disease Management

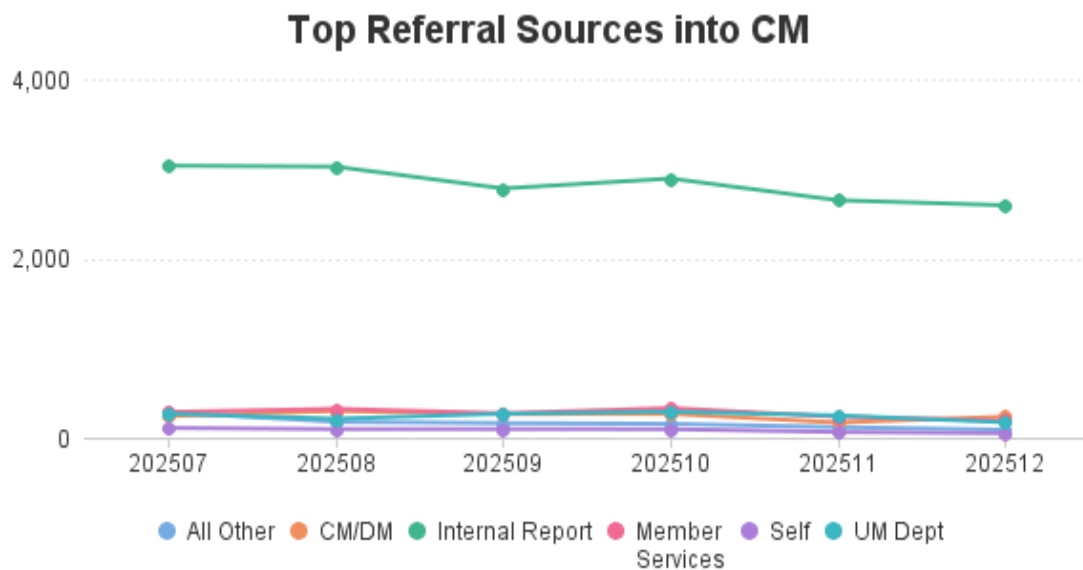
- The CM team is working hard to assist the high volume of members needing Transitional Care Services (TCS) as they transition from one level of care to another. This includes outreaching to members who are still hospitalized and following up post-discharge to help meet the member's needs.
- The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including but not limited to scheduling and ensuring follow-up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners, members, caregivers, support teams, etc.).
- CM is collaborating with UM and LTC to support members at hospitals with long-length stays and complex discharge barriers, including facilitating referrals to Community Supports, ECM and other community resources, as needed.
- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues to educate the provider network, including hospital discharge planners, and dialysis centers about PCS form requirements. The transportation liaison has also increased oversight of ModivCare's facility transportation services, including making onsite visits with hospitals to address transportation concerns.
- Preparation continues for DSNP case management. The Case Management (CM) leadership team has developed training for the internal CM team as well as informative overviews of CM for other teams and entities.



Source: #03342 TruCare Caseload



Source: #03342 TruCare Caseload



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

Source: #03881 Case and Disease Management Dashboard - *data available through November 2025

CalAIM

Enhanced Case Management

- All Populations of Focus are live:
 - Homeless children/youth and adults
 - High Utilizer children/youth and adults
 - SMI/SUD children/youth and adults
 - Children/Youth Transitioning from a Youth Correction Facility
 - Adults Transitioning from Incarceration
 - Adults Living in the Community and At Risk for Long-Term Care Institutionalization
 - Children/Youth Enrolled in CCS with Additional Needs Beyond the CCS Condition
 - Children/Youth Involved in Child Welfare
 - Children/Youth and Adults Who are Pregnant or Postpartum

- The ECM team is working closely with IT and IPD to automate creation of authorization shells, provide auto authorizations where possible, and centralize ECM referrals. This will improve referral processing and authorization determination decisions with improved turnaround times. Additionally, this will free up ECM staff to work on other areas of ECM (i.e. graduating or assisting with stepping members down to a lower level of care, clinical audits, additional support to Provider frontline staff to improve effectiveness of care plan outcomes and, further advance the growth of ECM especially in key POF areas that are underdeveloped like Birth Equity).
- Efforts to expand the ECM provider network have resumed. The screening panel reviews provider applications based on capacity to serve targeted Populations of Focus, demonstrated operational excellence in programming, and quality benchmarks.
- The Standardized ECM referral form and ECM authorization information is now visible to providers on the provider portal. Network-wide provider training started in July. All ECM providers have been trained in how to use the portal for referral submissions, checking member AAH eligibility, checking authorization status and checking ECM eligibility, however, there have been reported inconsistencies and AAH is working to resolve.
- The ECM team continues to build rapport with the ECM providers, meeting to discuss specific cases and work with the ECM providers to assist with moving members through the ECM program by addressing care plan barriers and offer support and services ECM providers may not be aware of. This has led to more collaboration and community referrals to additional resources. Additional meetings are scheduled with ECM providers for individual case conferences as needed. Clinical Operations meetings that support ECM provider leadership and processes are launching in January. These meetings will further support the relationship between the ECM provider and AAH.
- ECM and CS teams have begun a collaborative meeting to confirm communication is occurring between Community Supports providers and ECM lead care managers. The collaboration further enhances coordination of care, ensuring non-duplicative services and members receive appropriate services to meet their needs. One new area where collaboration is happening is in preparing for Transitional Rent, ensuring smooth transitions into ECM as necessary.

- As a result of the 2024 Fall's audit of ECM providers, the ECM team continues to develop training for the ECM providers to re-educate the ECM provider network on various topics applicable to ECM. The ECM team was successful in providing monthly training sessions for all ECM providers' frontline staff to reinforce ECM requirements and expectations. Based on this success, in 2026 there will be more ECM provider staff trainings.
- AAH continues to collaborate with Alameda County (AC) Health to discuss Street Medicine alignment. The ECM team works closely with the Street Team providers to make sure encounters are submitted and billed appropriately.
- Closed-Loop Referral (CLR) requirements went live on July 1, 2025. The closed-loop referral framework is designed to ensure that members, healthcare providers, and ECM/CS providers are aware of the status of referrals from beginning to end.

	September 2025		October 2025		November 2025	
ECM Providers	Outreach	Enrolled	Outreach	Enrolled	Outreach	Enrolled
ACBH	-	13	-	13	-	13
Alameda Health System (AHS)	35	248	28	248	23	228
Bay Area Community Services (BACS)	6	141	10	146	7	156
California Cardiovascular Consultants	-	147	-	147	-	148
California Children's Services (CCS)	4	44	6	45	4	110
CHCN	126	1,1143	90	1,1125	-	1,117
East Bay Innovations (EBI)	13	138	24	140	19	139
Full Circle	110	174	49	170	-	159
Institute on Aging	167	215	176	222	190	233
La Familia	51	38	55	38	55	35
MedZed	83	940	30	992	53	1,1013
Roots Community Health Center	4	704	-	648	-	673
Seneca Family Services	-	49	-	47	-	49
Pair Team	371	2,367	343	2,271	1	2,178
Titanium Health Care	191	1,336	82	1,385	11	1,416
Tiburcio Vasquez Health Center (Street Medicine)	-	118	-	118	-	114
BACH (Street Medicine)	-	80	-	84	-	82
Lifelong (Street Medicine)	2	411	2	412	2	417
Roots Community Health Center (Street Medicine)	Combined with Roots 'traditional' ECM program					

Source: #13360 ECM Dashboard

Community Supports (CS)

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

Community Supports	Services Authorized in September 2025	Services Authorized in October 2025	Services Authorized in November 2025
Housing Navigation	1,018	996	942
Housing Deposits	474	470	448
Housing Tenancy	976	1,006	1,114
Asthma Remediation	140	133	129
Meals	737	829	819
Medical Respite	60	60	46
Transition to Home	9	11	9
Nursing Facility	5	5	3
Home Modifications	4	6	6
Homemaker Services	41	38	35
Caregiver Respite	2	2	1
Total	3,466	3,556	3,552

Source: #13581 Community Supports Auth Dashboard

Total CS Authorization Volume			
Authorization Status	October 2025	November 2025	December 2025
Approvals	638	591	754
Partial Approvals	0	0	0
Denials	95	48	58
Total	733	639	812

Source: #02569_AuthTAT_Summary

LTC Turn Around Time Compliance (benchmark: 95%)			
Line of Business	October 2025	November 2025	December 2025
Medi-Cal	97%	99%	97%

Subject: Community Health Strategy (CHS) – December

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

Staffing Updates:

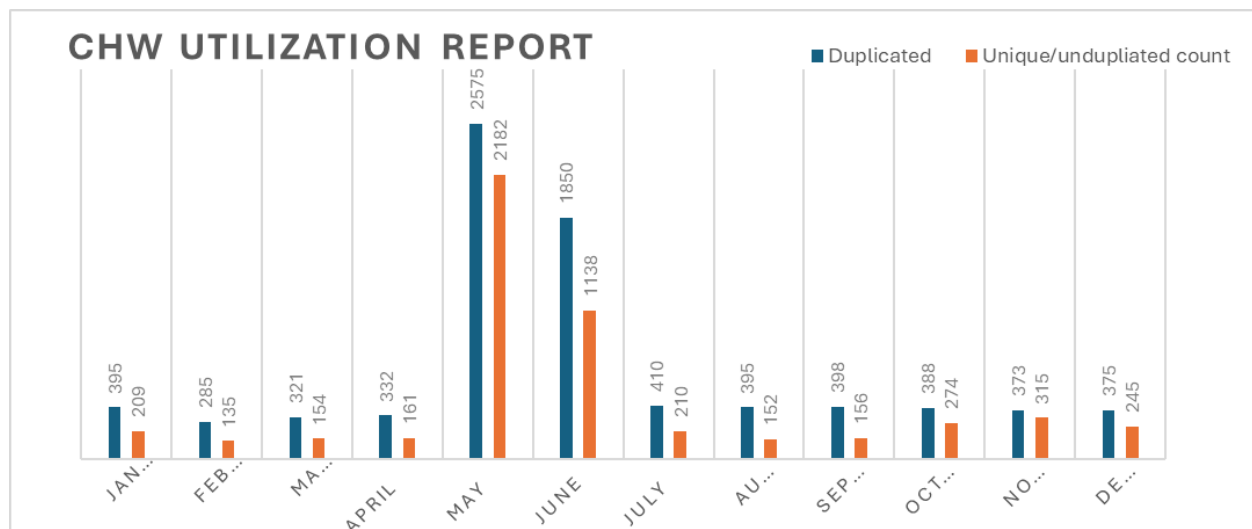
- Manager, Community Health Initiatives – New Hire will start February 2026

December Program Summary:

- December reflected the strength of cross-departmental collaboration and the collective commitment across Alameda Alliance to advance equity-centered care through Community Health Worker (CHW) integration. Health Care Services continues to play a vital role in socializing the CHW benefit across programs and clinical initiatives, ensuring CHWs are meaningfully embedded in member care pathways. Special recognition is extended to the Population Health team for partnering with CHS on two phases of the A1C outreach initiative, and to the Quality team for their perseverance in strengthening data linkages between CHW engagement and member outcomes, including efforts related to FUM in the ED. Quality leadership also supported opportunities for hospital partners to expand CHW staffing to reinforce post-acute care transitions and led CHW-supported outreach campaigns designed to help members control blood pressure. Additional progress this year included CHW-led equity interventions supporting perinatal depression and access to care. Looking ahead, new initiatives include a fatty liver disease project launching in February 2026 and a pediatric engagement strategy to support smaller clinics with member outreach and navigation.
- We also extend appreciation to the Communications & Outreach (C&O) team for expanding community awareness of CHW services and strengthening cross-functional collaboration. CHS plans to participate in at least five community outreach events in the coming year to further deepen trust-based engagement. This work remains grounded in the shared vision and leadership of Dr. Carey and Allison Lam, who continue to champion CHW integration as part of a coordinated continuum of care. December demonstrated what is possible when strategy, compassion, and partnership align in service to our members.

CHW Program – Member Utilization Snapshot

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



- Over the past year, CHW program utilization demonstrated steady and meaningful engagement among our members, reflecting both continued awareness and increasing alignment of CHW services with member needs. Monthly duplicated utilization ranged from approximately 285–395 visits through the first quarter, followed by a notable rise beginning in April and peaking in May at 2,575 duplicated encounters. This trend indicates strong uptake and reflects the increased connection of members to CHW-led care coordination, navigation, and social support services during that period.
- Unduplicated utilization (unique members served) follows a similar pattern, with consistent engagement in the early months and a sustained increase into the second quarter. The program reached its highest number of unique members in May (2,182), demonstrating that CHWs provided meaningful outreach and engagement to new members rather than only repeat visits to the same cohort. Even during months of lower total visit counts, the ratio of duplicated to unduplicated utilization suggests that CHWs are supporting both ongoing case engagement and new referrals, an important indicator of program health and relevance.

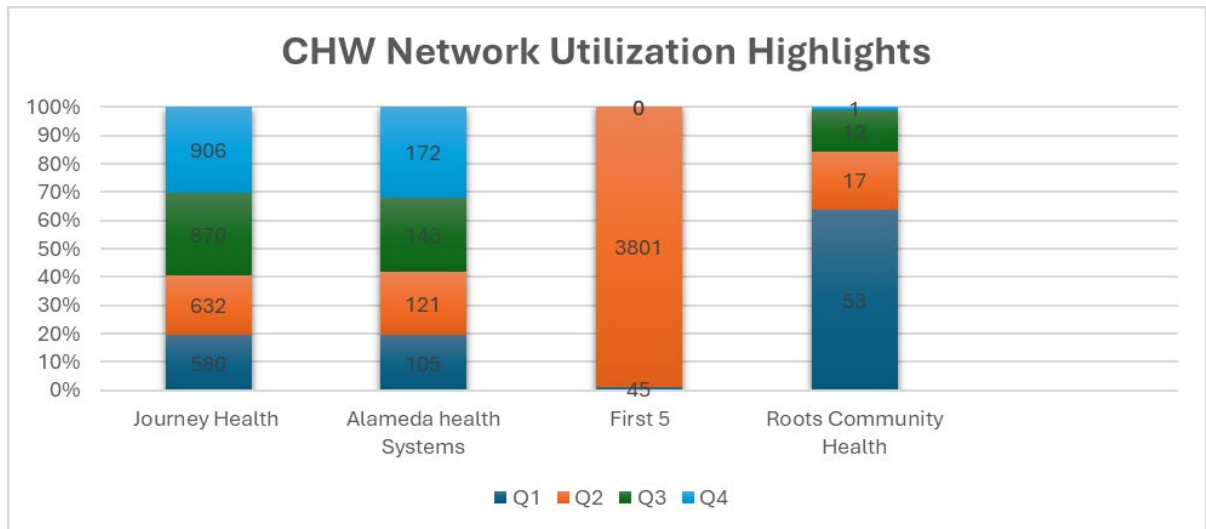
Key Observations

- Growing reach over time: The significant rise in CHW utilization during the spring months reflects increasing operational maturity, provider onboarding, and strengthened referral activity. A key contributor to this growth was the engagement of First 5 under a clearly defined scope-of-work model, transitioning away from prior grant-based participation. This shift supports stronger alignment between Quality initiatives and CHW-led interventions and demonstrates that when care management teams and CHWs coordinate through warm handoffs, member engagement measurably increases. This alignment represents a meaningful success indicator for both service integration and program strategy.
- Sustained engagement: Although utilization tapered modestly toward the end of the year, engagement remains materially higher than early-year baseline levels, suggesting durable program integration and continued relevance to member needs. At the same time, it is important to acknowledge that claims correction processes may introduce variability into reported totals. Specifically, when providers submit corrected claims, those revisions may not be consistently reflected in the claims portal currently used for reporting. The Community Health Strategy (CHS) team is actively exploring alternative reconciliation methods to improve reporting accuracy. As a result, utilization totals for high-engagement providers such as Journey Health and First 5 may be underestimated in current reporting cycles.
- Balanced utilization pattern: The data suggests that CHWs are supporting both new member engagement and ongoing longitudinal relationships. This balance between duplicated and unduplicated encounters demonstrates continuity of care while continuing to expand the program's reach—indicating increasing visibility, trust, and relevance within the member community.

Data Considerations and Limitations

- While the current dataset provides meaningful insight into program trends, several factors may influence reported totals and should be considered in interpretation:
 - Claims correction lag: Corrected claims are not always reflected uniformly across reporting systems, potentially under-representing total utilization for some providers.
 - Documentation maturity: As providers strengthen workflows and billing accuracy, utilization reporting is expected to stabilize further.
 - Program growth phase: Variation in referral volume and onboarding timelines may contribute to seasonal fluctuations in utilization.

- The CHS team is working collaboratively with internal partners to refine data capture and validation processes so that future reporting more fully reflects the breadth of member engagement.



- Our CHW program is intentionally built as a network model, leveraging the unique strengths of each provider to meet diverse member needs across clinical, behavioral, and social drivers of health. Quarterly utilization patterns highlight a deliberate, balanced, and mission-aligned network in which:
 - High-volume providers anchor scale and quality-driven outreach
 - Hospital partners extend CHW services into acute-care environments
 - Family-serving organizations strengthen early-childhood preventive care
 - Community-rooted providers advance condition-specific prevention and equity
- This structure supports our ability to reach high-risk members, prevent avoidable utilization, improve pediatric and chronic disease outcomes, and advance culturally responsive engagement across the continuum of care. As January 2026 approaches, we look forward to onboarding additional providers to further expand access and strengthen CHW-supported services for our members.

CHW Program – Recruitment Efforts:

- Alameda Alliance now maintains an active network of eighteen CHW provider organizations, with an additional twenty-one entities moving through our recruitment and readiness pipeline. This reflects strong market engagement and positions the Alliance to continue expanding CHW access while maintaining high standards for provider quality, readiness, and alignment with our mission.

- Alameda Alliance continues to make steady progress in strengthening and expanding the Community Health Worker (CHW) provider network. As of December, eighteen (18) CHW provider organizations are actively contracted and delivering services to members. Of these, eight (8) are directly contracted with Alameda Alliance and nine (9) participate as subcontracted providers through Journey Health Medical Group.
- Beyond the currently active network, an additional twenty-one (21) organizations are progressing through various stages of the CHW recruitment pipeline. This reflects strong market interest in partnering with Alameda Alliance to advance whole-person care, population health improvement, and community-rooted service delivery.

Recruitment Pipeline Profile

- The chart illustrates the distribution of organizations across key recruitment milestones:
 - 18 providers currently contracted and active, representing the core CHW delivery network.
 - 2 organizations remain in the outreach phase, where Alliance has initiated interest-building communication.
 - 4 organizations are in active recruitment, having received program information and assessing readiness to pursue certification and contracting.
 - 7 organizations are currently engaged in the CHW certification process, advancing toward eligibility for participation.
 - 3 organizations have moved into the pre-contracting stage, pending SLT review and approval.
 - 4 organizations have declined to proceed or were deemed ineligible, reflecting appropriate program standards and provider readiness assessment.
- This pipeline structure demonstrates a thoughtful balance between program growth, quality assurance, and provider readiness.



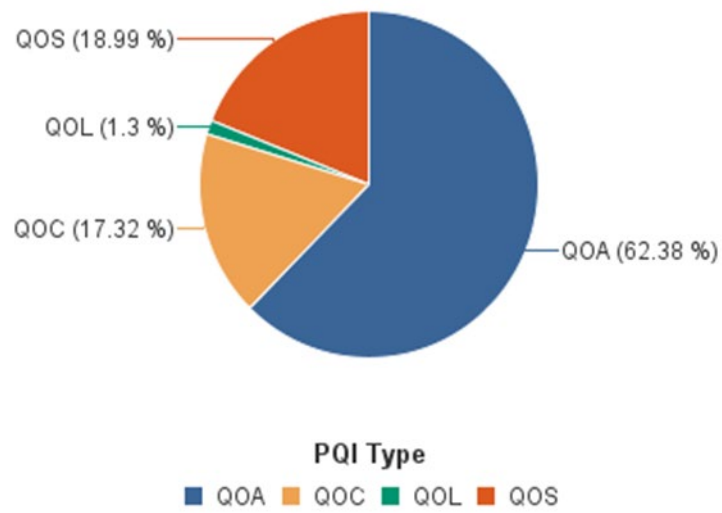
- There is sustained interest in program participation, particularly among organizations well-positioned to support CHW service delivery. The number of providers currently in certification and pre-contracting stages signals ongoing network expansion for the upcoming year. Providers exiting the process reflect appropriate safeguards and alignment of screening, ensuring that contracted organizations meet readiness, compliance, and service expectations. The recruitment pipeline remains robust and active, supporting continued scale of CHW services across clinical, social, and community-based care environments. As we prepare for 2026, the CHS team will keep in mind provider continued requests for outreach dollars for campaign programming through quality interventions. CHW providers continue to express interest is the low reimbursement rate not being efficient for program operations, which could impact direct contracting efforts in 2026.

Quality

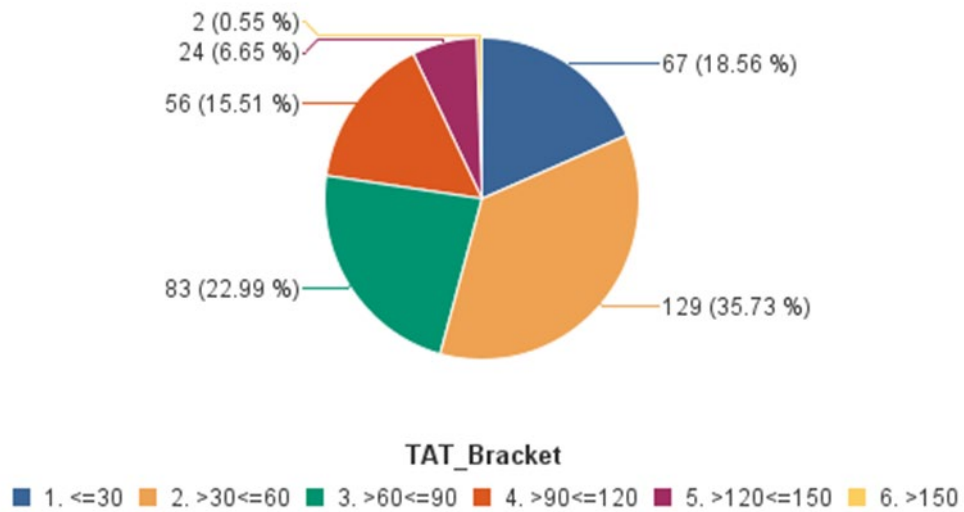
- The clinical team in QI is responsible for triaging all PQI types as they are received. This process involves assignment to an appropriate clinical reviewer for assessment, planning, intervention and evaluation. Upon initial assessment, the RN case owner makes necessary referrals when appropriate to CMDM and/or alerts QI leadership concerning issues or trends that need to be addressed prior to final MD review to prevent delays in necessary interventions and/or to prevent future similar incidents to ensure patient safety.
- Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics Services team. Quality of Care and Service issues are reviewed by the RN Clinical Reviewers. Final leveling for Quality-of-Care cases is determined by the Medical Director.

- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. The TAT goal for all PQIs is 150 days from receipt to resolution. QOC cases involve nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable. Corrective Action Plans are issued after the case is closed and where applicable.
- When cases are open past TAT, the reason is typically due to delay in receipt of medical records and/or provider responses. As part of the escalation process of obtaining medical records and/or responses, efforts are made to identify barriers with specific providers to find ways to better collaborate to achieve resolution.
- As of December 29, 2026, the turnaround time is 98.7% closed within 150 days which exceeded the standard of 95% case closure rate. With the arrival of the new QI Medical Director in October 2025, the TAT at which PQI cases are being leveled and closed with final MD recommendations was met for two consecutive months in November and December.
- Starting on December 8, 2025, a process improvement was implemented for grievance referrals to PQIs. The process was streamlined to minimize duplicate referrals, medical record requests, provider outreach for additional information, and reporting. The QI team will continue to monitor the trends from grievances and PQIs to address any system issues that may require further follow up.
- As always, the PQI process aims to support best practices in providing the highest level of care to Alliance members.

PQIs Closed by Type N= 537



PQI Aging Report as of 12/29/2025 N= 361



Alameda Alliance Provider Incentive Programs

Provider Pay for Performance

- The Alliance Pay-for-Performance (P4P) program is designed to improve quality, performance, and member outcomes by providing targeted financial incentives to providers. The program issues performance-based payments to primary care providers (PCPs) and PCP groups for both superior performance and yearly-over-year improvement.
- The 2026 P4P Program is aligned with Managed Care Accountability Set (MCAS), the DHCS Quality Factor rating and the DHCS Clinical Quality Bold Goals. It focuses on four priority domains: Preventative Care, Access, and Member Satisfaction.
- To strengthen provider engagement and accelerate quality improvement, total program funding is \$6 million for the 2026 program year. The program includes the following measures:

Clinical Quality Measure	
1	Breast Cancer Screening (BCS-E)
2	Cervical Cancer Screening (CCS-E)
3	Child and Adolescent Well-Care Visits (WCV)
4	Childhood Immunizations: Combo 10 (CIS-E)
5	Colorectal Cancer Screening (COL-E)
6	Controlling High Blood Pressure (140/90) (CBP)
7	Developmental Screening in the First 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 ($\leq 9\%$) (GSD)
10	Immunizations for Adolescents: Combo 2 (IMA-E)
11	Lead Screening in Children (LSC-E)
12	Topical Fluoride for Children (TFL-CH)
13	Well-Child Visits in the First 30 Months of Life: Two or More Visits (W30-6+)
14	Well-Child Visits in the First 30 Months of Life: Two or More Visits (W30-2+)
Other Measures	
15	Initial Health Appointment (IHA)
16	Member Satisfaction Survey: Non-Urgent Appt Availability
17	Member Satisfaction Survey: Urgent Appt Availability

Health Information Exchange (HIE) Participation

- As part of the 2026 P4P program, the Alliance is offering incentive payments to encourage participation in the Manifest MedEX Health Information Exchange (HIE). Manifest MedEx, the largest nonprofit health data network in California, supports improved efficiency and member experience by enabling faster, more informed care coordination. Participation also helps identify and close care gaps, enhances population health management and streamlining HEDIS® reporting. Provider and provider groups may earn the following incentive payments 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



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Health Equity

Lao Paul Vang

To: Alameda Alliance for Health Board of Governors
From: Lao Paul Vang, Chief Health Equity Officer
Date: January 9th, 2026
Subject: Health Equity Report

Internal Collaboration

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

External Collaboration

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update**
 - Ongoing discussions regarding health equity-related issues and DEI training curriculum.
- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**
 - The DHCS CHEO and MCPs CHEOs meet to collaborate on Health Equity and DEI initiatives.
 - The meeting included updates from DHCS and CHEO.
- **Local Initiatives DEI Training Monthly Collaborative Meeting**
 - Local MCPs continue to meet to update, share, and collaborate on the DEI Training Program. The monthly collaborative allows MCPs to ask questions, update each other on curriculum information, discuss

potential risks, and assist with moving the DEI Training forward. Many FQHC agencies expressed concerns about complying with the DEI training requirement because it may impact their federal funding.

Alliance Health Equity Strategic Roadmap Update

- The Health Equity Team identified two milestone priorities for FY25-26, namely, Community Engagement and SDOH Mitigation Measures. As milestones are implemented, updates will be available to show all activities and achievements accordingly.

- **NEW Health Equity Initiatives:**

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

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

- Rationale of the grant:

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

- Goals:

- To implement the **Beloved Black Babies (BBB) Initiative** to meet the unmet SDOH, which is a culturally appropriate and racially concordant post-natal group provided by Black medical providers for Black mothers and babies to improve the WCC and other social-emotional well-being among the Black mothers.

- The CIN grant, therefore, addresses two major health disparity gaps.

- a. WCC among the Black members of the Alliance has consistently not met MPL. WCC is an HEDIS measure and part of the DHCS Bold Goals.
 - b. Lack of culturally appropriate care is a major SDOH among the Black community.

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

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

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

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

D. SDOH Mitigation exploration with Direct Engagement with Providers.

- Beginning Sept 2025, Health Equity, in partnership with the QI team, began direct engagement with providers in the bimonthly quality meeting series, with the goal to explore potential partnerships for SDOH Mitigation Measures (Milestone #6), specifically food-is-medicine.
 - a) Tiburcio Vasquez: 9/11/2025
 - b) La-Clinica St Antonia Health Center: 9/12/2025
 - c) Axis: 9/24/2025
 - d) La-Clinica St Antonia Health Center: 10/21/2025 (in-person visit)
 - e) Baywell Health: 1/25/2025

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

Health Equity Milestone	Goals
1. Organization Transformation	a) CHEO collaborates with SLT to facilitate a system-wide organizational transformation that supports the long-term vision of health equity for the Alliance.

2. Data-Driven	a) Collaboration with UM, PHM, QI, and Analytics. b) Utilize grant-funded health equity projects to gather data that will augment the Alliance's claim data depository to formulate a comprehensive understanding of the SDOHs that perpetuate the health disparities faced by our Medicaid members.
3. Education	a) Lead in the development of DEI Training APL 24-016 (APL 23-025) and APL 24-017 (SB 923) TGI training. b) Collaboration with Culture and Linguistics, PHM, QI, and other stakeholders to ensure all our policies, services, and programs are rooted in the core foundation of health equity. c) Participation in various Functional Area Delegate (FAD) workgroups to ensure the Alliance work supports the health equity vision and mission.
4. Communication	a) Collaboration with the Community and Outreach to develop effective communications for all aspects of health equity activities to ensure that staff and members are fully informed.
5. Community Engagement	a) The Faith-Based Community Engagement workgroup was established in December 2024 and was recently renamed the Community Engagement Workgroup to reflect more accurately our broader mission. b) Direct Engagement with Provider's meetings, in partnership with QI team. c) Initiated potential providers' partnership in food-is-medicine initiatives. d) CIN membership (2025-2027).
6. SDOH Mitigation Measures	a) Initiated a partnership with AHS to implement the Beloved Black Babies pilot program to address HEDIS measures. b) Exploration of potential collaboration with selected providers to initiate Food-is-Medicine services. c) Collaborate with QI and PHM to identify high-value clinical partners who would co-develop a relevant intervention to address specific SDOH.

	d) Collaborate with CMO and HCS team to assess and analyze non-utilization data aimed at identifying health disparities.

DHCS-DMCS APL Update

- **DEI Training APL 23-025 Update**
 - We received DHCS approval for the DEI training curriculum.
 - Updated Timeline:
 - May 2025: DEI Provider Training Pilot with California Cardiovascular Consultants (CCC)
 - May – June 2025: pilot training completed.
 - July to Dec 2025: training given to subcontractors, downstream subcontractors, and network providers.
- **APL 24-018: TGI-SB 923 Update**
 - The Transgender, Gender Diverse, and Intersex (TGI) Cultural Competency Training was provided to all the Alliance staff.
 - The next step is to train our member-facing vendors, contractors, and downstream subcontractors, followed by training our providers. However, due to federal regulations and the uncertain future of TGI training, the Alliance SLT decided on 12/15/2025 to temporarily pause the TGI training/project at this time.
 - Timeline and completion rate:
 - Dec 2024: confirmation of vendor.
 - Jan-Feb 2025: Implementation of training for all Alliance staff.
 - Feb 14: 97% of the Alliance staff completed the mandatory training. The 3% of non-completion represents staff who were on vacation or medical leave. Upon returning to the office, they will have up to 30 days to complete the training.
 - Feb 14, 2025: submission of documents per APL to the State, including evidence-based TGI training curriculum, updated online Providers Directory for gender-confirming services, G&A, and Policy and Procedures.
 - Feb 28, 2025: Attestation was submitted to DHCS.
 - June 2025 to date: HE Team is working with the TGI work group to implement phase 2 and phase 3 of the training, which is member-facing vendors, contractors, and downstream subcontractors.
 - October 7, 2025: Based on the current situation involving TGI and DEI, SLT decided to pause phase 3 of the TGI training. However, the TGI working group will continue to discuss and work on specific issues that may impact DSNP's launch in January 2026.
 - December 12, 2025: SLT decided to pause the TGI training project until further notice by the state.

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

E. DEIB Committee Update

- At the DEIB Committee December 5th meeting, the committee discussed the pending merger and charter review. The committee was informed about the challenges of DEI and TGI provider training. Also, the DEI Road Map and Milestones implementation and activities were described.

F. VIA Committee Update

- At the VIA Committee December 8th meeting, the committee discussed pending legal guidance, committee membership, and charter revision. Also discussed were the annual giving and holiday drives.

Calendar of Community Engagements

CBO/FBO/Providers		Services	Status
1.	Alameda Health System	One of the pediatricians works predominantly with Black mothers and children.	• 10-21-2025: BBB grant-funded Partnership project kicked off. • Successful grant application of \$20K to implement a 10-month Beloved Black Babies Initiative (BBB): a culturally appropriate program designed to improve Well-Child measures and post-partum depression.
2.	La-Clinica St Antonia Health Center	Alliance contracted FQHC to serve our members.	• 10-21-2025: Visited the on-site food pantry and reviewed the food-is-medicine services. • 9-12-2025: Initiated partnership meeting. • Potential collaboration: data-driven food-is-medicine targeting chronic diseases.
3.	Glad Tidings International Church of God	Established in 1978, the church is well known in the Hayward community.	• 12-3-2025: visited with the church bishop and the executive director of the community outreach. • 10-21-2025: Visited the church food distribution. • 7-24-2025: Initiated meeting.

			• <i>Potential collaboration:</i> Promoting resources in health education, e.g., Doula services, diabetes, and other chronic diseases.
4.	California Improvement Network	A learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading good ideas, and implementing improvements.	• Oct 9 & May 8, 2025: in-person meetings to learn health equity best practices. • 7-9-2025: Presented health equity best practices at the Affinity group virtual meeting.
5..	School-based Health Center in Madison Park Academy, Oakland	One of the eight school-based health centers operated by Native Americans.	• July 8th, 2025: Visited the school clinic. • <i>Potential collaboration:</i> promote child health. • Collaborator: QI
6.	Allen Temple Baptist Church	A predominantly African American church established in 1919. They serve approximately 3,000 members and the broader community.	• June 2025: Initiated collaborative meetings. • <i>Potential collaboration:</i> Co-design community survey with the church to identify needs and SDOHs; support health education outreach to the congregation and community at large.
7.	Native American Health Center	Native Americans and other PCP services, WIC, and dental.	• July 6th, 2025: Table at the annual Indigenous Red Market event. • December 2024: Visited the health center.
8.	Oakland Unified School District (OUSD)	The largest school district in Alameda County, serving about 33,000 students in about 75 schools, K-12.	• April 2025: Collaborative meetings initiated. • <i>Potential collaboration:</i> Co-design Parent Survey with

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



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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 9th, 2026

Subject: Information Technology Report

Encounter Data

- In the month of December 2025, the Alliance submitted 156 encounter files to the Department of Health Care Services (DHCS) with a total of 464,039 records.

Enrollment

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

HEALTHsuite

- The Alliance received 320,327 claims in the month of December 2025.
- A total of 418,723 claims were finalized during the month out of which 380,455 claims auto adjudicated. This sets the auto-adjudication rate for this period to 90.9%.

TruCare

- A total of 21,360 authorizations were loaded and processed in the TruCare application.
- TruCare Application Uptime – 99.9%

Data Integration Project Updates

- Monthly OS patching during 2nd, 3rd and 4th week of the month
- On-going Data Masking Refresh to provide masked data for Offshore team
- Completion of D-SNP Production code development for ETL
- Completion of D-SNP Production code development for Application Development
- Performance Tuning by increasing memory for DBR1-PROD and SQLPROD
- Performance Tuning by increasing memory for SQLTEST

- Cut Over for Open Enrollment Period (OEP)
- ETL Code Optimization for HealthX through CR06395
- DWH Daily Refresh Code Optimization through CR06388

IT Security Program

- Perm Statement: The IT Security 3.0 initiative ranks among the Alliance's foremost objectives for fiscal year 2026. Our aim is to consistently enhance and advance our security measures, secure our network perimeter against threats and vulnerabilities, and bolster our security policies and procedures.
- Continued hardening of IT Security controls – (1) IT Security adopted industry standard frameworks NIST CSF v2 and 800-53 in support of HIPAA (2) creation of an exception process (3) remedial IT Security awareness training.
- Looking at developing an IT Security charter that defines mission, authority, scope, interfaces, and accountability.

Intune Mobile Migration

- Intune mobile migration for company owned devices.
- Purpose: Standardize mobile device management under Microsoft Intune for improved security.
- Scope: Includes corporate mobile devices across all departments.
- Enrollment phase for company owned devices complete.

Intune BYOD Migration

- Intune mobile migration for BYOD devices initiative currently in progress.
- Purpose: Standardize mobile device management under Microsoft Intune for improved security.
- Completion date: 1/31/26

Deployed Copilot to 144 users

- Intune mobile migration for BYOD devices initiative currently in progress.
- Purpose: Standardize mobile device management under Microsoft Intune for improved security.
- Completion date: 1/31/26

Information Technology

Supporting Documents

Enrollment

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

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

Month	Total MC ¹	MC ¹ - Add/ Reinstatements	MC ¹ - Terminated	Total GC ²	GC ² - Add/ Reinstatements	GC ² - Terminated
December	404,536	3,262	4,664	6,093	144	92

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 2025

Auto-Assignments	Member Count
Auto-assignments MC	3,115
Auto-assignments Expansion	2,587
Auto-assignments GC	73
PCP Changes (PCP Change Tool) Total	3,531

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of December 2025”.
- There were 19,199 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 2025

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,347
Provider Portal Requests (Zipari)	6,068
EDI (CHCN)	6,212
ADT	1,384
Behavioral Health COC Update - Online	63
Behavioral initial evaluation - Online	19
Manual Entry	3,400
OCR Face sheets	1,867
Total	21,360

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)

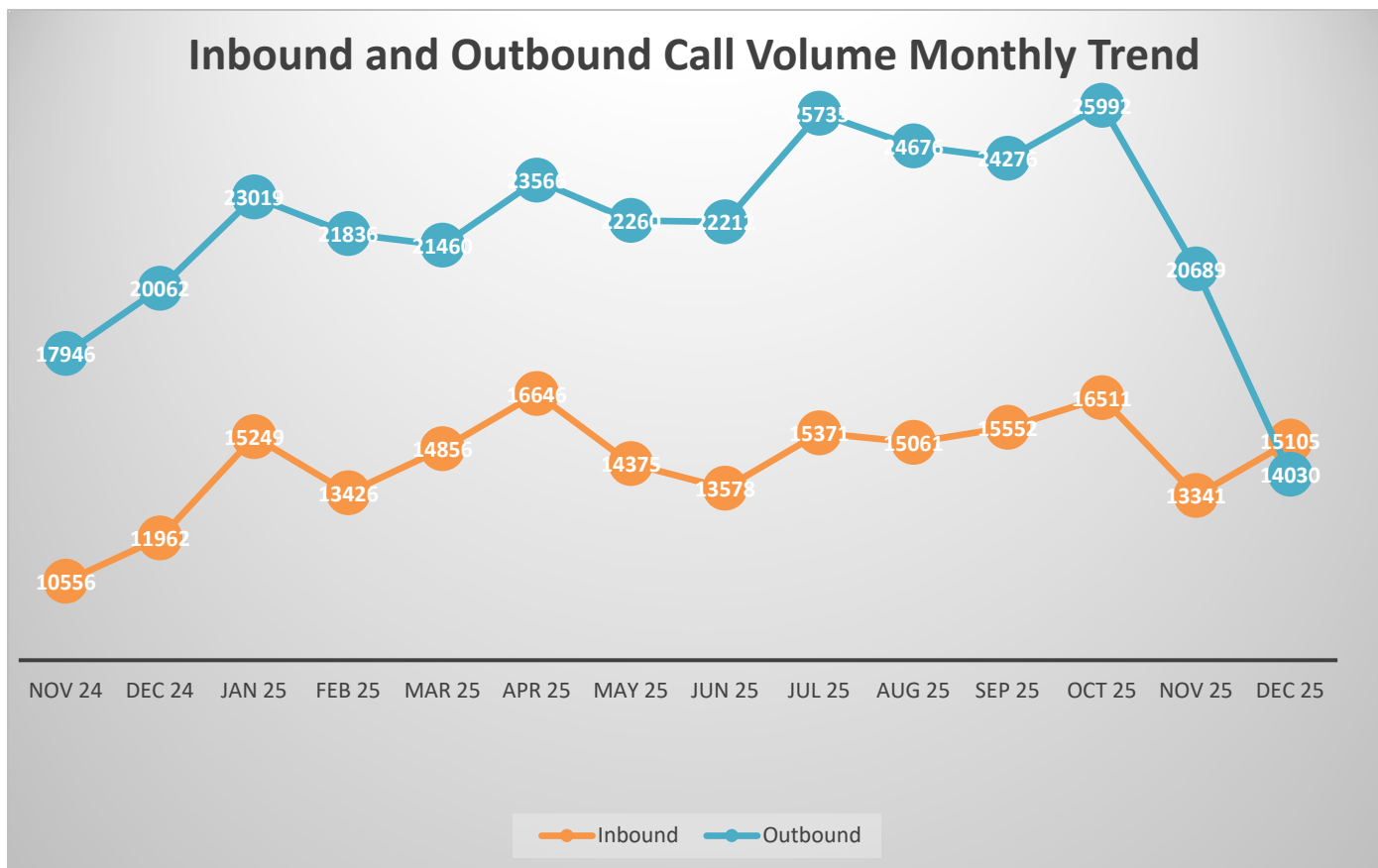
Table 3-1 Web Portal Usage for the Month of November 2025

Group	Individual User Accounts	Individual User Accounts Accessed		Total Logins	New Users
Provider	8,931	6,168		586,090	622
MCAL	135,423	3,724		8,817	1,144
IHSS	4,219	73		755	33
Total	148,573	9,965		595,662	1,799

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

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1,842,582
Provider - Claims	Claim Status	233,977
Provider - authorizations	Auth Search	9,103
Directory Config	Provider Directory	9,085
Provider - authorizations	Auth Submit	6,653
Provider - Claims	Submit professional claims	5,246
Member My Care	Member Eligibility	4,775
Member Help Resources	Find a Doctor or Hospital	3,152
Member Help Resources	ID Card	2,688
Provider - eligibility/claim	Member Roster	2,088
Member Help Resources	Select or Change Your PCP	1,830
Member Home	MC ID Card	1,646
Member My Care	My Claims Services	1,355
Provider - Home	Behavior Health Forms SSO	1,235
Provider - Home	Long Term Care Forms SSO	1,140
Member Config	Provider Directory	1,086
Provider - Provider Directory	Provider Directory 2019	1,004
Member My Care	Authorization	766
Provider - Home	Forms	568
Member My Care	My Pharmacy Medication Benefits	508
Provider - reports	Reports	485
Member My Care	Member Benefits Materials	349
Member Help Resources	FAQs	267
Member Help Resources	Forms Resources	235

Call Center – Call Volume Overview:



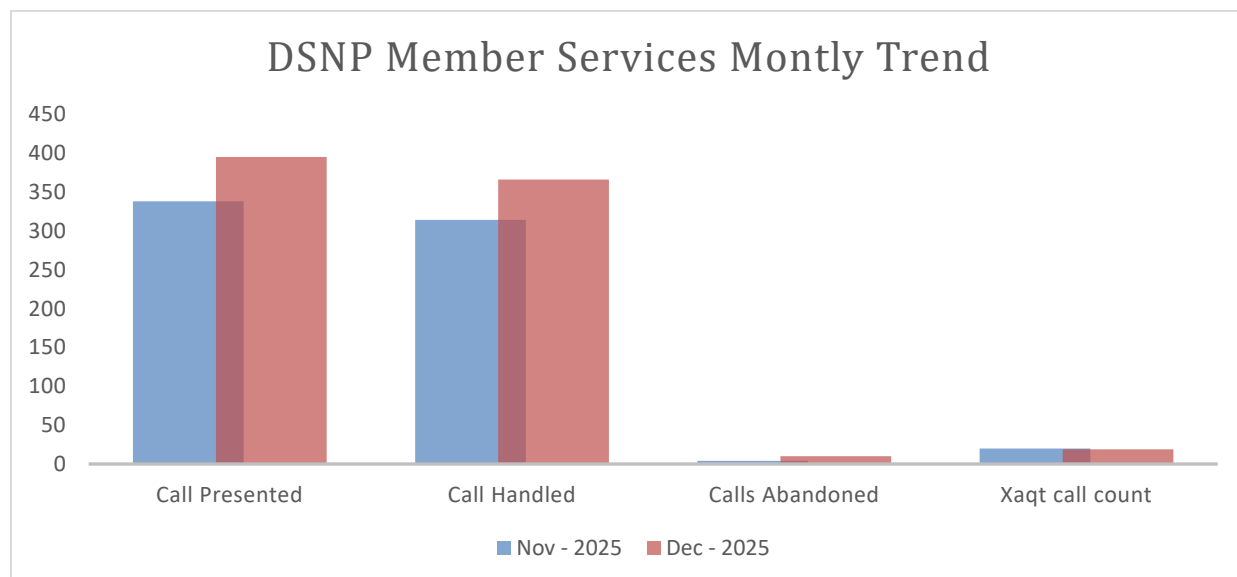
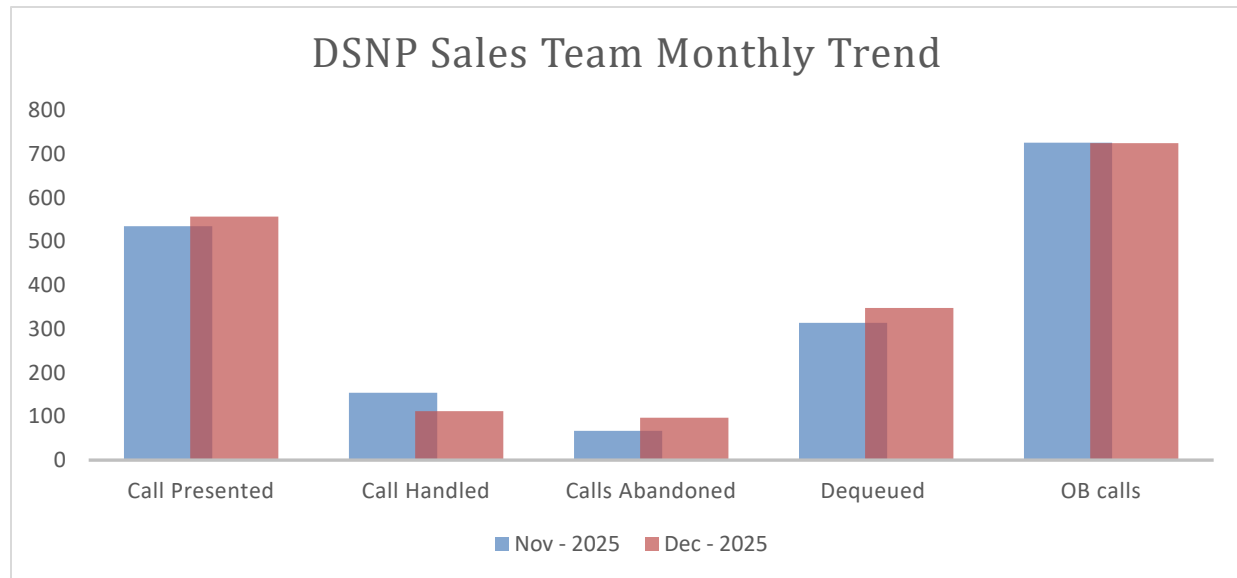
Members - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
July	14228	10876	1389
August	13903	10487	1291
September	14280	11457	1253
October	14628	12104	705
November	11827	9662	515
December	13436	11549	594

Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
July	11601	9503	1629
August	11243	8692	1926
September	11421	8473	2182
October	10884	8763	1592
November	8821	6474	1750
December	10851	7853	2251

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

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

Call Center – DSNP Sales and Member Services:



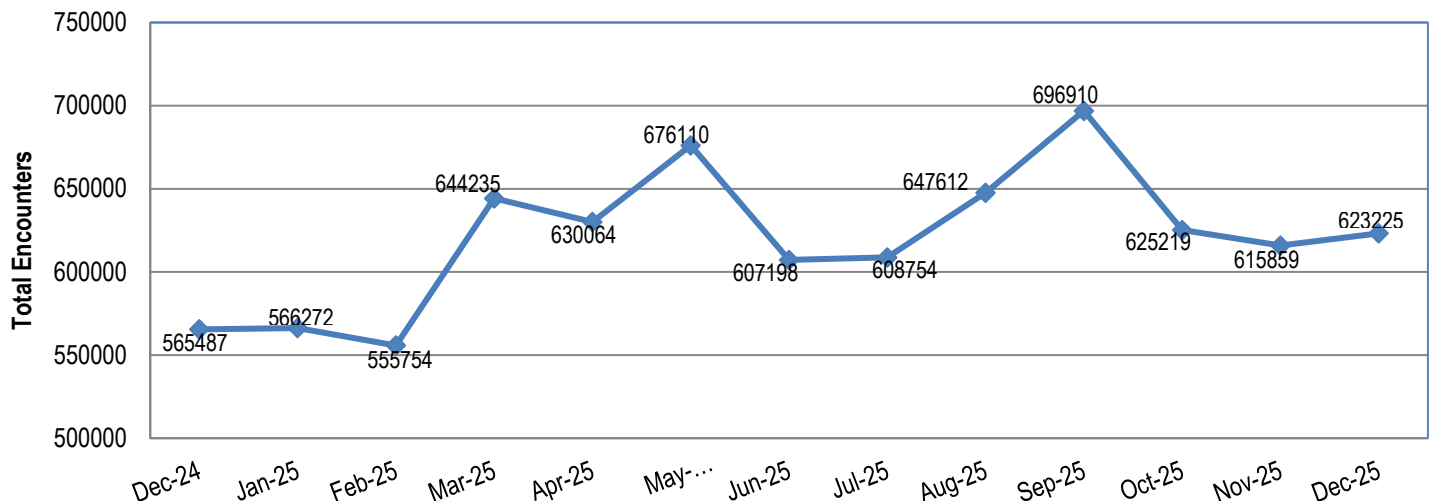
Encounter Data from Trading Partners 2025

- **AHS:** December weekly files (8,671 records) were received on time.
- **BACH:** December monthly files (0 records) were received on time.
- **BACS:** December monthly files (109 records) were received on time.
- **CHCN:** December weekly files (157,589 records) were received on time.
- **CHME:** December monthly files (7,579 records) were received on time.
- **CFMG:** December weekly files (16,647 records) were received on time.
- **Docustream:** December monthly files (0 records) were received on time.
- **EBI:** December monthly files (1,683 records) were received on time.
- **FULLCIR:** December monthly files (1,358 records) were received on time.
- **HCSA:** December monthly files (2,876 records) were received on time.
- **IOA:** December monthly files (3,095 records) were received on time.
- **LAFAM:** December monthly files (84 records) were received on time.
- **LIFE:** December monthly files (361 records) were received on time
- **LogistiCare:** December weekly files (59,563 records) were received on time.
- **March Vision:** December monthly files (7,336 records) were received on time.
- **MED:** December monthly files (2,894 records) were received on time.
- **PAIRTEAM:** December monthly files (10,633 records) were received on time.
- **Quest Diagnostics:** December weekly files (18,004 records) were received on time.
- **SENECA:** December monthly files (123 records) were received on time.
- **SERENE:** December monthly files (0 records) were received on time.
- **TITANIUM:** December monthly files (4,244 records) were received on time.
- **TVHC:** December monthly files (49 records) were received on time.
- **Magellan:** December monthly files (570,591 records) were received on time.

Trading Partner Encounter Inbound Submission History

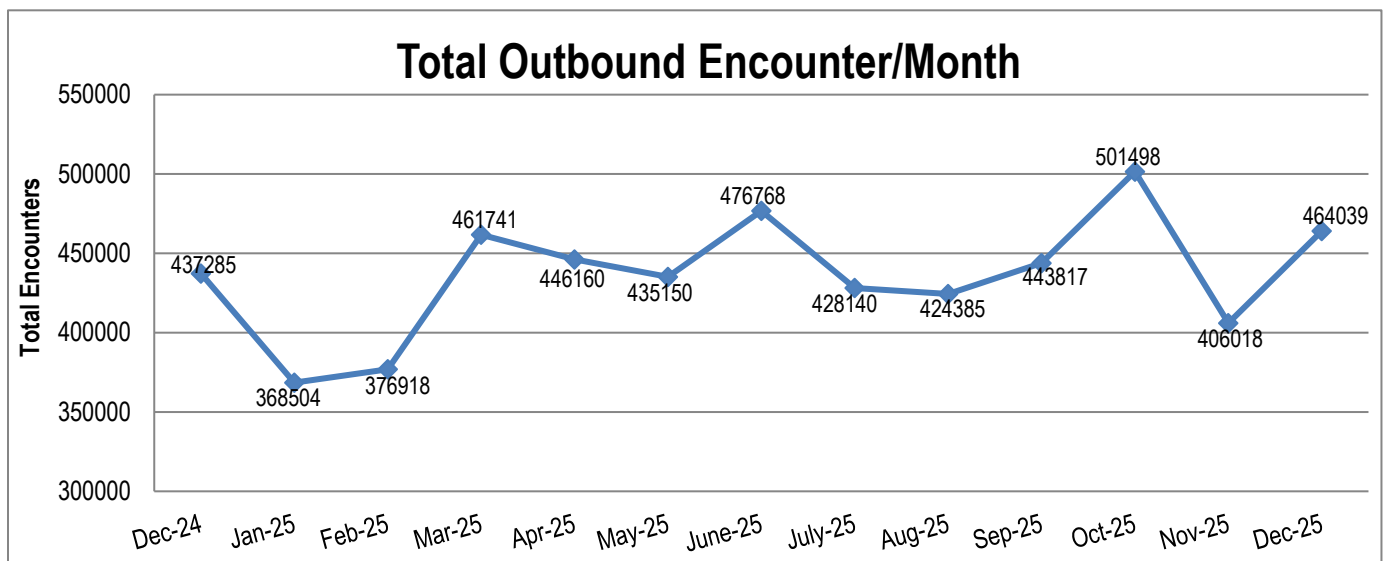
Trading Partners	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Health Suite	332108	339760	339840	347469	372126	387564	340224	355255	389082	372025	372246	349052	320327
AHS	7261	9709	8654	9273	8211	15875	7712	7880	10257	8455	9267	11333	8671
BACH		426		291	131		296	172	172	180	181		
BACS	104	93	113	81	72	88	128	81	82	100	102	114	109
CHCN	127327	117483	118972	181049	117350	151416	170810	125697	132885	170744	152102	138524	157589
CHME	7458	7781	7553	6794	8293	9045	8638	8115	8368	8228	7938	9119	7579
CFMG	16696	13536	17329	21767	15856	21443	15710	13266	13336	20280	17075	20083	16647
Docustream	828	694	808	770	891	1068	1052	1216	707	423	830	322	
EBI	1476	1440	1597	1390	2926	1457	1381	2946	1940	1800	1823	1922	1683
FULLCIR	1085	806	1534	2099	2025	1479	1441	3266	3972	5006	2176	168	1358
HCSA	2335	2432	2725	2118	2384	2628	2467	2671	2453	2930	172	2481	2876
IOA		3008	933	736		2068	3083	1851	635	1377	1683		3095
LAFAM	83	112	96	85	93	101	81	85	83	74	87	247	84
LIFE	997	228	267	431	317	1274	412	388	541	245	290	330	361
LogistiCare	34122	28671	32550	33754	55059	35875	15025	38834	34040	62760	15649	36206	59563
March Vision	6285	15146		6985	6704	7929	8100	6914	7877	8374	9295	9338	7336
MED	619	758	1182	775		1581	958	2722	1246	1172	1468	1299	2894
PAIRTEAM	5816	3436		2055	16360	9244	7724	15956	14426	9446	9972	7871	10633
Quest	18003	18002	18001	22502	18003	22501	18000	18000	22500	18001	18001	22500	18004
SENECA	131	1	69	129	108	109	160	76		188	66		123
SERENE	654	107		209				581					
TITANIUM	2099	2487	3531	2855	3039	2970	3792	2782	3010	4102	4796	4950	4244
TVHC		156		618	116	395							49
Total	565487	566272	555754	644235	630064	676110	607194	608754	647612	696910	625219	615859	623225

Total Encounters Received/Month



Outbound Encounter Submission

Trading Partners	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Health Suite	263242	182192	205804	264948	210745	226401	284779	212832	228707	246133	243105	207026	228028
AHS	6850	7710	8135	7952	4510	9326	14010	7038	10166	8358	9125	11095	8218
BACH	6	407		272	110		270	138		147	139		
BACS	41	128	87	59	23	51	59	60	52	82	77	86	79
CHCN	84649	85439	82973	95918	115571	106733	98329	106648	92163	89837	133350	93935	101887
CHME	7342	7426	7167	6682	8156	8914	8471	7991	8232	8090	7822	8407	7470
CFMG	11342	9362	11960	15008	11394	12430	13853	9238	9252	10764	11978	11518	13611
Docustream	239	634	559	478	551	540	385	381	192	131	247	99	
EBI	494	2208	1475	1308	1493	1346	1328	1885	1745	1634	1718	1834	1600
FULLCIR	79	1298	1251	1823	1658	1155	1236	2889	3407	2713	1748	89	1081
HCSA	2255	2497	2693	2103	2332	2603	2448	2637	2430	2871	149	2462	2840
IOA		2783	781	626		48	1836	1732	551	1176	1304		2911
Kaiser	23												
LAFAM	3	178	89	80	84	90	67	80	76	69	84	93	83
LIFE	202	508	63	65	116	93	202	122	142	152	111	222	175
LogistiCare	34035	28502	32441	33656	54971	35829	15010	38763	33974	36968	41267	36150	59480
March Vision	4156	9586	371	4354	3870	4591	4657	3888	4183	4724	5103	4847	3696
MED	55	546	1083	731		595	553	2471	1124	974	1103	1160	1547
PAIRTEAM	994	6334		1489	10873	4670	4549	9364	8386	8229	7901	5824	6500
Quest	21044	16828	16855	21048	16795	16853	21031	16774	16903	16855	20951	16810	20937
SENECA	6	112	60	116	101	98	139	63		164	19		109
SERENE		82		20				569					
TITANIUM	228	3600	3071	2551	2764	2714	3556	2577	2700	3746	4227	4361	3772
TVHC		144		454	43	70							15
Total	437285	368504	376918	461741	446160	435150	476768	428140	424385	443817	501498	406018	464039

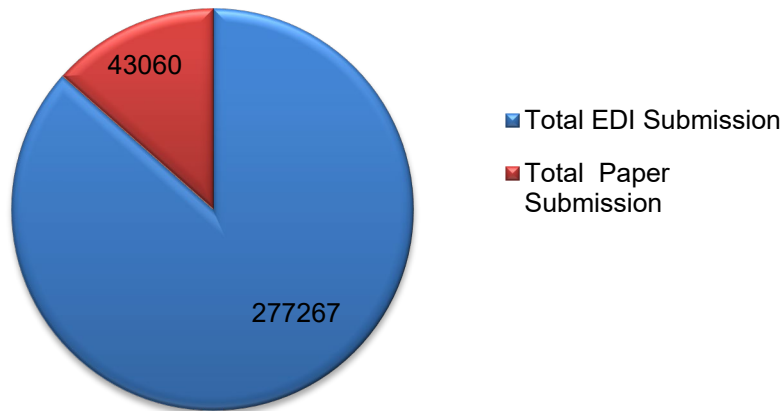


HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
25-Dec	277,267	43,060	320,327

Key: EDI – Electronic Data Interchange

EDI vs Paper Submission, December 2025

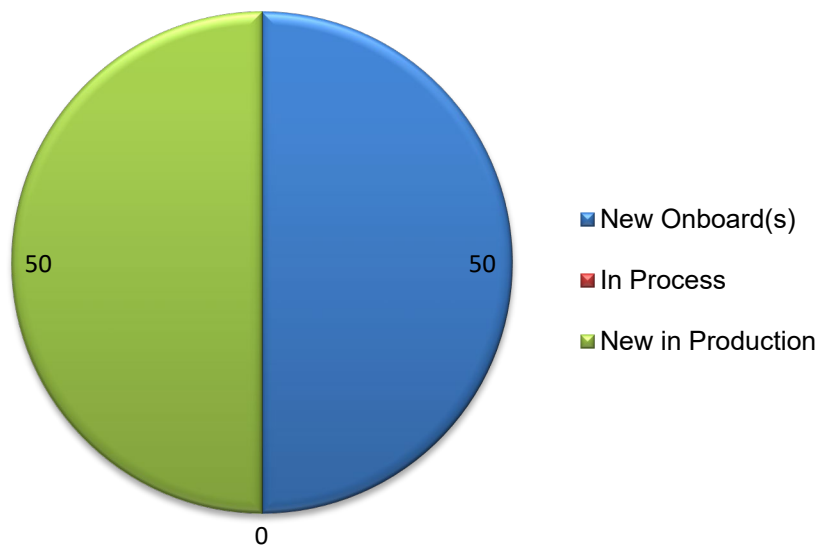


Onboarding EDI Providers – Updates

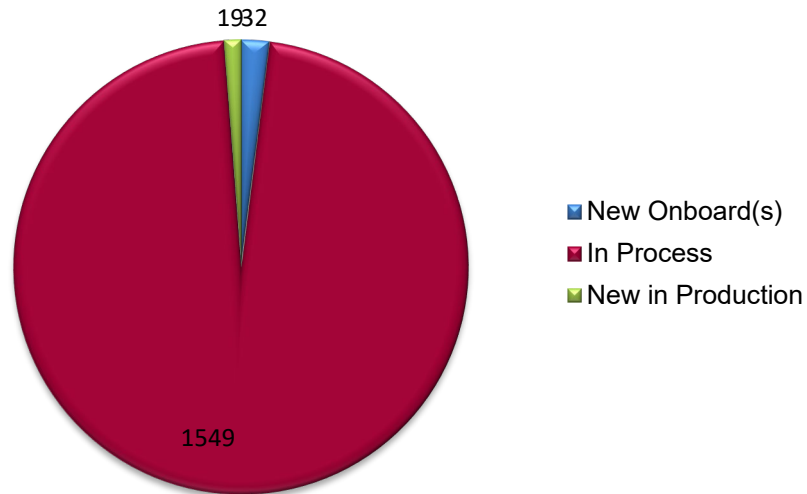
- December 2025 EDI Claims:
 - A total of 3355 new EDI submitters has been added since October 2015,
 - with 50 added in December 2025.
 - The total number of EDI submitters is 4095 providers.
- December 2025 EDI Remittances (ERA):
 - A total of 1571 new ERA receivers have been added since October 2015,
 - With 19 added in December 2025.
 - The total number of ERA receivers is 1587 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-25	61	8	53	3612	79	1234	22	1276
Feb-25	58	16	42	3654	83	1286	31	1307
Mar-25	46	3	43	3697	74	1328	32	1339
Apr-25	38	14	24	3721	63	1370	26	1365
May-25	47	3	44	3765	77	1402	45	1410
Jun-25	52	25	27	3792	62	1445	19	1429
Jul-25	52	0	52	3844	60	1487	18	1447
Aug-25	35	19	16	3860	37	1502	22	1469
Sep-25	92	6	86	3946	65	1516	51	1520
Oct-25	76	11	65	4011	42	1528	30	1550
Nov-25	41	7	34	4045	26	1536	18	1568
Dec-25	50	0	50	4095	32	1549	19	1587

837 EDI Submitters - Dec 2025



835 EDI Receivers - Dec 2025



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** 2025.

File Type	Dec-25
837 I Files	33
837 P Files	123
Total Files	156

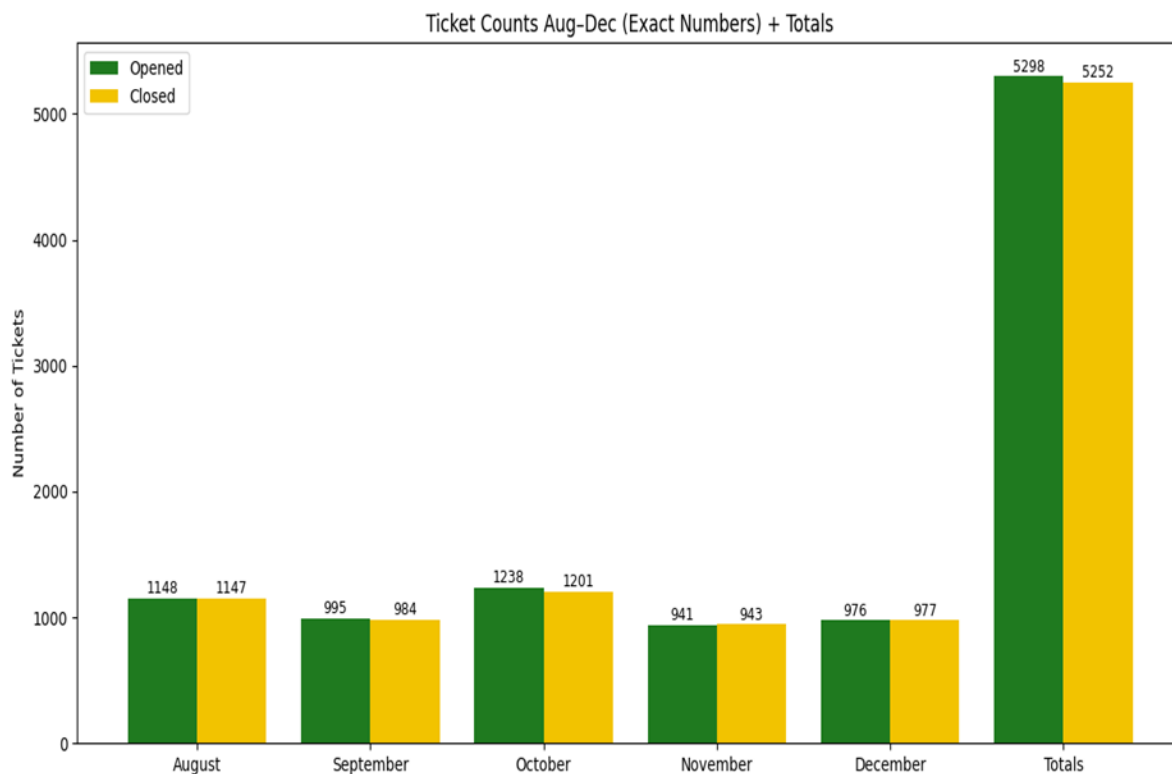
Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Dec-25	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	87%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	97%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	95%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	99%	80%

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

IT Stats: Service Desk

Month	Open Tickets	Closed Tickets
August	1148	1147
September	995	984
October	1238	1201
November	941	943
December	976	977



- 976 Service Desk tickets were opened in the month of December 2025, which is 3.59% higher than the previous month (941) and 12.95% lower than the previous 4-month average of 1081.
- 977 Service Desk tickets were closed in the month of December 2025, which is 21.48% higher than the previous month (943) and 8.60% lower than the previous 4-month average of 1069.

IT Stats: Security

Security Updates

Completed			
Infra + ITSec provided resolution to sensitive HR emails – UAT underway			
Revised Phishing policy (remedial training for phished users)			
Trued-up OKTA licensing count			
Scribe use – Gobi/Shyam leading POC. ITSec checking into Copilot			
Underway / Work-In-Progress	% Complete	ETC	Status
Remediating penetration test findings	90%	1.1.26	Delayed
Penetration test (follow up)		1.31.26	
Network Micro Segmentation – vendor selection (Illumio v. CSW)	20%	1.1.26	Delayed (till mid-Jan.)
OKTA true-up (framework meeting is scheduled)	25%	1.1.26	On-track
Security Risk Assessment (SRA) - 2025	60%	1.1.26	On-track
Preparing for 2026 Security Risk Assessment (SRA)	0%	7.1.26	
Cisco Umbrella – readying use of DLP module	80%	12.1.25	Delayed (till mid-Jan.)
Resources			
● JIRA workloads (Project: IT Security and Compliance)			
TrackIT workloads (WIP)			



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Service you can trust.

Analytics

Tiffany Cheang

To: Alameda Alliance for Health Board of Governors

From: Tiffany Cheang, Chief Analytics Officer

Date: January 9th, 2026

Subject: Performance & Analytics Report

Member Cost Analysis

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

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

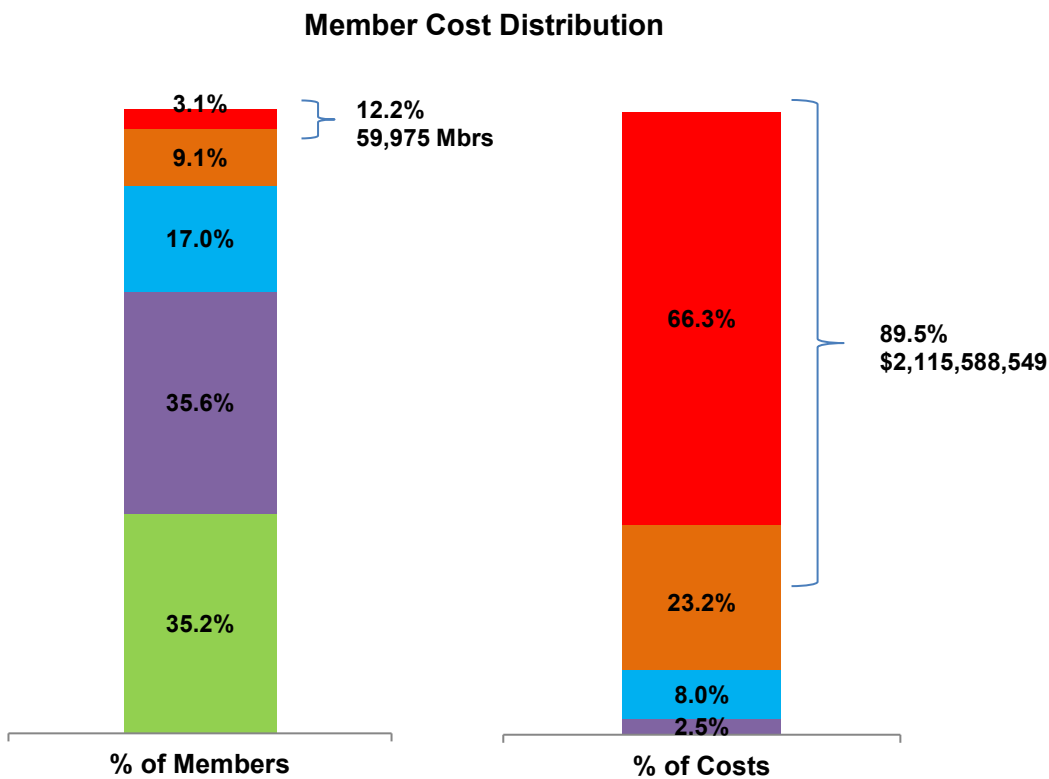
Prior reporting period: Oct 2023 – Sep 2024 dates of service

(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 12.2% of members account for 89.5% of total costs.
- In comparison, the Prior reporting period was lower at 9.7% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
 - The SPD/LTC (non duals) and ACA OE categories of aid decreased to account for 54.0% of the members, with SPD/LTCs accounting for 18.2% and ACA OE's at 35.8%.
 - The percent of members with costs $\geq$ \$30K increased from 2.6% to 3.1%.
 - Of those members with costs $\geq$ \$100K, the percentage of total members has slightly increased to 1.0%.
 - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 30.0%.
 - Demographics for member city and gender for members with costs $\geq$ \$30K follow the same distribution as the overall Alliance population.
 - However, the age distribution of the top 12.2% is more concentrated in the 45-66 year old category (34.2%) compared to the overall population (20.6%).

Analytics

Supporting Documents



Cost Range	Members	% of Members	Costs	% of Costs
\$30K+	15,322	3.1%	\$ 1,566,685,027	66.3%
\$5K - \$30K	44,653	9.1%	\$ 548,903,522	23.2%
\$1K - \$5K	83,027	17.0%	\$ 188,141,940	8.0%
< \$1K	174,408	35.6%	\$ 59,303,702	2.5%
\$0	172,224	35.2%	\$ -	0.0%
Totals	489,634	100.0%	\$ 2,363,034,191	100.0%

Enrollment Status	Members	Total Costs
Still Enrolled as of Sep 2025	406,820	\$ 2,143,025,722
Dis-Enrolled During Year	82,814	\$ 220,008,469
Totals	489,634	\$ 2,363,034,191

Top 12.2% of Members = 89.5% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
\$100K+	5,026	1.0%	\$ 1,017,406,528	43.1%
\$75K to \$100K	1,761	0.4%	\$ 153,501,560	6.5%
\$50K to \$75K	2,955	0.6%	\$ 180,727,072	7.6%
\$40K to \$50K	2,196	0.4%	\$ 98,191,507	4.2%
\$30K to \$40K	3,384	0.7%	\$ 116,858,360	4.9%
SubTotal	15,322	3.1%	\$ 1,566,685,027	66.3%
\$20K to \$30K	6,250	1.3%	\$ 151,671,388	6.4%
\$10K to \$20K	17,501	3.6%	\$ 248,696,505	10.5%
\$5K to \$10K	20,902	4.3%	\$ 148,535,629	6.3%
SubTotal	44,653	9.1%	\$ 548,903,522	23.2%
Total	59,975	12.2%	\$ 2,115,588,549	89.5%

Notes:

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

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

12.2% of Members = 89.5% of Costs

Lines of Business: MCAL, IHSS; Excludes Kaiser Members

Dates of Service: Oct 2024 - Sep 2025

Note: Data incomplete due to claims lag

Run Date: 12/29/2025

12.2% of Members = 89.5% of Costs

18.2% of members are SPD/LTCs and account for 25.0% of costs.

35.8% of members are ACA OE and account for 33.0% of costs.

8.2% of members disenrolled as of Sep 2025 and account for 9.5% of costs.

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

26.7% of members are SPD/LTCs and account for 29.7% of costs.

27.1% of members are ACA OE and account for 30.1% of costs.

8.8% of members disenrolled as of Sep 2025 and account for 9.7% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Members	% of Members
IHSS	IHSS	220	974	1,194	2.0%
MCAL	MCAL - ADULT	1,342	8,272	9,614	16.0%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	751	3,995	4,746	7.9%
	MCAL - ACA OE	5,048	16,453	21,501	35.8%
	MCAL - DUALS	-	-	-	0.0%
	MCAL - SPD-LTC	3,856	7,032	10,888	18.2%
	MCAL - SPD-LTC/Full Dual	2,594	4,542	7,136	11.9%
Not Eligible	Not Eligible	1,511	3,385	4,896	8.2%
Total		15,322	44,653	59,975	100.0%

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	51	1.0%
MCAL	MCAL - ADULT	299	5.9%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	89	1.8%
	MCAL - ACA OE	1,362	27.1%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,343	26.7%
	MCAL - SPD-LTC/Full Dual	1,438	28.6%
Not Eligible	Not Eligible	444	8.8%
Total		5,026	100.0%

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Costs	% of Costs
IHSS	IHSS	\$ 17,753,461	\$ 11,540,426	\$ 29,293,887	1.4%
MCAL	MCAL - ADULT	\$ 128,302,377	\$ 101,687,024	\$ 229,989,401	10.9%
	MCAL - BCCTP	\$ -	\$ -	\$ -	0.0%
	MCAL - CHILD	\$ 55,566,714	\$ 45,612,411	\$ 101,179,125	4.8%
	MCAL - ACA OE	\$ 496,278,216	\$ 202,538,592	\$ 698,816,807	33.0%
	MCAL - DUALS	\$ -	\$ -	\$ -	0.0%
	MCAL - SPD-LTC	\$ 437,730,202	\$ 91,133,105	\$ 528,863,307	25.0%
	MCAL - SPD-LTC/Full Dual	\$ 271,663,084	\$ 55,016,575	\$ 326,679,660	15.4%
Not Eligible	Not Eligible	\$ 159,390,974	\$ 41,375,389	\$ 200,766,363	9.5%
Total		\$ 1,566,685,027	\$ 548,903,522	\$ 2,115,588,549	100.0%

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	\$ 9,333,467	0.9%
MCAL	MCAL - ADULT	\$ 76,049,183	7.5%
	MCAL - BCCTP	\$ -	0.0%
	MCAL - CHILD	\$ 24,001,168	2.4%
	MCAL - ACA OE	\$ 306,487,828	30.1%
	MCAL - DUALS	\$ -	0.0%
	MCAL - SPD-LTC	\$ 302,594,812	29.7%
	MCAL - SPD-LTC/Full Dual	\$ 199,932,324	19.7%
Not Eligible	Not Eligible	\$ 99,007,745	9.7%
Total		\$ 1,017,406,528	100.0%

% of Total Costs By Service Type

% of Total Costs By Service Type				Breakout by Service Type/Location						
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
\$100K+	4%	0%	1%	15%	35%	1%	10%	3%	2%	35%
\$75K to \$100K	3%	0%	1%	21%	24%	3%	6%	4%	4%	37%
\$50K to \$75K	5%	0%	2%	27%	28%	5%	6%	6%	4%	23%
\$40K to \$50K	6%	0%	2%	34%	25%	8%	6%	8%	1%	19%
\$30K to \$40K	9%	0%	3%	33%	22%	12%	6%	8%	1%	19%
\$20K to \$30K	2%	1%	6%	37%	21%	7%	9%	9%	1%	17%
\$10K to \$20K	0%	0%	11%	37%	22%	6%	9%	10%	2%	15%
\$5K to \$10K	1%	0%	4%	32%	11%	11%	13%	14%	1%	19%
Total	4%	0%	3%	24%	28%	4%	9%	6%	2%	28%

Notes:

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



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Human Resources

Anastacia Swift

To: Alameda Alliance for Health Board of Governors

From: Anastacia Swift, Chief Human Resources Officer

Date: January 9th, 2026

Subject: Human Resources Report

Staffing

- As of January 1st, 2026, the Alliance had 681 full time employees and 1 part time employee.
- On January 1st, 2026, the Alliance had 18 open positions in which 5 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 13 positions open to date. The Alliance is actively recruiting for the remaining 13 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by division:

Division	Open Position January 1 st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	2	2	0
Operations	8	1	7
Healthcare Analytics	2	0	2
Information Technology	3	2	1
Finance	0	0	0
Compliance	0	0	0
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	18	5	13

- Our current recruitment rate is 3%.

Employee Recognition

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

5 years:

- Lorna G (Accounting)

6 years:

- Dominique C (Provider Services)
- Mai T (Grievance and Appeals)

7 years:

- Charles W (Privacy & SIU)

8 years:

- Anish R (Apps Management, IT Quality & Process Improvement)
- Alka P (Financial Planning & Analysis)

9 years:

- Gil R (Accounting)

10 years:

- Guneet W (IT Ops and Quality Apps Mgt)
- Beverly J (Medical Services)

11 years:

- Alexandria M (Provider Services)
- Tammia J (Case/Disease Management)

12 years:

- Ann C (Case/Disease Management)

13 years:

- Kathy G (Apps Management, IT Quality & Process Improvement)

14 years:

- Annie L (Provider Services)

21 years:

- Monica C (Claims)

27 years:

- Famina P (Claims)