



Board of Governors PACKET

JULY 10th, 2026



EXECUTIVE SUMMARY APPENDIX

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CEO Update

Matthew Woodruff

To: Alameda Alliance for Health Board of Governors
From: Matthew Woodruff, Chief Executive Officer
Date: July 10th, 2026
Subject: CEO Report

- **Financials:**

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

	<u>May</u>	<u>YTD</u>
Medi-Cal	\$3.7M	\$82.8M
Group Care	(\$1.3M)	(\$4.1M)
Medicare	(\$935K)	(\$10.2M)
Total	\$1.5M	\$68.5M

- **Revenue was \$184.5 million in May and \$2.1 billion Year-to-Date (YTD).**
 - Medical expenses were \$173.0 million in May and \$1.9 billion for the fiscal year-to-date; the medical loss ratio is 93.7% for the month and 92.4% for the fiscal year-to-date.
 - Administrative expenses were \$12.4 million in May and \$117.0 million for the fiscal year-to-date; the administrative loss ratio is 6.7% of net revenue for the month and 5.6% of net revenue year-to-date.
- **Tangible Net Equity (TNE):** Financial reserves are 301% of the required DMHC minimum, representing \$158.8 million in excess TNE.
- **Total enrollment in May was 374,886**, decreased by 5,501 Medi-Cal members compared to April 2026.
- **Key Performance Indicators – Grievances – MCAL & IHSS:**
 - **Regulatory Metrics:**
 - Standard grievances scored 90% processing time, which is below the 95% compliance mark.
 - Exempt grievance and expedited grievance cases were resolved within the 95% of regulatory timeframes.
 - Standard appeal and expedited appeal cases were resolved within the 95% of regulatory timeframes.
 - There was a total of 2,185 unique grievance cases resolved during the reporting period, with a total of 2,609 grievances including 423 shadow cases. Out of 2,609 cases, 37% were related to Access to Care, 35% were related to Quality of Service, 17% were related to

Coverage Dispute, 7% were related to “other” (enrollment and eligibility) and 4% were related to Quality of Care.

- For the month of June 2026, 78% of standard grievances were resolved in favor of members, 20% in favor of the Plan, and 2% were withdrawn by members; 84% of exempt grievance cases were resolved in favor of the members, and 16% were resolved in favor of the Plan.
- For the month of June 2026, there were a total of 1,514 unique exempt grievance cases resolved and 202 shadow cases – of these cases, 45% were category “other,” 33% were Quality of Service, and 22% were Access to Care.
- Of the 82 appeals for the month of June 2026, 88% of cases were upheld/denied, 10% were overturned/approved, and 2% were partially upheld.
- **Non-Regulatory Metrics:**
 - All non-regulatory metrics were met for January.
- **Grievances – D-SNP:**
 - For the D-SNP line of business, there were 113 standard grievance and first call resolution cases resolved within the regulatory timeframes of 100% compliance rate. There were no expedited grievance cases or standard or expedited appeal cases filed for D-SNP in the month of June 2026.
- **Legislative Updates:**
 - See Attachment
- **IT Workflow Automation – Next Update September 2026**
- **Alliance in the Community**
 - **Community Engagement:** As of July 2026, Alliance staff have participated in 92 out of 112 invited community events, including major Bay Area and countywide gatherings. These include but are not limited to:
 - First 5 Alameda County Father Friendly Providers Network (FFPN) Resource Fair
 - Building Opportunities for Self-Sufficiency (BOSS) Hayward Mental Wealth Block Party
 - 4Cs of Alameda County Annual Free Children’s Fair
 - 2026 Livermore Downtown Street Fest
 - United Seniors of Oakland and Alameda County (USOAC) 35th Convention Exhibitor Information
 - Wood Street Commons 5th Annual Block Party & Resource Fair

- Oakland Community Block Party
 - Asian Health Services Wilma Chan Park Food Distribution
 - Dr. Frank Staggers Prostate Cancer Walk
 - 2026 San Leandro Cherry Festival Parade
 - BANANAS Community Baby Shower
 - Roots Neighborhood Empowerment Day
 - Oakland Housing Authority Father's Day and Health & Wellness Resource Fair
 - 3rd Annual Black Women's Health Forum
 - Housing Authority of Alameda County (HACA) Resource Fair
 - All American Festival
 - 2026 San Leandro Senior Community Center Resource Fair
- **Community Relations Reinvestment Sponsorships:** The Alliance continues its community reinvestment sponsorships. These efforts through June include but are not limited to:
 - Celebrate Justice in Aging
 - Spectrum Show Your Love
 - Building Futures Jazz It Up 2026
 - Alameda Point Collaborative (APC) 14th Annual Urban Farm to Table
 - 3rd Annual Black Women's Health Forum
 - Family Bridges Lighting the Path through Education Gala
- **Medicare Overview**
 - Completed the **CY2027 Medicare Bid** and submitted all required materials by the June 1st, 2026, regulatory deadline.
 - The **State Medicaid Agency Contract (SMAC)** has been fully executed by both Alameda Alliance and the State of California. Remaining compliance attestations and matrixes are on track for completion in early July, maintaining readiness for the CY2027 plan year.
 - Advancing Medicare sales and enrollment infrastructure to support future growth and operational excellence.
 - Implementing call center and IVR enhancements to strengthen the prospective member experience and improve sales effectiveness.
 - Developing a Medicare Enrollment and Sales Power BI dashboard to enhance performance monitoring and data-driven decision-making with deployment targeted for July 2026.

- Continuing recruitment efforts for Medicare Field Sales and Community Agent positions to expand community outreach and enrollment capacity.
- The new PBM, MedImpact, is on track for deployment for CY2027. Selected a Medicare marketing partner and are finalizing the scope of work to support implementation efforts beginning in July 2026.
- Progress continues on the **D-SNP Centralized Website Initiative**, a key component of the Medicare member acquisition and engagement strategy. Upcoming milestones include:
 - **August 2026:** Launch of shopping and enrollment functionality.
 - **October 2026:** Deployment of member resource content and Annual Enrollment Period (AEP) materials.
 - **January 2027:** Transition to CY2027 plan year content and retirement of CY2026 materials.
- Communication materials are on track for the October 2026 AEP launch and are designed to improve member experience, support regulatory compliance, and facilitate a seamless onboarding process.
 - Continuing to enhance the Medicare enrollment and onboarding experience through redesigned enrollment kits and welcome materials.
- **Medi-Cal Incentive Programs**

Current Incentive and Grant Programs

The Incentives and Reporting team manages the incentive and grant programs outlined in the table below, including associated funding and expenditures.

Program	Duration	Status	Maximum	Awarded	Paid Out
Incentive Program					
Student Behavioral Health Incentive Program	2022-2024	Closed	\$9.7M	\$9.7M	\$9.1M
Housing & Homelessness Incentive Program	2022-2023	Open	\$44.3M	\$38.0M	\$27.9M
EPT Payments Program: <i>MCP Initial Provider Planning Incentive Payments</i>	2024 – 2026	Open	N/A	\$441k	\$297k
Alliance Grant Programs					
Provider Recruitment Initiative	2024-2025	Open	\$2.0M	\$1.9M	\$893k
Doula Scholarship Program	2024-2025	Closed	\$20k	\$18.5k	\$16k
Provider Recruitment Initiative	2025-2026	Open	\$2.0M	\$1.9M	\$297k
Doula Scholarship Program	2025-2026	Open	\$40k	\$18.7k	\$13.2k
First 5 Quality Grant	2025-2026	Open	\$1.1M	\$1.1M	\$360k

Externally Funded Grant Programs					
California Improvement Network (CIN)	2025-2027	Open	\$4.5k	\$4.5k	N/A
California Health Care Foundation (CHCF) CIN Action Project	Oct. 2025 - Aug. 2026	Open	\$20k	\$18k	N/A
CA Maternal Health Task Force (unfunded partner)	Feb. 2026 – Dec. 2026	Open	\$50k	NA	N/A
Total Overall			\$57.1M	\$53.1M	\$38.9M

Incentive and Grant Program Descriptions

Housing and Homelessness Incentive Program (HHIP) – Program launched in January 2022 to incentivize MCP progress on housing and homelessness as a social determinant of health; it ended December 31, 2023, with active projects continuing through 2030. Program updates:

- The Alliance is preparing to launch a final HHIP funding cycle in the coming months. Following a formal announcement, the application process will be open to eligible community organizations and providers.

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.

- Through the EPT Provider Directed Payment Program, Alameda Health System (AHS) is eligible to earn up to \$1.9M in pass through funding. To date, AHS has earned \$765K.

The Provider Recruitment Initiative (PRI) – Launched June 1, 2024, the program provides grants to help Alameda County safety net and community organizations hire and retain providers, strengthen the Alliance network, and expand culturally and linguistically responsive care. Funded grants include:

Provider Recruitment	FY24-25	FY25-26
MD/DO	4	8
OB/GYN	2	0
NP/PA	8	3
Behavioral Health	4	3
CHWs	34	127
Medical Assistants	N/A	4
Bilingual Positions	5	4

Housing Relocation	0	1
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Doula Scholarship Program – program launched in December 2024 to grow the Doula provider network to increase access to these services for members.

Doula Program	FY24-25	FY25-26
Awarded	20	15
Completed All Deliverables	14	11

First 5 Alameda County – First 5 Alameda County was awarded a grant for \$1.1M to support quality-related activities through June 2026.

California Improvement Network (CIN) Grant – the Alliance was selected, along with 24 other partners, to participate in an opportunity through CHCF called the CIN, a learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading ideas, and implementing improvements.

- Through the CHCF CIN grant, the Alliance was invited to apply for, and received, an Action Project award. In partnership with Alameda Health System, the project aims to increase child visits and immunization rates while reducing maternal depression.

CA Maternal Health Task Force – On January 27, Black Women Birthing Justice was awarded a California Maternal Health Innovation grant. The Alliance supported the application and will serve as an unfunded partner, contributing subject matter expertise to expand the doula workforce by addressing credentialing and billing challenges.



Demographics

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

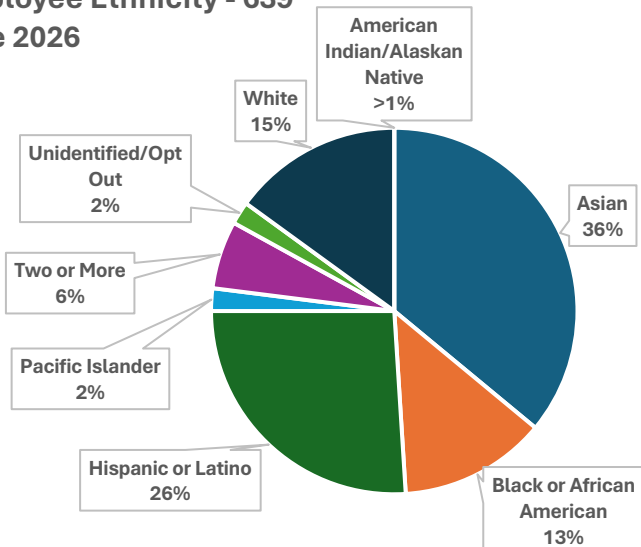
The demographic data for Alameda County, including total population figures and detailed demographic breakdowns, is sourced from Healthy Alameda County, a centralized data repository of information related to Alameda County, sponsored by the Alameda County Public Health Department. This platform provides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

Category	Alameda Alliance for Health (Workforce information last updated June 2026)	Alameda County (Population information last updated in May 2026)
Population/Total Employees	639	1,647,132
Race & Ethnicity		
Asian	36%	35.62%
Hispanic	26%	23.53%
White	15%	24.90%
Black/African American	13%	8.82%
Native Hawaiian/Pacific Islander	2%	0.77%
American Indian/Alaskan Native	>1%	0.24%
Two or More Races	6%	5.51%
Unidentified/Opt Out	>1%	-
Gender		
Male	26%	49.57%
Female	74%	50.43%
Non-Binary	>1%	-
Undefined	>1%	-
Age Distribution		
Under 25	>1%	8.29%
25-34	18%	13.55%
35-44	37%	16.25%
45-54	28%	13.64%
55-Older	16%	29.35%

AAH Employee Demographics Data Report June 2026

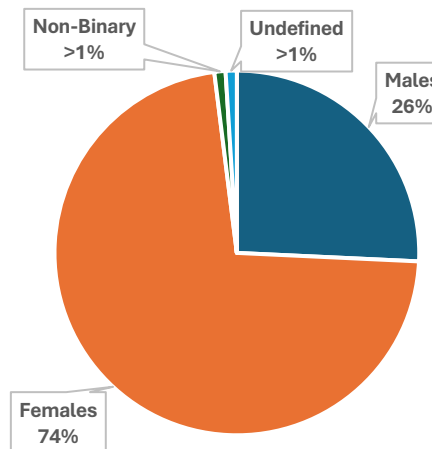
Employee Ethnicity - 639

June 2026



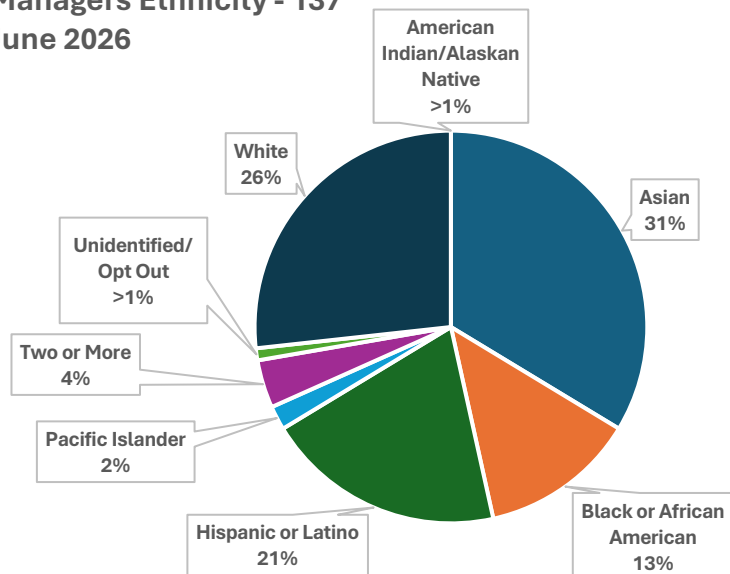
Employee Gender - 639

June 2026



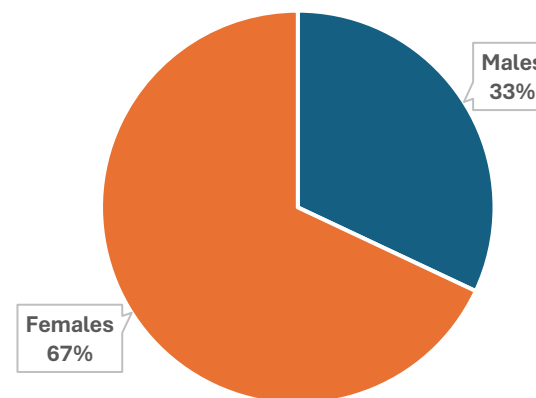
Managers Ethnicity - 137

June 2026

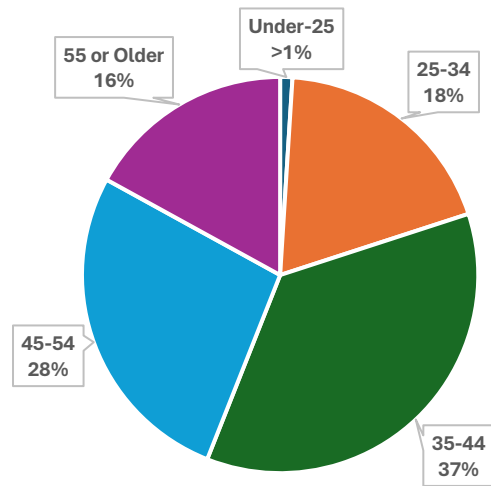


Managers Gender - 137

June 2026



Employee Age Demographics - 639
June 2026





Legislative Tracking

July 2026 Legislative Update

Legislative Affairs and Media Relations Department

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

Federal Policy Update

On June 1, 2026, the Centers for Medicare and Medicaid Services (CMS) released an interim final rule (IFR), "Medicaid Program; Community Engagement Requirement for Certain Individuals." The IFR will go into effect on July 1st and there is an opportunity to submit public comment until then. The IFR goes into details on how individuals can demonstrate that they have met work requirements and on assessing their compliance. It codifies the H.R. 1 language on what would qualify meeting the work requirements, including:

- 80 or more hours of work, or a work program,
- enrolled in an education program at least half time,
- combination of these activities,
- or have a monthly income that is more than the federal min. wage multiplied by 80 hours or being a seasonal worker and how that's defined.

The IFR offers guidance on how states can verify compliance and offers examples such as establishing data agreements with state university systems or other educational settings. CMS also codifies the exemptions and exceptions that were included in H.R.1 and provides details and definitions.

The IFR codifies mandatory exemptions for work requirements including those who are younger than 19 and those in Medicare Part A or B, caregivers, and other groups. Additionally, those who are considered medically frail. CMS defined 'medically frail' as an individual whose physical, mental, or other health condition, significantly impairs them from complying with work requirement and is blind or disabled, has a SUD, a disabling mental health disorder, has a physical/intellectual or developmental disability or serious medical condition.

The IFR outlines how managed care plans can play a role – by conducting outreach and educating enrollees and sharing data with the state to inform their determination of the applicability of work requirements. It provides a conflict-of-interest safeguard that prohibits MCPs from determining enrollee compliance.

On June 29, 2026, 24 attorneys general and two governors, including California Attorney General Rob Bonta [filed a lawsuit](#) over the Trump Administration's unlawful implementation of new Medicaid work requirements included in H.R. 1. Their lawsuit challenges provisions of the

IFR, including the adoption of a new interpretation of key terms like “medically frail” which they argue would make it harder for medically vulnerable individuals to be excused from the work requirements. Additionally, they challenge the requirement that states must notify Medicaid recipients about these changes by August 31, 2026, and argue that there is a need for significant lead time to prepare those communications.

Additionally, Representative Neguse, a democratic representative from Colorado is circulating [a sign-on letter among House Democrats](#) to send to CMS with concerns on the medical frailty exclusion. Energy and Commerce and Leadership Democrats are supporting this effort with the goal of getting every Democratic member to sign onto the letter.

The Alliance continues to participate in coordinated multi-agency efforts to address Medi-Cal changes due to H.R. 1 and the state budget. Our work is focused on preserving coverage for Medi-Cal beneficiaries. The Alliance continues to send out approximately 45,000 ‘Keep Your Coverage’ postcards every month to Alliance members and maintains a comprehensive media campaign throughout Alameda County.

State Legislative Update

On June 26, 2026, the California State Senate, Assembly, and Newsom Administration reached an agreement on the 2026-27 state budget. The finalized budget was signed into law on June 30, 2026, and while numerous delays in healthcare cuts were included, it achieves a balanced budget.

Despite strong opposition from our trade associations, including LHPC and our own legislative advocacy, the final 2026-27 budget approved the transition of Medi-Cal Members with unsatisfactory immigration status (UIS) from managed care to the fee-for-service (FFS) delivery system. It includes:

- \$31M for care coordination to support the transition of individuals with UIS.
- \$8M for contracts with clinics and community-based organizations to provide culturally and linguistically appropriate care navigation services to Medi-Cal members transitioning from managed care to the FFS delivery system.
- \$5.2M for DHCS to hire staff or enter into non-competitive bid contracts to assist with expediting Medi-Cal provider enrollment, revalidation, or recertification applications and reduce any backlogs.

LHPC has begun efforts to work with the Legislature and other partners to identify solutions that restore robust, coordinated access to care for the UIS population through Medi-Cal managed care and preserve the benefits of integrated, community-based care delivery, and the Alliance will partner and support those efforts.

The final 2026-27 budget provides \$351.7 billion in total expenditures in 2026-27 including \$251.5 billion from the General Fund and allocates \$35.2 billion to the state reserves to safeguard against future budget shortfalls. Notably, the budget:

- Rejects immediate Medi-Cal asset limit cuts, and lowers the asset limit to \$21,000 (for a household with one member) starting in 2027-28.
- Delays dental supplemental payment cuts and UIS dental cuts until July 1, 2027.
- Prevents an automatic premium increase for UIS Medi-Cal Members and requires California's next Governor to set a premium between \$30 to \$50 in the 2027 May Revise.
- Delays the elimination of full-scope Medi-Cal for asylees, human trafficking victims, domestic violence victims, etc. until July 1, 2027.
- Rejects cap rates for the Programs for All-Inclusive Care for the Elderly (PACE).
- Rejects the elimination of the Medi-Cal acupuncture benefit.
- Allocates \$197 million for Medi-Cal County eligibility workers to address workload increases related to H.R. 1.
- Allots \$90 million to support distressed hospitals through grants and an additional \$250 million to support designated public hospitals.
- Maintains the Medi-Cal mobile crisis benefit until July 1, 2027, and the Legislature will continue to work with the Administration to ensure long-term funding for the 988 system and mobile crisis response services.
- Provides \$100 million for the CalFood program to support demand for emergency food as Californians lose access to CalFresh due to H.R. 1.

The gubernatorial race to determine the successor to Governor Newsom occurred on June 2, 2026. The two contenders that will advance to the November 3 general election are Xavier Becerra (D) and Steve Hilton (R). Former U.S. Health Secretary Xavier Becerra received 28.1 percent of California votes (2,590,958) while former Fox News host Steve Hilton received 24.7 percent (2,276,271).

Our team will continue to track the Governor's race, the 2026-27 finalized state budget, and attend relevant stakeholder meetings to ensure alignment with pending legislative and/or regulatory changes.

Priority Bill List

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

Measure	Author	Topic	Summary
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AB 1126	Patterson	Medi-Cal Managed Care Plans: Enrollees with Other Health Care Coverage	This bill would require the department, in the case of a Medi-Cal managed care plan enrollee who also has other health care coverage and for whom the Medi-Cal program is a payer of last resort, to ensure that a provider that is not contracted with the plan and that is billing the plan for Medi-Cal allowable costs not paid by the other health care coverage does not face administrative requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system. Under the bill, in the case of an enrollee who meets those coverage criteria, except as specified, a Medi-Cal fee-for-service provider would not be required to contract as an in-network provider with the Medi-Cal managed care plan in order to bill the plan for Medi-Cal allowable costs for covered health care services. The bill would authorize a Medi-Cal managed care plan to require a letter of agreement, or a similar agreement, under specified circumstances, including if a covered service requires prior authorization, or if a service is not covered by the other health care coverage but is a covered service under the plan, as specified. The bill would require the department to take the actions that it deems necessary to provide clarification regarding the conditions for billing plans to providers that render services to enrollees who also have other health care coverage. The bill would specify the intent of the Legislature that the department offer educational resources to an enrollee who needs assistance with understanding continuity of care and coordinating Medi-Cal and their other health care coverage when requested by the enrollee.
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AB 1648	Rodriguez	Public Health: California Epilepsy Program	This bill would require the State Department of Public Health to establish the California Epilepsy Program for the purposes of epidemiological assessments of the incidence and prevalence of epilepsy and seizures. The bill would require the department to convene an advisory panel comprised of specified individuals to provide support and advice for the implementation of the program. AB 1648 would authorize the department to seek private or public funding and to spend those funds for the purposes of the program, and would authorize the department to contract with various entities for the purposes of collecting and collating data. The bill would require the department to analyze available data, to prepare and publish reports on its internet website as necessary, and to publish on its internet website a listing of agencies that offer services to individuals affected by epilepsy, as specified.
AB 1670	Arambula	Medi-Cal: Dental Care	This bill would make behavior management and desensitization services without an accompanying dental procedure covered benefits under the Medi-Cal program, subject to utilization controls, when a patient's physical, behavioral, developmental, or emotional condition requires significant extra time, attention, or personnel, or requires such services preceding a dental visit, respectively, in order to safely deliver dental care. The bill would condition implementation of these provisions on the availability of federal financial participation and any necessary federal approvals having been obtained. The bill would, notwithstanding any other law, authorize the department to implement, interpret, or make specific provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions without taking any further regulatory action.

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

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

			charging an enrollee or insured, prior to the plan payment, more than an estimate of the enrollee's or the insured's cost sharing for the treatment or a deposit that approximates that cost share. The bill would require a noncontracting dental provider to make specified disclosures to an enrollee or insured before accepting an assignment of benefits. Because a willful violation of these provisions relative to health care service plans would be a crime, this bill would impose a state-mandated local program.
AB 1649	Ahrens	Monthly Maintenance Amount: Personal and Incidental Needs	Existing law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. This bill would increase the monthly maintenance amount for personal and incidental needs from \$35 to \$50, and would require that the amount be increased annually, as specified. The bill would make these changes subject to receipt of necessary federal approvals.
AB 1717	Castillo	Medi-Cal Dental Reimbursement: House/Extended Care Facility Call	Under the Medi-Cal Dental Provider Handbook, the maximum allowance for a house/extended care facility call under a specified billing code is \$20. This bill would require the department to increase the Medi-Cal reimbursement base rate for a house/extended care facility call in order to reflect the reasonable travel costs for purposes of delivering dental services in the patient's private residence or applicable facility instead of the location of the dental provider.
AB 1773	Blanca Rubio	Pharmacy Benefit Managers	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the

			Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a pharmacy benefit manager contracting with a health care service plan or health insurer to secure a license from the Department of Managed Health Care on or after January 1, 2027, or the date on which the department has established the licensure process, whichever is later. This bill would require the department to maintain a public internet website displaying specified information for each licensed pharmacy benefit manager, including, among other things, the legal name, license number, and license expiration date.
AB 1887	Zbur	Prescription Drug Coverage for Rare Diseases	This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to require a health care service plan or health insurer to complete prior authorization or other utilization review within 30 days upon initial request, as specified, for a drug approved for the treatment of a rare disease if the drug is prescribed by a specialist with expertise in the condition or disease being treated and the specialist has determined the drug is medically necessary, unless a biosimilar, interchangeable biologic, or generic version of the drug is available. The bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, from imposing step therapy for these drugs.
AB 1949	Lee	Medi-Cal: Acupuncture Treatments	This bill would state the intent of the Legislature to enact legislation that allows more flexibility in Medi-Cal coverage for acupuncture treatments. require the Medi-Cal program to cover up to 24 acupuncture visits per beneficiary per calendar year and would state that additional visits per calendar year may be

			authorized based on medical necessity and the extent of federal funding.
AB 1970	Harabedian	Health Care Coverage: Mental Health or Substance Use Disorders	This bill would prohibit a health care service plan contract or a health insurance policy that is issued, amended, or renewed on or after January 1, 2027, from imposing step therapy as a prerequisite to authorizing coverage of any prescription drug used for the treatment of a serious mental illness or substance use disorder, as those terms are defined. The bill would specify that the prohibition on step therapy does not apply when the United States Food and Drug Administration-labeled indications and usage of a drug indicate that some prior medication must be taken.
AB 1979	Bonta	Health Care Services: Artificial Intelligence	This bill would require a health facility, clinic, physician's office, or office or a group practice to ensure that no clinical decision, as specified, is based solely on the output of a clinical decision support system, as defined, and that a licensed health care professional exercises independent professional judgment when reviewing and approving a clinical decision that is based on the output of a clinical decision support system. The bill would authorize the appropriate professional licensing board to pursue an injunction or restraining order to enforce these provisions to the extent that a violation constitutes the practice of a health care profession without a license. The bill would specify that these provisions do not prohibit the use of artificial intelligence for documentation and communication that does not involve the application of professional judgment, including automated messages to inform patients of updates to their health records. By placing new requirements on health facilities and clinics, this bill would expand the scope of a crime and would impose a state-mandated local program

AB 2036	Patel	Medi-Cal: Federally Qualified Health Centers and Rural Health Clinics	Under existing law, to the extent that federal financial participation is available, federally qualified health center (FQHC) services and rural health clinic (RHC) services are covered Medi-Cal benefits. Under existing law, FQHCs and RHCs receive a per-visit prospective payment system (PPS) rate for each visit. Existing law provides different methods by which an FQHC or RHC may establish a PPS. This bill would authorize an FQHC or RHC that has multiple PPS rates to elect to consolidate those rates into a single PPS rate to be applied uniformly for all FQHC and RHC services.
AB 2077	Macedo	Protect the Promise Act	This bill, the Protect the Promise Act, would require the department, in coordination with counties, to verify Medi-Cal eligibility before enrollment approval whenever reliable data sources are available. The bill, subject to any exceptions under federal law, would prohibit self-attestation alone for Medi-Cal eligibility purposes from being accepted for the eligibility factors of income, residency, identity, household composition, or citizenship or immigration status. The bill would require the department and the county to fully utilize certain data sets and verification systems. The bill would require the department to cross-reference beneficiary data with certain databases, complete a one-time submission of enrollment data to the federal government, and review information from specified federal and state sources. The bill would require the department to maintain a continuous process to identify changes in residency. The bill would require the department to require regular and systematic eligibility redeterminations, as specified. The bill would require the department and the county to identify eligibility errors, correct errors, and recover improper payments. The bill would require the department to establish

			enforceable accountability mechanisms, including, among others, reports to the Legislature and designation of officials.
AB 2081	Stefani	Medi-Cal: Home and Community-Based Alternatives Waiver	This bill would recast the waiver provisions to refer to the HCBA Waiver and would delete the provision relating to the 5,000 slots. The bill would require the department, beginning in 2027, and for the HCBA Waiver period, to increase the total number of waiver slots by 10,000, in addition to any planned expansion of waiver slots federally approved as of January 1, 2026, as specified. The bill would require the department, by March 1, 2027, to seek any necessary amendments to the HCBA Waiver to ensure that there is sufficient capacity to enroll all individuals who are eligible for, and express an interest in, participating in the HCBA Waiver who are currently on a waiting list. The bill would require the department to continue to monitor the capacity of the HCBA Waiver and to expand capacity, as specified.
AB 2160	Celeste Rodriguez	Medi-Cal: Lactation Services	This bill would require the department to, by July 1, 2027, issue updated Medi-Cal guidance that clarifies Medi-Cal coverage for lactation services. The bill would also require guidance to, among other things, clarify Medi-Cal coverage policies for a continuum of lactation services, including health education related to lactation, basic lactation support, and clinical lactation consultation. The bill would require the department to seek stakeholder input on draft guidance prior to issuing the guidance. The bill would make the implementation of these provisions contingent to the extent that federal financial participation is available and any necessary federal approvals are obtained.

AB 2161	Bonta	Medi-Cal: Work or Community Engagement	This bill would state the intent of the Legislature that the department implement work or community engagement requirements under the above-described federal law to ensure that all eligible Medi-Cal applicants and beneficiaries obtain and maintain coverage in ways that are least administratively burdensome to those individuals. The bill would set forth provisions to conform to the above-described federal provisions, including work or community engagement requirements, exemptions, and notices of noncompliance if applicable. The bill would require the department, before verifying an individual's compliance, to ensure and confirm that systems are programmed to maintain coverage with minimal data request requests to an applicant or beneficiary, as specified. For beneficiaries who cannot be deemed compliant following ex parte review, the bill would require the county to request a Medi-Cal managed care plan to provide any data that will verify that a beneficiary is exempted or meets the requirements before requesting information directly from the beneficiary.
AB 2123	Aguiar-Curry	Medical Debt Relief Act of 2026	This bill, the Medical Debt Relief Act of 2026, would establish the medical debt relief program, which would be administered by the authority. The bill would require the authority to enter into an interagency agreement with the Department of Health Care Access and Information to implement the program. The bill would require the authority and department to convene a stakeholder advisory group, as specified, no later than July 1, 2027, to advise on the development, implementation, and administration of the program. The bill would require the stakeholder advisory group, on or before January 1, 2028, to develop recommendations for the authority and department, including, among others, criteria for the ranking and priority of eligible recipients to receive discharge of their medical debt.

			This bill would authorize the authority, in consultation with the department, to, among other things, contract with a medical debt relief coordinator, as defined, for purposes of acquiring medical debt of eligible recipients either directly from a providing health institution or from a debt buyer, as specified. The bill would require the authority to, among other things, maintain books and records of all the medical debt acquired and canceled. The bill would require the authority to maintain a public internet website for information about the program. This bill would create the California Medical Debt Relief Program Account within the California Health Facilities Financing Authority Fund and would make all money in the account available, upon appropriation by the Legislature, to the authority for conducting the purposes of the Medical Debt Relief Act of 2026. The bill would require the authority, in consultation with the department, to provide a report to the Legislature and Governor by January 1 of each year, starting January 1, 2028.
AB 2138	Krell	Medi-Cal: Enhanced Care Management: Peer Support Specialists	This bill would require the department to require, as a condition of providing ECM, that any ECM provider, whose caseload of members meets certain criteria, maintain an interdisciplinary care team that includes at least one peer support specialist or trainee, as defined, who is integrated into ECM service delivery and available to support ECM members. The bill would set forth the functions of a peer support specialist or trainee for ECM purposes. The bill would require the department to allow an ECM provider to satisfy the requirement through any combination of staffing models, as specified. The bill would require the department to ensure that Medi-Cal managed care plan contracts, policies, and guidance reflect the requirement and to establish monitoring and compliance mechanisms to ensure

that ECM providers implement the requirement. The bill would require the department to recognize virtual, telephonic, and technology-enabled peer support service delivery as meeting the integration requirement.

Under the bill, an ECM provider subject to these provisions would have until January 1, 2028, to achieve full compliance, as specified. The bill would prohibit the department, a county, a Medi-Cal managed care plan, or a Medi-Cal provider, as applicable, from disqualifying a peer support specialist solely or primarily on the basis of a criminal background check, fingerprint-based background check, or similar screening that is a condition of employment, contracting, certification, credentialing, enrollment, or participation in providing peer support services.

Under the bill, this restriction would be implemented to the extent not in conflict with federal law, and the restriction would not prohibit background checks under specified circumstances. The bill will also authorize consideration of an individual's criminal record as part of their overall fitness for the position of peer support specialist if the criminal record has a nexus to that position or its duties. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

AB 2201	Boerner	Medi-Cal: Eligibility Redetermination	Existing state law generally requires a county to perform eligibility redeterminations for Medi-Cal beneficiaries every 12 months and to promptly redetermine eligibility whenever the county receives information about changes in a beneficiary's circumstances, as specified. This bill would amend those redetermination provisions to conform to the 6-month redetermination requirement under the above-
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			described federal law for Medicaid expansion adults. The bill would make other conforming changes to related provisions. This bill would require the county, in the case of an annual or semiannual redetermination, to verify countable income and assets at renewal without requesting additional verification information or documentation if any of specified sets of conditions are met, relating to certain financial data sources. This bill would require that these provisions be implemented subject to an appropriation made by the Legislature.
AB 2208	Stefani	Medi-Cal: Cost Sharing, Retroactivity, and Accessibility	This bill would, no sooner than October 1, 2028, set a copayment of \$0.01 for nonemergency services for the above-described population, as specified. The bill would authorize the provider to collect, retain, or waive the copayment amount. The bill would not apply the copayment requirements to emergency services, family planning services, or any services under certain categories. The bill would prohibit a service provider from denying care or services to an individual solely because of nonpayment of copayment. The bill would create an exemption from a copayment requirement for any visit, service, device, or item for which the Medi-Cal program's payment is \$10 or less. The bill would prohibit the total aggregate amount of deductions, cost sharing, or similar charges imposed for all individuals in a family from exceeding 5% of the family income.
AB 2240	Stefani	Medi-Cal: Private Duty Nursing	Existing law, the Medi-Cal Act, establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Under existing law, early and periodic screening, diagnostic, and treatment (EPSDT) services, including private duty nursing services, are covered under Medi-Cal for an individual under 21 years of age in accordance with certain federal provisions. The Medi-Cal program is

			in part governed by, and funded pursuant to, federal Medicaid program provisions. This bill would require the department to measure and assess whether private duty nursing services provided as part of the EPSDT benefit follow federal Medicaid requirements, as specified. The bill would require the assessment to include a comparison of the hours of EPSDT private duty nursing services authorized by the Medi-Cal program to the hours actually provided to eligible beneficiary children and a determination of whether the reimbursement rates for those services are sufficient to ensure that all authorized hours are able to be provided. The bill would require the department to prepare and submit a report to the Legislature on the findings of the assessment by no later than March 1, 2027.
AB 2268	Schiavo	In-Home Supportive Services Program	Existing law establishes the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, and disabled persons are provided with services to permit them to remain in their own homes. This bill would state the intent of the Legislature to enact legislation relating to the In-Home Supportive Services program.
AB 2278	Ávila Farías	In-home Supportive Services: Community First Choice Option Program: Noncompliance Penalties	Existing federal law, the Community First Choice Option (CFCO) program, authorizes states to provide home- and community-based attendant services and supports to eligible Medicaid enrollees, as specified. Existing federal law provides federal financial participation for a state that provides services under the CFCO program. Existing state law establishes the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, and disabled persons are provided with services in order

			to permit them to remain in their own homes. Existing law requires the state and counties to share the annual cost of providing IHSS pursuant to a specified cost ratio. Existing law requires all counties to have a rebased County IHSS Maintenance of Effort (MOE) and requires the rebased MOE to be adjusted for the annualized cost of increases in provider wages, health benefits, or other benefits, as prescribed. Existing law commencing July 1, 2026, requires a county to pay, separate from the rebased County IHSS MOE payment, a 100% share of the enhanced federal financial participation that would have been received if the state ceases to receive that funding for the provision of services due to noncompliance of timely case reassessment for the federal CFCO program. This bill would require the department to, on or before July 1, 2029, prepare and submit to the Legislature a report on the amount of the above-described payments made by counties due to noncompliance of timely case reassessment for the federal CFCO program.
AB 2327	Lowenthal	Medi-Cal: Subcontractors: Rates	This bill would authorize a subcontracting plan subject to the above-described agreement to request a review of the Medi-Cal managed care rates paid by the primary plan for a particular rating period, as specified. The bill would require the department to direct an independent, qualified actuarial consultant to review those rates upon a showing by the subcontracting plan that certain conditions have occurred or are likely to occur, including, among others, a medical loss ratio in excess of 93% for the preceding 12-month period. If the department determines that the rates paid by the primary plan to the subcontracting plan for a particular rating period are not actuarially sound, the

			bill will require the department to order a revision of those rates, as specified. The bill would make any failure by the department to comply with these provisions reviewable and subject to appeal at the request of the subcontracting plan through a notice of dispute pursuant to the terms of the Medi-Cal managed care contract. The bill would require these disputes to be concluded and resolved within 120 calendar days of the initial request. The bill would authorize the department to implement, interpret, or make specific provisions through the use of all-county letters, plan letters, plan bulletins, amendments to the state Medi-Cal managed care contract, or similar instructions without taking any further regulatory action.
AB 2348	Bonta	Medi-Cal: Community Supports	This bill would require the department, by July 1, 2027, to produce model managed care coverage standards and policy, reflecting best practices, for each community support provided for plan years beginning on January 1, 2028. If a managed care plan deviates from the standards and policy, the bill would require the plan to provide to the department a specific explanation and justification for that deviation. The bill would require the department to provide ongoing technical assistance to managed care plans and to require the plans to continue to provide technical assistance to providers of community supports. The bill would require the department to publicly post any policy changes for stakeholder input, and to publicly release written updates to the department's policy guidance, as specified. The bill would require a managed care plan to track and report to the department certain quantitative data regarding nonprofit community providers, as defined, and would require the department to publish a report on these data not less than annually. The bill would modify a requirement for the

			department to publish a public report on ECM and community supports utilization data, populations served, and demographic data, from annual to quarterly publications instead. The bill would require the department, by March 31, 2029, to provide to the legislative committees information necessary to inform legislative consideration of transitioning community supports to benefits that are required to be covered under the Medi-Cal program. The bill would require the department, until January 1, 2032, to continue to convene the CalAIM Implementation Advisory Group that is in effect on January 1, 2026, and as most recently updated. For purposes of the above-described provisions on ECM and community supports coverage, the bill would remove references to their implementation in accordance with CalAIM Terms and Conditions.
AB 2352	Valencia	Medi-Cal Providers: Nonprofit Public Benefit Corporations	Existing law sets forth various procedures, including the submission of an application package, for provider enrollment, continuing enrollment, or enrollment at a new location or a change in location under the Medi-Cal program. Existing law requires an applicant or provider who is a natural person and is licensed or certificated under provisions relating to healing arts, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or is a professional corporation, to comply with the above-described procedures and to be enrolled in the Medi-Cal program as either an individual provider or as a rendering provider in a provider group for each application package that is submitted and approved. This bill would also apply the above-described provision to a nonprofit public benefit corporation that has been granted tax-exempt status and through which licensed providers enumerated in the Medicaid state plan provide non-specialty mental health services, as specified.

AB 2355	Gonzalez	Medi-Cal	In developing the comprehensive hospital value strategy described above, this bill would require the department to engage with relevant stakeholders with firsthand experience, including, but not limited to, hospitals, cities, counties, cities and counties, organizations representing these groups, and other affected stakeholders as the department deems necessary. The bill would require the department to ensure that the comprehensive hospital value strategy includes a focus on rural hospitals, critical access hospitals, and public hospitals.
AB 2359	Ta	Medi-Cal	Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Pursuant to existing law, health care granted under the Medi-Cal program is subject to laws amending, repealing, or supplementing provisions affecting the Medi-Cal program, and subject to the rules and regulations of the department. Existing law provides that an individual receiving health care from the Medi-Cal program does not have a claim for compensation or otherwise because their service is affected by those changes. This bill would make technical, non-substantive changes to that provision.
AB 2431	Patel	Downcoding Medical Claims	This bill would require a determination to downcode a claim, which is the unilateral alteration by a payer of the service or procedure code submitted on a claim resulting in a lower payment, to include a documented review of the clinical information supporting the billed service. The bill would set forth requirements for and limitations of downcoding decisions, and, if a claim is downcoded, would require a plan or insurer to provide a billing provider with specified information and a clear and accessible process for disputing downcoded claims.

			The bill would prohibit a plan or insurer from using downcoding practices in a targeted or discriminatory manner against physicians or other health care providers who routinely treat patients with high acuity, complex, or chronic conditions, and would authorize the departments to take action against a plan or insurer that engages in a pattern or practice of discriminatory downcoding or that otherwise violates these provisions. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would require the departments to collect data on coding and claims adjustment practices, evaluate the information, and submit a report with specified information to the Legislature.
AB 2448	Bauer-Kahan	Medical Information: Confidentiality	Existing law, the Confidentiality of Medical Information Act (CMIA), generally prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information regarding a patient, enrollee, or subscriber without first obtaining an authorization, unless a specified exception applies. Existing law makes a violation of the CMIA that results in economic loss or personal injury to a patient punishable as a misdemeanor. Existing law requires specified businesses that electronically store or maintain medical information on the provision of sensitive services on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer to develop capabilities, policies, and procedures, on or before July 1, 2024, to enable certain security features, including limiting user access privileges and segregating medical information related to gender affirming care, abortion and abortion-related services, and contraception, as specified. This bill would also require those specified businesses to enable the above-specified capabilities, policies, and procedures for those

			security features, as specified. Because the bill would expand the scope of an existing crime, it would impose a state-mandated local program
AB 2457	Connolly	Health Care Provider Credentialing	Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires a full-service health care service plan, excluding a Medi-Cal managed care plan, or its delegate, to subscribe to and use the Council for Affordable Quality Healthcare credentialing form on and after January 1, 2028. On and after January 1, 2027, existing law requires a health care service plan, excluding a Medi-Cal managed care plan, or its delegate, that credentials health care providers for its networks to decide regarding the credentials of a provider within 90 days after receiving a completed provider credentialing application. This bill would extend the application of the above-described requirements to Medi-Cal managed care plans. Because a willful violation of these requirements by a Medi-Cal managed care plan would be a crime, the bill would impose a state-mandated local program.
AB 2511	Ahrens	Behavioral Health Provider Comparable Worth Study	This bill would require the department, in consultation with the Department of Managed Health Care, the Department of Insurance, the Department of Health Care Access and Information, and the Office of Health Care Affordability, to conduct a comparable worth study to examine and compare compensation and reimbursement for behavioral health providers with compensation and reimbursement for similarly situated medical-surgical providers. The bill would require a health care service plan or health insurer to report certain data to the department with respect to payments made directly

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

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

AB 2610	Addis	Patient Access to Health Records	Existing law generally governs a patient's access to the patient's own health records. Existing law establishes procedures for providing access to health care records or summaries of those records by patients and by those people who have responsibility for decisions regarding the health care of others, as described. Existing law sets forth the Legislature's findings and declarations regarding the right of access to that information, as specified. This bill would make technical, non-substantive changes to those findings and declarations.
AB 2613	Sharp-Collins	Health Care Service Plans: Notice	This bill would additionally require a health care service plan to notify an enrollee by email or text message, as specified, at least 60 days before the termination date of a contract between a health care service plan and a provider group or a general acute care hospital to which the enrollee is assigned. If the plan reaches an agreement with a terminated provider after sending the notice of termination, the bill will require the health care service plan to send written notice by United States mail and by email or text message, as specified, to affected enrollees within 60 days of reaching the agreement. Because a willful violation of these provisions would be a crime, this bill would impose a state-mandated local program.

AB 2614	Dixon	Public Health: Body Brokering and Patient Referral Integrity Act	This bill would prohibit any person from offering, paying, soliciting, or receiving a commission, benefit, bonus, or other form of remuneration or from engaging in a split-fee arrangement to induce a referral to a residential treatment facility or in return for acceptance of an individual into a residential treatment facility. The bill would make a violation of that provision a misdemeanor. The bill would define a “residential treatment facility” to include any sober living home, group home, recovery residence, residential care facility, or similar facility providing housing or residential services, in connection with alcohol or substance use disorder treatment or behavioral health recovery.
AB 2670	Castillo	Medi-Cal: Fraud Assessment Task Force	Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to qualified low-income people pursuant to a state plan. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would, upon appropriation by the Legislature, require the department to convene a task force of specified members by no later than January 1, 2027, to conduct a comprehensive assessment of fraud risks in the Medi-Cal program. The bill would require the task force, within 6 months of formation, to review current fraud prevention tools, analyze data-sharing gaps, and evaluate how best practices from the federal government and other states could be applied in California. The bill would require the task force to submit specified recommendations based on this assessment to the appropriate policy and fiscal committees of the Legislature by no later than January 1, 2028.
AB 2729	Bonta	Medi-Cal: Employer Responsibility for	Existing federal law, Public Law 119-21, enacted on July 4, 2025, sets forth various changes to different health care programs, including certain

		Medi-Cal Trust Fund	requirements for Medicaid eligibility with regard to work or community engagement reporting, redeterminations, and cost sharing, among other factors, for certain Medicaid populations pursuant to a specified implementation timeline. Existing law, the federal Patient Protection and Affordable Care Act, imposes a certain assessment on an applicable large employer, as defined, that offers full-time employees and their dependents the opportunity to enroll in minimum essential coverage, and for whom one or more full-time employees have been certified as having enrolled in a qualified health plan for which a premium tax credit or cost-sharing reduction is allowed or paid. This bill would create the Employer Responsibility for Medi-Cal Trust Fund to consist of new taxes and deposits, including employer penalties specified in the Budget Act of 2026. The bill would continuously appropriate money in the funds to the department to fund the costs of administering the Medi-Cal program in a manner necessary to prevent loss of or to restore health care coverage, benefits, or access to care following the passage of Public Law 119-21 and subsequent state budget actions. The bill would state that these provisions would become operative only if the Medicaid provisions of Public Law 119-21 are not repealed prior to January 1, 2027. By creating a continuously appropriated fund, the bill would make an appropriation. This bill would declare that it is to take effect immediately as an urgency statute.
SB 490	Umberg	Alcohol and Drug Programs	This bill would require the department, if it determines whether it has jurisdiction over the allegation, to initiate that investigation within 10 days of receiving the allegation and, except as specified, complete the investigation within 60 days of initiating the investigation. The bill would require the department, if it receives a complaint that does not fall under its jurisdiction, to notify the complainant that it does not investigate that type of

complaint. The bill would require the employee or agent to provide the notice described above within 10 days of the employee or agency submitting their findings to the department and to conduct a follow-up site visit to determine whether the facility has ceased providing services as required.

The bill would authorize, in counties that elect to administer the Drug Medi-Cal organized delivery system and provide optional recovery housing services, the county behavioral health agency to request approval from the department to conduct a site visit of a recovery residence that is alleged to be operating without a license. The bill would permit the department to approve that request in certain circumstances, including that the department has sufficient evidence to substantiate the allegation.

This bill would require the department, if it acts against a recovery residence pursuant to that provision, to conduct a site visit of a certified program or licensed facility that has disclosed the specified interest in the recovery residence. The bill would also require, no later than July 15, 2026, and by July 15 each year thereafter, that all programs certified or facilities licensed by the department submit to the department a report of all money transfers between the program or facility and a recovery residence during the previous fiscal year, in order to detect patient brokering, illicit kickbacks, or unethical inducements that harm patients. The bill would require the department to analyze that data and develop guidelines for permissible and impermissible transfers.

SB 874	Weber Pierson	Medi-Cal: Behavioral Health Treatment Workgroup	This bill would require the department, on or before July 1, 2027, to ensure that certain individuals providing BHT services under Medi-Cal undergo background checks. The bill would require the department to convene a stakeholder workgroup made up of BHT providers, managed care plans, and consumers with autism, among others, to review the implementation of BHT services in Medi-Cal and to advise the department on, among other topics, clinical guidelines for the provision of BHT services, treatment plan requirements, requirements for the provision of center-based services compared to services provided elsewhere, and supervision of unlicensed and uncertified professionals, as specified. The bill would require the department, on or before January 1, 2028, to release and maintain clear clinical guidance for the provision of the BHT benefit, as specified. The bill would require the department, on or before January 1, 2029, to report to the legislature on the utilization of the BHT benefit, a synopsis of changes made as a result of the stakeholder workgroup, and recommendations for actions necessary to ensure Medi-Cal reimbursement practices align with federal Medicaid program integrity requirements.
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SB 912	Cervantes	Comprehensive Perinatal Services	This bill would require DHCS to oversee a statewide comprehensive community-based perinatal services program and enroll health care providers to deliver these services to Medi-Cal members and make conforming changes, but would maintain the State Department of Public Health's role with related contracts, grants, and agreements. The bill specifies that any participation by the State Department of Public Health does not change the State Department of Health Care Services' authority to implement comprehensive community-based perinatal services for purposes of the Medi-Cal program. By January 1, 2028, the bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health, to clarify each department's roles and responsibilities regarding comprehensive perinatal services by regulation. The bill would, among other things, require the State Department of Health Care Services to develop informational and educational materials on comprehensive perinatal services by January 1, 2028, and require all Medi-Cal managed care plans to disseminate the materials, as specified. The bill would require the State Department of Health Care Services, no later than July 15, 2027, to submit to the Assembly Committee on Health and the Senate Committee on Health, and post on its internet website, a report that identifies the number of pregnant and postpartum individuals that received comprehensive perinatal services from January 1, 2022, to January 1, 2025, inclusive. The bill would also require the State Department of Health Care Services, commencing July 15, 2028, and every 3 years thereafter, to submit to those committees, and post on its internet website, a report that identifies the number of pregnant and postpartum individuals that received and were offered comprehensive perinatal services during the previous 3 calendar years.
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SB 944	Wiener	Medi-Cal: Acupuncture	Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Existing law sets forth a schedule of benefits covered under the Medi-Cal program, including acupuncture, but only to the extent federal matching funds are provided for acupuncture. This bill would remove the limitation requiring federal matching funds for acupuncture to be a covered benefit, thereby making acupuncture a covered benefit under Medi-Cal.
SB 950	Weber Pierson	Health Care Coverage: Dementia	This bill would require a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2027, to include coverage for all medically necessary treatments or medications, as determined by a health care provider, approved by the United States Food and Drug Administration (FDA) for the treatment of Alzheimer's disease or other related dementia. Under the bill, contracts and policies would not be required to cover drugs or treatments that are pharmaceutically equivalent drug products if the FDA approves more than one. On and after January 1, 2027, the bill would prohibit a health care service plan or health insurer from imposing step therapy protocols as a prerequisite to authorizing that coverage, except as provided.
SB 964	Smallwood- Cuevas	Prescription Drug Coverage: Dose Adjustments	This bill would authorize an enrollee's or insured's treating provider to request, and would require that they be granted, the authority to adjust the dose or frequency of a drug to meet the specific medical needs of the enrollee or insured without prior authorization if specified conditions are met.
SB 1023	Laird	Health Care Coverage:	This bill would prohibit a health care service plan, excluding a Medi-Cal managed care plan, or health

		Antiretroviral Drugs, Drug Devices, and Drug Products	insurer from subjecting antiretroviral drugs, drug devices, or drug products that are medically necessary for the prevention of HIV/AIDS to prior authorization or step therapy. The bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, that covers non-self-administered antiretroviral drugs, drug devices, or drug products that are approved by the United States Food and Drug Administration (FDA) for the prevention of HIV/AIDS as a medical benefit to also include those non-self-administered antiretroviral drugs, drug devices, or drug products as an outpatient prescription drug benefit. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.
SB 1089	Richardson	Preventive Treatment Health Care Act	Existing law requires the California Health and Human Services Agency (CHHSA) to enter into partnerships resulting in the production of generic prescription drugs, including at least one form of insulin made available at production and dispensing costs, if one does not already exist in the market. Existing law additionally authorizes CHHSA to enter into partnerships to increase competition, lower prices, and address supply shortages for generic or brand name drugs to address emerging health concerns. This bill would specify that the above-described authorized partnerships include those for at least one glucagon-like peptide-1 (GLP-1) approved by the United States Food and Drug Administration (FDA).

SB 1037	Weber Pierson	Health Care Coverage: Rate Review	This bill would instead define “unreasonable rate increase,” for the above-described purposes, to mean a rate increase that the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, determines is excessive, unjustified, unfairly discriminatory, or otherwise unreasonable. This bill would instead require a health care service plan or health insurer to demonstrate the impact of health care cost targets on rate development, including medical trends, medical inflation, and medical administrative costs. If a plan or insurer asserts that aging, high-cost drugs, or other cost drivers explain a rate increase, the bill would require the plan or insurer to explain how it reconciles this information with analysis published by the Office of Health Care Affordability. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill would require, in determining whether a rate increase is unreasonable, the director to consider whether the plan, and the commissioner to consider whether the insurer, has sufficient or excessive financial capacity for the past 3 years using specified measures. The bill would require the Department of Managed Health Care and the Department of Insurance, in collaboration with the Office of Health Care Affordability, as part of the existing rate review process, to each conduct an enhanced rate review to determine if health care premiums are affordable, as defined, for individual and group purchasers. The bill would require the review to include the annual change in premiums and cost sharing for the prior 5 years, including deductibles, copayments, coinsurance, and any other cost sharing that impact actuarial value.
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SB 1199	Weber Pierson	Prescription Drug Cost Sharing	This bill would require a health care service plan or health insurer, when calculating an enrollee's or insured's overall contribution to an out-of-pocket maximum or cost sharing requirement under the plan contract or insurance policy, to count any amount paid by the enrollee or insured or on behalf of the enrollee or insured toward the enrollee's or insured's cost sharing, including any form of direct support offered by drug manufacturers that is permitted, except as provided. The bill would prescribe an administrative penalty for each violation by a health insurer that is enforceable by the Insurance Commissioner after appropriate notice and opportunity for hearing. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.
SB 1202	Weber Pierson	Medi-Cal: Dashboard and Outreach	This bill would require the department to establish a data dashboard that provides data on applications, enrollment, redeterminations, disenrollments, and terminations, with certain objectives in consideration, related to the impact of the above-described federal law on Medi-Cal eligibility and enrollment, as specified. The bill would require the dashboard to track and report on the specific data for work or community engagement requirements and exemptions. The bill would require the department to undertake efforts to conduct outreach about work or community engagement requirements, more frequent redetermination, and changes to retroactive eligibility to impacted Medi-Cal beneficiaries, and to conduct listening sessions, as specified. Under the bill, beneficiary outreach and education would be coordinated across public social services programs to help minimize barriers to administrative disenrollments.

			The bill would require a Medi-Cal managed care plan to establish and conduct an outreach and education plan for its enrollees about the work or community engagement guidelines set forth in federal law based on guidance provided by the department. The bill would require the plan to address certain information on Medi-Cal eligibility, the right to appeal or reinstate Medi-Cal coverage, and resources, and to meet certain cultural and linguistic appropriateness standards. This bill would remove the requirement for the managed care plan to ask the beneficiary for approval for purposes of providing contact information to the county. The bill would remove the requirement for the county to make the verification attempt and would remove a related provision on the method of contact. The bill would require the department to share, or require each county to share, beneficiary redetermination data with applicable managed care plans to aid in managed care plans' efforts to assist beneficiaries with retaining Medi-Cal coverage, as specified. To the extent the bill creates new duties for counties relating to the sharing of Medi-Cal redetermination data, it would impose a state-mandated local program.
SB 1242	Choi	Community Assistance, Recovery, and Empowerment (CARE) Court Program	This bill would authorize the original petitioner to provide specified information regarding the respondent, including the respondent's condition, treatment history, and housing status. The bill would require the CARE team to review specified parts of the provided information, including that relevant to the respondent's care and treatment, and would authorize the court to consider that information in evaluating the respondent's progress and compliance, among other things. The bill would specify that the respondent's consent is not required to receive this information from the

			original petitioner and that submission of this information does not confer party status on the original petitioner or create a right to direct treatment decisions, obtain discovery, access confidential records, receive protected health information, attend confidential proceedings, or otherwise participate in the proceedings without the respondent's consent, except as expressly provided by law.
SB 1244	Allen	Public Agency Benefits Intermediary Compensation Disclosure Act	This bill, the Public Agency Benefits Intermediary Compensation Disclosure Act, would require a covered service provider, defined to mean a broker, agent, consultant, or advisor that meets specified criteria, to disclose to a public agency or its group health plan the direct and indirect compensation it expects to receive for providing brokerage or consulting services, among other information, before it enters into, extends, renews, or materially amends a contract or arrangement for brokerage services or consulting services with the public agency or its plan. The bill would also require a covered service provider to disclose compensation and material financial interests related to a covered health care benefits arrangement that the covered service provider recommends, places, renews, services, or materially influences for the public agency or its group health plan. Disclosure would be required under these provisions if the covered service provider reasonably expected it would receive \$1,000 or more in compensation during the term of the contract or arrangement. The bill would require these disclosures at specified times. This bill would prohibit a covered service provider from requesting, accepting, or receiving direct or indirect compensation in connection with brokerage services or consulting services provided to a public agency or its plan unless the

			compensation is disclosed, and would prohibit evasion of disclosure requirements.
SB 1252	Durazo	California Resident Taxpayer Health Care Coverage	This bill would state that every person who is a resident subject to a tax and whose income is at or below 138% of the federal poverty level using the modified adjusted gross income methodology, as specified, is entitled to access to the public health care coverage their tax dollars support. The bill would require the State Department of Health Care Services to ensure that these individuals have access to public health care coverage through programs it administers, including Medi-Cal. To the extent that these provisions would alter the population of beneficiaries for Medi-Cal, the bill would impose a state-mandated local program. The bill would make related findings and declarations.
SB 1221	Stern	Lanterman-Petris-Short Act: Conservatorships	This bill would authorize the district attorney to review all filed documents regarding the investigation, initiation, termination, or modification of, and to be present and represent public safety interests at all hearings that consider, a conservatorship of a person who is gravely disabled, as defined by being found mentally incompetent and meeting the above-described conditions, to provide input to the court about appropriate placement or interim placement by the public conservator. The bill would require a copy of the conservatorship investigation report to be transmitted to the district attorney if the investigation was initiated as part of a determination of mental competence for trial. The bill would authorize the district attorney, if the individual has been appointed a conservator under specified provisions, to challenge the recommendation of the public conservator after the conservatorship investigation for an abuse of discretion in a contested hearing before a judge. The bill would prohibit the district attorney from using

the information contained in these reports in subsequent criminal proceedings, except as specified. To the extent the bill imposes a higher level of service on county agencies that prepare and transmit conservatorship investigation reports and on a district attorney to receive those reports, the bill would impose a state-mandated local program. This bill would authorize a county with a population size of 750,000 or greater to consider prioritizing the placement of specified conservatees in a state hospital run by the State Department of State Hospitals if at least 40 of those conservatees are waiting for placement in a state hospital. The bill would also authorize the placement to be on an interim basis at a county detention facility pending acceptance into a facility that achieves the purposes of treatment of the conservatee and protection of the public. The bill would require the conservatee to receive treatment services in accordance with the conservatorship plan within the detention facility pending permanent placement and would require the court to review the conservator’s placement efforts every 60 calendar days.			
SB 1261	Laird	Aging and Disability Resource Connection Program	Existing law establishes an Aging and Disability Resource Connection (ADRC) program, administered by the California Department of Aging, to provide information to consumers and their families on available long-term services and supports (LTSS) programs and to assist older adults, caregivers, and persons with disabilities in accessing LTSS programs at the local level. This bill would prohibit the California Department of Aging from revoking the designation of an ADRC program solely due to the revocation or voluntary termination of a designation, suspension, or temporary inability of either the area agency on aging or the independent living center partner to serve in its operator role, and would authorize the remaining

			partner to continue to operate the ADRC independently during a transition period, as specified.
SB 1280	Valladares	Health Care Coverage For Mental Health and Substance Use Disorders	This bill would require a health care service plan or disability insurer to reimburse a noncontracting individual health professional the greater of the average contracted rate or 125% of the amount Medicare reimburses for similar services, as specified, for out-of-network services that are provided as described above. The bill would prohibit an enrollee or insured from owing the health professional more than the in-network cost-sharing amount, and would prohibit the health professional from billing or collecting an amount from the enrollee or insured that is more than that amount. The bill would require any communication from the health professional to an enrollee or insured, before the receipt of information about the amount the individual owes for services provided, to include a notice informing the individual that it is not a bill and not to pay until they are informed by their plan or insurer of any applicable cost sharing. The bill would require a plan or insurer to inform an enrollee or insured and the noncontracting individual health professional of the in-network cost-sharing amount owed by the individual at the time of payment by the plan or insurer to the health professional. Under the bill, the payments made by the plan or insurer and enrollee or insured pursuant to these provisions would constitute full payment. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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

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

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

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Financials

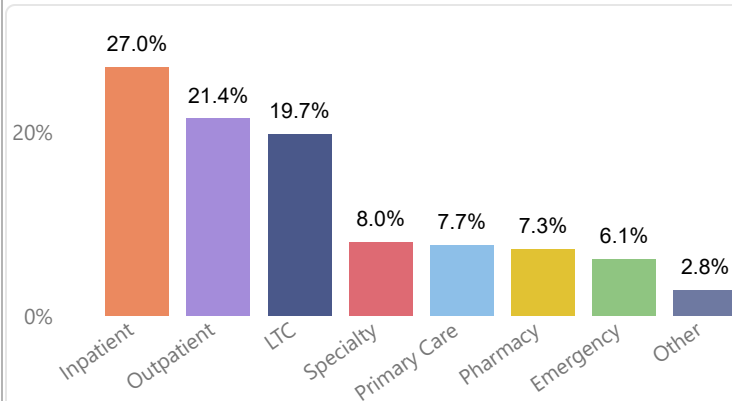
Income & Expenses

	MAY 2026	FISCAL YTD
REVENUE	\$ 246.7 M	\$ 2.8 B
MEDICAL EXPENSE	\$ (173.0) M	\$ (1.9) B
ADMIN EXPENSE	\$ (12.4) M	\$ (117.0) M
OTHER/TAX	\$ (59.9) M	\$ (681.5) M
NET INCOME	\$ 1.5 M	\$ 68.5 M

Medical Loss % (Fiscal YTD)

92.4%

Medical Expenses



Liquid Reserves

TNE %

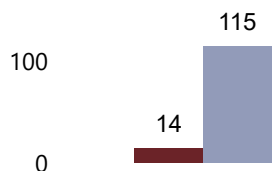
301.3%

TNE \$

\$237.8M

Reinsurance Cases

New Submitted

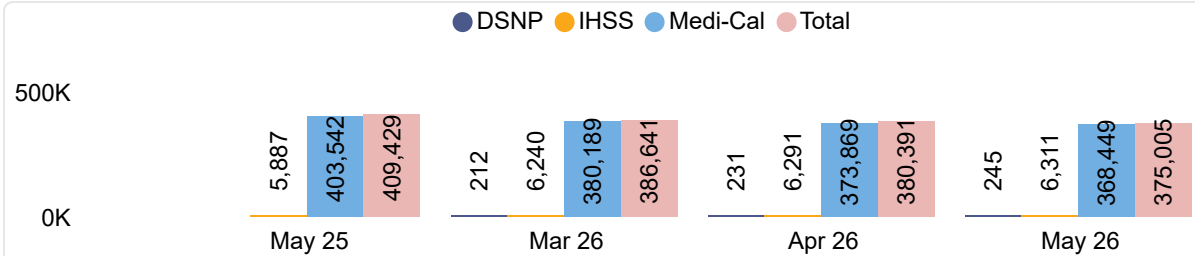


Balance Sheet

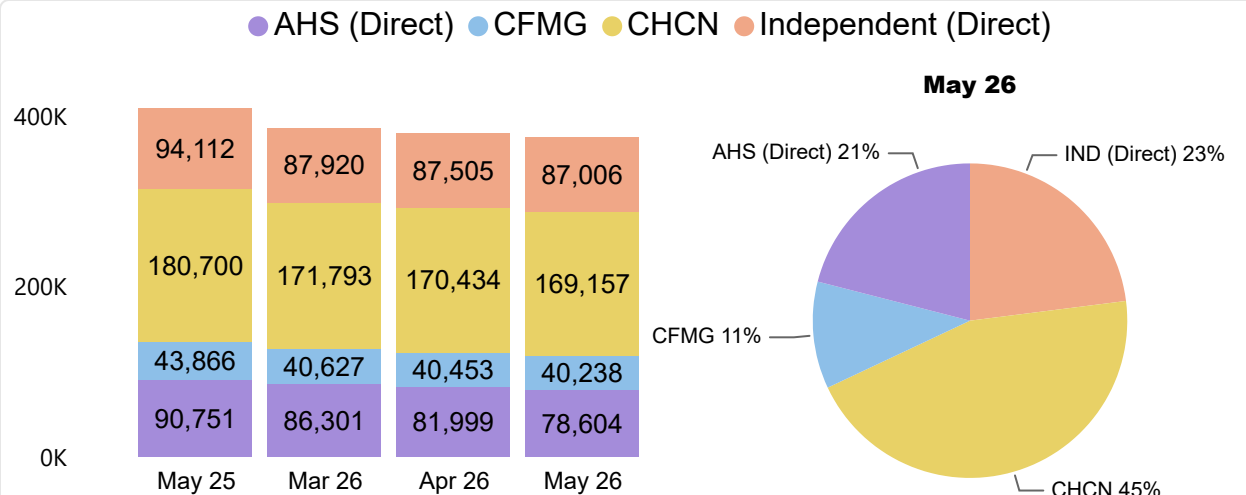
Cash Equivalents	\$635.1M	Current Ratio 1.22
Pass-Through Liabilities	\$164.8M	
Uncommitted Cash	\$470.2M	
Working Capital	\$184.4M	

Membership

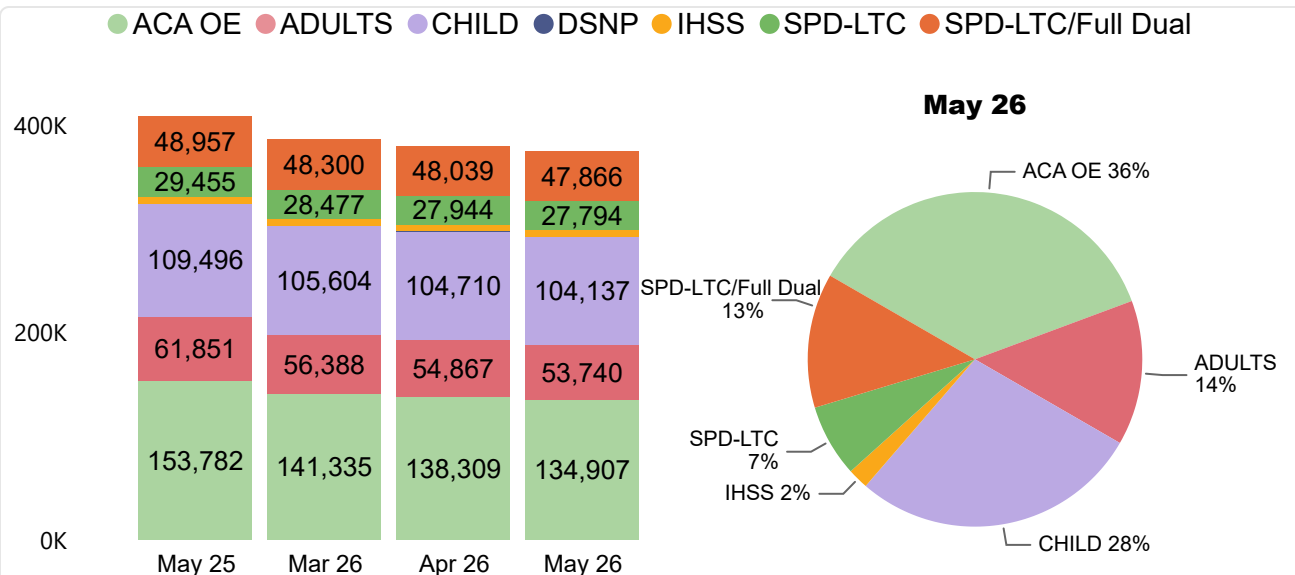
By Plan



By Network



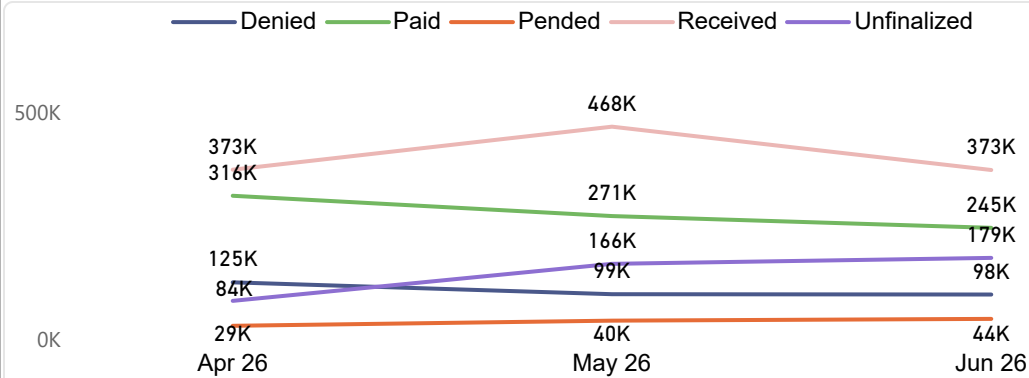
By Category



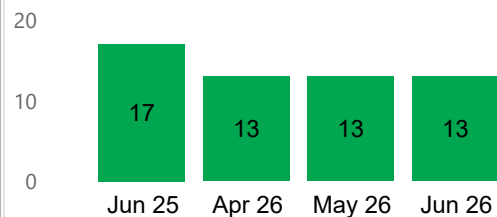
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Claims

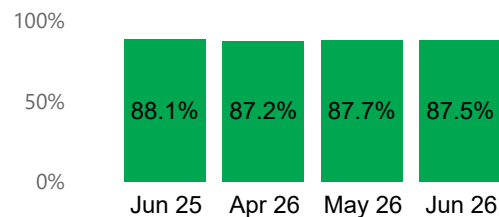
Claims Processing



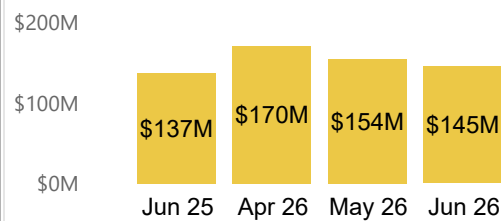
Average Payment TAT (Days)



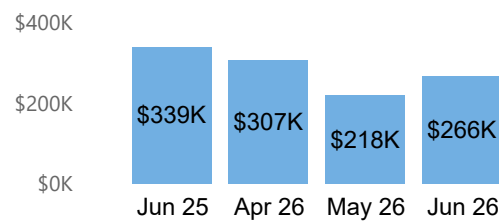
Auto Adjudication Rate (%)



Claims Paid (\$)

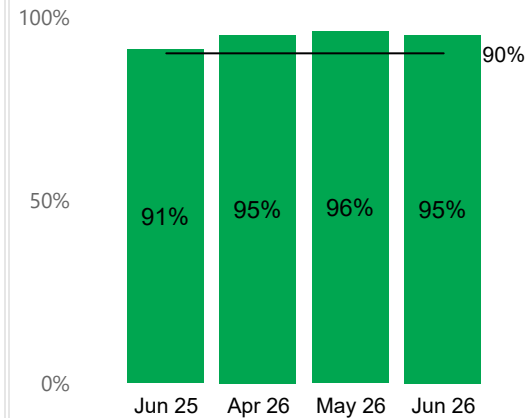


Interest Paid (\$)

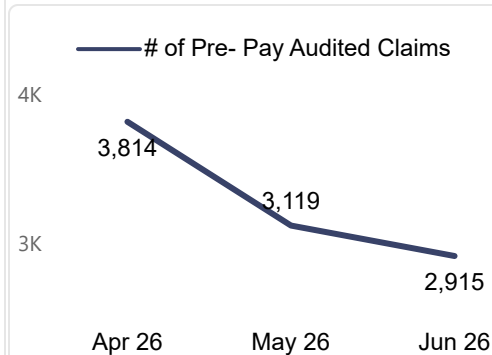


Claims Compliance

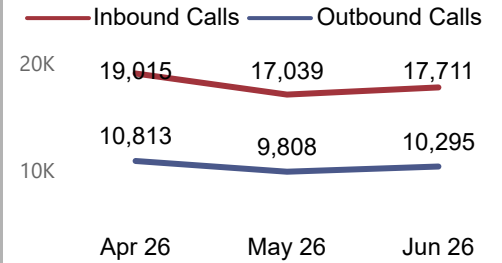
Processed 30 Cal Days (%)



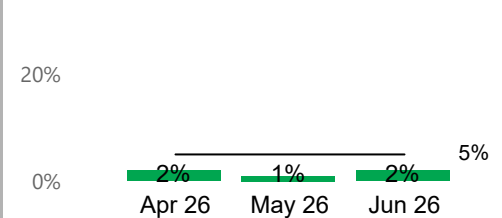
Claims Auditing



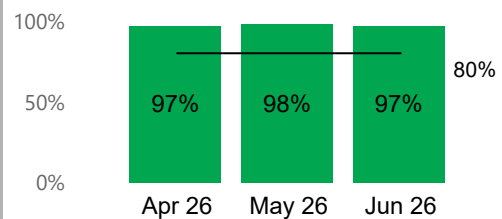
Member Services



Abandoned Call Rate (%)



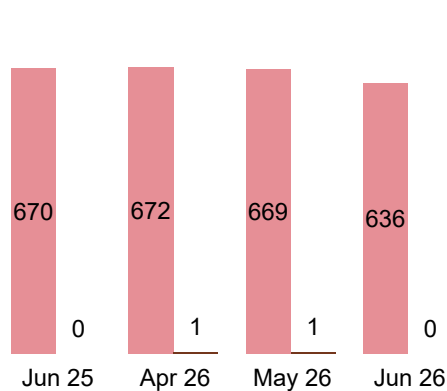
Calls Answered in 30 Seconds (%)



Average Call Times	Apr 26	May 26	Jun 26
Wait Time	00:08	00:06	00:08
Call Duration	07:28	07:18	07:34

Human Resources

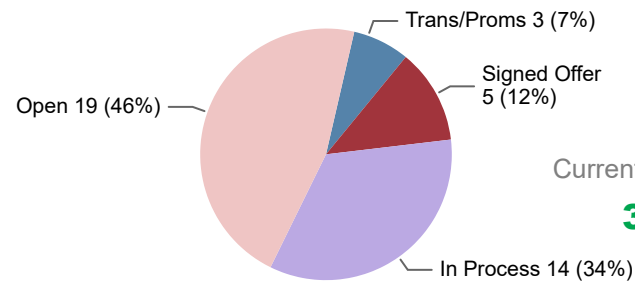
Full Time Part Time



Recruiting Status

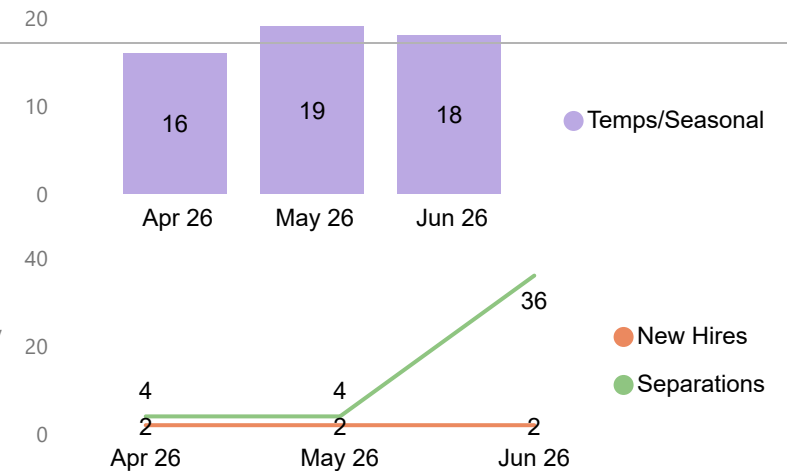
Jun 26

Trans/Proms Signed Offer In Process Open



Current Vacancy

3%



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Provider Services

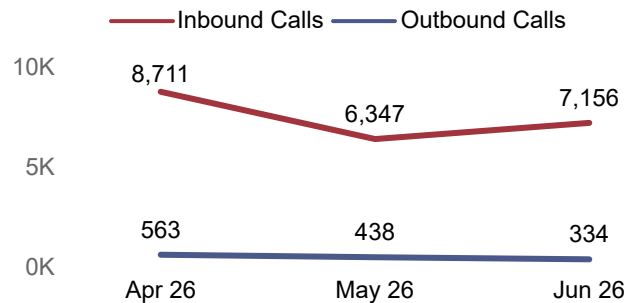
Provider Network

Hospital	17
Specialist	12,292
Primary Care Physician	715
Skilled Nursing Facility	107
Urgent Care	14
Health Centers (FQHCs and Non-FQHCs)	88
TOTAL	13,233

Provider Credentialing

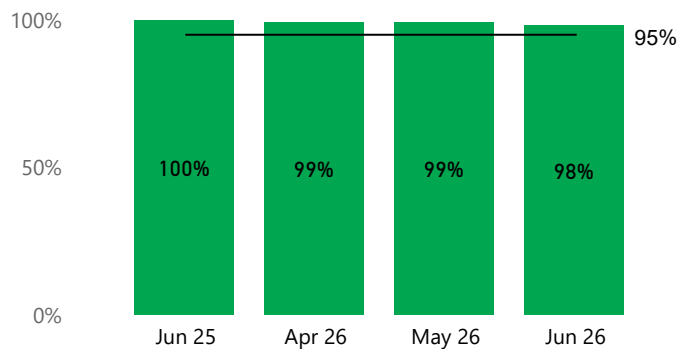
6,007

Provider Call Center



Provider Disputes & Resolutions

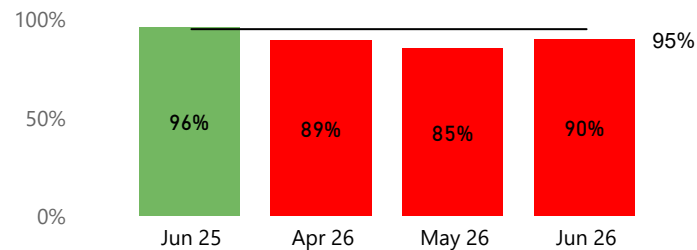
Turnaround Compliance (45 business days)



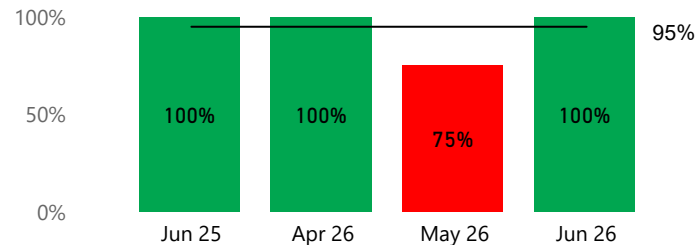
Compliance

Member Grievances

Standard (30 calendar days)

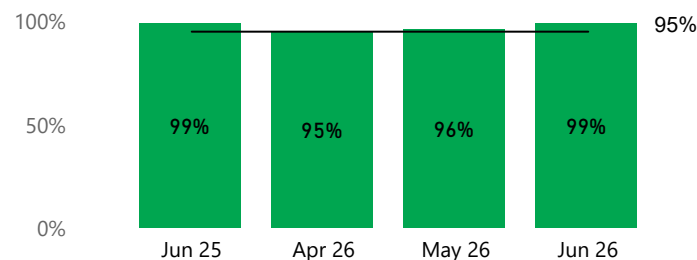


Expedited (3 calendar days)

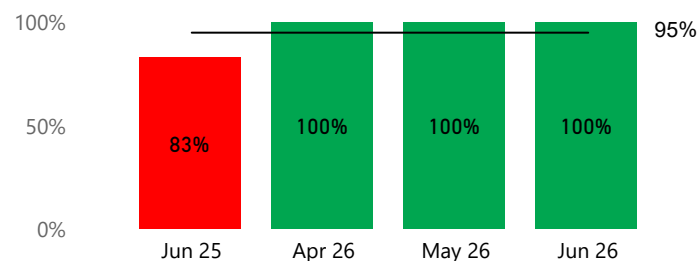


Member Appeals

Standard (30 calendar days)

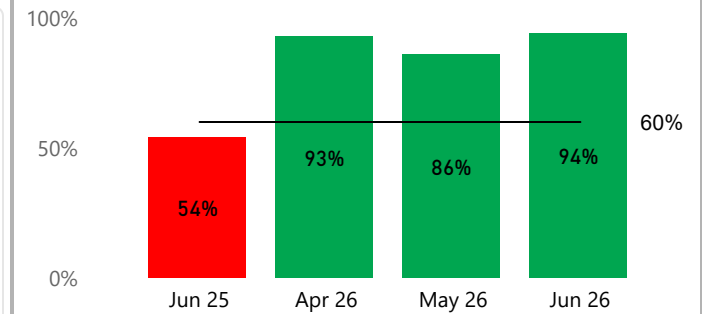


Expedited (3 calendar days)

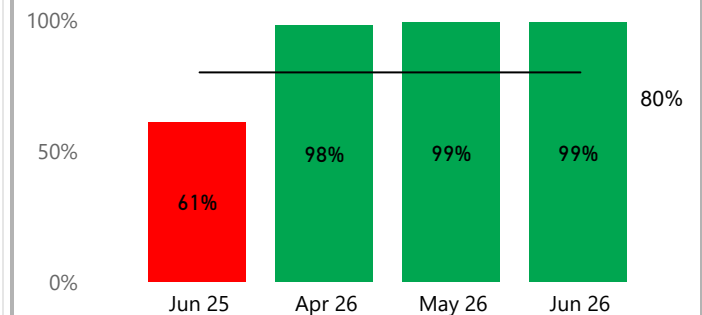


Encounter Data

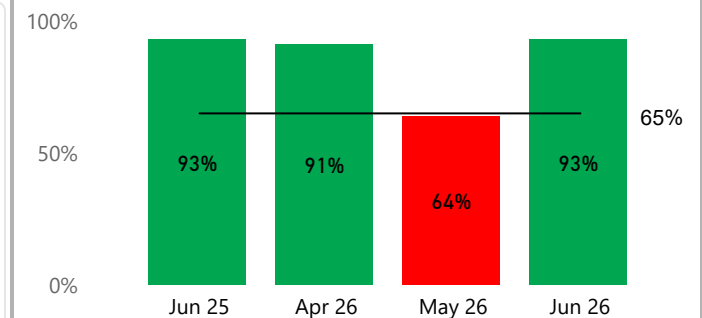
Institutional 0-90 days



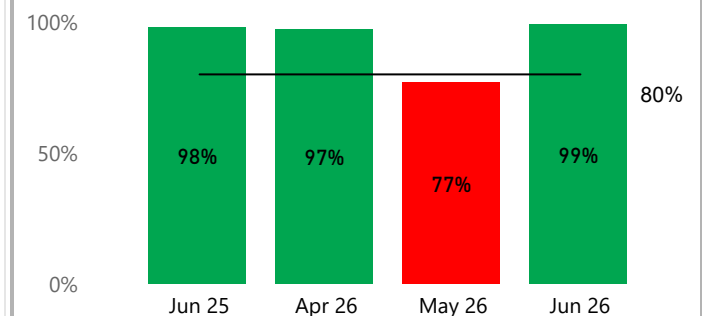
Institutional 0-180 days



Professional 0-90 days



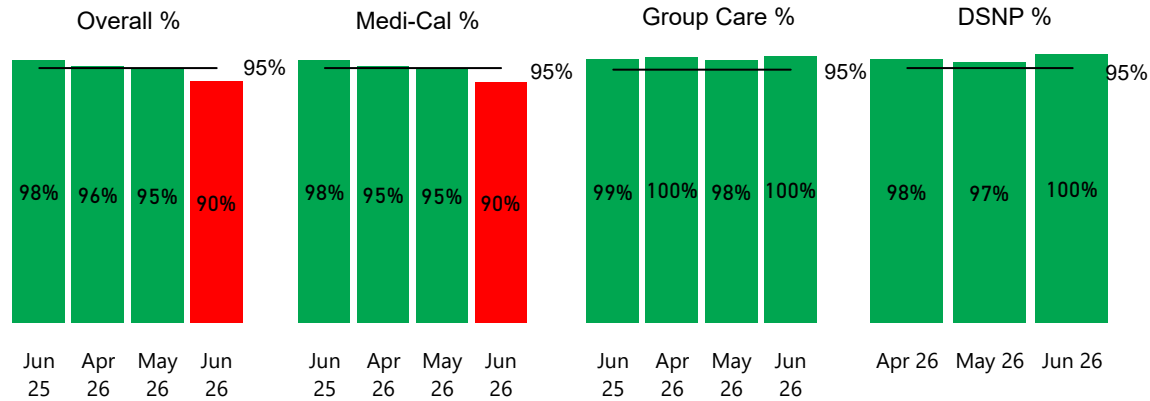
Professional 0-180 days



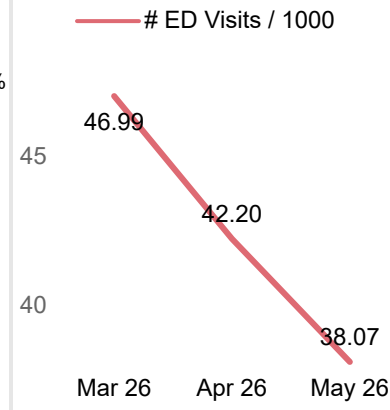
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Health Care Services

Authorization Turnaround



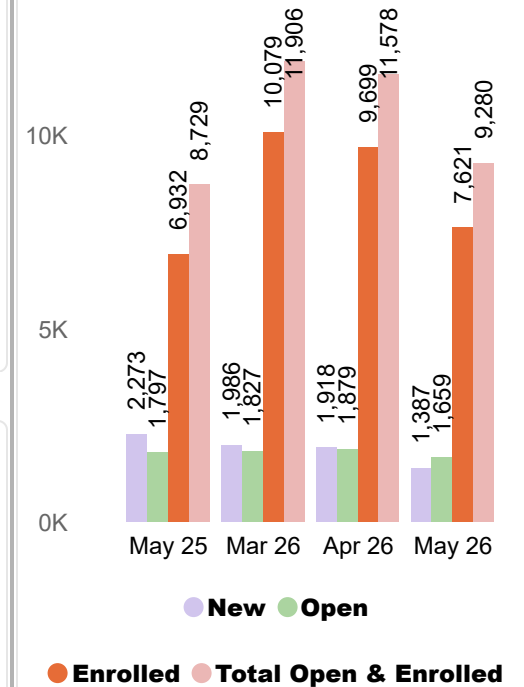
ED Utilization



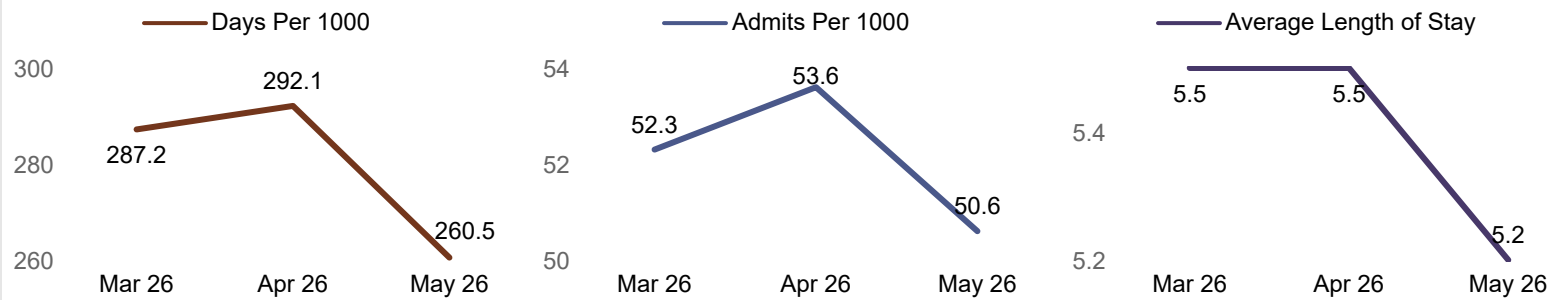
Case Management

Total Cases^

^ ECM Metrics since 2022



Inpatient Utilization

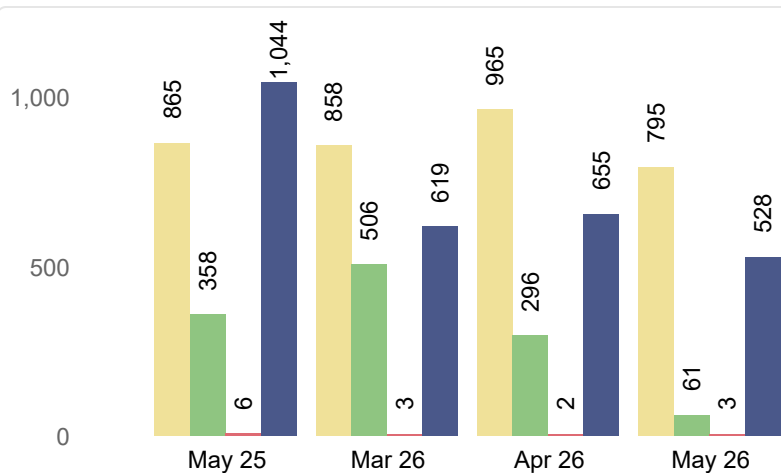


Case Management^

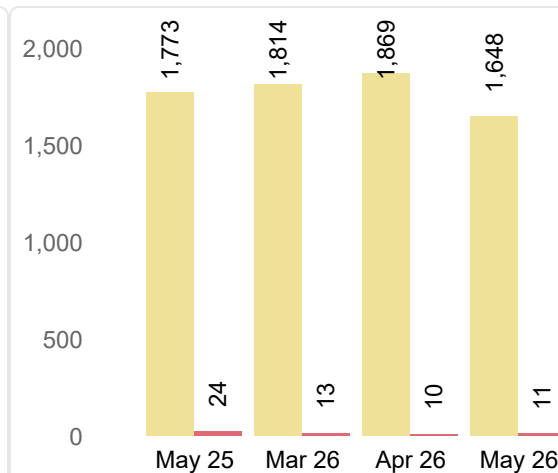
● Care Coordination ● Community Supports ● Complex Cases ● Enhanced Case Management

^ ECM Metrics since 2022

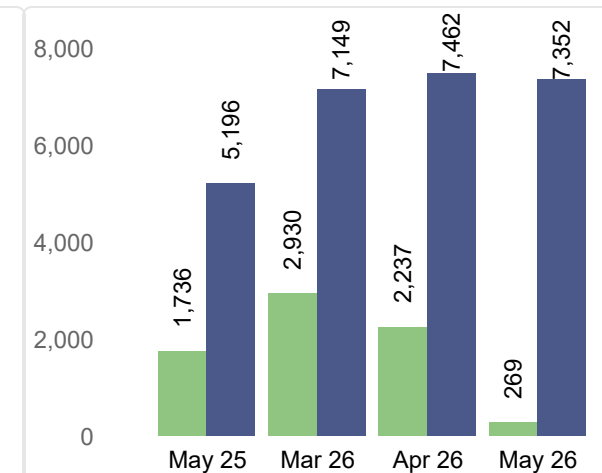
New Cases



Open Cases



Enrolled Cases



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Technology (Business Availability)

Applications ▲	Jun 25	Apr 26	May 26	Jun 26
HEALTHsuite System	99.9%	99.5%	99.5%	100.0%
Other Applications	99.6%	100.0%	99.9%	99.5%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Jun 25	Apr 26	May 26	Jun 26
Denial Rate Excluding Partial Denials (%)	5.0%	4.8%	4.3%	4.3%
Overall Denial Rate (%)	6.0%	5.1%	4.6%	4.7%
Partial Denial Rate (%)	1.0%	0.2%	0.3%	0.4%

* IHSS and Medi-Cal Line Of Business

Pharmacy Authorizations

Authorizations ▲	Jun 25	Apr 26	May 26	Jun 26
Approved Prior Authorizations	37	45	57	59
Closed Prior Authorizations	17	12	19	24
Denied Prior Authorizations	78	97	89	91
Total Prior Authorizations	132	154	165	174



Finance

Gil Riojas

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

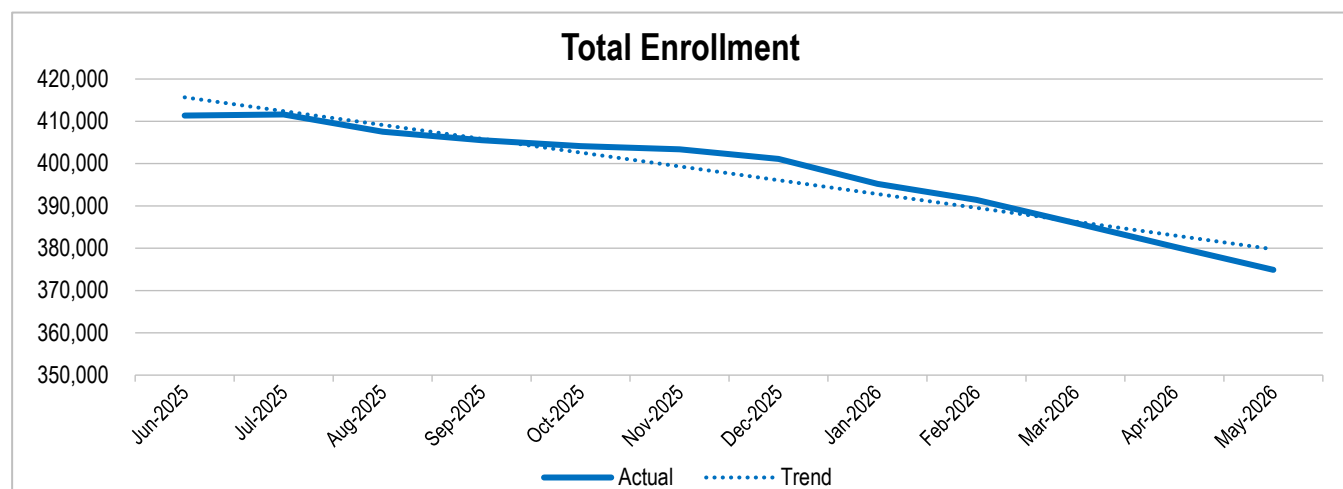
Date: July 10th, 2026

Subject: Finance Report – May 2026 Financials

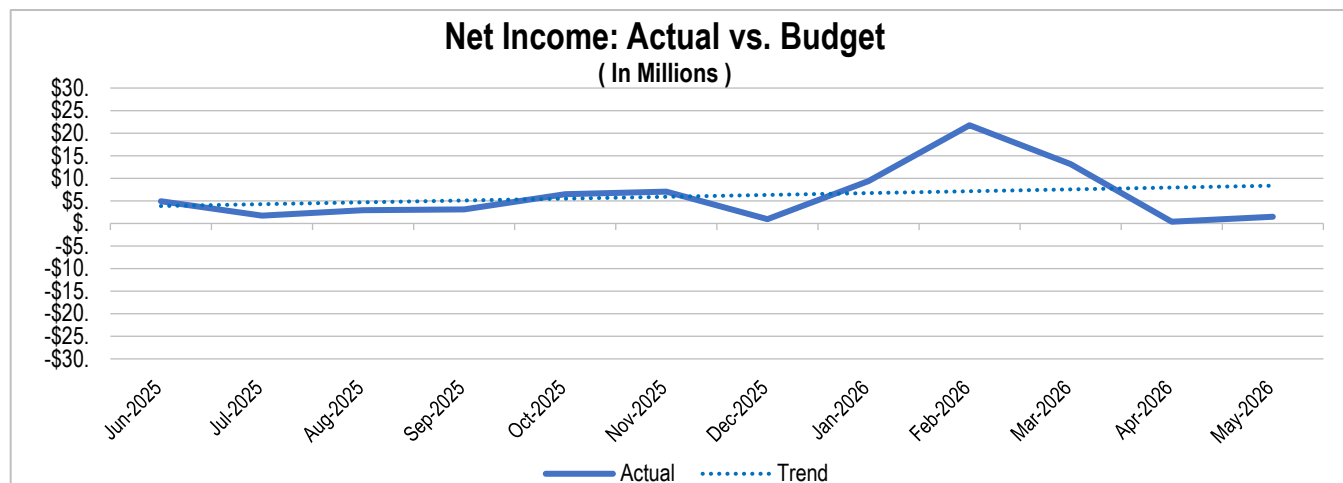
Executive Summary

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

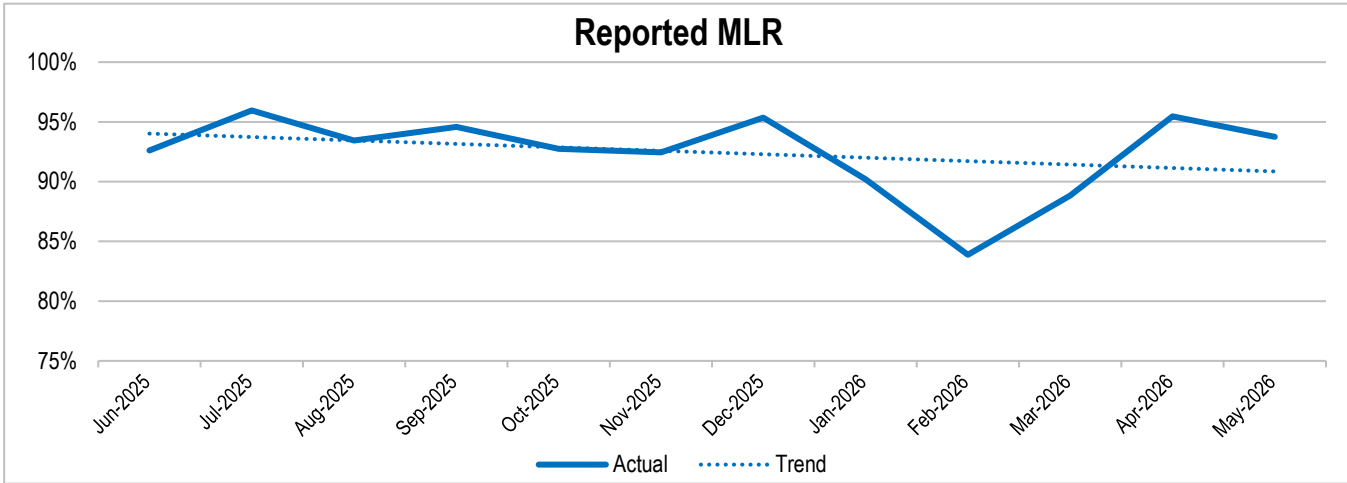
Enrollment – In May, Enrollment decreased by 5,467 members.



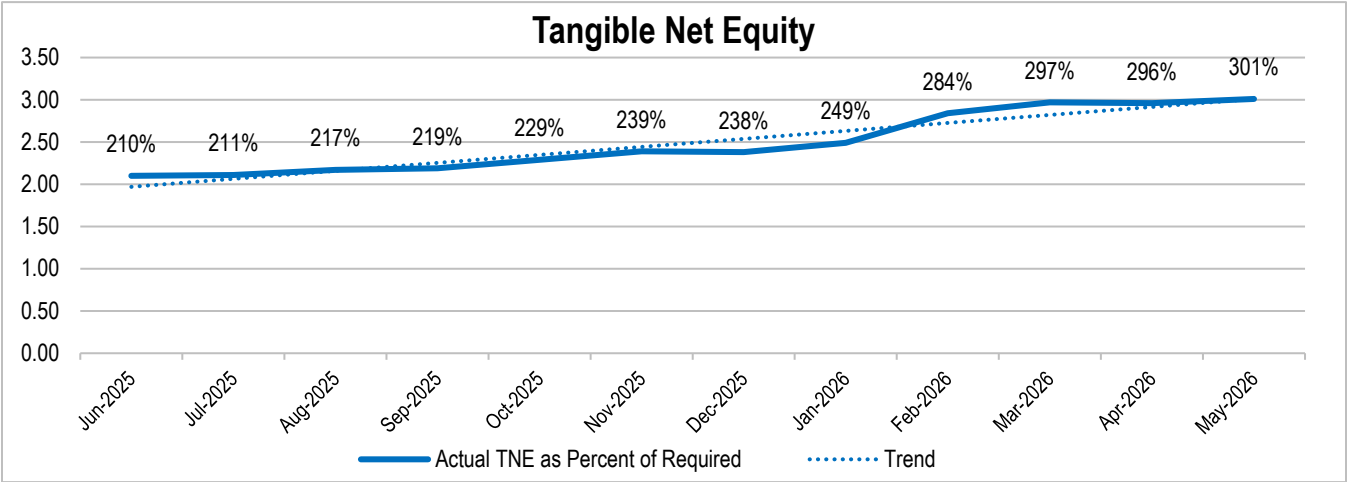
Net Income – For the month ended May, actual Net Income was \$1.5 million vs. budgeted Net Loss of \$1.0 million. For the fiscal YTD, actual Net Income was \$68.5 million vs. budgeted Net Income of \$20.1 million. For the month, Premium Revenue was favorable to budget, actual Revenue was \$184.5 million vs. budgeted Revenue of \$181.0 million. Premium Revenue favorable variance of \$3.5 million is primarily due to current month Medi-Cal and IHSS volume variance. Medicare Part A Buy-In Phase II on “pause” caused the majority of this volume variance. Over 7,000 members were Budgeted to transition from SPD with LTC to Duals with LTC but not reflected in the actual Financial Enrollment.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 93.7% for the month, and 92.4% for fiscal YTD.



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



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

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: July 10th, 2026

Subject: Finance Report – May 2026

Executive Summary

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

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

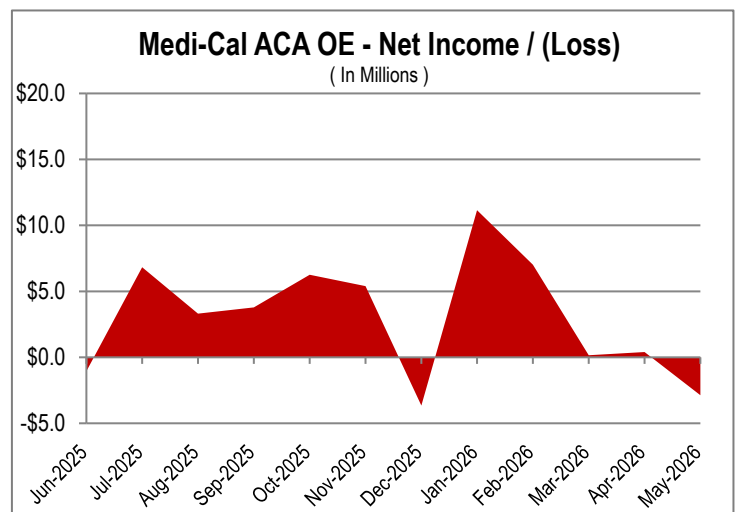
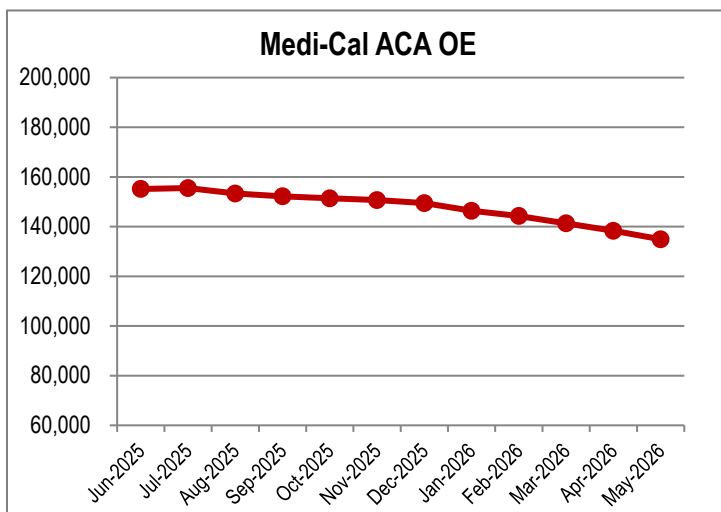
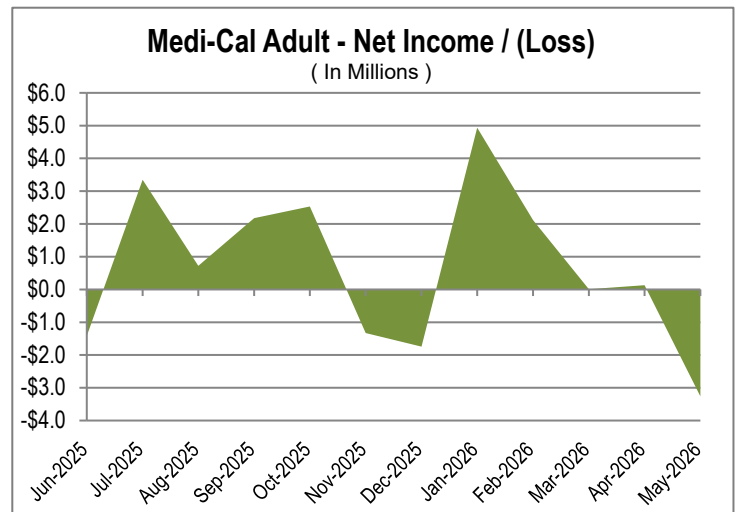
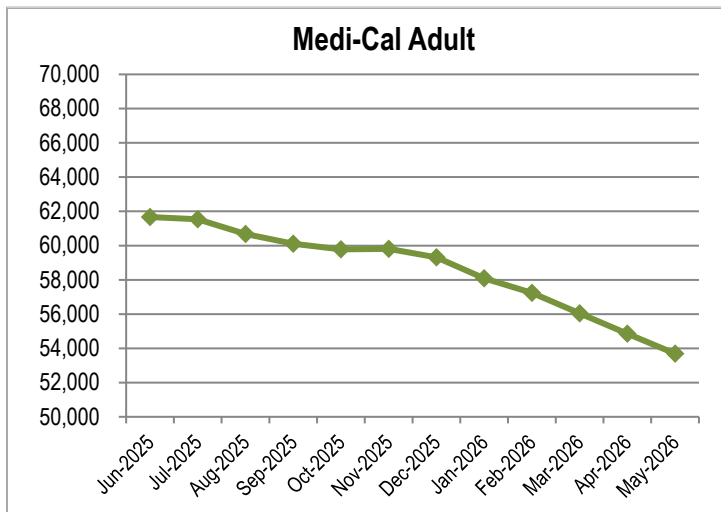
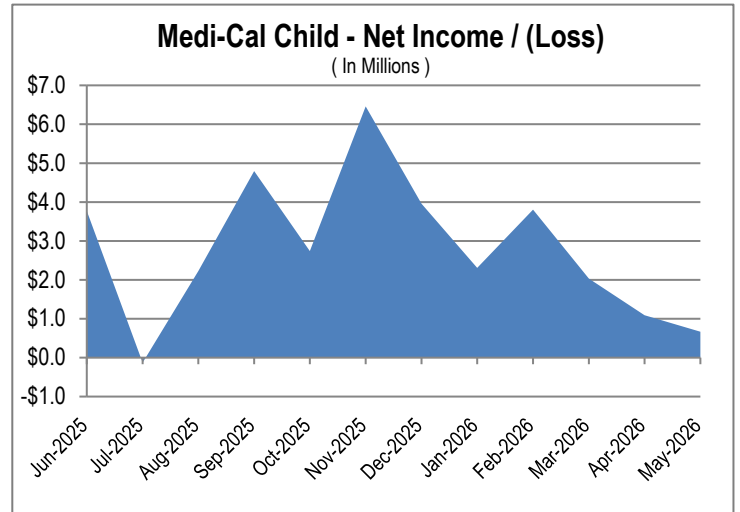
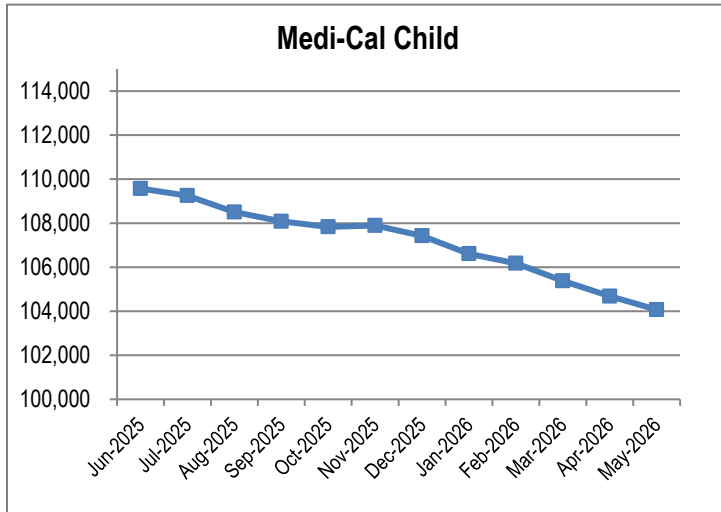
<u>Net Income by Program: (in Thousands)</u>		
	Month	YTD
Medi-Cal	\$3,658	\$82,800
Group Care	(1,250)	(4,127)
Medicare	(935)	(10,196)
	\$1,474	\$68,477

Enrollment

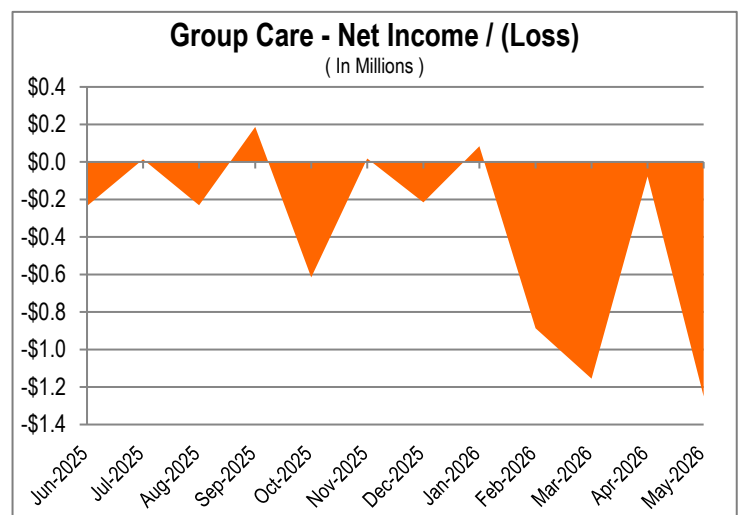
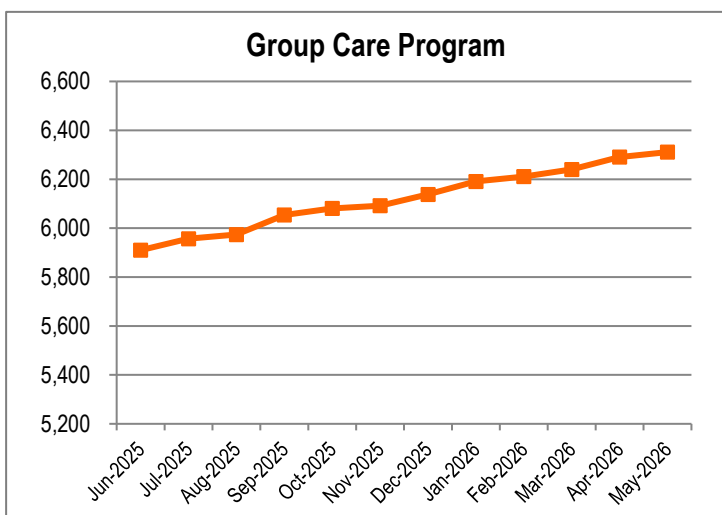
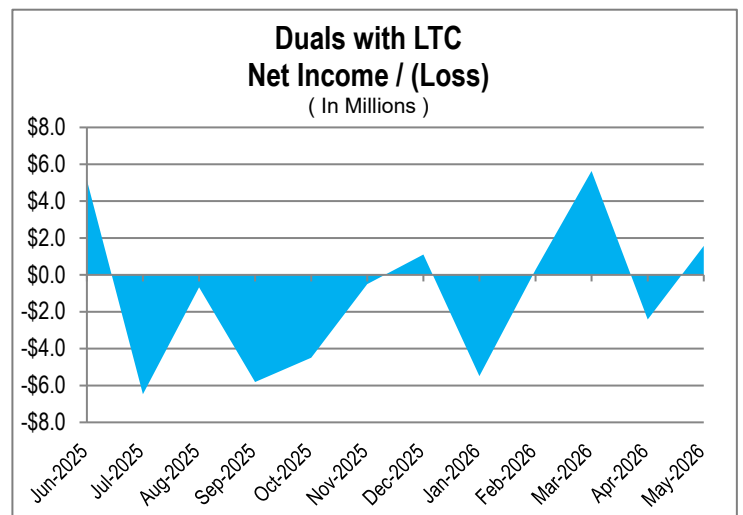
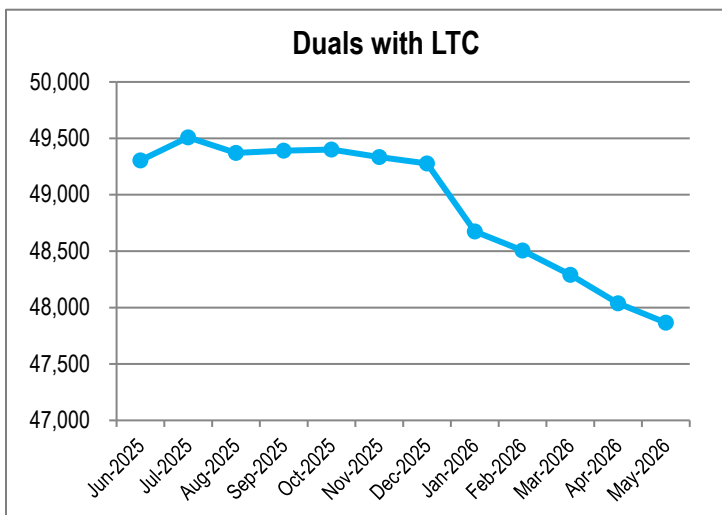
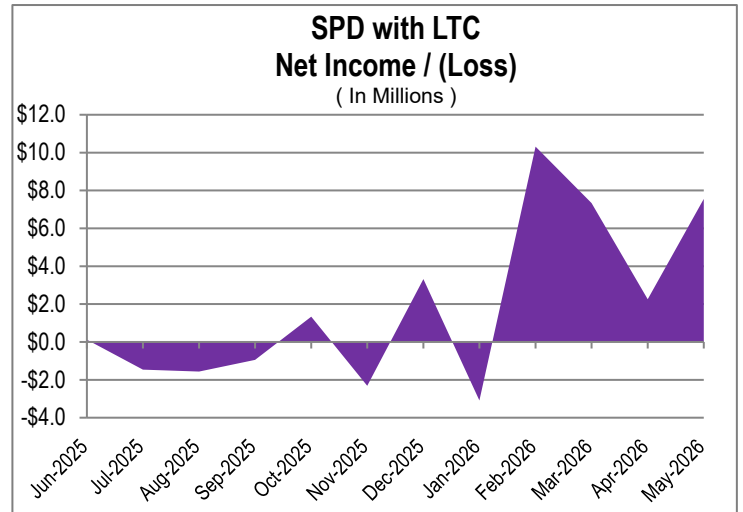
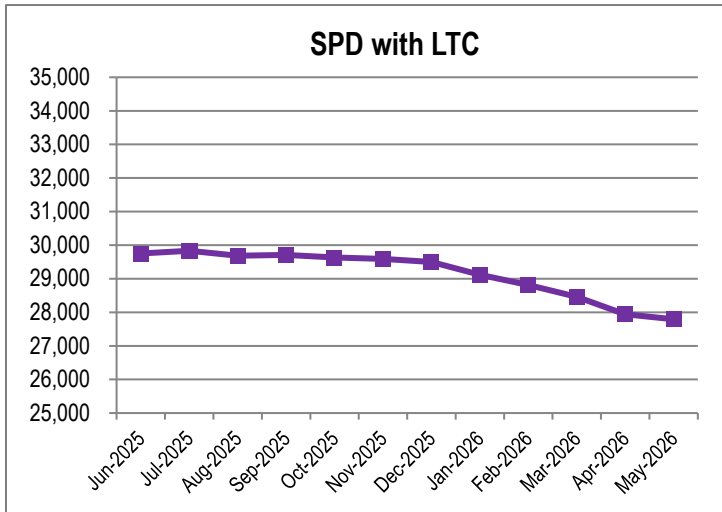
- Total enrollment decreased by 5,467 members since April 2026.
- Total enrollment decreased by 36,497 members since June 2025.

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

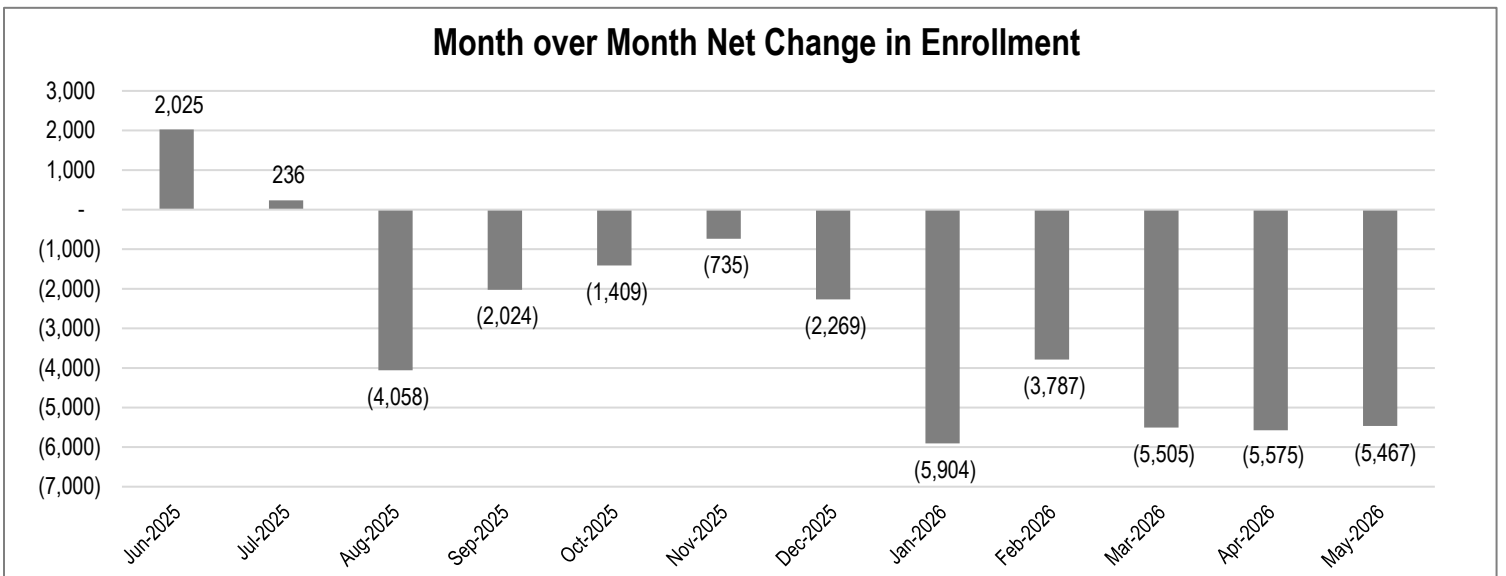
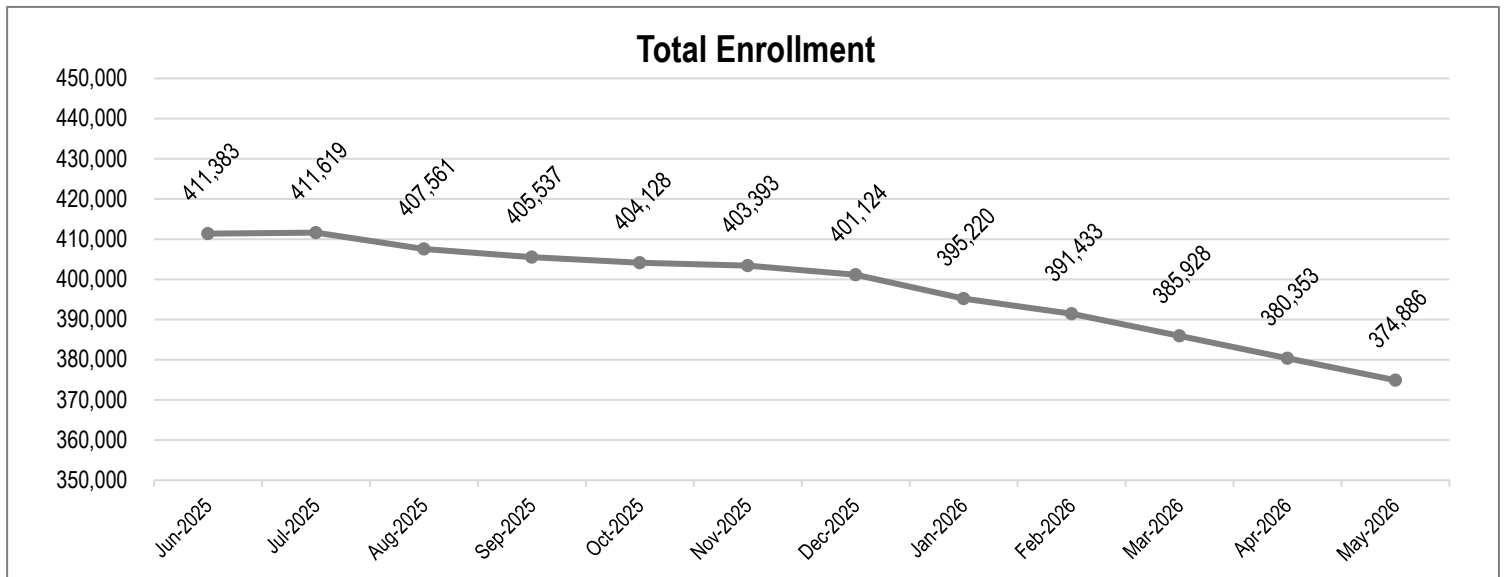
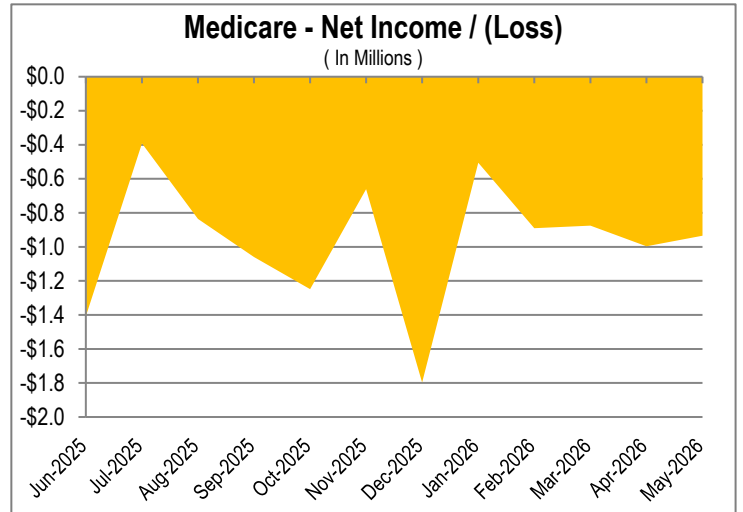
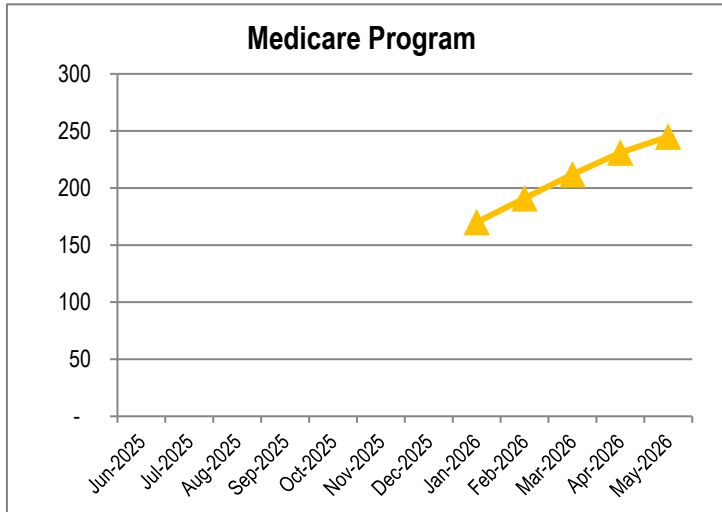
Enrollment and Profitability by Program and Category of Aid



Enrollment and Profitability by Program and Category of Aid

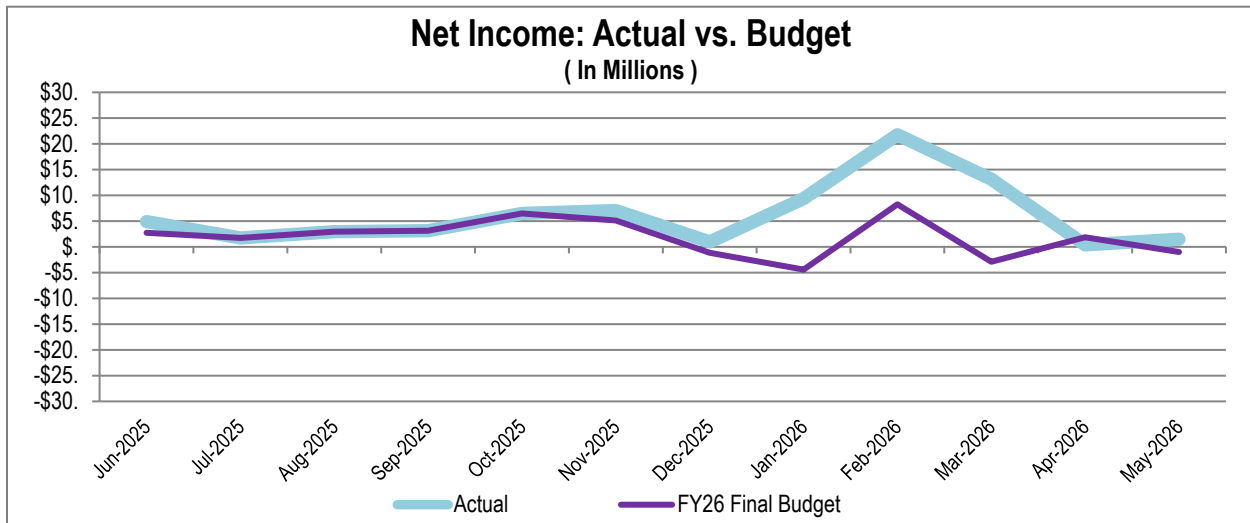


Enrollment and Profitability by Program and Category of Aid



Net Income

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

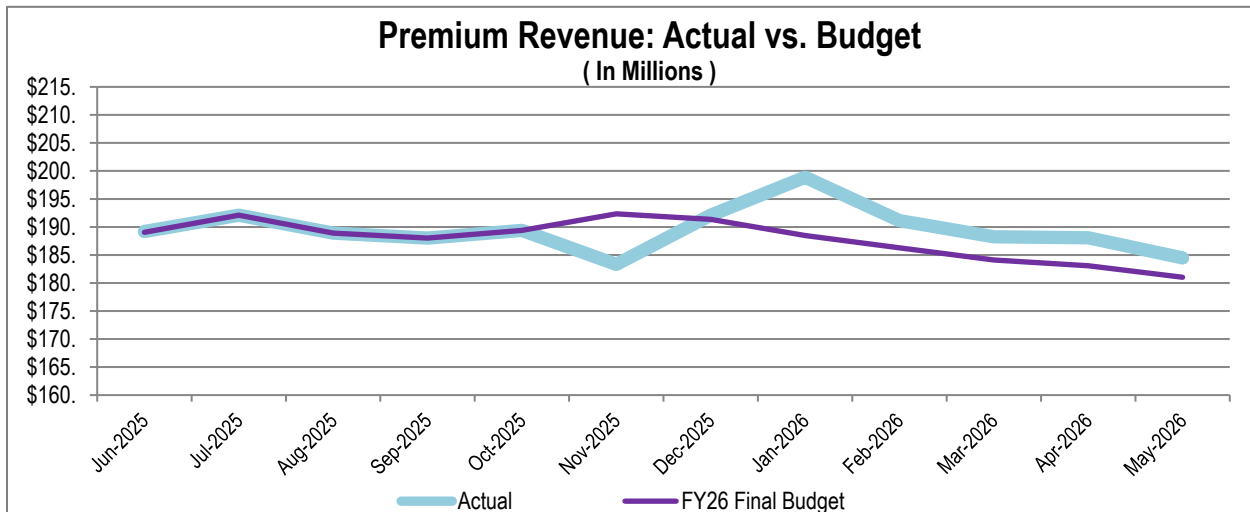


The favorable variance of \$2.5 million in the current month is primarily due to:

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

Premium Revenue

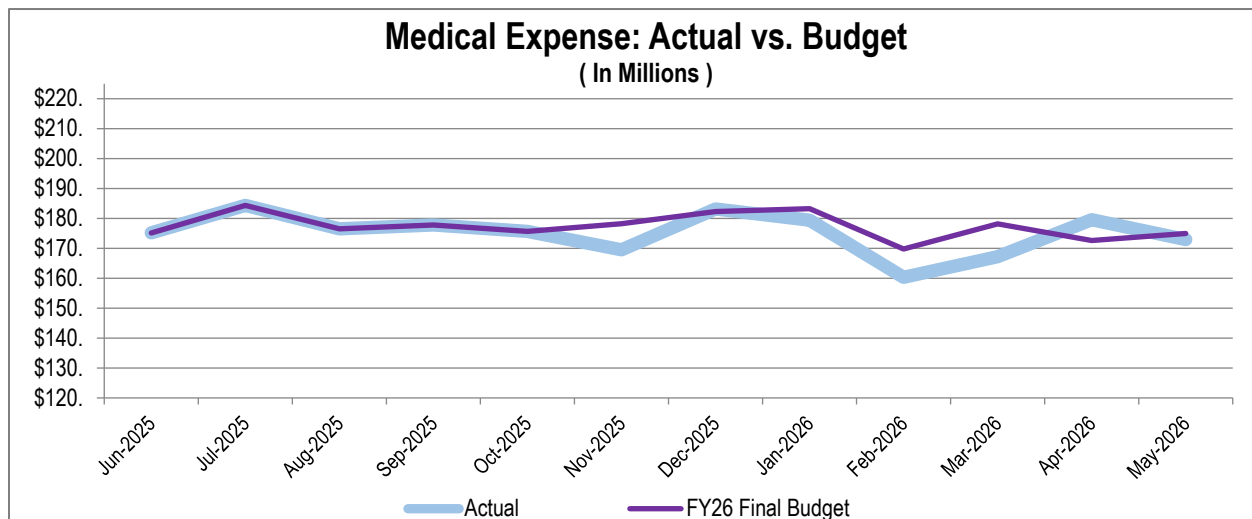
- For the month ended May 31st, 2026:
 - Actual Revenue: \$184.5 million.
 - Budgeted Revenue: \$181.0 million.
- For the fiscal YTD ended May 31st, 2026:
 - Actual Revenue: \$2.1 billion.
 - Budgeted Revenue: \$2.1 billion.



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

Medical Expense

- For the month ended May 31st, 2026:
 - Actual Medical Expense: \$173.0 million.
 - Budgeted Medical Expense: \$174.9 million.
- For the fiscal YTD ended May 31st, 2026:
 - Actual Medical Expense: \$1.9 billion.
 - Budgeted Medical Expense: \$2.0 billion.



- Reported financial results include medical expense, which contains estimates for Incurred-But-Not-Paid (IBNP) claims. Calculation of monthly IBNP is based on historical trends and claims payment. The Alliance’s IBNP reserves are reviewed by actuarial consultants.
- For May, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by \$2.7 million. Year to date, the estimate for prior years decreased by \$12.6 million (per table below).

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

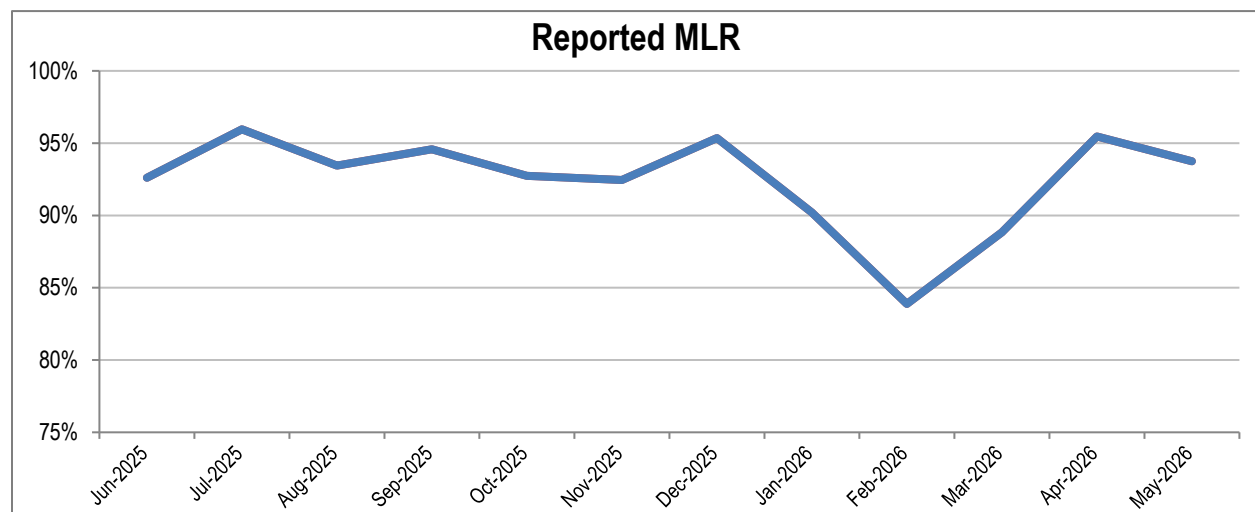
Medical Expense - Actual vs. Budget (Per Member Per Month)						
Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance: Actual Adjusted vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical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

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

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

Medical Loss Ratio (MLR)

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



Administrative Expense

- For the month ended May 31st, 2026:
 - Actual Administrative Expense: \$12.4 million.
 - Budgeted Administrative Expense: \$10.1 million.
- For the fiscal YTD ended May 31st, 2026:
 - Actual Administrative Expense: \$117.0 million.
 - Budgeted Administrative Expense: \$121.7 million.

Summary of Administrative Expense (In Dollars)									
For the Month and Fiscal Year-to-Date									
Favorable/(Unfavorable)									
Current Month					Year-to-Date				
Actual	Budget	Variance \$	Variance %		Actual	Budget	Variance \$	Variance %	
\$9,360,131	\$6,177,102	(\$3,183,029)	(51.5%)		Personnel Expense	\$75,152,575	\$74,405,786	(\$746,788)	(1.0%)
92,225	93,846	1,621	1.7%		Medical Benefits Admin Expense	832,218	1,041,755	209,538	20.1%
2,049,832	2,320,431	270,598	11.7%		Purchased & Professional Services	23,637,769	27,008,239	3,370,470	12.5%
871,717	1,460,677	588,960	40.3%	Other Admin Expense	17,363,321	19,214,992	1,851,671	9.6%	
\$12,373,905	\$10,052,056	(\$2,321,850)	(23.1%)	Total Administrative Expense	\$116,985,882	\$121,670,773	\$4,684,890	3.9%	

The year-to-date variances include:

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

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

Other Income / (Expense)

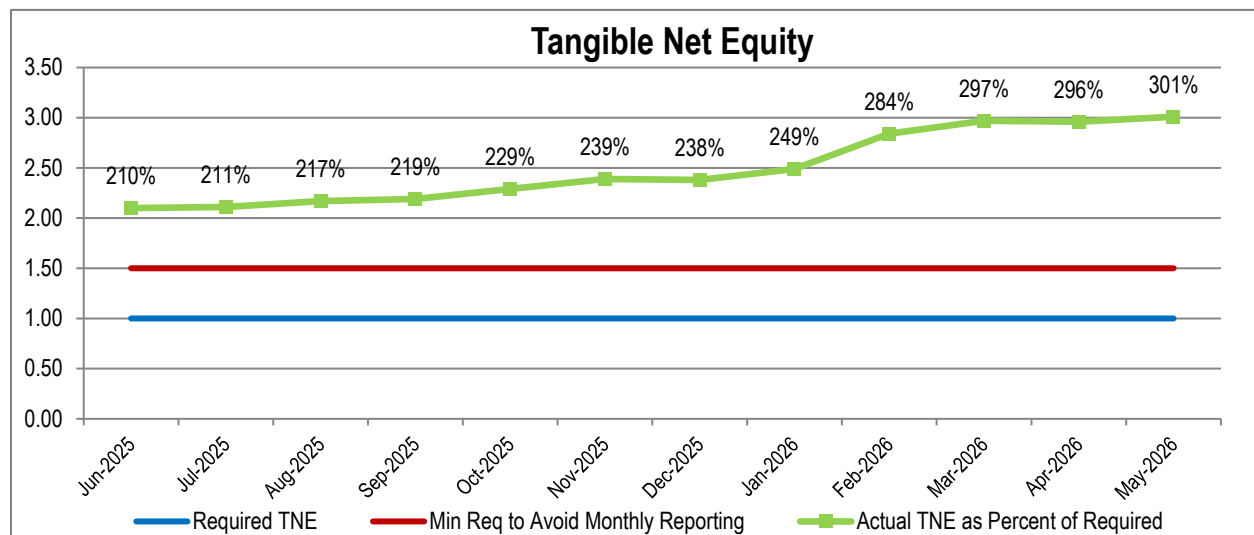
Other Income & Expense is comprised primarily of investment income. Fiscal year-to-date net investments show a gain of \$27.2 million.

Managed Care Organization (MCO) Provider Tax

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

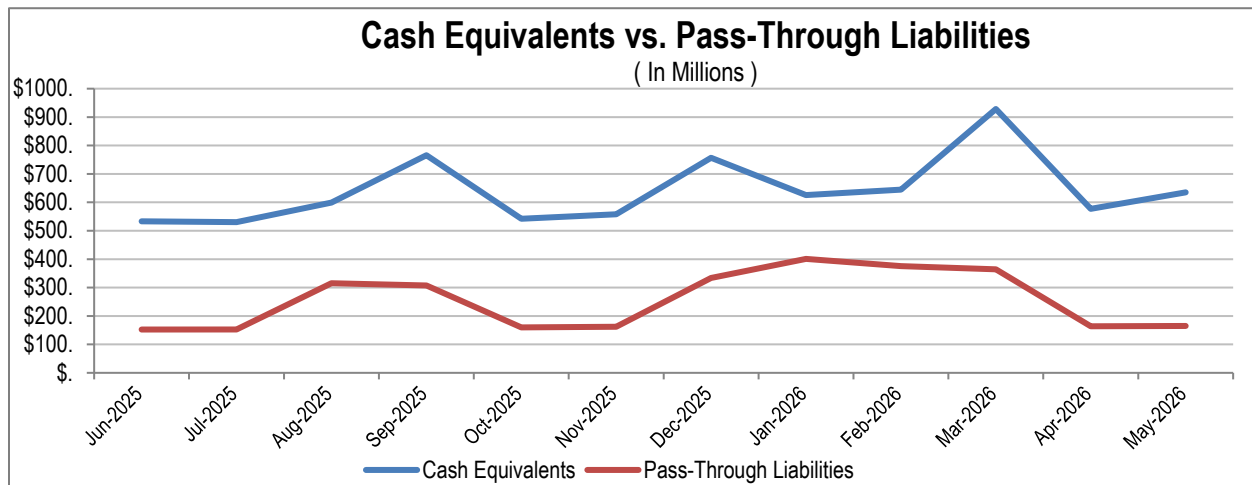
Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus total liabilities divided by a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
 - Required TNE \$78.9 million
 - Actual TNE \$237.8 million
 - Excess TNE \$158.8 million
 - TNE % of Required TNE 301%



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

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



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

Capital Investment

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

Caveats to Financial Statements

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

Finance

Supporting Documents

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

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

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

	5/31/2026	4/30/2026	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	\$25,186,278	\$38,803,262	(\$13,616,984)	(35.1%)
CNB Short-Term Investment	609,884,182	538,461,270	71,422,913	13.3%
Interest Receivable	3,304,671	2,567,688	736,983	28.7%
Premium Receivables	363,006,778	369,828,884	(6,822,105)	(1.8%)
Reinsurance Recovery Receivable	14,290,310	15,427,507	(1,137,197)	(7.4%)
Other Receivables	2,380,452	1,819,688	560,764	30.8%
Prepaid Expenses	716,683	784,800	(68,117)	(8.7%)
TOTAL CURRENT ASSETS	1,018,769,354	967,693,099	51,076,256	5.3%
OTHER ASSETS				
CNB Long-Term Investment	37,486,717	37,458,394	28,323	0.1%
CalPERS Net Pension Asset	(6,465,233)	(6,465,233)	0	0.0%
Deferred Outflow	15,271,214	15,271,214	0	0.0%
Restricted Asset-Bank Note	364,852	363,852	1,001	0.3%
GASB 87-Lease Assets (Net)	42,575	45,850	(3,275)	(7.1%)
GASB 96-SBITA Assets (Net)	7,306,844	7,552,000	(245,156)	(3.2%)
TOTAL OTHER ASSETS	54,006,969	54,226,076	(219,107)	(0.4%)
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,893,508	9,893,508	0	0.0%
Furniture And Equipment	13,400,309	13,400,309	0	0.0%
Leasehold Improvement	902,447	902,447	0	0.0%
Internally Developed Software	14,824,002	14,824,002	0	0.0%
Fixed Assets at Cost	39,020,265	39,020,265	0	0.0%
Less: Accumulated Depreciation	(34,077,836)	(34,015,137)	(62,699)	0.2%
PROPERTY AND EQUIPMENT (NET)	4,942,429	5,005,128	(62,699)	(1.3%)
TOTAL ASSETS	1,077,718,752	1,026,924,303	50,794,449	4.9%
CURRENT LIABILITIES				
Trade Accounts Payable	11,663,872	11,973,779	(309,907)	(2.6%)
Incurred But Not Reported Claims	310,505,030	324,464,820	(13,959,790)	(4.3%)
Other Medical Liabilities	151,725,198	150,744,348	980,850	0.7%
Pass-Through Liabilities	164,834,303	164,043,127	791,176	0.5%
MCO Tax Liabilities	181,015,941	118,815,233	62,200,708	52.4%
GASB 87 and 96 ST Liabilities	3,041,162	2,941,215	99,946	3.4%
Payroll Liabilities	11,533,934	12,012,751	(478,817)	(4.0%)
TOTAL CURRENT LIABILITIES	834,319,439	784,995,272	49,324,166	6.3%
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	2,403,081	2,406,356	(3,275)	(0.1%)
Deferred Inflow	3,240,306	3,240,306	0	0.0%
TOTAL LONG TERM LIABILITIES	5,643,386	5,646,661	(3,275)	(0.1%)
TOTAL LIABILITIES	839,962,825	790,641,934	49,320,891	6.2%
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	168,439,128	168,439,128	0	0.0%
Year-To-Date Net Surplus (Deficit)	68,476,567	67,003,009	1,473,558	2.2%
TOTAL NET WORTH	237,755,927	236,282,369	1,473,558	0.6%
TOTAL LIABILITIES AND NET WORTH	1,077,718,752	1,026,924,303	50,794,449	4.9%
Additional Information				
Cash Equivalents	635,070,460	577,264,531	57,805,929	10.0%
Pass-Through	164,834,303	164,043,127	791,176	0.5%
Uncommitted Cash	470,236,158	413,221,405	57,014,753	13.8%
Working Capital	184,449,916	182,697,826	1,752,089	1.0%
Current Ratio	122.1%	123.3%	(1.2%)	(1.0%)

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

May 31, 2026

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

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

May 31, 2026

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

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

May 31, 2026

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

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

May 31, 2026

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

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF APRIL 2026

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

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE APRIL 2026

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

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

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

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

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

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

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

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

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

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 5/31/26	\$ 39,020,265
Fixed Assets @ Cost - 6/30/25	\$ 38,969,405
Fixed Assets Acquired YTD	\$ 50,860

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

TANGIBLE NET EQUITY (TNE)

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

LIQUID TANGIBLE NET EQUITY

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

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

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

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,251	108,503	108,083	107,831	107,894	107,424	106,611	106,175	105,381	104,683	104,072		1,175,908
Adult	61,536	60,679	60,106	59,780	59,806	59,312	58,090	57,240	56,039	54,857	53,691		641,136
ACA OE	155,533	153,348	152,196	151,404	150,677	149,473	146,364	144,297	141,305	138,309	134,907		1,617,813
SPD with LTC	29,833	29,686	29,708	29,631	29,590	29,500	29,119	28,813	28,461	27,944	27,794		320,079
Duals with LTC	49,509	49,371	49,390	49,401	49,334	49,277	48,675	48,506	48,290	48,038	47,866		537,657
Medi-Cal Program	405,662	401,587	399,483	398,047	397,301	394,986	388,859	385,031	379,476	373,831	368,330		4,292,593
Group Care Program	5,957	5,974	6,054	6,081	6,092	6,138	6,191	6,211	6,240	6,291	6,311		67,540
Medicare Program	0	0	0	0	0	0	170	191	212	231	245		1,049
Total	411,619	407,561	405,537	404,128	403,393	401,124	395,220	391,433	385,928	380,353	374,886		4,361,182

Month Over Month Enrollment Change:

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

Enrollment Percentages:

Medi-Cal Program % of Total:													
Child % of Medi-Cal	26.9%	27.0%	27.1%	27.1%	27.2%	27.2%	27.4%	27.6%	27.8%	28.0%	28.3%		27.4%
Adult % of Medi-Cal	15.2%	15.1%	15.0%	15.0%	15.1%	15.0%	14.9%	14.9%	14.8%	14.7%	14.6%		14.9%
ACA OE % of Medi-Cal	38.3%	38.2%	38.1%	38.0%	37.9%	37.8%	37.6%	37.5%	37.2%	37.0%	36.6%		37.7%
SPD with LTC % of Medi-Cal	7.4%	7.4%	7.4%	7.4%	7.4%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%		7.5%
Duals with LTC % of Medi-Cal	12.2%	12.3%	12.4%	12.4%	12.4%	12.5%	12.5%	12.6%	12.7%	12.9%	13.0%		12.5%
Medi-Cal Program % of Total	98.6%	98.5%	98.5%	98.5%	98.5%	98.5%	98.4%	98.4%	98.3%	98.3%	98.3%		98.4%
Group Care Program % of Total	1.4%	1.5%	1.5%	1.5%	1.5%	1.5%	1.6%	1.6%	1.6%	1.7%	1.7%		1.5%
Medicare Program % of Total	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%		0.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%

**ALAMEDA ALLIANCE FOR HEALTH
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FOR THE FISCAL YEAR 2026**

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

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted:													
Directly Contracted (DCP)	93,933	93,268	93,599	92,670	93,415	91,466	90,039	90,223	87,617	87,480	86,918		1,000,628
Alameda Health System	92,861	91,758	91,032	91,084	90,621	90,714	88,985	87,443	86,119	81,995	78,601		971,213
Directly-Contracted Subtotal	186,794	185,026	184,631	183,754	184,036	182,180	179,024	177,666	173,736	169,475	165,519		1,971,841
Delegated:													
CFMG	43,381	42,852	42,253	42,053	41,790	41,683	41,247	40,893	40,565	40,449	40,233		457,399
CHCN	181,444	179,683	178,653	178,321	177,567	177,261	174,949	172,874	171,627	170,429	169,134		1,931,942
Delegated Subtotal	224,825	222,535	220,906	220,374	219,357	218,944	216,196	213,767	212,192	210,878	209,367		2,389,341
Total	411,619	407,561	405,537	404,128	403,393	401,124	395,220	391,433	385,928	380,353	374,886		4,361,182
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(518)	(1,768)	(395)	(877)	282	(1,856)	(3,156)	(1,358)	(3,930)	(4,261)	(3,956)		(21,793)
Delegated:													
CFMG	(128)	(529)	(599)	(200)	(263)	(107)	(436)	(354)	(328)	(116)	(216)		(3,276)
CHCN	882	(1,761)	(1,030)	(332)	(754)	(306)	(2,312)	(2,075)	(1,247)	(1,198)	(1,295)		(11,428)
Delegated Subtotal	754	(2,290)	(1,629)	(532)	(1,017)	(413)	(2,748)	(2,429)	(1,575)	(1,314)	(1,511)		(14,704)
Total	236	(4,058)	(2,024)	(1,409)	(735)	(2,269)	(5,904)	(3,787)	(5,505)	(5,575)	(5,467)		(36,497)
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	45.4%	45.4%	45.5%	45.5%	45.6%	45.4%	45.3%	45.4%	45.0%	44.6%	44.2%		45.2%
Delegated:													
CFMG	10.5%	10.5%	10.4%	10.4%	10.4%	10.4%	10.4%	10.4%	10.5%	10.6%	10.7%		10.5%
CHCN	44.1%	44.1%	44.1%	44.1%	44.0%	44.2%	44.3%	44.2%	44.5%	44.8%	45.1%		44.3%
Delegated Subtotal	54.6%	54.6%	54.5%	54.5%	54.4%	54.6%	54.7%	54.6%	55.0%	55.4%	55.8%		54.8%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%

**ALAMEDA ALLIANCE FOR HEALTH
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FOR THE FISCAL YEAR 2026**

FINAL BUDGET

	Budget Jul-25	Budget Aug-25	Budget Sep-25	Budget Oct-25	Budget Nov-25	Budget Dec-25	Budget Jan-26	Budget Feb-26	Budget Mar-26	Budget Apr-26	Budget May-26	Budget Jun-26	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,251	108,503	108,083	107,831	107,623	107,014	106,408	105,806	105,210	104,615	104,025	103,439	1,277,808
Adult	61,536	60,679	60,106	59,780	59,301	58,778	57,982	57,197	56,422	55,659	54,907	54,167	696,514
ACA OE	155,533	153,348	152,196	151,404	150,461	149,482	145,792	142,205	138,719	135,332	132,040	128,840	1,735,352
SPD with LTC	29,833	29,686	29,708	29,631	29,574	29,456	21,811	21,666	21,525	21,382	21,241	21,100	306,613
Duals with LTC*	49,509	49,371	49,390	49,401	49,195	49,072	56,469	56,344	56,220	56,096	55,973	55,850	632,890
Medi-Cal Program	405,662	401,587	399,483	398,047	396,154	393,802	388,462	383,218	378,096	373,084	368,186	363,396	4,649,177
Group Care Program	5,957	5,974	6,054	6,081	6,079	6,085	6,079	6,085	6,091	6,097	6,103	6,109	72,794
Medicare Program	0	0	0	0	0	0	266	370	473	619	722	825	3,275
Total	411,619	407,561	405,537	404,128	402,233	399,887	394,807	389,673	384,660	379,800	375,011	370,330	4,725,246

Month Over Month Enrollment Change:

Medi-Cal Program:													
Child	(1,402)	(748)	(420)	(252)	(208)	(609)	(606)	(602)	(596)	(595)	(590)	(586)	(7,214)
Adult	(1,546)	(857)	(573)	(326)	(479)	(523)	(796)	(785)	(775)	(763)	(752)	(740)	(8,915)
ACA OE	3,222	(2,185)	(1,152)	(792)	(943)	(979)	(3,690)	(3,587)	(3,486)	(3,387)	(3,292)	(3,200)	(23,471)
SPD with LTC	(97)	(147)	22	(77)	(57)	(118)	(7,645)	(145)	(141)	(143)	(141)	(141)	(8,830)
Duals with LTC	2,092	(138)	19	11	(206)	(123)	7,397	(125)	(124)	(124)	(123)	(123)	8,433
Medi-Cal Program	2,269	(4,075)	(2,104)	(1,436)	(1,893)	(2,352)	(5,340)	(5,244)	(5,122)	(5,012)	(4,898)	(4,790)	(39,997)
Group Care Program	188	17	80	27	(2)	6	(6)	6	6	6	6	6	340
Medicare Program	0	0	0	0	0	0	266	104	103	146	103	103	825
Total	2,457	(4,058)	(2,024)	(1,409)	(1,895)	(2,346)	(5,080)	(5,134)	(5,013)	(4,860)	(4,789)	(4,681)	(38,832)
													0

Enrollment Percentages:

Medi-Cal Program:													
Child % of Medi-Cal	26.9%	27.0%	27.1%	27.1%	27.2%	27.2%	27.4%	27.6%	27.8%	28.0%	28.3%	28.5%	27.5%
Adult % of Medi-Cal	15.2%	15.1%	15.0%	15.0%	15.0%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	14.9%	15.0%
ACA OE % of Medi-Cal	38.3%	38.2%	38.1%	38.0%	38.0%	38.0%	37.5%	37.1%	36.7%	36.3%	35.9%	35.5%	37.3%
SPD with LTC % of Medi-Cal	7.4%	7.4%	7.4%	7.4%	7.5%	7.5%	5.6%	5.7%	5.7%	5.7%	5.8%	5.8%	6.6%
Duals with LTC % of Medi-Cal	12.2%	12.3%	12.4%	12.4%	12.4%	12.5%	14.5%	14.7%	14.9%	15.0%	15.2%	15.4%	13.6%
Medi-Cal Program % of Total	98.6%	98.5%	98.5%	98.5%	98.5%	98.5%	98.4%	98.3%	98.3%	98.2%	98.2%	98.1%	98.4%
Group Care Program % of Total	1.4%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.6%	1.6%	1.6%	1.6%	1.6%	1.5%
Medicare Program	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%	0.2%	0.2%	0.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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

FINAL BUDGET													
	Budget Jul-25	Budget Aug-25	Budget Sep-25	Budget Oct-25	Budget Nov-25	Budget Dec-25	Budget Jan-26	Budget Feb-26	Budget Mar-26	Budget Apr-26	Budget May-26	Budget Jun-26	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	93,933	93,268	93,599	92,670	93,410	92,946	94,780	93,808	92,860	91,962	91,058	90,177	1,114,471
Alameda Health System	92,861	91,758	91,032	91,084	90,325	89,753	87,421	85,899	84,414	82,969	81,558	80,181	1,049,255
Directly-Contracted Subtotal	186,794	185,026	184,631	183,754	183,735	182,699	182,201	179,707	177,274	174,931	172,616	170,358	2,163,726
Delegated:													
CFMG	43,381	42,852	42,253	42,053	41,673	41,447	40,713	40,456	40,203	39,951	39,701	39,454	494,137
CHCN	181,444	179,683	178,653	178,321	176,825	175,741	171,893	169,510	167,183	164,918	162,694	160,518	2,067,383
Delegated Subtotal	224,825	222,535	220,906	220,374	218,498	217,188	212,606	209,966	207,386	204,869	202,395	199,972	2,561,520
Total	411,619	407,561	405,537	404,128	402,233	399,887	394,807	389,673	384,660	379,800	375,011	370,330	4,725,246
0													
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	1,762	(665)	331	(929)	740	(464)	1,834	(972)	(948)	(898)	(904)	(881)	(1,994)
Alameda Health System	1,869	(1,103)	(726)	52	(759)	(572)	(2,332)	(1,522)	(1,485)	(1,445)	(1,411)	(1,377)	(10,811)
Directly-Contracted Subtotal	3,631	(1,768)	(395)	(877)	(19)	(1,036)	(498)	(2,494)	(2,433)	(2,343)	(2,315)	(2,258)	(12,805)
Delegated:													
CFMG	(640)	(529)	(599)	(200)	(380)	(226)	(734)	(257)	(253)	(252)	(250)	(247)	(4,567)
CHCN	(534)	(1,761)	(1,030)	(332)	(1,496)	(1,084)	(3,848)	(2,383)	(2,327)	(2,265)	(2,224)	(2,176)	(21,460)
Delegated Subtotal	(1,174)	(2,290)	(1,629)	(532)	(1,876)	(1,310)	(4,582)	(2,640)	(2,580)	(2,517)	(2,474)	(2,423)	(26,027)
Total	2,457	(4,058)	(2,024)	(1,409)	(1,895)	(2,346)	(5,080)	(5,134)	(5,013)	(4,860)	(4,789)	(4,681)	(38,832)
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	22.8%	22.9%	23.1%	22.9%	23.2%	23.2%	24.0%	24.1%	24.1%	24.2%	24.3%	24.4%	23.6%
Alameda Health System	22.6%	22.5%	22.4%	22.5%	22.5%	22.4%	22.1%	22.0%	21.9%	21.8%	21.7%	21.7%	22.2%
Directly-Contracted Subtotal	45.4%	45.4%	45.5%	45.5%	45.7%	45.7%	46.1%	46.1%	46.1%	46.1%	46.0%	46.0%	45.8%
Delegated:													
CFMG	10.5%	10.5%	10.4%	10.4%	10.4%	10.4%	10.3%	10.4%	10.5%	10.5%	10.6%	10.7%	10.5%
CHCN	44.1%	44.1%	44.1%	44.1%	44.0%	43.9%	43.5%	43.5%	43.5%	43.4%	43.4%	43.3%	43.8%
Delegated Subtotal	54.6%	54.6%	54.5%	54.5%	54.3%	54.3%	53.9%	53.9%	53.9%	53.9%	54.0%	54.0%	54.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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

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

MEDICARE SUPPLEMENT

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

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

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

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

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

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

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

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

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

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

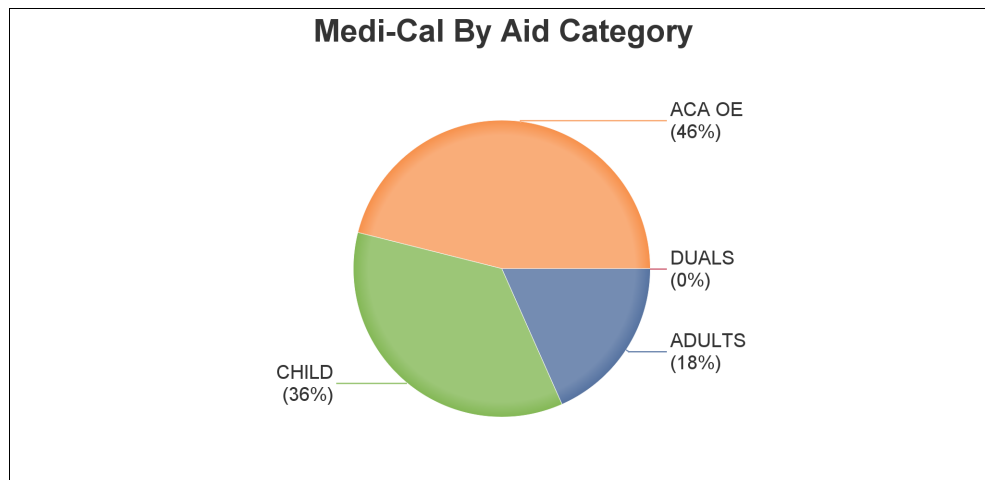
CURRENT MONTH				FISCAL YEAR TO DATE				
		\$ Variance	% Variance				\$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
(140,442)	0	140,442	0.0%	IBNR Claims Fluctuation (ANC)	(252,453)	(256,479)	(4,026)	1.6%
(91,811)	0	91,811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

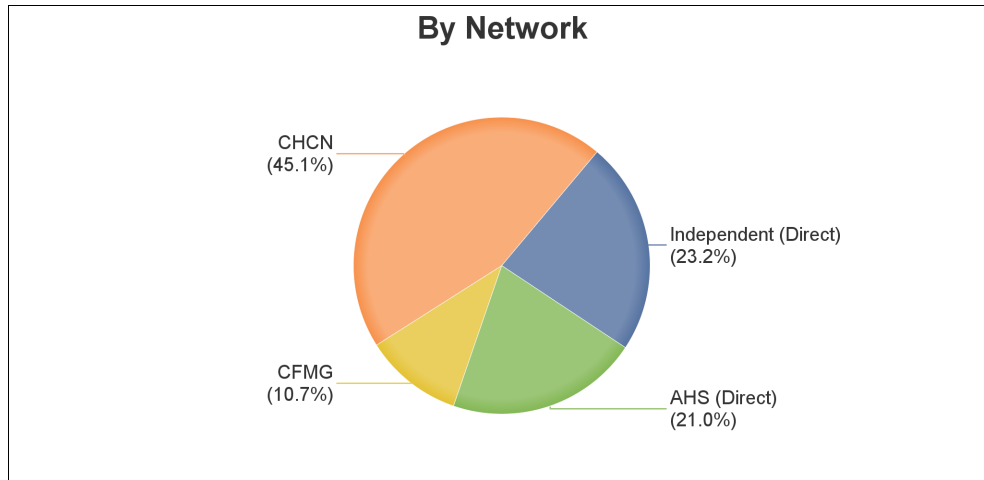
**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 MAY, 2026**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

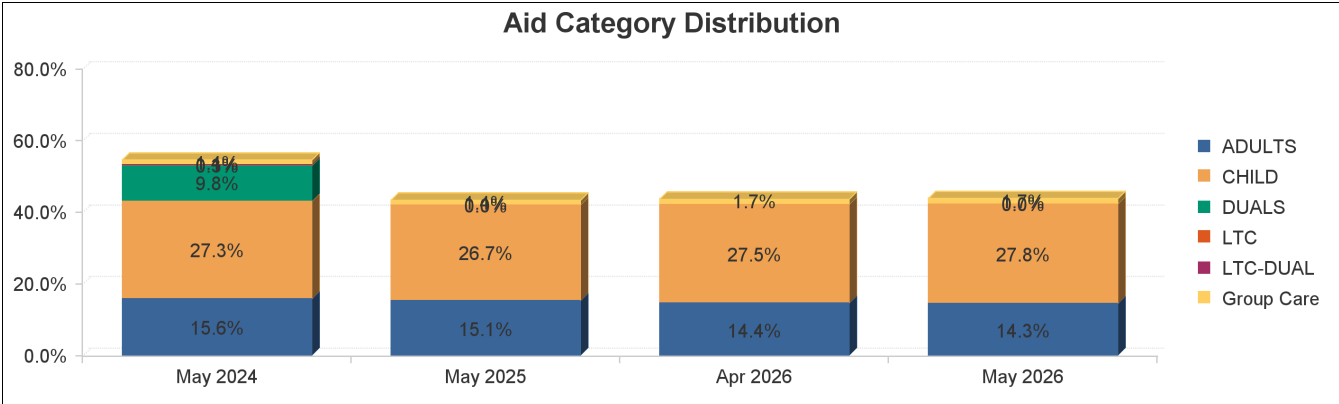
Category of Aid Trend						
Category of Aid	May 2026	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	53,740	15%	11,078	12,643	2	30,017
CHILD	104,137	28%	9,527	13,697	37,295	43,618
SPD	0	0%	0	0	0	0
ACA OE	134,907	37%	25,147	42,728	1,426	65,606
DUALS	5	0%	5	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL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



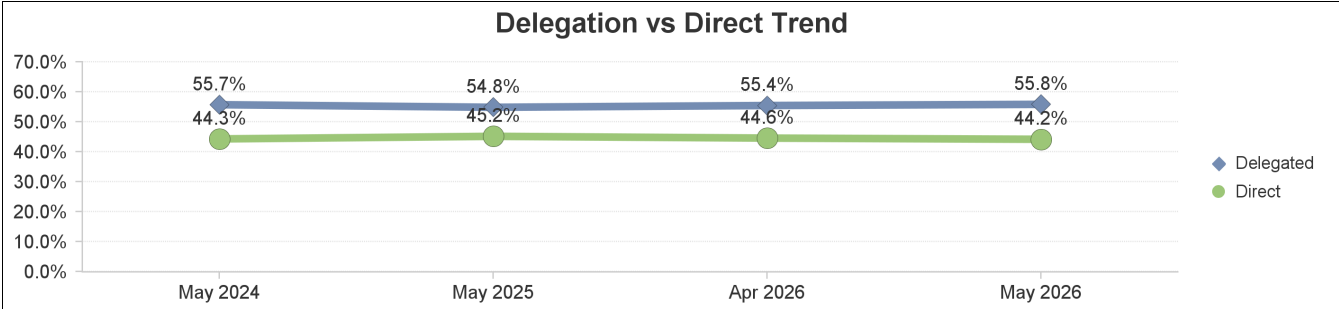


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

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

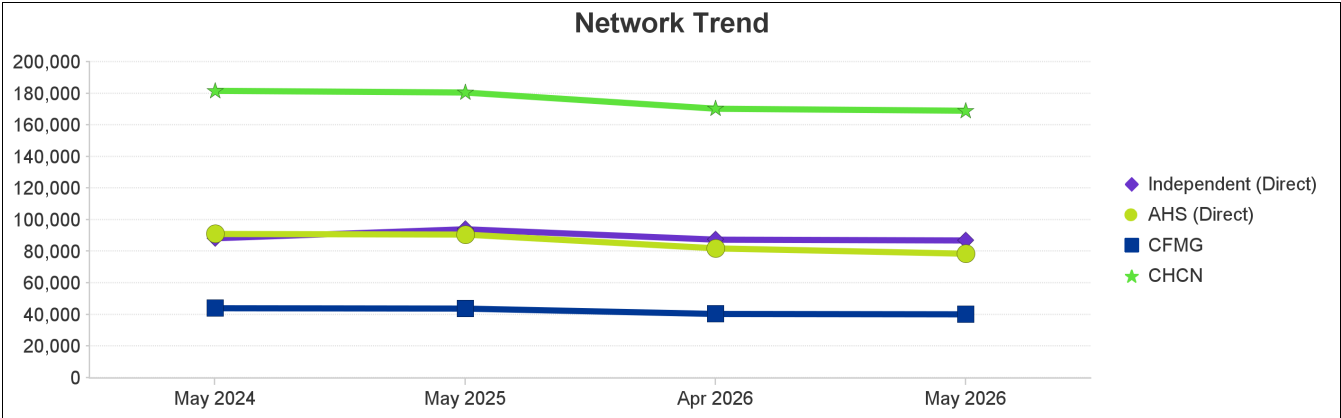


Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2024	May 2025	Apr 2026	May 2026	May 2024	May 2025	Apr 2026	May 2026	May 2024 to May 2025	May 2025 to May 2026	Apr 2026 to May 2026
Delegated	225,844	224,566	210,887	209,395	55.7%	54.8%	55.4%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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

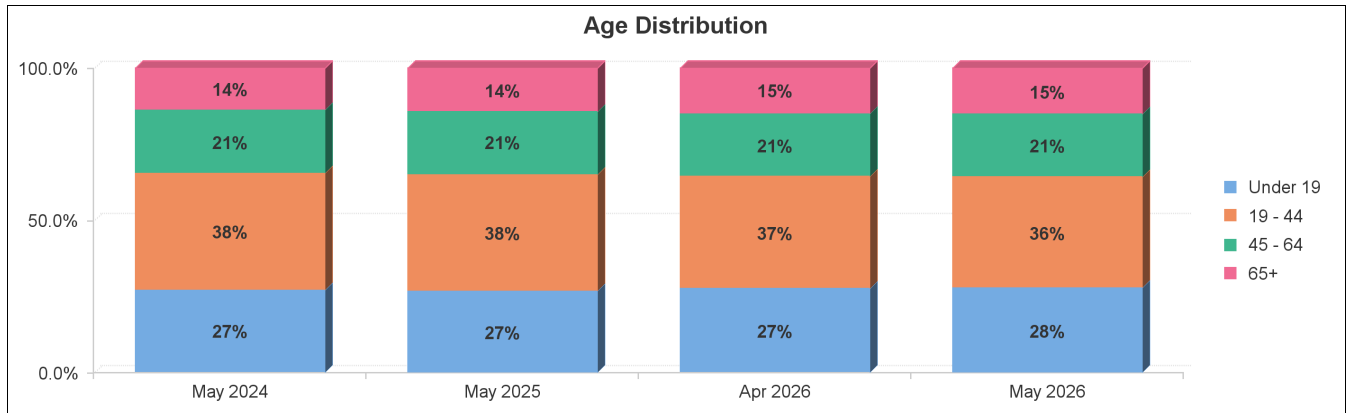
Network Trend											
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2024	May 2025	Apr 2026	May 2026	May 2024	May 2025	Apr 2026	May 2026	May 2024 to May 2025	May 2025 to May 2026	Apr 2026 to May 2026
Independent (Direct)	88,381	94,112	87,505	87,006	21.8%	23.0%	23.0%	23.2%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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

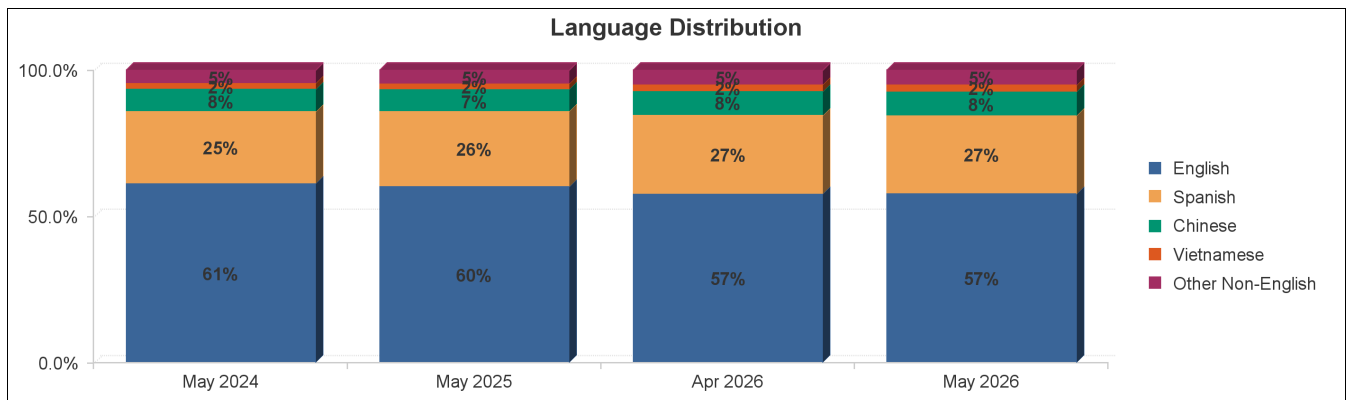
Age Category Trend

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



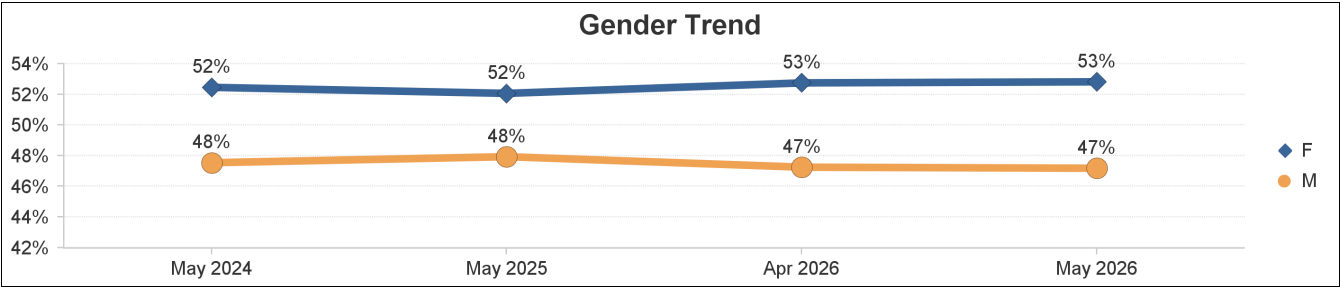
Language Trend

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

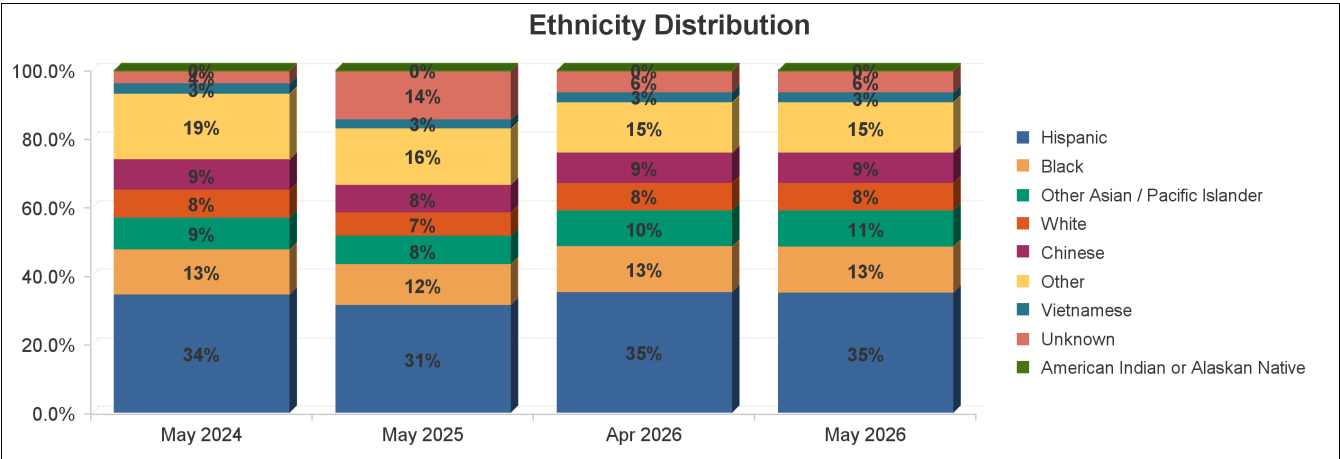


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

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



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



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

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

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

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

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

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

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

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



Operations

Beau Hennemann

To: Alameda Alliance for Health Board of Governors

From: Operations Department

Date: July 10th, 2026

Subject: Operations Report

Member Services

- 12-Month Trend Blended Summary:
 - The Member Services Department received 17,771 calls in June 2026 compared to 16,253 in June 2025 and represents a 9% increase in calls.
 - The abandonment rate for June 2026 was 2% compared to 4% in June 2025.
 - The Department's service level was 97% in June 2026, compared to 95% in June 2025. The average speed to answer (ASA) was eight seconds (00:08) in June 2026, compared to eleven seconds (00:11) in June 2025. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
 - The average talk time (ATT) was seven minutes and thirty-four seconds (7:34) for June 2026 compared to seven minutes and fifty seconds (7:50) for June 2025.
 - 100% of calls were answered within 10 minutes for June 2026 and 100% of calls were answered within 10 minutes for June 2025.
 - Outbound calls totaled 10,295 in June 2026 compared to 8,515 in June 2025.
 - The top five (5) call reasons for June 2026 were 1) Eligibility/Enrollment, 2) Change of PCP, 3) Grievances/Appeal, 4) Benefits, and 5) Provider Network Information. The top five (5) call reasons for June 2025 were: 1) Eligibility/Enrollment, 2) Change of PCP, 3) Grievances/Appeals, 4) Benefits, and 5) Provider Network Information.
 - June 2026 utilization of the member automated eligibility IVR system totaled 1,348 compared to 1,225 in June 2025.
 - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests, and in-person). The Department responded to 796 web-based requests in June 2026 compared to 1,300 in June 2025. The top three (3) web reason requests for June 2026 were: 1) Change of PCP, 2) ID Card Requests, and 3) Update Contact Information. 57 members were assisted in-person in June 2026 compared to 62 in June 2025.

- MS Behavioral Health:
 - The Member Services Behavioral Health (MS BH) Unit received a total of 964 calls in June 2026 compared to 1,037 in June 2025.
 - The abandonment rate was 2% in June 2026 compared to 7% in June 2025.
 - The service level was 93% in June 2026 and 81% in June 2025.
 - The average speed to answer (ASA) was eighteen seconds (00:18) compared to forty seconds (00:40) in June 2025.
 - In June 2026, 100% of calls were answered within 10 minutes, compared to 99% in June 2025.
 - The Average Talk Time (ATT) was nine minutes and thirty-two seconds (9:32) compared to nine minutes and eight seconds (09:08) in June 2025. The MS BH Team utilizes the DHCS age-appropriate screening tools for Medi-Cal Mental Health Services to determine the appropriate delivery system for members who are not currently receiving mental health services when they contact the plan.
 - 1,858 outbound calls were completed in June 2026 compared to 991 in June 2025.
 - 111 screenings were completed in June 2026 compared to 111 in June 2025.
 - 19 referrals were made to the County (ACCESS) in June 2026 compared to 29 June 2025.
 - 18 members were referred to Center Point for SUD services in June 2026 compared to 15 in June 2025.

- D-SNP Member Services blended:
 - The Member Services D-SNP Unit received a total of 566 calls in June 2026.
 - The abandonment rate was 2%.
 - The Average Speed to Answer (ASA) was eight seconds (00:08).
 - The service level was 100%.
 - The Average Talk Time (ATT) was seven minutes and thirty-nine seconds (7:39).
 - The top five (5) call reasons were: 1) Appeals/Grievances, 2) Benefits, 3) Eligibility/Enrollment, 4) Provider Network Info, and 5) Change of PCP.

Claims

- 12-Month Trend Summary:
 - The Claims Department received 372,767 claims for all lines of business in June 2026 compared to 340,224 in June 2025.
 - The Auto Adjudication rate was 87.5% in June 2026 compared to 88.1% in June 2025.
 - Claims compliance for the 30-day turn-around time was 95.3% in June 2026 compared to 91.3% in June 2025.
 - Routine training is being conducted remotely and onsite by the Claims Trainer.
- Medi-Cal/Group Care Monthly Analysis:
 - In June, we received a total of 371,893 claims in the HEALTHsuite system, which represents a decrease of 25.6% from May 2026. It is also 10% higher than the number of claims received in June 2025 (340,224).
 - 90% of claims were received via EDI, and 9.6% of claims via paper during June.
 - The Auto Adjudication rate was 87.5% for June.
- D-SNP Monthly Analysis:
 - In June, we received a total of 874 claims in the HEALTHsuite system, which represents a 25% decrease from May 2026, when 1,096 claims were received.
 - 575 claims (66%) were received via EDI, and 299 claims (34%) were received via paper in June.
 - Out of 874 claims, 432 claims have been finalized.
 - The Auto Adjudication rate was 46% for June.
- D-SNP YTD Analysis
 - A total of 4,248 D-SNP claims have been received since the January 1st, 2026, go live, and 3,790 claims have been finalized.

Provider Dispute Resolution

- 12-Month Trend Summary:
 - In June 2026, the Provider Dispute Resolution (PDR) team received 2,800 PDRs versus 3,843 in June 2025.
 - The PDR team resolved 2,147 cases in June 2026 compared to 2,634 cases in June 2025.
 - In June 2026, the PDR team upheld 76% of cases versus 83% in June 2025.

- The PDR team resolved 98.3% of cases within the compliance standard of 95% within 45 working days in June 2026, compared to 99.6% in June 2025.
- In June 2026, the Provider Dispute Resolution (PDR) team received 2,800 PDRs versus 2,648 in May 2026. This represents a 6% Increase from May 2026.
- In June 2026, 2,147 PDRs were resolved, with 1,625 upheld and 522 overturned.
- 2,111 of 2,147 cases were resolved within 45 working days, resulting in a 98.3% compliance rate.
- The average turnaround time for resolving PDRs in June was 37 days.
- There were 4,197 PDRs pending resolution as of 06/30/2026, with no cases older than 45 working days.
- The overturn rate for PDRs was 24%, which did meet our goal of 25% or less.

Grievances & Appeals (MCAL & IHSS)

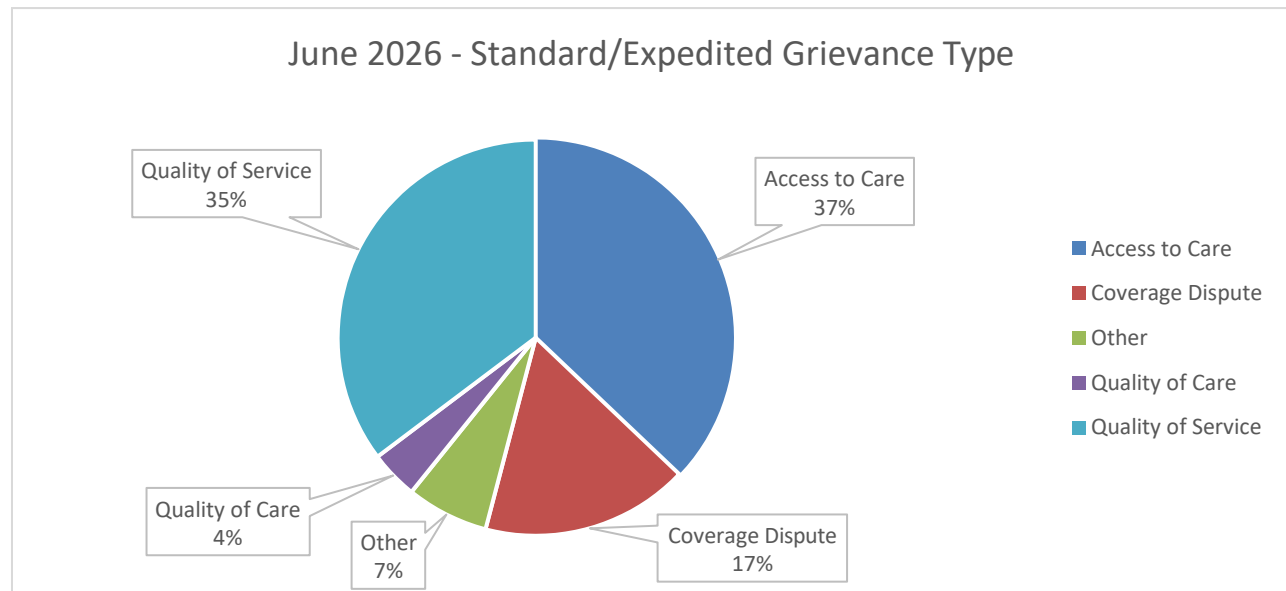
- Standard Grievance cases were not resolved within the goal of 95% of regulatory timeframes.
- Exempt Grievance and Expedited Grievance cases were resolved within the goal of 95% of regulatory timeframes.
- Standard Appeal and Expedited Appeal cases were resolved within the goal of 95% of regulatory timeframes.
- Total Unique grievances resolved in June were 10 complaints per 1,000 members.

June 2026 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,607	30 Calendar Days	95% compliance within standard	2,340	89.8%	5.91
Expedited Grievance	2	72 Hours	95% compliance within standard	2	100.0%	0.00
Exempt Grievance	1,716	Next Business Day	95% compliance within standard	1,714	99.9%	4.10
Standard Appeal	80	30 Calendar Days	95% compliance within standard	79	98.8%	0.21
Expedited Appeal	2	72 Hours	95% compliance within standard	2	100.0%	0.00
Total Cases:	4,407		95% compliance within standard	4,137	93.9%	10.0

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

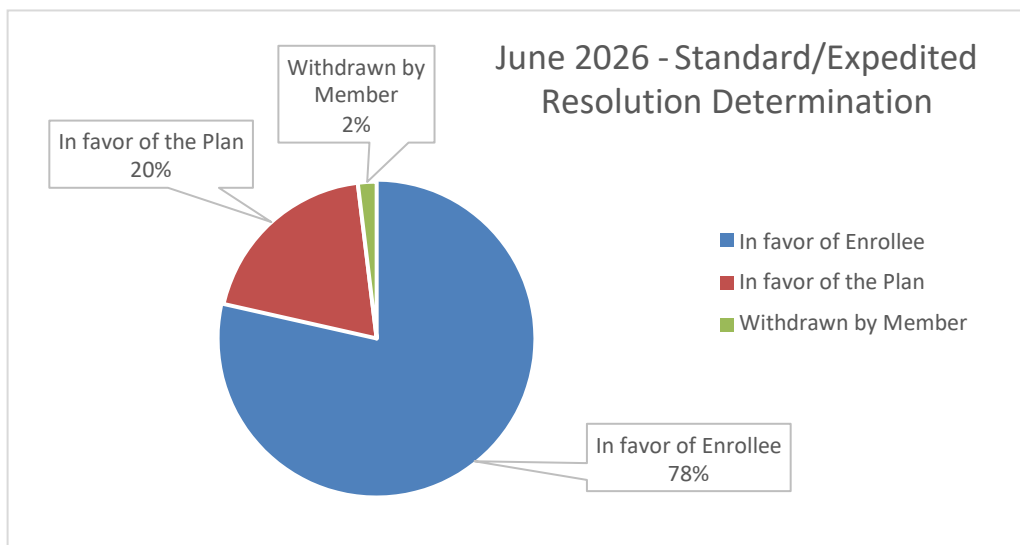
Standard/Expedited Grievances:

There were 2,185 unique grievance cases resolved during the reporting period, with a total of 2,609 grievances including 423 shadow cases.



- **968** of 2,609 (37%) cases were related to Access to Care; the following are the top four (4) categories:
 - Technology/telephone – 283
 - Timely Access – 263
 - Authorization – 177
 - Provider Availability – 103
- **920** of 2,609 (35%) cases were related to Quality of Service; the following are the top four (4) categories:
 - Plan Customer Service – 240
 - Provider / Staff Attitude – 173
 - Authorization – 168
 - Referral – 113
- **443** of 2,609 (17%) cases were related to Coverage Dispute; the following are the top two (2) categories:
 - Provider Balance Billing – 218
 - Provider Direct Member Billing – 142
- **175** of 2,609 (7%) cases were related to Other; the following are the top two (2) categories:
 - Enrollment – 108
 - Eligibility – 58
- **103** of 2,609 (4%) cases were related to Quality of Care; the top category was:
 - Quality of Care – 90

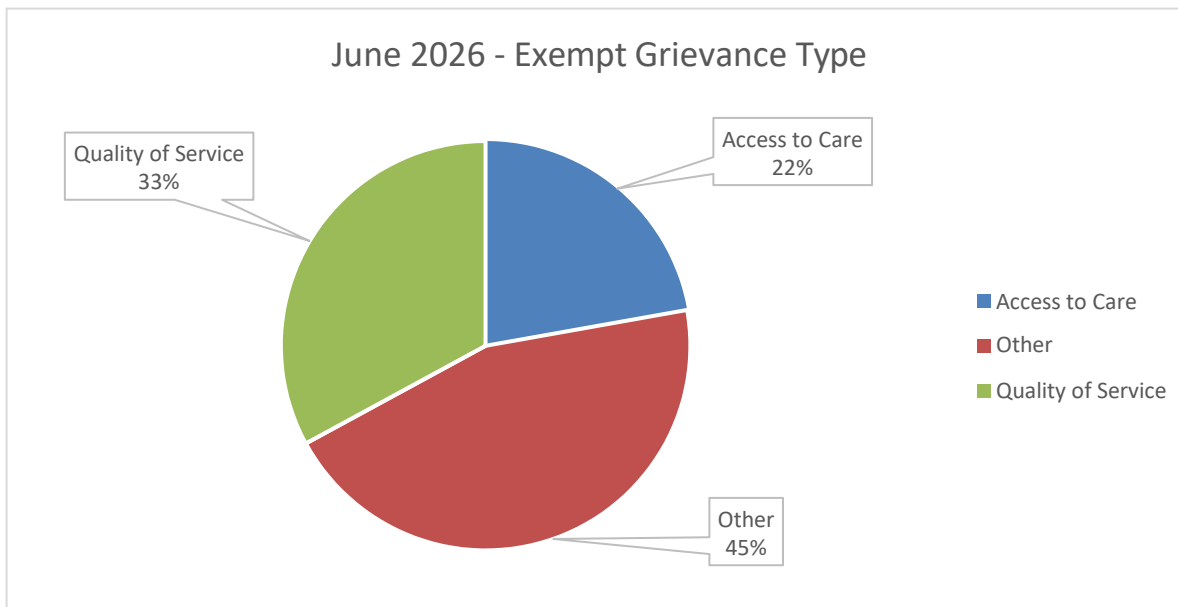
Resolution Determination:



- **2,049** of 2,609 (78%) cases were resolved In Favor of Enrollee
- **510** of 2,609 (20%) cases were resolved In Favor of the Plan
- **50** of 2,609 (2%) cases were Withdrawn by Member

Exempt Grievances:

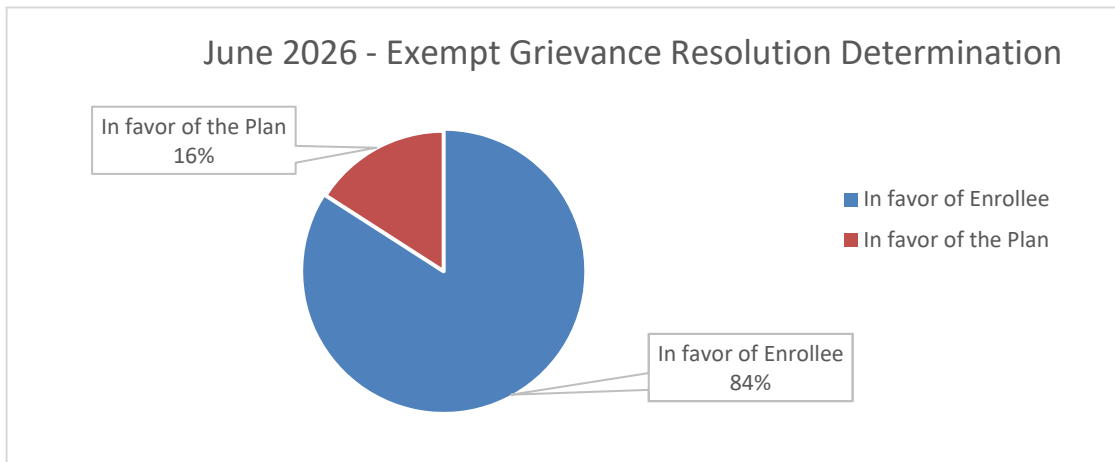
There were 1,514 unique exempt grievance cases resolved during the reporting period, with a total of 1,716 exempt grievances including 202 shadow cases.



- **770** of 1,716 (45%) cases were related to Other; the following are the top two (2) categories:
 - Enrollment – 720
 - Eligibility – 50

- **565** of 1,716 (33%) cases were related to Quality of Service; the following are the top two (2) categories:
 - Plan Customer Service – 328
 - Provider/Staff Attitude – 195
- **381** of 1,716 (22%) cases were related to Access to Care; the following are the top two (2) categories:
 - Provider Availability – 142
 - Technology / Telephone – 117

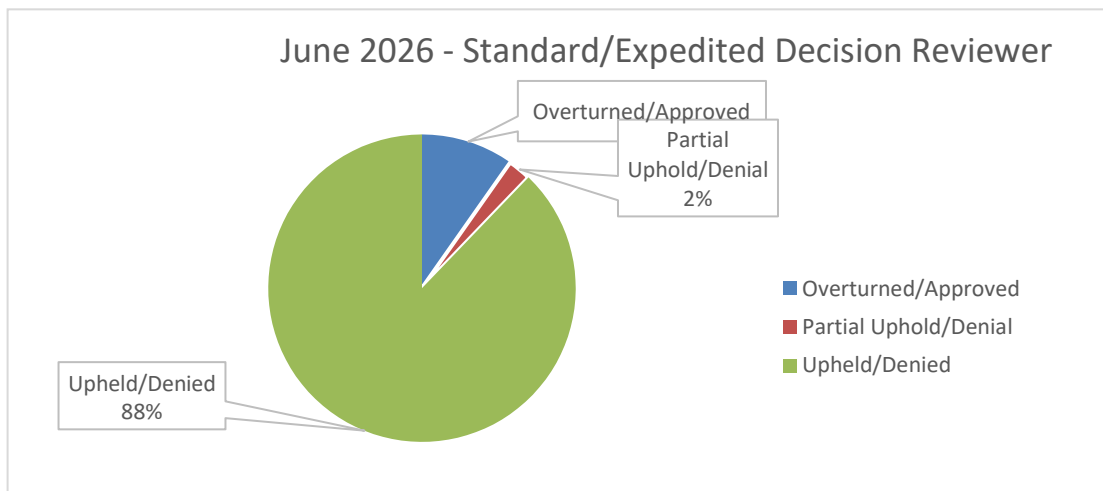
Resolution Determination:



- **1,443** of 1,716 (84%) cases were resolved In Favor of Enrollee
- **273** of 1,716 (16%) cases were resolved In Favor of the Plan

Appeals:

The Alliance's goal is to have an overturn rate of less than 25%; for the reporting period of June 2026, we met our goal with a 10% overturn/approved rate.



- **72** out of 82 (88%) cases had an upheld/denied decision for the month of June 2026:
 - Disputes Involving Medical Necessity – 57
 - Out of Network – 15
- **8** out of 82 (10%) cases had an overturn/approved decision for the month of June 2026:
 - Disputes Involving Medical Necessity – 8
- **2** out of 82 (2%) cases had a partial uphold/denial decision for the month of June 2026:
 - Disputes Involving Medical Necessity – 2

D-S NP Grievances & Appeals (Resolved)

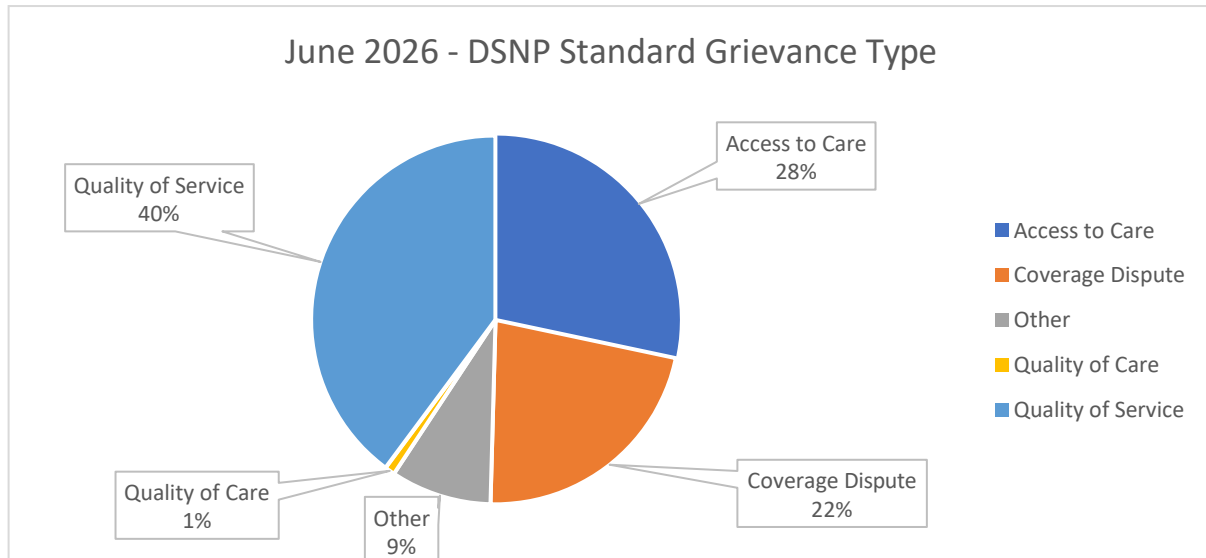
- Standard Grievance and First Call Resolution cases were resolved within the goal of 95% of regulatory timeframes.
- There were no Expedited Grievance cases filed in June 2026.
- There were no Standard or Expedited Appeal cases filed in June 2026.

June 2026 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate
Standard Grievance	113	30 Calendar Days	95% compliance within standard	113	100.0%
Expedited Grievance	0	72 Hours	95% compliance within standard	0	N/A
First Call Resolution	24	Next Business Day	95% compliance within standard	24	100.0%
Standard Appeal	0	30 Calendar Days	95% compliance within standard	0	N/A
Expedited Appeal	0	72 Hours	95% compliance within standard	0	N/A
Total Cases:	137		95% compliance within standard	137	100.0%

*Per 1,000 not calculated for DSNP because enrollment is below 1000.

Standard Grievances:

There were 66 unique grievance cases resolved during the reporting period, with a total of 113 grievances including 47 shadow cases.

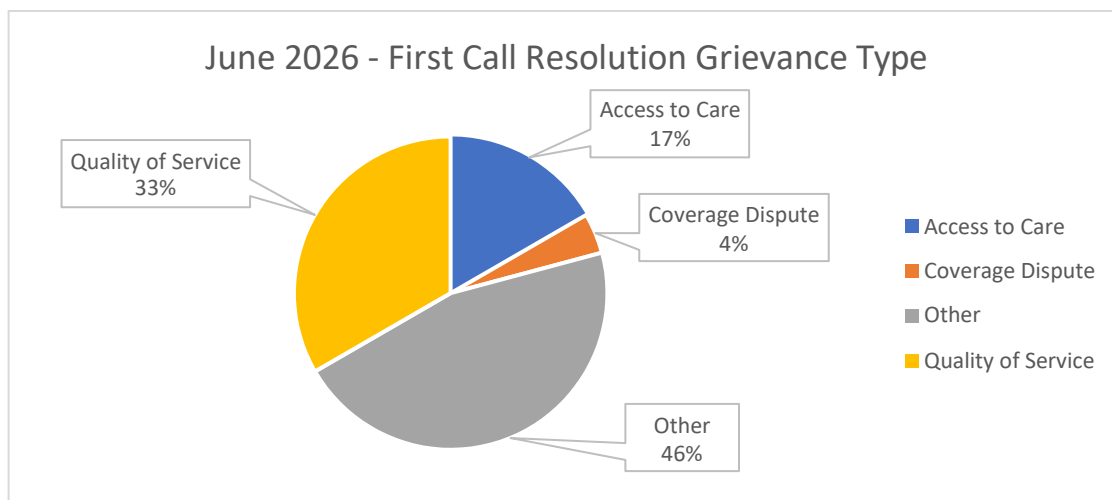


- **45** of 113 (40%) cases were related to Quality of Service; the categories are:
 - Referral – 17
 - Authorization – 7
 - Plan Customer Service – 7
 - Member Services – 5
 - Nations – 2
 - Case Management/Care Coordination – 5
 - Provider/Staff Attitude – 4
 - Member Informing Materials – 3
 - Transportation – 2
- **32** of 113 (28%) cases were related to Access to Care; the categories are:
 - Authorization – 14
 - Technology/Telephone – 9
 - Timely Access – 5
 - Out-of-Network – 2
 - Language Access – 1
 - Provider Availability – 1
- **25** of 113 (22%) cases were related to Coverage Dispute; the categories are:
 - Provider Direct Member Billing – 9
 - Provider Balance Billing – 8
 - Benefit – 5
 - Reimbursement – 3

- 10 of 113 (9%) cases were related to Other; the categories are:
 - Enrollment – 8
 - Eligibility – 2
- 1 of 113 (1%) case was related to Quality of Care; the category is:
 - Quality of Care – 1

First Call Resolution (FCR) Grievances:

There were 18 unique exempt grievance cases resolved during the reporting period, with a total of 24 cases, including 6 shadow cases



- **11 of 24 (46%)** cases were related to Other; the categories are:
 - Enrollment – 10
 - Eligibility – 1
- **8 of 24 (33%)** cases were related to Quality of Service; the categories are:
 - Authorization – 4
 - Provider/Staff Attitude – 2
 - Plan Customer Service:
 - Case Management – 2
- **4 of 24 (17%)** cases were related to Access to Care; the categories are:
 - Timely Access – 2
 - Geographic Access – 1
 - Out-of-Network – 1
- **1 of 24 (4%)** cases were related to Coverage Dispute; the category is:
 - Provider Direct Member Billing – 1

Appeals:

- There were no appeals filed in the month of June 2026.

Complaint Tracking Module Information:

- There were no CTMs filed in the month of June 2026.

Provider Services

- 12-Month Trend Summary:
 - The Provider Services department's call volume in June 2026 was 7,156 calls (5,918 Medi-Cal/Group Care and 1,238 D-SNP) compared to 9,214 calls in June 2025.
- Monthly Analysis:
 - The Provider Services department completed 397 calls/visits during June 2026.
 - The Provider Services department answered 5,867 calls (4,843 Medi-Cal/Group Care and 1,024 D-SNP) for June 2026 and made 334 outbound calls (285 Medi-Cal/IHSS and 49 D-SNP).
 - 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) meetings held on June 16th, 2026, there were one hundred and eighty-two (182) initial network providers approved.
 - Two (2) primary care providers
 - Five (5) specialists
 - 26 ancillary providers
 - Eight (8) midlevel providers
 - 141 behavioral health providers
 - 76 providers were re-credentialed at this meeting
 - Six (6) primary care providers
 - 15 specialists
 - Five (5) ancillary providers
 - 10 midlevel providers
 - 40 behavioral health providers
 - 431 facilities are currently credentialed

Community Relations and Outreach

- 12-Month Trend Summary and Quarterly Analysis:
 - In Q4 2026, the Alliance completed 1,927 member orientation outreach calls and 179 member orientations by phone compared to 2,777 member orientation outreach calls and 274 member orientations by phone in Q4 2025.
 - The C&O Department reached 32,876 people compared to approximately 2,282 people in Q4 2025.
 - The C&O Department spent a total of \$833.53 on donations, fees, and/or sponsorships, compared to \$520.00 in Q4 2025.
 - The C&O Department reached members in 17 cities/unincorporated areas throughout Alameda County, the Bay Area, and the U.S., compared to 21 locations in Q4 2025.
- Monthly Analysis:
 - In June 2026, the C&O Department completed 594 member orientation outreach calls, 54 new member orientations by phone, 10 non-utilizer member orientations by phone, and 25 Alliance website inquiries.
 - Among the 30,979 people reached during outreach activities, 2% identified as Alliance members.
 - In June 2026, the C&O Department reached members in 10 locations throughout Alameda County, the Bay Area, and the U.S.
 - Please see attached **Addendum A**.

Medicare Operations

Medicare Operations Division

- **D-SNP Upcoming Key Initiatives and Dates:**
 - CMS SMAC, Matrixes, & Attestation Submission – July 6th, 2026.
 - Rebate Allocation with CMS and Health Plan – July / August 2026.
 - Annual Enrollment Period (AEP) – October 15th through December 7th, 2026.
 - Open Enrollment Period (OEP) Begins – January 1st, 2027.
- **D-SNP Activities – June 2026**
 - Medicare Product Updates:
 - Dental – Liberty Dental
 - Member Materials & Compliance Language (Medi-Cal Dental) – Clarifying Medi-Cal Dental FFS vs. Dental Managed Care by incorporating county-specific rules and exceptions effective July 1st, 2026.

- Member Communications & Materials – Annual mandated member material communications have been approved.
- Vision – Vision Service Plan (VSP)
 - Ongoing VSP Operational Governance (Bi-Weekly Cadence) – Regular bi-weekly meetings are occurring with VSP covering Medical and D-SNP vision benefits. Vision operations are in a steady-state governance phase with consistent oversight and structured communication.
 - Member Communications & Materials – Annual mandated member material communications have been approved.
- Over the Counter (OTC) and Hearing – Nations Benefits
 - Ongoing Nations Operational Governance (Bi-Weekly Cadence) – Regular bi-weekly meetings are occurring with Nations covering OTC benefits and rewards/incentives. Operations are in a steady-state governance phase with consistent oversight and structured communication.
 - Encounter / File Processing & Testing – Production file readiness and data exchange processes are in progress.
 - Member Communications & Materials – Annual mandated member material communications have been approved.
- Medicare Online Enrollment Center (OEC):
 - Continued discussions to evaluate the feasibility and timeline of implementing the Medicare OEC functionality so that prospective members can enroll in Alameda Alliance Wellness (D-SNP) via medicare.gov.
- Medicare Reporting Project:
 - Completed a review of CMS and State of California reporting requirements, including applicable regulations, submission timelines, and required metrics. Partnered with stakeholders to identify existing reporting and identify needs and gaps. In the process of submitting requests for the development of required reports to support ongoing compliance and regulatory reporting obligations.
- 2027 Medicare Bid Submission:
 - Completed CMS bid submission (June 1st) - All major workstreams (Product, Actuarial, PBM, Compliance, and Vendor teams) aligned to meet the submission deadline with weekly bid workgroup governance ensuring coordination, issue resolution, and timeline adherence.
 - 2027 benefit design was finalized. These decisions reflect a balance between member affordability, market competitiveness, and financial sustainability.
 - Senior Leadership Team (SLT) approval was received before submission. This represented the final governance checkpoint to confirm alignment on strategy, financial assumptions, and benefit design before submission to CMS.

- State Medicaid Agency Contract (SMAC) has been fully executed by Alliance CEO and the State of California. Collaborated with Legal and Compliance on filling out the Matrixes and attestation associated with the SMAC. On track for successful completion on Monday, July 6th.
- Medicare Projects:
 - Work to implement new Pharmacy Benefit Manager (PBM), MedImpact, is in progress.
 - CHCN delegation project charter has been approved by AAH leadership and is currently under CHCN review. Currently working on delegation agreement and Delegation of Financial Responsibility DOFR).
- Medicare Sales & Retention Updates:
 - Staffing Updates:
 - Interview process ongoing for 2nd Medicare Field Sales and Community Agent.
 - Continued interviews for 3rd Medicare Field Sales and Community Agent.
 - Approval received for three (3) additional licensed Medicare Field Sales and Community Agents.
 - Sales/IT Enhancements and Projects:
 - Phone tree enhancement in process and targeting early July for implementation.
 - Sales IVR verbiage finalized and targeting early July for implementation.
 - Four (4) new CHCN lead list files successfully uploaded into Cirrus.
 - Continued development of Cirrus CRM Sales Tool reporting dashboards for enrollment and retention data.
 - Translation of all sale scripts in threshold languages completed.
 - New PCP assignment process implemented during D-SNP enrollment initiated.
 - Individual D-SNP Sales queues created within Finesse for improved prospective member experience.
 - Data field requirements completed for PowerBI Dashboard (enrollment/disenrollment and retention).
 - Policies and SOPs:
 - FQHC on-site visit SOP finalized.
 - Sales disciplinary policy updated.
- Medicare Marketing, Communications, & Branding Updates:
 - Marketing Vendor Assessment & Selection:
 - Completed evaluation of vendor proposals and selected a vendor to lead go-to-market strategy and execution.
 - Contracting (SOW/MSA) in progress and onboarding on track for July implementation.
 - Enrollment and Onboarding Experience Improvement:

- Enhancing enrollment kits and welcome materials to improve member experience and align with CY2027 plan year requirements.
- Materials on track for AEP launch (10/1/2026), supporting compliance, clarity, and improved onboarding.
- D-SNP Centralized Website:
 - All content and page language completed and currently under C&O review.
 - Upcoming milestones include building and deploying to test environment, followed by Marketing QC in preparation for phased launches:
 - 8/10/2026: Shopping/Enrollment page
 - 10/1/2026: Member Resource pages and AEP cycle content
 - 1/1/2027: Removal of CY2026 plan year content
- FQHC Clinic Branding:
 - Clinic branding work is underway to refine our visual identity, messaging, and patient facing experience.
 - Developing D-SNP branded materials and promotional assets for in-clinic sales.
 - Partnering with Alameda Health Consortium (AHC) for ongoing alignment on priorities, timelines, and deliverables for the co-branding campaign.
- D-SNP Organizational Training:
 - Assessing enterprise training needs to inform 2026 learning strategy.
 - Engaging external consultants and internal content owners to update and develop training materials.
- Unplanned Regulator Required Notices:
 - Ongoing monitoring and communication of regulatory updates impacting members and benefits.
 - Medi-Cal Dental Changes (Effective July 1st, 2026):
 - Member notice completed, approved, and submitted – distribution on track for regulatory mailing delivery 7/1/2026 deadline.
 - Integrated materials (EOC, SOB, Provider Directory) submitted by the 6/5/2026 regulatory deadline; pending approval, updated documents will be published on the public Medicare website.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	June 2026
Incoming Calls (R/V)	17,771
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	17,373
Average Speed to Answer (ASA)	00:08
Calls Answered in 30 Seconds (R/V)	97%
Average Talk Time (ATT)	07:34
Calls Answered in 10 minutes	100%
Outbound Calls	10,295

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

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

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

Change PCP
ID Card Requests
Update Contact Information

Member Services Behavioral Health	June 2026
Incoming Calls (R/V)	964
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	949
Average Speed to Answer (ASA)	00:18
Calls Answered in 30 Seconds (R/V)	93%
Average Talk Time (ATT)	09:32
Calls Answered in 10 minutes	100%
Outbound Calls	1,858
Screenings Completed	111
ACBH Referrals	19
SUD referrals to Center Point	18

Blended Call Results

D-SNP Blended Results	June 2026
Incoming Calls (R/V)	566
Abandoned Rate (R/V)	2%
Answered Calls (R/V)	554
Average Speed to Answer (ASA)	00:07
Calls Answered in 30 Seconds (R/V)	99%
Average Talk Time (ATT)	06:58
Calls Answered in 2 minutes	100%

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

Claims Processing May 2026 and June 2026

METRICS

Claims Compliance	May-26	Jun-26
90% of clean claims processed within 30 calendar days	96.4%	95.3%
Claims Volume (Received)	May-26	Jun-26
Paper claims	46,760	37,946
EDI claims	421,600	334,821
Claim Volume Total	468,360	372,767
	(includes D-SNP)	(includes D-SNP)
Percentage of Claims Volume by Submission Method	May-26	Jun-26
% Paper	10.0%	10.2%
% EDI	90.0%	89.8%
Claims Processed	May-26	Jun-26
HEALTHsuite Paid (original claims)	271,175	245,200
HEALTHsuite Denied (original claims)	98,814	98,102
HEALTHsuite Original Claims Sub-Total	369,989	343,302
HEALTHsuite Adjustments	22,021	3,424
HEALTHsuite Total	392,010	346,726
Claims Expense	May-26	Jun-26
Medical Claims Paid	\$153,904,105	\$144,907,848
Interest Paid	\$218,482	\$266,104
Auto Adjudication	May-26	Jun-26
Claims Auto Adjudicated	324,577	300,288
% Auto Adjudicated	87.7%	87.5%
Average Days from Receipt to Payment	May-26	Jun-26
HEALTHsuite	13	13
Pended Claim Age	May-26	Jun-26
0-30 calendar days	38,172	42,647
HEALTHsuite		
31-62 calendar days	2,291	1,718
HEALTHsuite		
Over 63 calendar days	4	4
HEALTHsuite		
Overall Denial Rate	May-26	Jun-26
Claims denied in HEALTHsuite	98,814	98,102
% Denied	25.2%	28.3%

Claims Processing May 2026 and June 2026

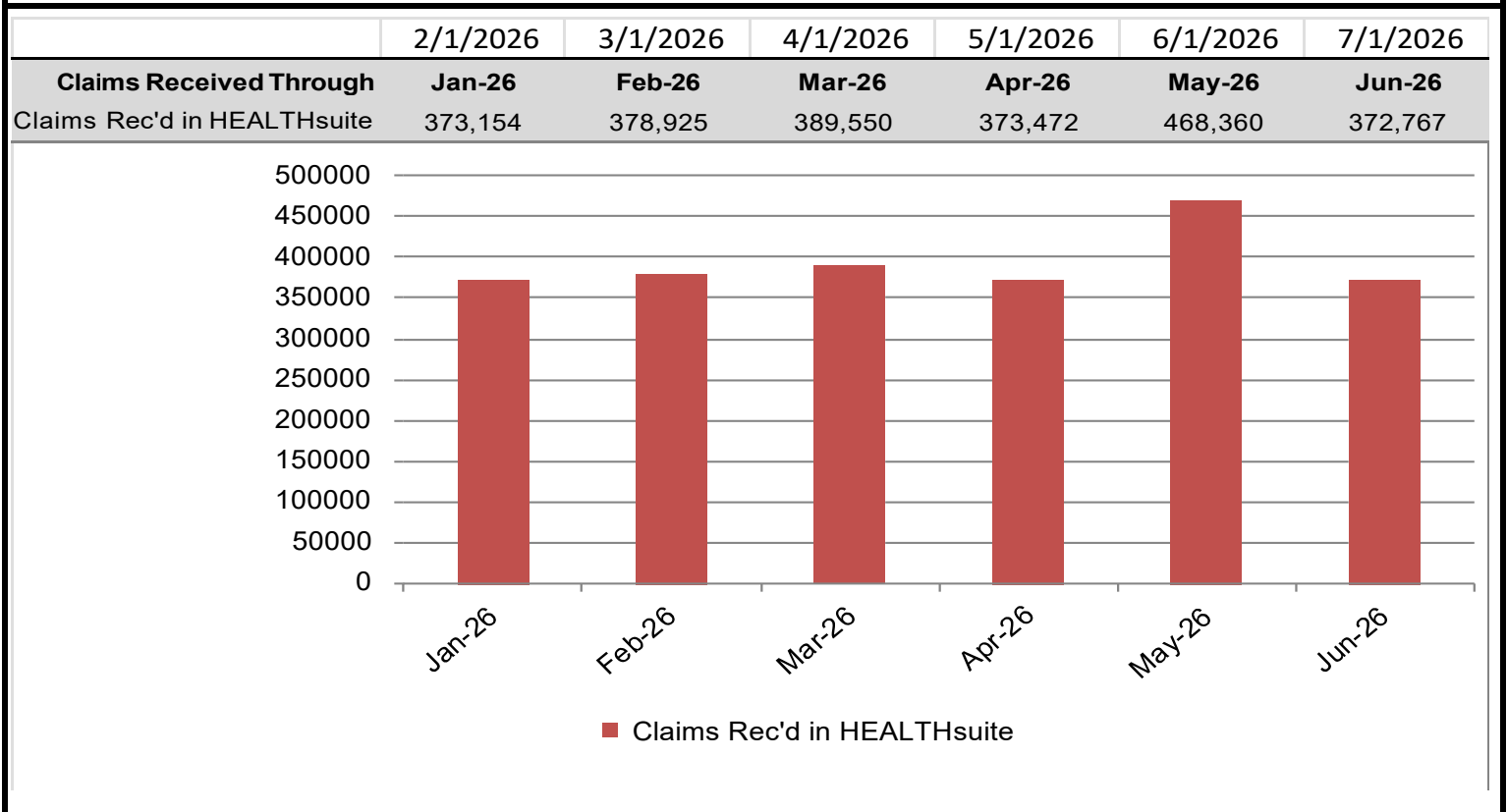
Jun-26

Top 5 HEALTHsuite Denial Reasons

% of all denials

Responsibility of Provider	19%
No Benefits Found For Dates Of Service	15%
Non-Covered Benefit For This Plan	13%
Must Submit Paper Claim With Copy of Primary Payor EOB	11%
Duplicate Claim	7%
% Total of all denials	65%

Claims Received By Month



Claims Year Over Year Summary		
Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing June 2026 to June 2025 as follows: 30 Days - 95.3% (2026) vs 91.3% (2025)	* 95% of clean claims in 30 calendar days (effective 1/1/2026) <i>(interest is required on any claim paid after 30 calendar days)</i>	* 95% of clean claims in 30 calendar days (effective 1/1/2026) * 99% of all claims in 90 calendar days <i>(interest is required on any claim paid after 30 calendar days)</i>
Claims Received - AAH received 372,767 claims for all lines of business in June 2026 vs 340,224 in June 2025	N/A	N/A
EDI - the volume of EDI submissions was ~90% which is slightly above the normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 343,302 in June 2026 (22 working days) vs 309,088 in June 2025 (20 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in June 2026 was \$144,907,848 (4 check runs) vs \$136,772,939 in June 2025 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in June 2026 was \$266,104 vs \$338,827 in June 2025	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in June 2026 was 87.5% vs 88.1% in June 2025	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in June 2026 was 13 days vs 17 days in June 2025	N/A	<= 25 days
Pended Claim Age - comparing June 2026 to June 2025 as follows: 0-30 calendar days - 42,647 (2026) vs 44,872 (2025) 31-62 calendar days - 1,718 (2026) vs 37,936 (2025) Over 63 calendar days - 4 (2026) vs 65,511 (2025)	N/A	N/A
Top 5 Denial Reasons - the claim denial reasons remain consistent from month to month so there is no significant changes to report from June 2026 to June 2025	N/A	N/A

Provider Dispute Resolution

May 2026 and June 2026

METRICS

PDR Compliance	May-26	Jun-26
# of PDRs Resolved	2,131	2,147
# Resolved Within 45 Working Days	2,106	2,111
% of PDRs Resolved Within 45 Working Days	98.8%	98.3%
PDRs Received	May-26	Jun-26
# of PDRs Received	2,648	2,800
PDR Volume Total	2,648	2,800
PDRs Resolved	May-26	Jun-26
# of PDRs Upheld	1,520	1,625
% of PDRs Upheld	71%	76%
# of PDRs Overturned	611	522
% of PDRs Overturned	29%	24%
Total # of PDRs Resolved	2,245	2,147
Average Turnaround Time	May-26	Jun-26
Average # of Days to Resolve PDRs	39	37
Oldest Resolved PDR in Days	171	307
Unresolved PDR Age	May-26	Jun-26
0-45 Working Days	4,242	4,197
Over 45 Working Days	0	0
Total # of Unresolved PDRs	4,242	4,197

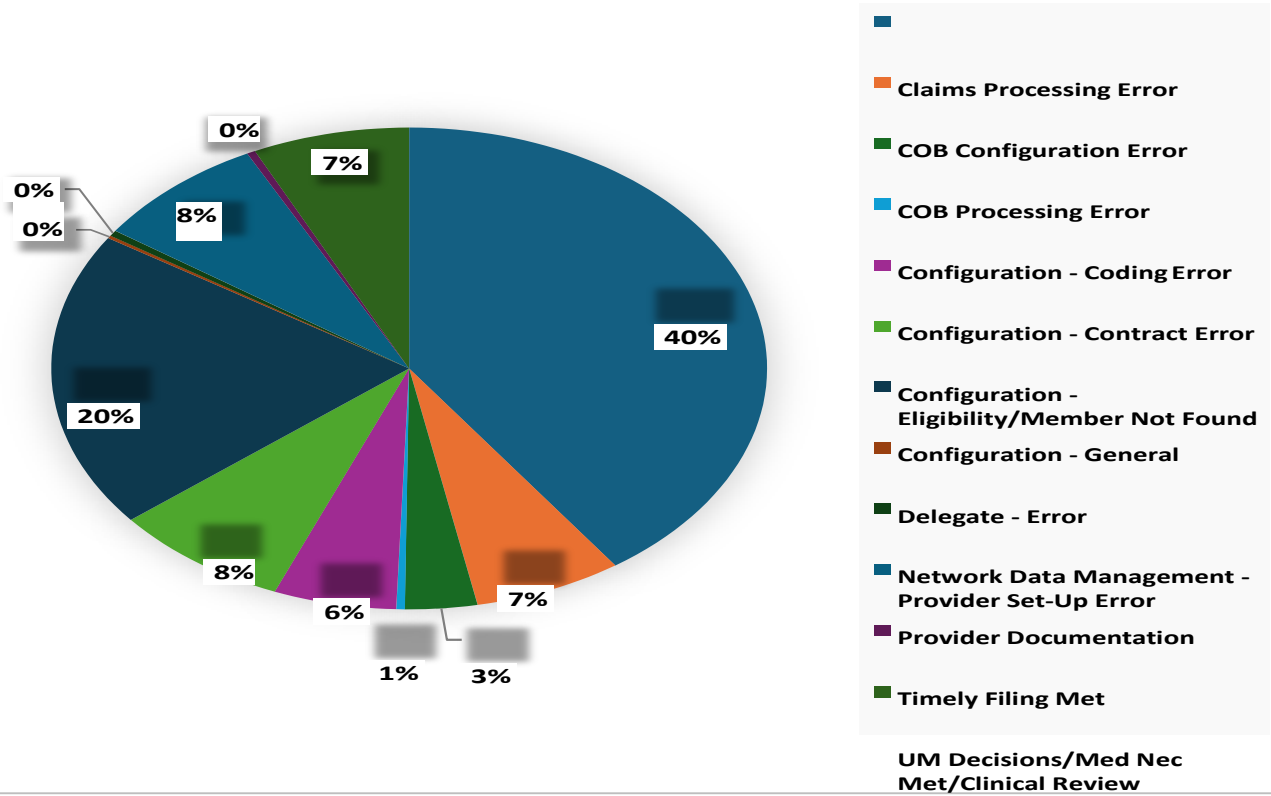
Provider Dispute Resolution

May 2026 and June 2026

Jun-26

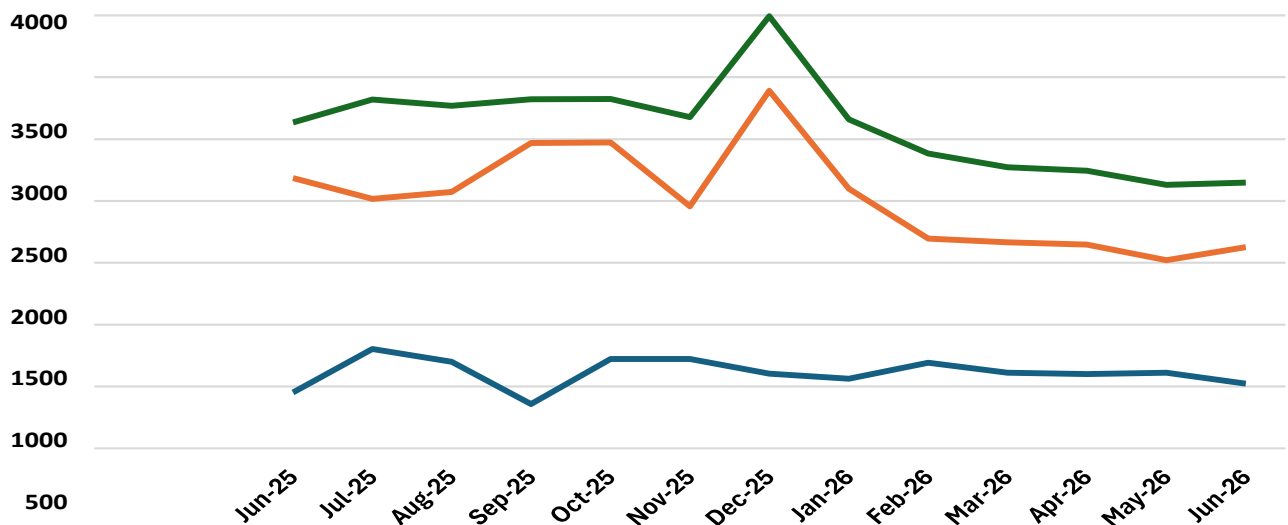
PDR Resolved Case Overturn Reasons

June 2026



Rolling 12-Month PDR Trend Line

June 2026



Provider Dispute Resolution Year Over Year Summary		
Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Resolved - 2,147 in June 2026 vs 2,634 in June 2025	N/A	N/A
# of PDRs Received - 2,800 in June 2026 vs 3,843 in June 2025	N/A	N/A
# of PDRs Resolved within 45 working days - 2,111 in June 2026 vs 2,626 in June 2025	N/A	N/A
% of PDRs Resolved within 45 working days - 98.3% in June 2026 vs 99.6% in June 2025	95%	95%
Average # of Days to Resolve PDRs - 37 days in June 2026 vs 38 days in June 2025	N/A	30
Oldest Resolved PDR in Days - 307 days in June 2026 vs 370 days in June 2025	N/A	N/A
# of PDRs Upheld - 1,625 in June 2026 vs 2,183 in June 2025	N/A	N/A
% of PDRs Upheld - 76% in June 2026 vs 83% in June 2025	N/A	> 75%
# of PDRs Overturned - 522 in June 2026 vs 451 in June 2025	N/A	N/A
% of PDRs Overturned - 24% in June 2026 vs 17% in June 2025	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 40% (2026) vs 54% (2025) Configuration errors - 35% (2026) vs 30% (2025) COB - 10% (2026) vs 5% (2025) Clinical Review/UM Decisions/Medical Necessity Met - 15% (2026) vs 11% (2025)	N/A	N/A

Provider Relations Call Center Dashboard

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

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

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

Provider Relations Call Reasons & Field Visits Dashboard

D-SNP Call Reasons

Category	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
D-SNP Authorizations	3%	1%	2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Benefits	4%	3%	5%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Claims	59%	53%	55%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Eligibility	18%	27%	20%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Enrollment	1%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP PCP Assignment	4%	8%	9%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP PDR/Reconsideration	8%	3%	2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Check Tracer	1%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Provider Portal	1%	2%	2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Contracts / Credentialing	1%	1%	4%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Interpreter Request	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Member Call	1%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Transportation Services	1%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Provider Information Updates / W9	0%	0%	2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
D-SNP Pharmacy	0%	0%	0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL	100%	100%	100.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Medi-cal and Group Care Call Reasons

Category	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	6%	6.1%	5.2%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Benefits	5%	4.1%	3.7%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Claims Inquiry	39%	41.9%	42.3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Change of PCP	3%	2.2%	2.4%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Check Tracer	1%	0.9%	0.7%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Complaint/Grievance (includes PDRs)	10%	12.2%	12.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Contracts/Credentialing	0.7%	0.6%	1.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Demographic Change	0.1%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Disconnected Calls	4.7%	4.9%	4.6%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Eligibility	19.6%	17.7%	18.3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Exempt Grievance/ G&A	2.3%	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Intepreter Services Request	0.5%	0.4%	0.4%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Provider Portal Assistance	1.0%	3.1%	2.4%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Pharmacy	0.3%	0.1%	0.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Prop 56	0.0%	0.1%	0.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Provider Information Updates/ W9	1.0%	0.5%	0.5%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Transportation Services	0.1%	0.1%	0.3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
All Other Calls	5.1%	5.0%	6.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

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

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALIAED PRACTITIONERS - June 2026											
Practitioners		PCP 414	SPEC 792	AHP 898	BH/ABA 3,891	PCP/SPEC 12					
Direct Network vs Delegated Network Breakdown			AAH 4,675	AHS 296	CHCN 672	COMBINATION OF GROUPS 364					
Facilities	431										
VENDOR SUMMARY											
Credentialing Verification Organization, Symplyr CVO											
	Number	Average Calendar Days in Process	Goal - 25 Business Days*	Goal - 98% Accuracy	Compliant						
Initial Files in Process	62	5	Y	Y	Y						
Recred Files in Process	163	11	Y	Y	Y						
Expirables updated Insurance, License, DEA, Board Certifications					Y						
Files currently in process	225										
* 25 business days = 35 calendar days											
June 2026 Peer Review and Credentialing Committee Approvals											
Initial Credentialing	Number										
PCP	2										
SPEC	5										
ANCILLARY	26										
MIDLEVEL/AHP	8										
BH/ABA	141										
Sub-total	182										
Recredentialing											
PCP	6										
SPEC	15										
ANCILLARY	5										
MIDLEVEL/AHP	10										
BH/ABA	40										
Sub-total	76										
TOTAL	258										
June 2026 Facility Approvals											
Initial Credentialing	0										
Recredentialing	12										
Sub-total	12										
Facility Files in Process	45										
June 2026 Employee Metrics (6 FTEs)		Goal	Met (Y/N)								
File Processing	Timely processing within 3 days of receipt		Y								
Credentialing Accuracy	<3% error rate		Y								
DHCS, DMHC, CMS, NCQA Compliant	98%		Y								
MBC Monitoring	Timely processing within 3 days of receipt		Y								

LAST_NAME	FIRST_NAME	CATEGORY	INITIAL/RECRED	CRED_DATE
Abdullah	Kashif	Primary Care Physician	INTIAL	6/16/2026
Abodeely	Michelle	BH/ABA-Telehealth	INTIAL	6/16/2026
Adams	Amie	BH/ABA-Telehealth	INTIAL	6/16/2026
Aguilar Garcia	Anayancy	BH/ABA-Telehealth	INTIAL	6/16/2026
Alvarez Alvarado	Reina	Doula	INTIAL	6/16/2026
Amezcu	Eliseo	BH/ABA	INTIAL	6/16/2026
Arellano	Jan Patricia	BH/ABA-Telehealth	INTIAL	6/16/2026
Ariza	Marlene	Doula	INTIAL	6/16/2026
Armes	Amy	BH/ABA-Telehealth	INTIAL	6/16/2026
Barnes	Jasmine	BH/ABA-Telehealth	INTIAL	6/16/2026
Barney	Marysha	BH/ABA-Telehealth	INTIAL	6/16/2026
Barron	Lisette	BH/ABA-Telehealth	INTIAL	6/16/2026
Barton	Cierra	BH/ABA-Telehealth	INTIAL	6/16/2026
Becker	Jennifer	Doula	INTIAL	6/16/2026
Bellomo	Kimberly	BH/ABA-Telehealth	INTIAL	6/16/2026
Bhuta	Anuja	Doula	INTIAL	6/16/2026
Bigladeri	Jazmyne	BH/ABA	INTIAL	6/16/2026
Blanchard	Taylor	BH/ABA-Telehealth	INTIAL	6/16/2026
Blandino	Valerie	BH/ABA-Telehealth	INTIAL	6/16/2026
Bolanos	Jeralyn	BH/ABA-Telehealth	INTIAL	6/16/2026
Borovich	Lali	BH/ABA-Telehealth	INTIAL	6/16/2026
Bothwell	Alicia	BH/ABA-Telehealth	INTIAL	6/16/2026
Bradley	Gabriel	Allied Health	INTIAL	6/16/2026
Brown	Amber	BH/ABA-Telehealth	INTIAL	6/16/2026
Butcher	Stephen	BH/ABA-Telehealth	INTIAL	6/16/2026
Cabahug	Mariette	BH/ABA-Telehealth	INTIAL	6/16/2026
Camacho	Ana	BH/ABA-Telehealth	INTIAL	6/16/2026
Chacon	Ingrid	BH/ABA-Telehealth	INTIAL	6/16/2026
Chhabra	Rita	BH/ABA-Telehealth	INTIAL	6/16/2026
Compton	Lauren	BH/ABA-Telehealth	INTIAL	6/16/2026
Dagenhart	Marisa	BH/ABA-Telehealth	INTIAL	6/16/2026
Daniel	Sheila	Doula	INTIAL	6/16/2026
Dave	Kavina	Ancillary	INTIAL	6/16/2026
Davis	Jessie	BH/ABA-Telehealth	INTIAL	6/16/2026
Davis	Kandace	Doula	INTIAL	6/16/2026
Davison	Hilary	BH/ABA-Telehealth	INTIAL	6/16/2026
Desuacido	Aaron	BH/ABA	INTIAL	6/16/2026
DiPanni	Adam	BH/ABA-Telehealth	INTIAL	6/16/2026
Do	Lan	Allied Health	INTIAL	6/16/2026
Drew	Tara	BH/ABA-Telehealth	INTIAL	6/16/2026
Dwyer	Shannon	BH/ABA-Telehealth	INTIAL	6/16/2026
Ede	Theresa	BH/ABA-Telehealth	INTIAL	6/16/2026
Eife	Michaleen	BH/ABA-Telehealth	INTIAL	6/16/2026
Emami	Nadine	BH/ABA-Telehealth	INTIAL	6/16/2026
Escobar Garcia	Miranda Decire	Doula	INTIAL	6/16/2026
Espinoza	Christina	BH/ABA-Telehealth	INTIAL	6/16/2026
Felix	Dafina	BH/ABA-Telehealth	INTIAL	6/16/2026
Fletcher	Tyisha	BH/ABA-Telehealth	INTIAL	6/16/2026
Flores	Chrysteven	Doula	INTIAL	6/16/2026
Foreman	Grahame	BH/ABA	INTIAL	6/16/2026
Foydl	Andria	Doula	INTIAL	6/16/2026
Garcia	Daniela	BH/ABA-Telehealth	INTIAL	6/16/2026
Garcia	Teresa	BH/ABA-Telehealth	INTIAL	6/16/2026
Gardeen	Kelisha	BH/ABA	INTIAL	6/16/2026
Garrett	Emily	BH/ABA-Telehealth	INTIAL	6/16/2026

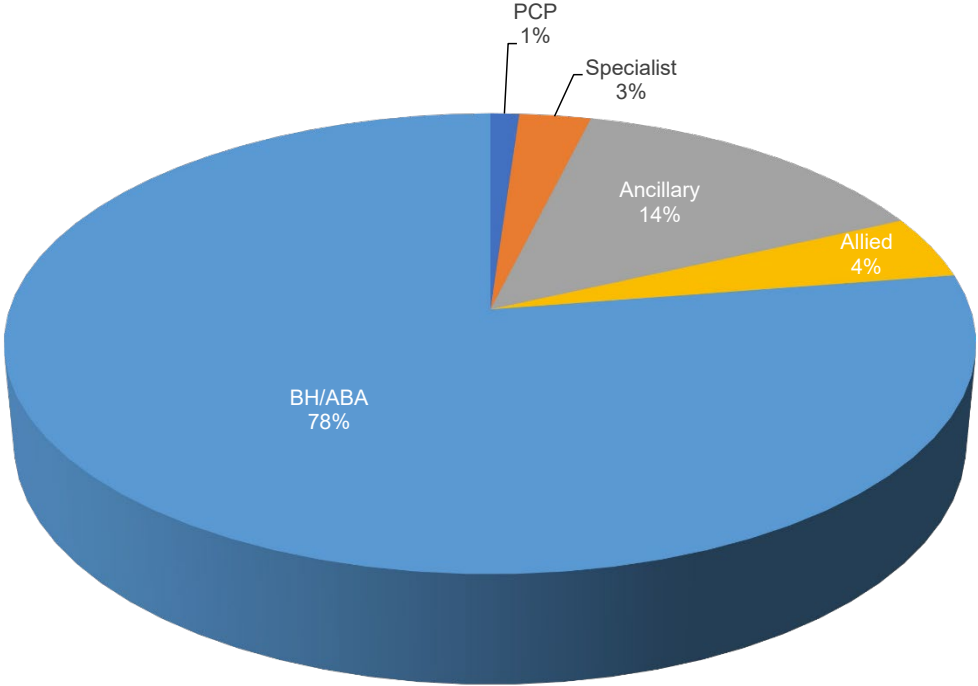
LAST_NAME	FIRST_NAME	CATEGORY	INITIAL/RECRED	CRED_DATE
Gibson	Antoinette	BH/ABA-Telehealth	INTIAL	6/16/2026
Givens	Sunny	BH/ABA-Telehealth	INTIAL	6/16/2026
Gomez	Monica	BH/ABA-Telehealth	INTIAL	6/16/2026
Gondara	Shabeg	BH/ABA	INTIAL	6/16/2026
Gonzalez	Jacquelyn	BH/ABA	INTIAL	6/16/2026
Gonzalez Avina	Nancy	BH/ABA-Telehealth	INTIAL	6/16/2026
Gozal	Sharenne	BH/ABA-Telehealth	INTIAL	6/16/2026
Greene	Sarah	BH/ABA-Telehealth	INTIAL	6/16/2026
Grintsvayg	Svetlana	BH/ABA-Telehealth	INTIAL	6/16/2026
Harvey	Tisha	BH/ABA	INTIAL	6/16/2026
Hedgpeth	Margaret	BH/ABA	INTIAL	6/16/2026
Hernandez Lopez	Gerardo	BH/ABA-Telehealth	INTIAL	6/16/2026
Ho	Vicky	BH/ABA-Telehealth	INTIAL	6/16/2026
Hollie	Michelle	Doula	INTIAL	6/16/2026
Holtzman	Annie	BH/ABA-Telehealth	INTIAL	6/16/2026
Hsu	Hui-Fen	Ancillary	INTIAL	6/16/2026
Huang	Crystal	BH/ABA-Telehealth	INTIAL	6/16/2026
Husband	Jessica	BH/ABA-Telehealth	INTIAL	6/16/2026
Jackson	Rachel	BH/ABA-Telehealth	INTIAL	6/16/2026
Jain	Seema	Primary Care Physician	INTIAL	6/16/2026
Jarahzadeh	Audrey	BH/ABA-Telehealth	INTIAL	6/16/2026
Jennings	Iyanna	Doula	INTIAL	6/16/2026
Jeronimo Mendoza	Belinda Araceli	Doula	INTIAL	6/16/2026
Johnson	Bridie	BH/ABA	INTIAL	6/16/2026
Jordan Taubenfeld	Nina	BH/ABA-Telehealth	INTIAL	6/16/2026
Kane	Steven	BH/ABA-Telehealth	INTIAL	6/16/2026
Kelly	Li	BH/ABA-Telehealth	INTIAL	6/16/2026
Kent	Dolores	Specialist	INTIAL	6/16/2026
Ko	Jenny	BH/ABA-Telehealth	INTIAL	6/16/2026
Krueger	Kristie	BH/ABA-Telehealth	INTIAL	6/16/2026
Kudalkar	Prajakta	Ancillary	INTIAL	6/16/2026
Lara	Patricia	BH/ABA-Telehealth	INTIAL	6/16/2026
Lechuga	Jose	BH/ABA-Telehealth	INTIAL	6/16/2026
Lee	Karin	Allied Health	INTIAL	6/16/2026
Lehman	Ludivine	Doula	INTIAL	6/16/2026
Leigh	Stephanie	BH/ABA-Telehealth	INTIAL	6/16/2026
Levine	Barrett	BH/ABA	INTIAL	6/16/2026
Li	Danlu	BH/ABA-Telehealth	INTIAL	6/16/2026
Li	Katie	BH/ABA-Telehealth	INTIAL	6/16/2026
Liao	Minyu	BH/ABA-Telehealth	INTIAL	6/16/2026
Lopez	Jacob	BH/ABA-Telehealth	INTIAL	6/16/2026
Love	Taylor	Doula	INTIAL	6/16/2026
Marino	Julia	BH/ABA-Telehealth	INTIAL	6/16/2026
Martinez Torres	Alexandra	Ancillary	INTIAL	6/16/2026
Masters	Chrishay	Doula	INTIAL	6/16/2026
McCarthy	Patrick	BH/ABA-Telehealth	INTIAL	6/16/2026
Mcnealy	Hu-ann	BH/ABA-Telehealth	INTIAL	6/16/2026
Medina	Wendy	BH/ABA-Telehealth	INTIAL	6/16/2026
Miranda Olivera	Laura	BH/ABA	INTIAL	6/16/2026
Molina	Lynnea	BH/ABA	INTIAL	6/16/2026
Moreno	Ashley	BH/ABA-Telehealth	INTIAL	6/16/2026
Mota	Irma	BH/ABA-Telehealth	INTIAL	6/16/2026
Mukabire	Peter	BH/ABA	INTIAL	6/16/2026
Mulligan	Dana	BH/ABA-Telehealth	INTIAL	6/16/2026
Munir	Syeda	BH/ABA	INTIAL	6/16/2026
Nayak	Asha	BH/ABA-Telehealth	INTIAL	6/16/2026

LAST_NAME	FIRST_NAME	CATEGORY	INITIAL/RECRED	CRED_DATE
Newman	Elise	BH/ABA-Telehealth	INTIAL	6/16/2026
Nielson	Anne	BH/ABA-Telehealth	INTIAL	6/16/2026
Olmos	Rochelle	BH/ABA	INTIAL	6/16/2026
O'Neill Garcia	Hania	BH/ABA-Telehealth	INTIAL	6/16/2026
Ou	Jiayan	BH/ABA-Telehealth	INTIAL	6/16/2026
Palumbo	Michaela	BH/ABA-Telehealth	INTIAL	6/16/2026
Pan	Wang	BH/ABA-Telehealth	INTIAL	6/16/2026
Partiyeli	Megan	BH/ABA-Telehealth	INTIAL	6/16/2026
Parungao	Romina	Doula	INTIAL	6/16/2026
Patil	Harshal	Specialist	INTIAL	6/16/2026
Perez	Irene	BH/ABA-Telehealth	INTIAL	6/16/2026
Pham	Vanquynh	Allied Health	INTIAL	6/16/2026
Posey	Olivia	Doula	INTIAL	6/16/2026
Rally	Sanjeev	BH/ABA-Telehealth	INTIAL	6/16/2026
Ramirez	Karla	BH/ABA-Telehealth	INTIAL	6/16/2026
Ramirez	Riley	BH/ABA-Telehealth	INTIAL	6/16/2026
Rand	Erica	BH/ABA	INTIAL	6/16/2026
Randle	Nyvia	BH/ABA-Telehealth	INTIAL	6/16/2026
Reeves	Erin	Allied Health	INTIAL	6/16/2026
Rittenberry Kraemer	Jolie rosally	BH/ABA-Telehealth	INTIAL	6/16/2026
Rodrigo de la Torre	Marco	BH/ABA-Telehealth	INTIAL	6/16/2026
Rogers	Heather	BH/ABA-Telehealth	INTIAL	6/16/2026
Romero	Monica	BH/ABA-Telehealth	INTIAL	6/16/2026
Roper	Penny	BH/ABA-Telehealth	INTIAL	6/16/2026
Rosas	Anelle	Allied Health	INTIAL	6/16/2026
Ruiz	Adilene	BH/ABA-Telehealth	INTIAL	6/16/2026
Samimi	Ariana	Allied Health	INTIAL	6/16/2026
Sanchez-Ware	Maritza	BH/ABA	INTIAL	6/16/2026
Sanders	McKenzie	BH/ABA-Telehealth	INTIAL	6/16/2026
Sarvasy	Estie	BH/ABA	INTIAL	6/16/2026
Sayed	Marium	BH/ABA-Telehealth	INTIAL	6/16/2026
Schulz	Christopher	BH/ABA-Telehealth	INTIAL	6/16/2026
Scott	Joanna	Doula	INTIAL	6/16/2026
Serrano	Evelyn	BH/ABA-Telehealth	INTIAL	6/16/2026
Sethi	Prithipal	Specialist	INTIAL	6/16/2026
Shah	Ishani	Ancillary	INTIAL	6/16/2026
Sharou	Julie	BH/ABA-Telehealth	INTIAL	6/16/2026
Sigler	Cassie	BH/ABA-Telehealth	INTIAL	6/16/2026
Silva Sayago	Antonio	Specialist	INTIAL	6/16/2026
Skipper	Molly	BH/ABA-Telehealth	INTIAL	6/16/2026
Smoot	Shannon	BH/ABA	INTIAL	6/16/2026
Solis Vitatoe	Ruby	BH/ABA	INTIAL	6/16/2026
Stack	Brittany	BH/ABA-Telehealth	INTIAL	6/16/2026
Stafford	Tamesha	BH/ABA	INTIAL	6/16/2026
Stamps	Shari	Doula	INTIAL	6/16/2026
Sun	Ching-Fang	BH/ABA-Telehealth	INTIAL	6/16/2026
Tam	Ashley	BH/ABA-Telehealth	INTIAL	6/16/2026
Taylor	Doreece	BH/ABA-Telehealth	INTIAL	6/16/2026
Taylor	Joan	BH/ABA-Telehealth	INTIAL	6/16/2026
Thakkar	Tarjane	BH/ABA-Telehealth	INTIAL	6/16/2026
Thurau	Renee	BH/ABA-Telehealth	INTIAL	6/16/2026
Tolani	Renuka	Specialist	INTIAL	6/16/2026
Torres	Destiny	BH/ABA-Telehealth	INTIAL	6/16/2026
Tovar	Madeline	BH/ABA-Telehealth	INTIAL	6/16/2026
Toy	Leslie	BH/ABA	INTIAL	6/16/2026
Valle Alegria	Emily	BH/ABA-Telehealth	INTIAL	6/16/2026

LAST_NAME	FIRST_NAME	CATEGORY	INITIAL/RECRED	CRED_DATE
Valles	Jacqueline	Ancillary	INTIAL	6/16/2026
Velez	Liberty	BH/ABA	INTIAL	6/16/2026
Villalobos	Gabriela	BH/ABA-Telehealth	INTIAL	6/16/2026
Villanueva	Katie	BH/ABA-Telehealth	INTIAL	6/16/2026
Vo	Lily	BH/ABA-Telehealth	INTIAL	6/16/2026
Walker	Sophie	BH/ABA-Telehealth	INTIAL	6/16/2026
Washington	DeAndrea	Allied Health	INTIAL	6/16/2026
Watkins	Stephanie	BH/ABA-Telehealth	INTIAL	6/16/2026
Way	Renata	BH/ABA	INTIAL	6/16/2026
Wells	Brianna	Doula	INTIAL	6/16/2026
Wilson	Michelle	BH/ABA	INTIAL	6/16/2026
Xu	Mu	BH/ABA	INTIAL	6/16/2026
Yoo	Kaelyn	BH/ABA-Telehealth	INTIAL	6/16/2026
Zavala Vargas	Rosalina	BH/ABA-Telehealth	INTIAL	6/16/2026
Zelada-Arenas	Fatima	BH/ABA-Telehealth	INTIAL	6/16/2026
Ani	Michael	BH/ABA	RECRED	6/16/2026
Arnold	Monica	BH/ABA-Telehealth	RECRED	6/16/2026
Avise	Jennifer	Specialist	RECRED	6/16/2026
Budayr	Amer	Specialist	RECRED	6/16/2026
Canlas	John Patrick	Ancillary	RECRED	6/16/2026
Chu	Jason	Specialist	RECRED	6/16/2026
Daileader	Jamey	BH/ABA-Telehealth	RECRED	6/16/2026
Delaplane	Kathryn	Allied Health	RECRED	6/16/2026
Dubrrall	Lillian	Allied Health	RECRED	6/16/2026
Duran	Pedro	BH/ABA	RECRED	6/16/2026
Elhaj	Alaa	BH/ABA	RECRED	6/16/2026
Evans	Alexandrea	BH/ABA	RECRED	6/16/2026
Fanaee	Soheila	BH/ABA-Telehealth	RECRED	6/16/2026
Ferraro	Pia	BH/ABA-Telehealth	RECRED	6/16/2026
Fujimoto	Deborah	BH/ABA	RECRED	6/16/2026
Garcia	Glaizzel	BH/ABA	RECRED	6/16/2026
Garmur	Kelly	Allied Health	RECRED	6/16/2026
Goodfriend-Reano	Eva	Allied Health	RECRED	6/16/2026
Gorman	Jodi	Allied Health	RECRED	6/16/2026
Grawert	Lauren	BH/ABA-Telehealth	RECRED	6/16/2026
Hull	Candy	BH/ABA-Telehealth	RECRED	6/16/2026
Ikekwere	Joseph	BH/ABA	RECRED	6/16/2026
Jay	Jordan	BH/ABA	RECRED	6/16/2026
Jones	Lucas	BH/ABA	RECRED	6/16/2026
Khade	Ushakiran	Primary Care Physician	RECRED	6/16/2026
Kleiman	Sean	BH/ABA	RECRED	6/16/2026
Kugman	Adriana	BH/ABA	RECRED	6/16/2026
Latta	Dana	BH/ABA	RECRED	6/16/2026
Le	Crystal	Specialist	RECRED	6/16/2026
Leuzinger	Brooke	BH/ABA	RECRED	6/16/2026
Lopez-Nandam	Aneesh	BH/ABA	RECRED	6/16/2026
Ma	Daveena	Primary Care Physician	RECRED	6/16/2026
Manaoat	Jonathan	BH/ABA	RECRED	6/16/2026
Mancao	MariLisa	Primary Care Physician	RECRED	6/16/2026
Markowski	Meghan	Allied Health	RECRED	6/16/2026
McCleary	Theresa	Allied Health	RECRED	6/16/2026
Mogannam	Abid	Specialist	RECRED	6/16/2026
Murphy	Aileen	Specialist	RECRED	6/16/2026
Navarrete Hernande	Fabiola	BH/ABA	RECRED	6/16/2026
Nguyen	Catherine	BH/ABA	RECRED	6/16/2026

LAST_NAME	FIRST_NAME	CATEGORY	INITIAL/RECRED	CRED_DATE
Nguyen	Hanh	BH/ABA	RECRED	6/16/2026
Nicolaou	Daemeon	Specialist	RECRED	6/16/2026
Noorani	Ghulam	BH/ABA	RECRED	6/16/2026
Obnial	Gonzalo	Specialist	RECRED	6/16/2026
Okeke	Ogechi	Ancillary	RECRED	6/16/2026
Oleinick	Cydnie	BH/ABA-Telehealth	RECRED	6/16/2026
Osibun	Ashley	BH/ABA-Telehealth	RECRED	6/16/2026
Paff	Eugenia	BH/ABA	RECRED	6/16/2026
Pearson	Catherine	Specialist	RECRED	6/16/2026
Ponnuraju	Girija	Allied Health	RECRED	6/16/2026
Priesman	Corey	BH/ABA	RECRED	6/16/2026
Ruiz	Lauren	Allied Health	RECRED	6/16/2026
Samplawski	Olga	BH/ABA	RECRED	6/16/2026
Schumm	Derek	BH/ABA	RECRED	6/16/2026
Shah	Neha	Specialist	RECRED	6/16/2026
Sharma	Amita	Primary Care Physician	RECRED	6/16/2026
Sharma	Padmaja	Specialist	RECRED	6/16/2026
Shem	Alyssa	BH/ABA	RECRED	6/16/2026
Sheth	Sonali	Primary Care Physician	RECRED	6/16/2026
Smith-Heimer	Alana	Allied Health	RECRED	6/16/2026
Spinale	Michelle	BH/ABA	RECRED	6/16/2026
Stallsmith	Joelle	BH/ABA	RECRED	6/16/2026
Suri	Vikram	Specialist	RECRED	6/16/2026
Svec	Ioana	Ancillary	RECRED	6/16/2026
Sykes	Susan	Specialist	RECRED	6/16/2026
Tamura	Eddy	Specialist	RECRED	6/16/2026
Trautner	Rick	BH/ABA	RECRED	6/16/2026
Valdez	Jamie	BH/ABA	RECRED	6/16/2026
Velazquez-Hernand	Marlen	BH/ABA-Telehealth	RECRED	6/16/2026
Waldo	Stephanie	BH/ABA	RECRED	6/16/2026
Woodward	Eleanor	BH/ABA	RECRED	6/16/2026
Wu	Diana	Primary Care Physician	RECRED	6/16/2026
Yu	Anne	Specialist	RECRED	6/16/2026
Yu	Connie	BH/ABA	RECRED	6/16/2026
Zhang	Zhonghua	Ancillary	RECRED	6/16/2026
Zhi	Qi	Ancillary	RECRED	6/16/2026

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



PCP	2
SPECIALIST	5
ANCILLARY	26
ALLIED HEALTH	8
<u>BH/ABA</u>	<u>141</u>
TOTAL	182

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2025 - 2026 | 4TH QUARTER (Q4) OUTREACH REPORT

ALLIANCE IN THE COMMUNITY

FY 2025 - 2026 | 4TH QUARTER (Q4) OUTREACH REPORT

Alliance in the Community Events and Activities:

Between April and June 2026, the Alliance completed **1,927** member orientation outreach calls among net new members and non-utilizers and conducted **157** net new member orientations and **22** non-utilizer member orientations (**9.3%** member participation rate). In addition, the Outreach team completed **33** Alliance website inquiries, **24** service requests, **19** community events, **5** member education events, and **1** Coffee & Conversations event in Q4. Notably, we participated in the San Leandro Cherry Festival Parade in June, continuing our 9-year commitment to supporting this community event. The parade provided an opportunity to engage with more than **30,000** attendees, increasing community awareness of our organization and strengthening relationships with local residents and partners.

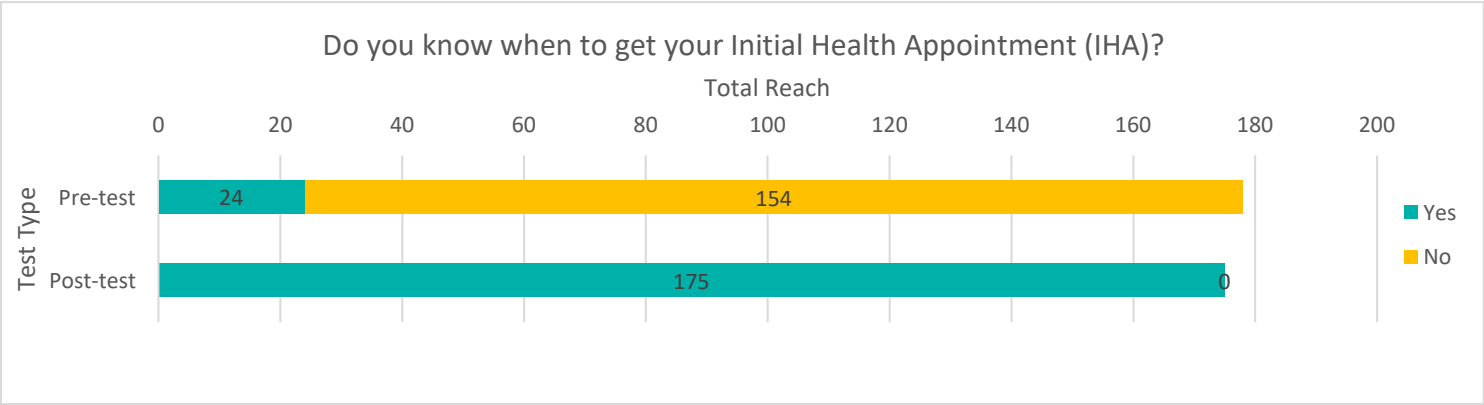
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, approximately **47,228** self-identified Alliance members have been reached during outreach activities.

Alliance Member Orientation Program:

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

On **Wednesday, March 18th, 2020**, the Alliance began conducting member orientations by phone. As of **Tuesday, June 30th, 2026**, the Outreach Team has completed **58,194** member orientation outreach calls and conducted **10,569** orientations, achieving a **18%** participation rate.

Between April 1st through June 30th, 2026, **179** members completed an MO by phone. After completing the MO, **100%** of members who completed the post-test survey in Q4 FY 25-26 reported knowing when to get their IHA, compared to only **13.5%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 25-26\Q4\June 2026**

ALLIANCE IN THE COMMUNITY
FY 2025 - 2026 | 4TH QUARTER (Q4) OUTREACH REPORT

Q4 FY 2025-2026 TOTALS

			
19	COMMUNITY EVENTS	32363	TOTAL REACHED AT COMMUNITY EVENTS
5	MEMBER EDUCATION EVENTS	327	TOTAL REACHED AT MEMBER EDUCATION EVENTS
179	MEMBER ORIENTATIONS	179	TOTAL REACHED AT MEMBER ORIENTATIONS
1	MEETINGS/ PRESENTATIONS	7	TOTAL REACHED AT MEETINGS/PRESENTATIONS
34	TOTAL INITIATED/INVITED EVENTS	1579	TOTAL MEMBERS REACHED AT EVENTS
204	TOTAL EVENTS	32876	TOTAL REACHED AT ALL EVENTS

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

TOTAL REACH 17 CITIES

Cities represent the mailing addresses for members who completed a Member Orientation by phone. The following cities had <1% reach during Q4 2026: Cherryland, Fairview, and San Francisco. The C&O Department started including these cities in the Q3 FY21 Outreach Report.


\$833.53
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

* Includes refundable deposit.

COMMUNICATIONS & OUTREACH DEPARTMENT

SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | June 2026

The Alliance Communications and Outreach (C&O) Department created the social media and website activity (SM&WA) Report to provide a high-level overview of stakeholder engagement through various digital media platforms. Between **June 1st, 2026**, and **June 30th, 2026**:

1. Alliance Website:
 - Received **173,100** unique visits
 - Served more than **646,100** page visits
 - The top **10** website page visits were:
 - i. Homepage
 - ii. Providers
 - iii. Find a Doctor
 - iv. Provider Portal
 - v. Medi-Cal
 - vi. Benefits and Covered Services
 - vii. Members
 - viii. Get a New ID Card
 - ix. Contact Us
 - x. Careers
2. Facebook Page:
 - Increased followers from **702** to **705**
 - Did not receive any reviews in **June 2026**
3. Glassdoor Page:
 - Maintained **3.1** out of a **5-star** overall rating
 - Did not receive any reviews in **June 2026**
4. Google Page:
 - **1,555** website clicks were made from the business profile
 - **1,589** calls were made from the business profile
 - Receive one (1) review in **June 2026**
5. Instagram Page:
 - Increased in followers from **746** to **750**
6. LinkedIn Page:
 - Increased followers from **7.6k** to **7.7k**
 - Received **220** page clicks
7. X (previously Twitter) Page:
 - Maintained followers at **351**
8. Yelp Page:
 - Page visits **46**
 - Appeared in Yelp searches **72** times
 - Did not receive any reviews in **June 2026**

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

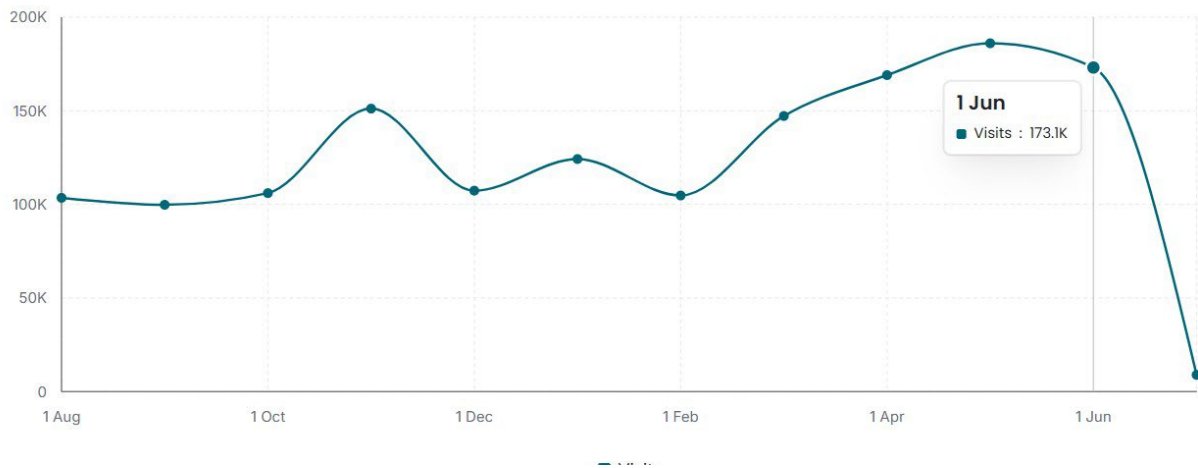
FY 2025-2026 | June 2026

ALLIANCE WEBSITE OVERVIEW:

Site metrics

Daily Weekly Monthly

Visits for the last 12 months ⓘ



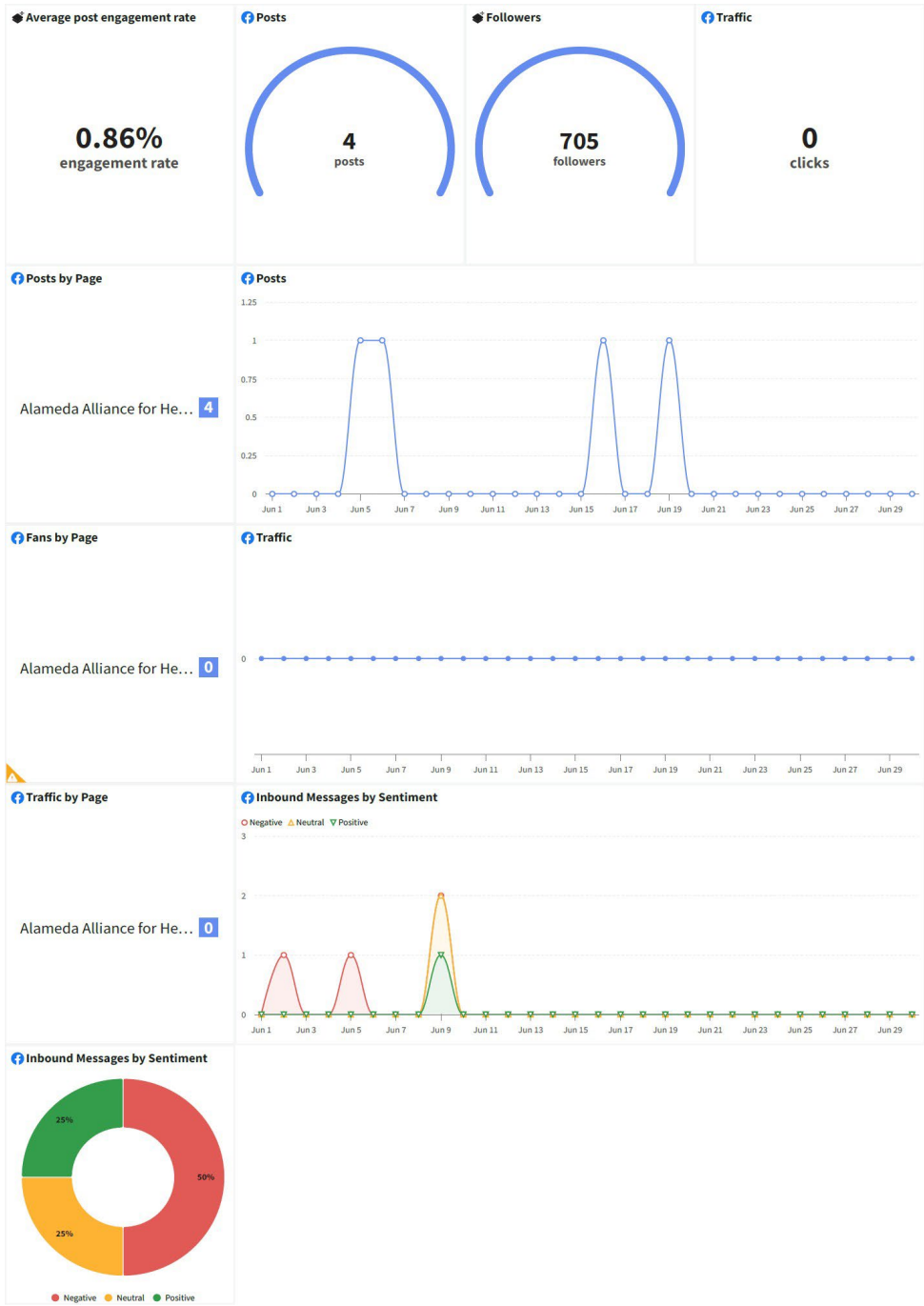
Pages served for the last 12 months ⓘ



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q4\2. June 2026

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

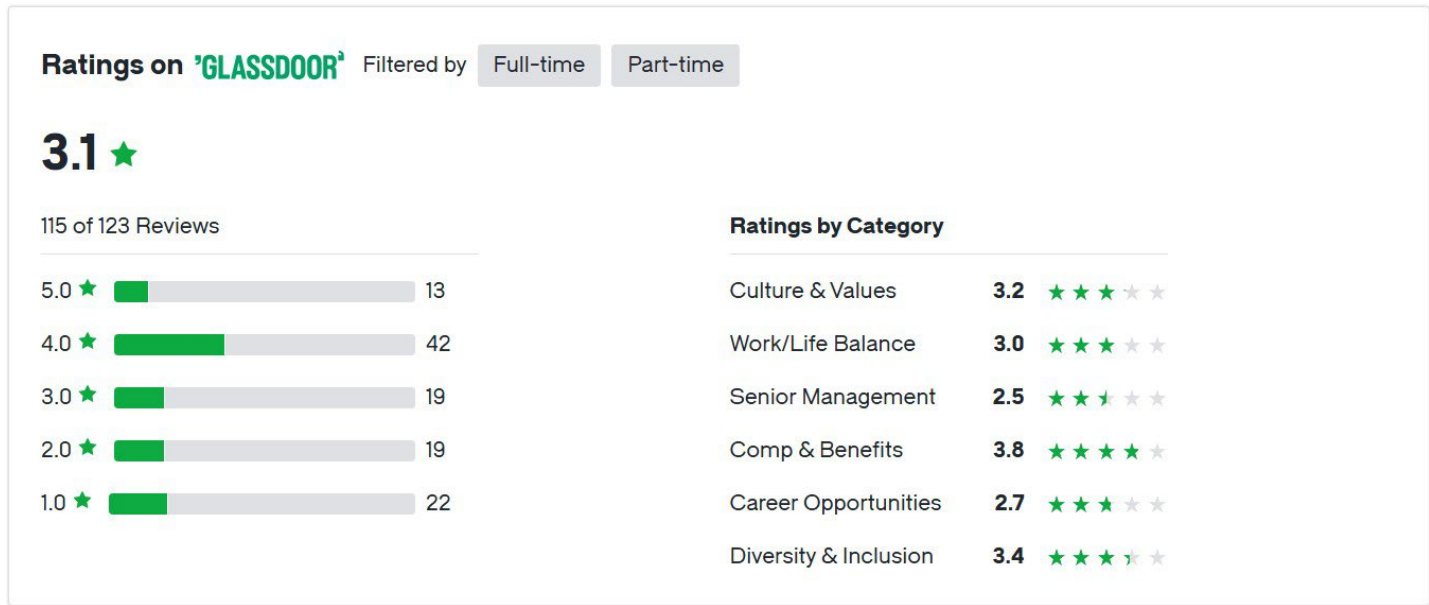
FACEBOOK OVERVIEW



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q4\2. June 2026

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

GLASSDOOR OVERVIEW



Ratings by category

3.2	Culture & values
3.4	Diversity, Equity & Inclusion
3.0	Work/Life balance
2.5	Senior management
3.8	Compensation and benefits
2.7	Career opportunities

Ratings distribution

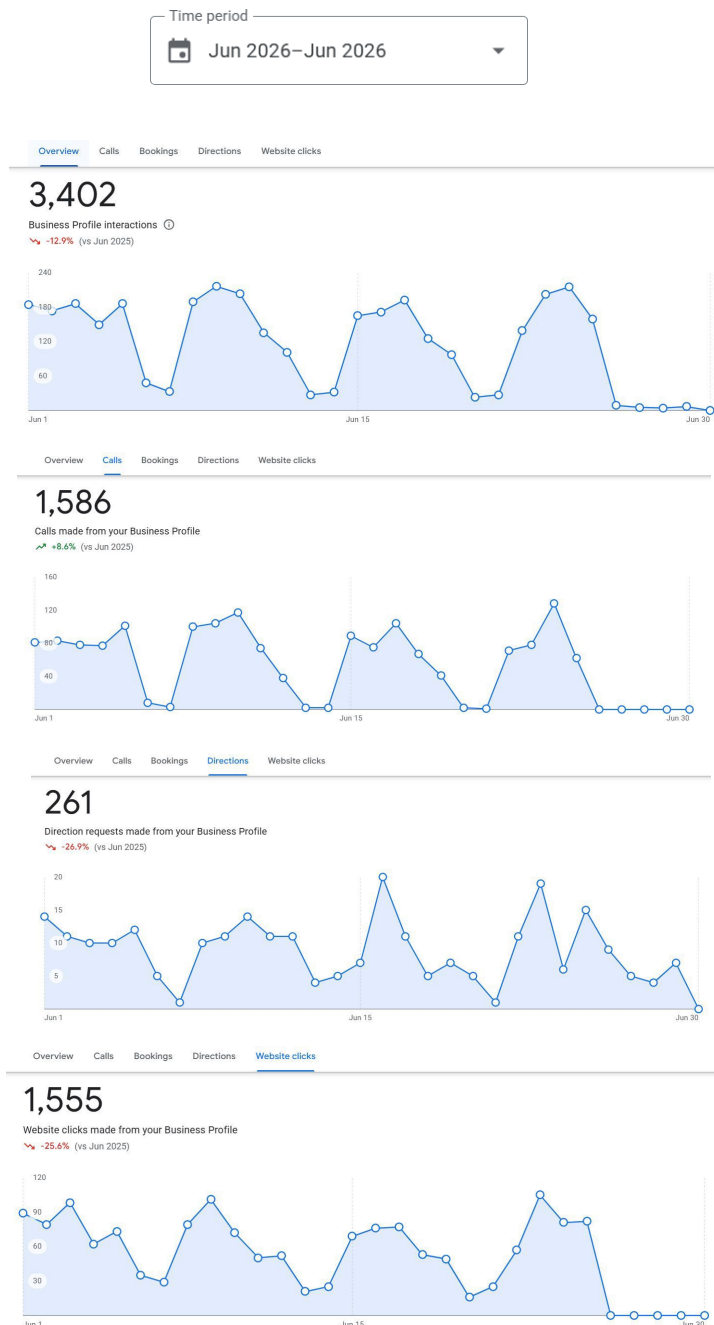
5 stars	11%
4 stars	37%
3 stars	17%
2 stars	17%
1 star	19%

All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q4\2. June 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | June 2026

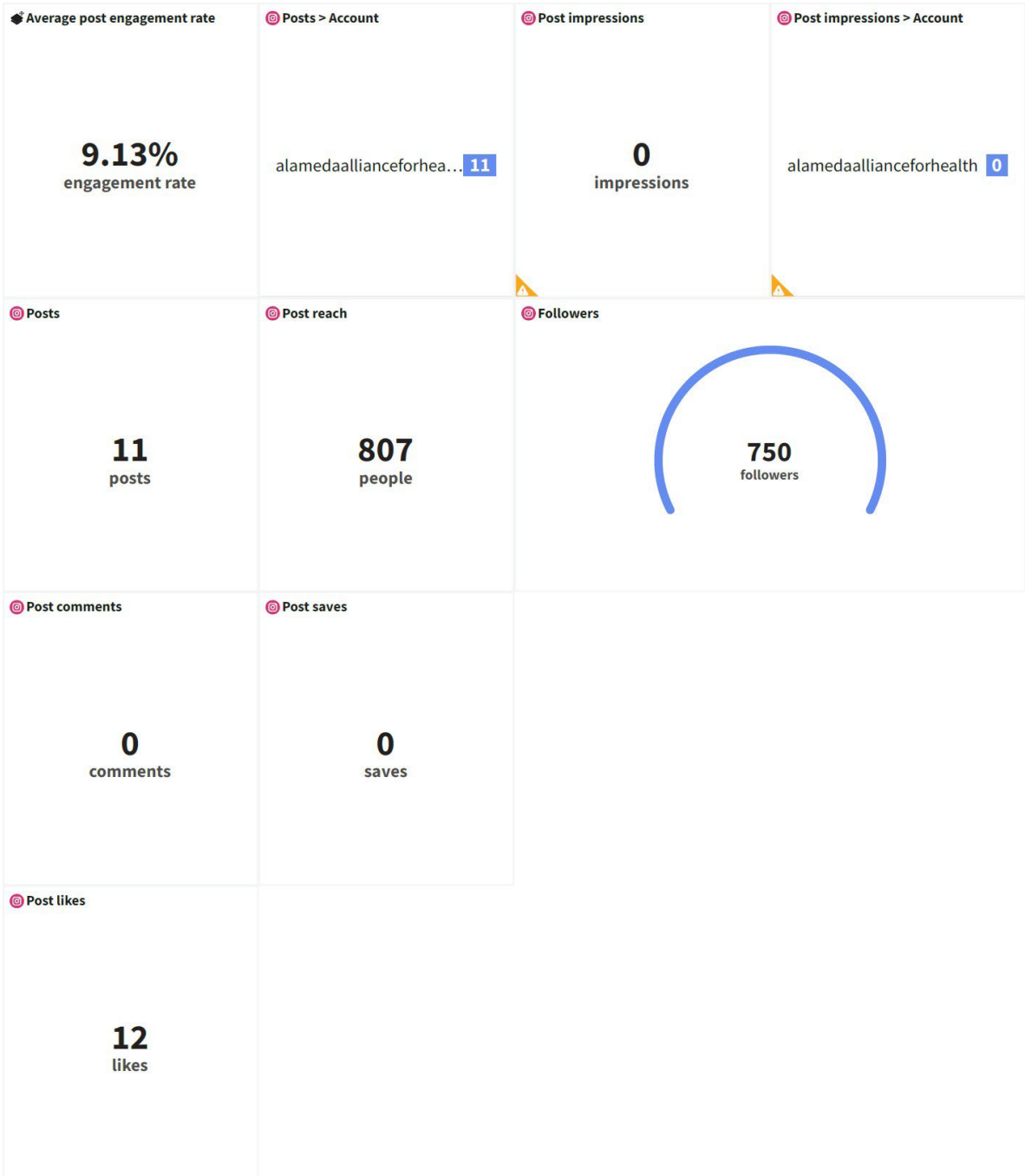
GOOGLE OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q4\2. June 2026

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

INSTAGRAM OVERVIEW:

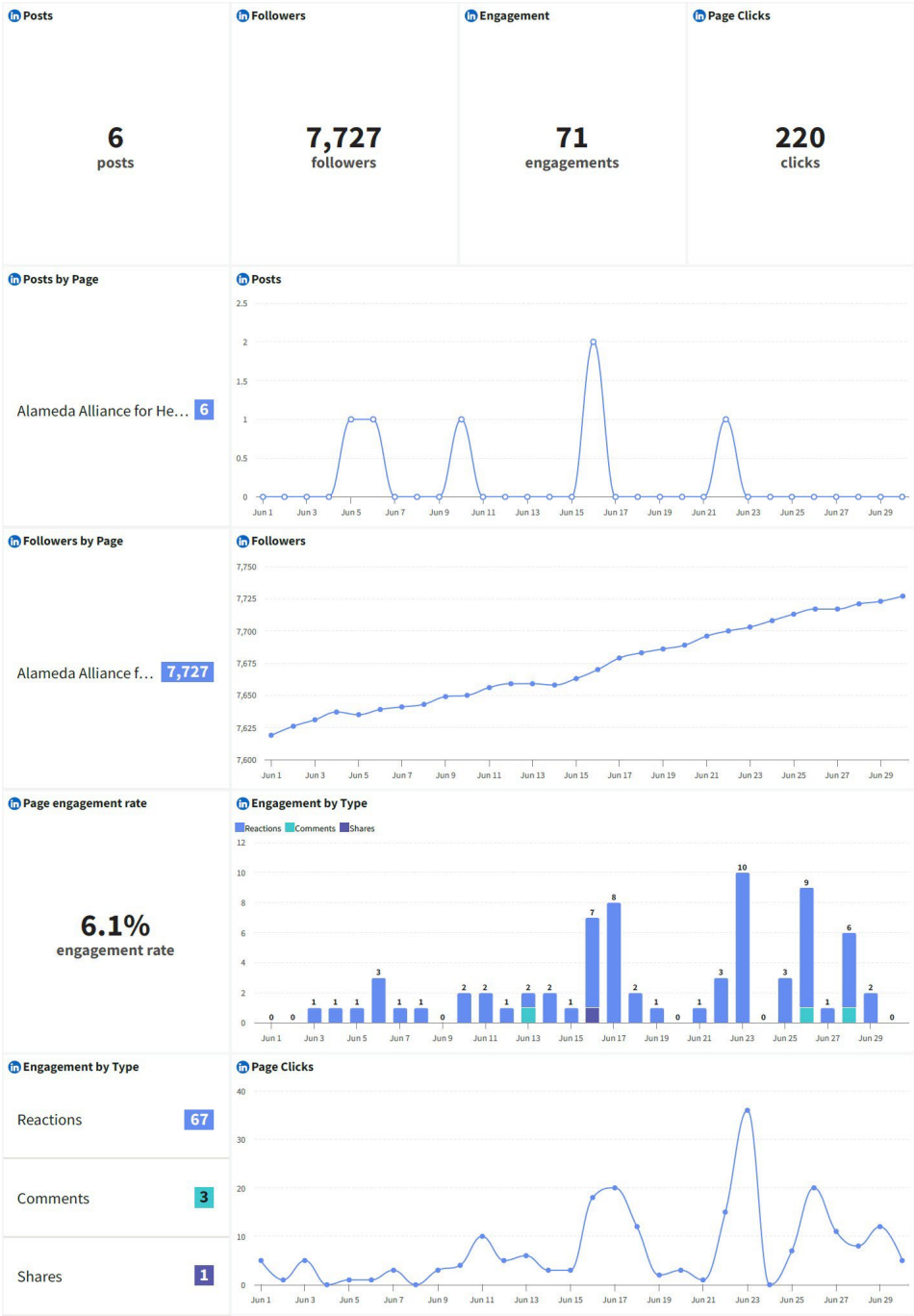


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q4\2. June 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | June 2026

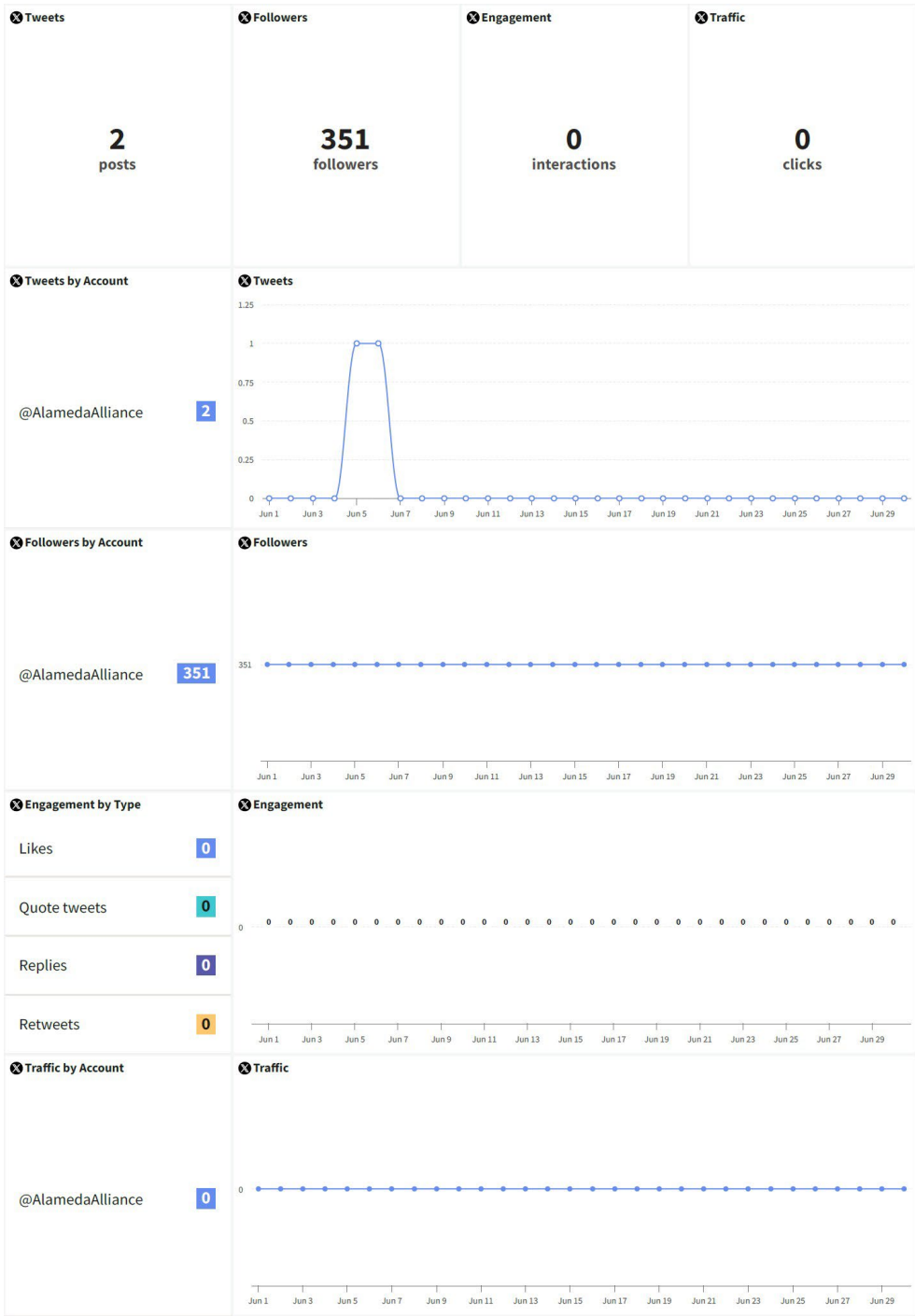
LINKEDIN OVERVIEW



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q4\2. June 2026

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

X (previously TWITTER) OVERVIEW

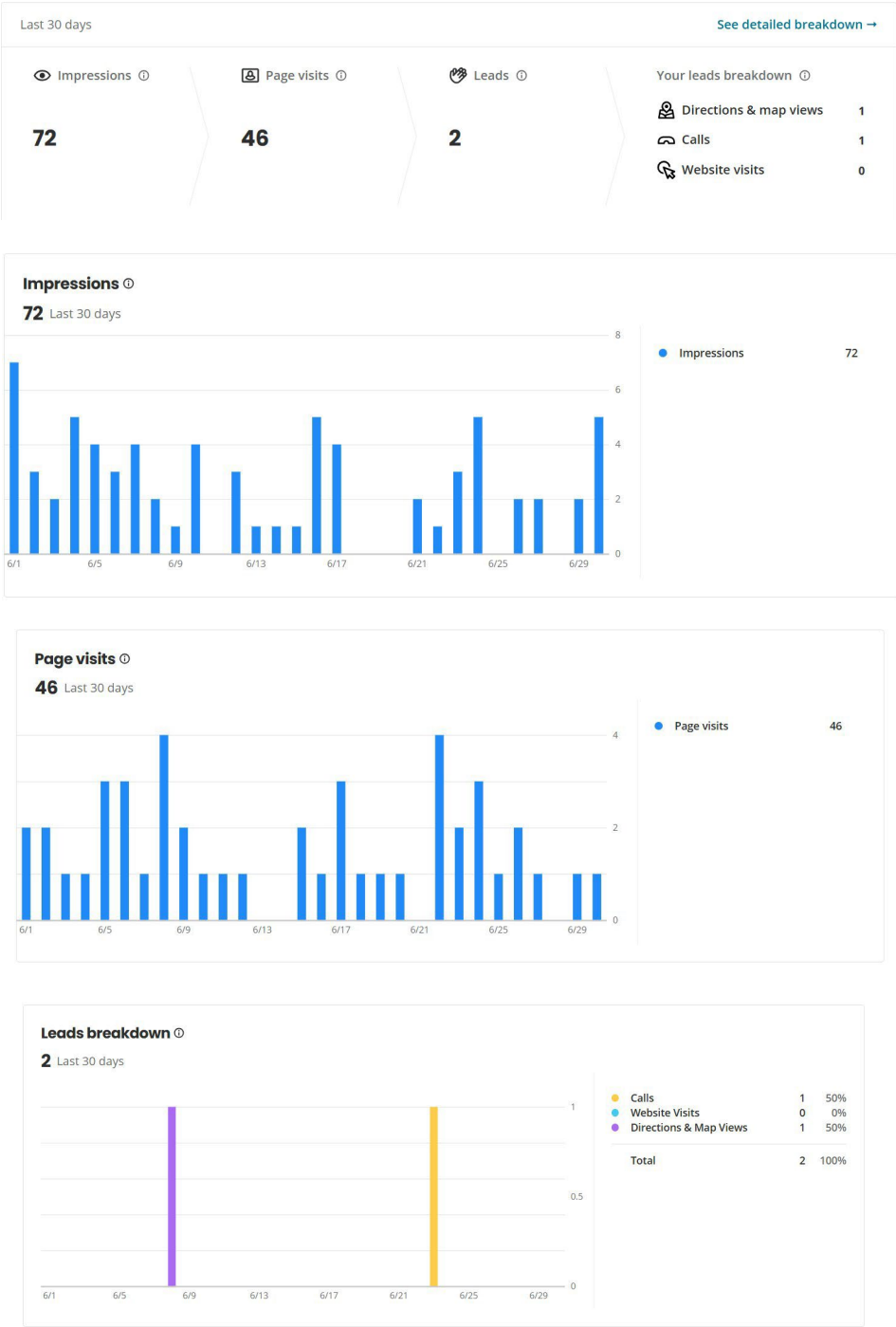


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q4\2. June 2026

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | June 2026

YELP OVERVIEW



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q4\2. June 2026



Integrated Planning

Sasikumar Karaiyan

To: Alameda Alliance for Health Board of Governors

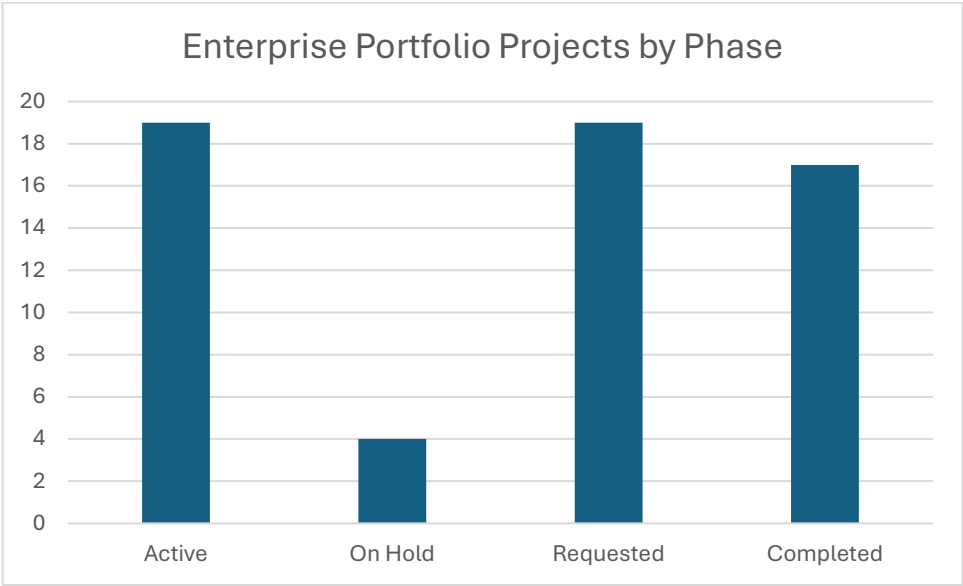
From: Sasi Karaiyan, Chief Information Officer & Chief Security Officer

Date: July 10th, 2026

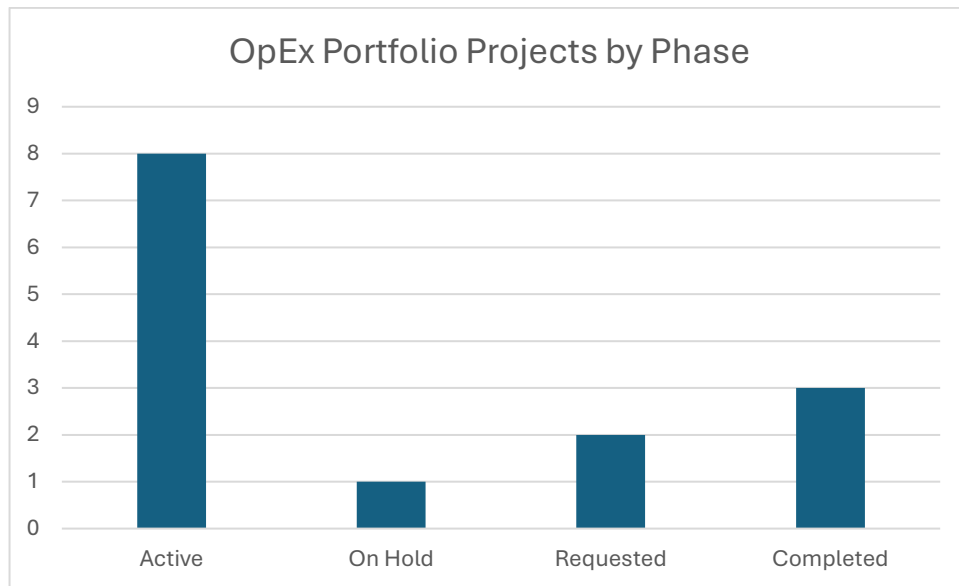
Subject: Integrated Planning Division Report – June 2026 Activities

Integrated Planning Division

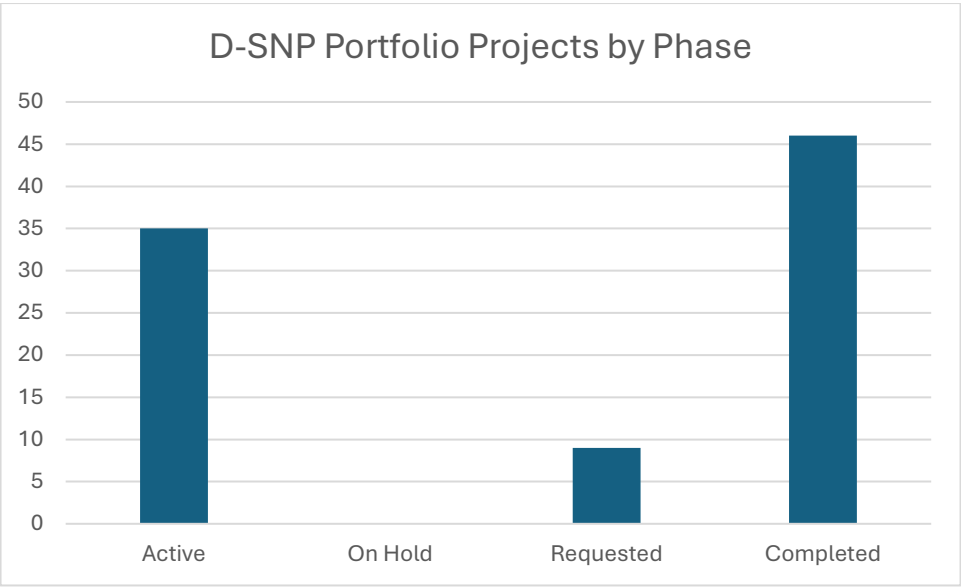
- Enterprise Portfolio
 - 42 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
 - 19 Active projects (discovery, initiation, planning, execution, warranty)
 - 4 On Hold projects
 - 19 Requested and Approved Projects
 - 17 Completed Projects (F-YTD)



- Operational Excellence (OpEx) Portfolio
 - o 11 initiatives on the AAH OpEx portfolio
 - 8 Active projects (discovery, initiation, planning, execution, warranty)
 - 1 On hold project
 - 2 Pipeline/Backlog
 - 3 Completed projects



- D-SNP Portfolio
 - 44 projects currently on the AAH D-SNP portfolio
 - 35 Active projects (discovery, initiation, planning, execution, warranty)
 - 0 On Hold
 - 9 Requested Projects
 - 46 Completed in Total



- **Enterprise Portfolio (Active Projects) for all Lines of Business (includes projects in Initiation, Planning, and Execution)**
 - **(CMS-0057-F) Interoperability and Prior Authorization Final Rule (TDX ID 5816)**
 - Project Phase: *Planning
 - Project Health: **Yellow
 - Risk 4833: Currently do not have a provider to partner with for electronic Prior Auth and Provider Access APIs
 - High Level Milestones (Completed in June):
 - Fit Gap Analysis (FGA): Completed and Approved for electronic Prior Auth and Patient Access APIs
 - High Level Milestones (In Flight in June):
 - FGA: Completed and Approved for Payer to Payer and Provider Access APIs
 - Alameda Planning Complete
 - **2026 PBM Transition – PerformRx to MedImpact (TDX 14906)**
 - Project Phase: *Planning
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - Business Requirements Document (BRD) completed
 - Established HPMS access for additional MedImpact Resources
 - Set-up of sFTP site for file and data sharing between AAH and MedImpact
 - High Level Milestones (In Flight in June):
 - Technical requirements gathering, including file library and crosswalk of current eligibility and claims files with new MedImpact layouts
 - Completion of information questionnaires and initiation of program design phase with MedImpact
 - Initiation of transition planning with current PBM, PerformRx
 - Project charter review and approvals
 - **AOR Workflow Optimization and Systems Integration (TDX 11260)**
 - Project Phase: *Executing
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - Development changes to support the member AOR data sent to the vendors
 - High Level Milestones (In Flight in June):
 - Quality Assurance Testing
 - UAT Planning
 - **CS Policy Guide 04.30.25 Changes**
 - Project Phase: *Executing
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - Updated the language in the following contracts
 - Alameda County Health (AC Health)
 - East Bay Innovations (EBI)
 - Omatochi
 - Completed Requirement Session 1 – AC Health

- Completed Requirement Session 2 – EBI
- High Level Milestones (In Flight in June):
 - Sent contracts to AC Health for signature
 - Updating BRD with changes from requirement sessions 1 & 2
 - Identifying CRs that need to be created for IT configuration changes needed in HEALTHsuite
- CYBHI Statewide Multi-Payer School-Linked Fee Schedule (TDX ID 4186)
 - Project Phase: *Executing
 - Project Health: **Yellow
 - Risk 4736: BAA – A fully executed BAA is required before AAH can proceed with the transfer of member data; a test file was scheduled for submission to Carelon on 4/20. Without the BAA, this will delay project efforts
 - High Level Milestones (Completed in June):
 - BAA executed on 6/26
 - High Level Milestones (In Flight in June):
 - Eligibility Test File shared with Carelon's IT team to continue work
- D-SNP: 1A Contracting & Credentialing (TDX ID 6924)
 - Project Phase: *Executing
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - Farsi translations returned from vendor
 - IT is working to identify new Text to Speech (TTS) software; this has been in progress since beginning of June
 - Dependency to record the TTS scripts is on the procurement and configuration of this software
 - High Level Milestones (In Flight in June):
 - None
- D-SNP: 2D Chronic Care Improvement Program (TDX ID 6936)
 - Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - Care Plan elements for CCIP Diagnosis of Diabetes and Hypertension configured, validated, and ready for deployment
 - CCIP Workflow draft completed
 - High Level Milestones (In Flight in June):
 - Care Plan elements for CCIP Diagnosis of Chronic Kidney Disease defined and configured in TruCare
 - CCIP Member Welcome Letter finalization by C&O
- D-SNP: 6G Organizational Training (TDX ID 6908)
 - Project Phase: *Execution
 - Project Health: **Yellow
 - Risk 4926: Completion of CM & UM training courses is causing the project to be extended past the June 30th deadline.
 - High Level Milestones (Completed in June):
 - Training completed the conversion of UM Modules 1-9
 - HR completed testing of UM Modules 1-8

- High Level Milestones (In Flight in June):
 - Completion of UM Modules 9-13
 - Training transition plan in preparation of project completion
 - Identifying owners of each training content for future revisions
- D-SNP: 8A (TDX ID 6996) and 16K Claims (TDX ID 10170)
 - Project Phase: *Closing
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - Closeout documents are complete and currently under review by leadership
 - High Level Milestones (In Flight in June):
 - None
- D-SNP: 10A PBM Implementation (TDX ID 7046)
 - Project Phase: *Executing
 - Project Health: **Yellow
 - Issue 4510: Ongoing delays with receiving letter proofs for the M3P program from Echo Health (PerformRx's M3P Vendor). Echo has stated that they will not be able to accommodate formatting requests, specifically 1-inch margins. C&O, RAC, and Pharmacy are currently evaluating level of risk to determine next steps
 - High Level Milestones (Completed in June):
 - None
 - High Level Milestones (In Flight in June):
 - Approval of M3P Program member letters received from Echo Health in all threshold languages; see issue above for more information
- D-SNP: CHCN Delegation (TDX 14333)
 - Project Phase: *Initiation
 - Project Health: **Yellow
 - Issue 5003: D-SNP Delegation Scope has not been finalized; CHCN is reviewing project charter
 - Issue 480: CHCN is currently on a Medi-Cal Corrective Action Plan from 2025; must be resolved by 8/31/2026 in order for project to proceed
 - High Level Milestones (Completed in June):
 - Project Stakeholder Registry completed
 - Project Charter Draft shared with CHCN for collaboration
 - High Level Milestones (In Flight in June):
 - None
- D-SNP Medicare Reporting (TDX ID 14876)
 - Project Phase: *Executing
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - Finalized Medicare Ops Reporting Tracker
 - Identified report owners and points of contact
 - Development of Training/Instruction Guide for Impacted Business areas around how to submit a report request and track reports that are due to regulators

- Training/Instruction Guide published for all impacted business areas
 - High Level Milestones (In Flight in June):
 - None
- D-SNP: Provider Exclusions Project (TDX 15452)
 - Project Phase: *Initiating
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - Determination made to spin off as independent project due to identification of additional scope
 - Additional Scope – three provider exclusion lists and development of a Provider Repository Module flagging excluded providers
 - Part C and D Member Letter reviewed and approved by Medicare Ops Executive Director
 - High Level Milestones (In Flight in June):
 - Project Plan extracted from previous project (DSNP 1A Contracting and Credentialing) into new independent project
 - Development of Project Charter – In Progress
 - Identification of Policies in need of updating by Business Area
 - Review of Part C and D Member Letter in review with Project Driver and Workstream Lead
- DHCS APL 25-015 Data Sharing and Quality Rate Production (TDX ID 14146)
 - Project Phase: *Execution
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - Completed IT workflows for EDI & ADT
 - High Level Milestones (In Flight in June):
 - Finalize PDR reporting process/Smartsheet to DHCS
 - Assign business owners
 - Update sheet with automatic total for each business area
- DHCS APL 26-004 Medi-Cal MCP Responsibilities for BH (TDX 15101)
 - Project Phase: *Executing
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - Attestation for working on Policy updates submitted on time to DHCS
 - High Level Milestones (In Flight in June):
 - Review proposed MOU with ACBH
- DMHC APL 25-021 Infertility and Fertility Services [SB 729] (TDX ID 14637)
 - Project Phase: *Execution
 - Project Health: **Yellow
 - Issue 4820: Without DMHC billing guidance, AAH needs to create our own approach to billing and reimbursement for APL required services, including rates and codes. AAH has no historical data to pull from or billing/procedure codes associated with these services as they are not covered by Medi-Cal or Medicare. Outreach to sister plans for collaboration has not yet provided fruitful guidance.

- Issue 4941: Lack of Billing Structure/Reimbursement Methodology for providers is creating an impediment for contracting efforts with UCSF and increasing financial risk to the plan. Without a rate established, the potential cost to the health plan for this type of service is very high as AAH may have to resort to a percentage of billed charges.
- High Level Milestones (Completed in June):
 - Operational Workflows documented and approved
 - Confirmed UCSF is interested in contracting to support this benefit expansion
 - Received DMHC feedback on Evidence of Coverage (EOC) draft and policies & procedures
- High Level Milestones (In Flight in June):
 - Documentation of billing strategy and approach, as well as confirmed billing codes
 - Completion of business requirements documentation and initiation of technical requirement configuration
- ECM Enhancement (TDX 15268)
 - Project Phase: *Planning
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - Deployment of Provider Portal enhancement so that ECM providers may have visibility to ECM eligible Members who are not enrolled for outreach
 - Deployment of automated ECM authorizations for referrals that come via the Provider Portal
 - Current State Process flow of the current state ECM billing and reimbursement Process
 - High Level Milestones (In Flight in June):
 - Solutioning for the future state ECM billing and reimbursement process
 - ECM Authorization Automation for ECM referrals from the MIF and RTF – complete documentation of requirements
- Member Correspondence (TDX ID 12697)
 - Project Phase: *Planning
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - High-Level business requirements complete
 - Decision on “Buy or Build” for project solution complete
 - IT decided to move forward with an internal build of system solution using AppExtender
 - High Level Milestones (In Flight in June):
 - Complete IT Requirement refinement (Jira)
- PY2026-D-SNP: Centralized Medicare Website Enhancement (TDX ID 14617)
 - Project Phase: *Initiation
 - Project Health: **Yellow
 - Risk 4828: DSNP content submission short deadline. We were able to meet the deadline and C&O completed the content changes. Once we

get business feedback, we can close out this risk and project status should change to green.

- High Level Milestones (Completed in June):
 - C&O Shopping & Enrollment submission completed
 - C&O Shopping and Enrollment content changes completed
 - C&O Member Resource/Member Requirements C&O submission completed
 - High Level Milestones (In Flight in June):
 - Business review of Enrollment page content changes
 - C&O complete content changes for Member Resource/Member Requirements
 - Business review of Member Resource/Member Requirements content changes
 - IT User ID & Password for Web test environment
 - Final content validation
 - PY2027 D-SNP Acquisition and Retention Marketing
 - Project Phase: *Initiation
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - Project approved, funded, and activated
 - Project Manager and Business Analyst assigned
 - Initial project intake and stakeholder discussions completed
 - High Level Milestones (In Flight in June):
 - Finalize Statement of Work (SOW) with marketing agency
 - Confirm project scope, objectives, and deliverables
 - Identify project governance structure and stakeholder roles
 - Begin charter and project plan development upon SOW approval
 - PY2027-D-SNP Bid Strategy, Submission & Approval (TDX ID 14636)
 - Project Phase: *Monitoring
 - Project Health: **Green
 - High Level Milestones (Completed in June):
 - CY2027 D-SNP Bid Package successfully submitted to CMS
 - CY2027 Medication Therapy Management (MTM) program submission and attestation completed
 - Project transitioned from bid development/submission into monitoring and review phase
 - High Level Milestones (In Flight in June):
 - Continue monitoring CMS guidance and the scheduled benchmark release in late July - August
 - Support CMS bid and Plan Benefit Package (PBP) reviewer inquiries
 - Support transition planning for the internally approved bid design and downstream CY2027 AEP/OEP Benefit and Operational Readiness activities, pending Medicare Ops and IPD leadership project structuring
 - Receiving, Storing, and Retrieving SOGI Data (TDX ID 6623)
 - Project Phase: *Execution
 - Project Health: *Green
-

- High Level Milestones (Completed in June):
 - Completed creation of SOPs & P&Ps
 - Disability HO-2D
 - Race Ethnicity HO-2A
 - Geographic Classification HO-2F
 - Sexual Orientation HO-2C
 - Language HO-2B
 - SOPs reviewed by stakeholders
- High Level Milestones (In Flight in June):
 - P&Ps final review with stakeholders is in progress
 - Continued working on requirements
 - Finalizing Business Requirements Document (BRD)
- sPayer Contracting Repository (TDX 1283)
 - Project Phase: *Planning
 - Project Health: **Yellow
 - Issue 4883: Re-planning kickoff meeting rescheduled until the vendor's project plan has been refined, vetted, and approved by IPD project stakeholders
 - High Level Milestones (Completed in June):
 - IPD PM, Program Manager, and IT meeting with new vendor PM to discuss re-planning kick off meeting approach
 - Internal IT technical team meetings to update their technical plan and edit proposed timeline
 - High Level Milestones (In Flight in June):
 - Date provided by AAH PM was declined due to vendor resource constraints. Proposed new times week of 7/13.



Compliance

Stephen A. Smythe

To: Alameda Alliance for Health Board of Governors

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

Date: July 10th, 2026

Subject: Compliance Division Report

Enterprise Audit Updates

- 2025 Department of Managed Health Care (DMHC) Routine Full Medical Survey
 - The Plan received the Department's final report on May 19th, 2026. Efforts remain ongoing to address the twelve (12) open deficiencies identified in the final report. The Plan remains on track for supplemental responses for deficiencies related to Pharmacy Formulary and Concurrent Review Process, both due to the department on July 18th, 2026.
- 2026 Department of Health Care Services (DHCS) Routine Audit
 - The Plan has completed its annual audit with DHCS. DHCS continues to conduct its quality review of the draft audit reports. The Plan continues to wait for notification of the formal exit conference and receipt of the preliminary audit report.
- 2026 Health Services Advisory Group (HSAG) Network Adequacy Validation (NAV) Audit
 - HSAG issued the NAV Audit Document Request Packet on May 11th, 2026, and conducted a Technical Assistance Webinar on May 12th, 2026. Following the May 29th, 2026, Kick-Off Call, the Plan timely submitted the ISCAT and all required pre-audit materials on June 18th, 2026. The Plan remains on track and is preparing for the upcoming virtual review and system demonstration activities while responding to any follow-up requests from HSAG.
- 2026 Health Services Advisory Group (HSAG) Encounter Data Validation (EDV) Audit
 - HSAG conducted the EDV Technical Assistance Webinar on June 1st, 2026, and distributed the EDV questionnaire and supporting materials on June 2nd, 2026. The Plan coordinated with internal SMEs and delegated entities to

complete the required questionnaire and supporting documentation. Audit deliverables are on track for submission on July 2nd, 2026, and the Plan continues to work with HSAG and external partners to address any remaining requests and support the ongoing review process.

Compliance Program Activity

- Vision Service Plan Material Modification
 - The Plan selected Vision Service Plan (VSP) as its vision provider for both the D-SNP and Medi-Cal lines of business. DMHC required both the Plan and VSP to submit Material Modification e-Filings for review and approval. Prior to the D-SNP launch, DMHC granted conditional approval. On June 29th, 2026, DMHC provided its final approval and closed this filing.
- Compliance Support of Pharmacy Benefit Manager Transition
 - On June 9th, 2026, the Compliance Department engaged with the Department of Managed Health Care (DMHC) through a pre-filing conference to support the Material Modification related to the transition from PerformRx to MedImpact as the Plan's pharmacy benefit manager (PBM). Impacting both Group Care and D-SNP lines of business, this transition also require updates to the provider and pharmacy directories and Member Handbooks. The Alliance filed the agreement by the June 25th, 2026, due date. In addition, Compliance is an active contributor to the enterprise-wide work group.
- Network Adequacy Submissions
 - The Centers for Medicare and Medicaid Services (CMS) Network Adequacy Review is a triennial regulatory assessment used to verify that Medicare Advantage Health Plans, such as the Alliance, have sufficient provider and facility networks to ensure members have timely access to covered services. Health plans must submit detailed provider network data to CMS, which is reviewed against federal access standards to confirm network adequacy and identify any needed corrective actions or exceptions. After CMS opened the submission window, the Alliance successfully submitted its files to CMS on June 9th, 2026, with internal review reflecting 100% network adequacy compliance at the time of submission. CMS subsequently advised on June 17th, 2026, that no network adequacy exceptions were anticipated.

- Subcontractor Network Certification (SNC) - DHCS completed its review of the Plan's 2025 SNC Landscape Analysis and provided approval in advance of the SNC Exhibits submission. The Compliance Division submitted all 2025 SNC Exhibits to DHCS on February 13th, 2026, and continues to work with internal resources to respond to DHCS' follow up requests to provide additional insight regarding delegate networks. The submission is pending DHCS' final review.
- Annual Network Certification (ANC) - DHCS requires Medi-Cal managed care plans to demonstrate compliance with time and distance standards, mandatory provider types, and related policies and procedures. The Compliance team submitted all 2025 ANC Exhibits to DHCS on February 16th, 2026. Compliance continues to work with internal SMEs to respond to additional inquiries and requests from DHCS. The last response was submitted on May 19th, 2026, and the submission is pending DHCS' final review.
- Legislative and Regulatory Implementation
 - DMHC published APL 25-020 Newly Enacted Statutes for the 2025 Legislative session on December 19th, 2025. This APL 25-020 provides guidance and outlines compliance requirements related to twelve (12) newly enacted statutes. Of the twelve statutes, one is not applicable to the Alliance and the Plan is awaiting additional DMHC guidance on two statutes. On June 12th, 2026, the Plan received its second round of comments for which responses are due by July 10th, 2026.
 - DMHC published APL 25-021 on December 30th, 2025. The APL provides guidance and outlines Senate Bill (SB) 729 - Treatment for Infertility and Fertility Services compliance requirements. Although it is only applicable to Group Care, implementation of SB 729 is operationally complex, as a result implementation has been elevated to an enterprise-wide project. The project workgroup continues to meet on a weekly basis and is expecting to go-live by January 1st, 2027. On May 13th, 2026, the Plan submitted updated Policies and Procedures to DMHC and has since received comments that are due by July 10th, 2026. The workgroup is also developing updates for the 2026 Group Care Member Handbook.
- CY 2027 Medicare Final Rule – Implementation Planning

- On April 2nd, 2026, CMS (Centers for Medicare and Medicaid Services) published CY 2027 Medicare Final Rule. Review of the final rule identified minimal policy and process gaps.
- CY 2027 State Medicaid Agency Contract
 - DHCS issued the Alliance's CY 2027 D-SNP State Medicaid Agency Contract (SMAC) amendment on June 11th, 2026. The Alliance completed review and returned the signed agreement to DHCS on June 18th, 2026, received the fully executed contract on June 25th, 2026, and subsequently submitted the required SMAC documentation, attestations, and supporting materials to CMS on July 1st, 2026, ahead of the July 6th, 2026, deadline.

Privacy Office (The Privacy Office): Operational Updates

- 2026 Privacy and Security Forum Development
 - In June, the team successfully advanced the Privacy & Security Forum (scheduled for September 18th, 2026) into a fully operational, cross-organizational initiative. The forum, intended to be an opportunity to discuss current Privacy initiatives and challenges has expanded from a Privacy-only concept to a joint Privacy & Security effort, with confirmed external speakers from L.A. Care Health Plan and the Central California Alliance for Health. A focused agenda is being finalized addressing key regulatory and emerging risks, including AI, AB 133 data sharing, and DHCS reporting. The team is also working on completing a comprehensive Privacy & Security Resource Binder, consolidating cross-plan best practices and tools.
- June 2026 – Privacy Team Training Accomplishments.
 - In June 2026, the Privacy team demonstrated strong commitment to workforce education and awareness, delivering targeted trainings and expanding internal capability:
 - Targeted Operational Trainings:
 - Delivered focused privacy trainings to key business units, including Grievance & Appeals and Member Services, reinforcing critical practices such as minimum necessary use, incident escalation, and regulatory compliance expectations.
 - Enterprise Awareness Efforts: Integrated privacy education into standing team and all-staff forums, ensuring consistent messaging and reinforcing a culture of compliance across frontline operations.

- Cross-Training Program Completion: Achieved 100% completion of a comprehensive internal cross-training initiative, enabling full coverage across core privacy functions and strengthening team resilience and operational continuity.
- Member-Facing Education: Developed and published privacy-focused educational content (e.g., sensitive information protections), extending training impact beyond staff to member awareness and engagement.
- Outcome: Training efforts in June strengthened both organizational compliance awareness and internal team capability, directly supporting improved incident performance and sustained regulatory adherence.
- June 2026 Privacy Policy Updates
 - June 2026 Minimum Necessary Use and Disclosures Policy Update
 - This policy establishes how the Alliance ensures that all uses, disclosures, and requests for Protected Health Information (PHI) comply with the HIPAA Minimum Necessary Standard. It requires limiting PHI access and sharing to only what is needed for a specific purpose and defines controls such as role-based access, use of limited data sets, and standardized protocols, while distinguishing between routine and non-routine disclosures and incorporating federal and California requirements.
 - The policy was updated to add D-SNP to the Lines of Business and to strengthen alignment with CMS, Medicare, Medi-Cal, and California law, including CMIA and AB 1184. Enhancements include more prescriptive controls, clearer operational requirements, expanded guidance on sensitive services, and strengthened oversight of Business Associates and workforce compliance, improving regulatory alignment and audit defensibility and addressing NCQA requirements.
 - June 2026 Confidential Communication Requests Policy Update
 - This policy establishes that Alameda Alliance for Health must honor a member's or Personal Representative's request to receive communications containing PHI through alternative means or at alternative locations in accordance with HIPAA. It requires reasonable accommodations within defined timelines and ensures secure

communication methods are used unless the member provides documented consent for unencrypted communication.

- The policy was updated to clarify that members are not required to provide a reason for confidential communication requests and to expand and standardize definitions, including CCR and Personal Representative. Enhancements include added operational detail for intake, identity verification, implementation, and routing, along with strengthened compliance language related to unencrypted communications, minor rights, timelines, and monitoring.
- June 2026 Authorized Representative Policy Update
 - This policy establishes the process for recognizing and managing a member's Authorized Representative (AOR), including defining the scope of authority granted and safeguards to protect member autonomy. It requires that AOR authority is based on the member's explicit authorization, limits disclosures to the minimum necessary, applies additional protections for sensitive services, and ensures proper review, processing, and oversight.
 - The policy was updated to strengthen restrictions on disclosure of sensitive services without specific authorization and to reinforce the minimum necessary standard across AOR workflows. Enhancements clarify limitations on AOR authority, expand operational requirements for verification and scope validation, and formalize controls related to incomplete authorizations, AOR duration, and termination upon the member's death.

Alameda Alliance Special Investigations Unit: Operational Updates

- Fraud, Waste, and Abuse Program Overview and Performance
 - The Special Investigations Unit (SIU) continues to manage and evaluate potential fraud, waste, and abuse (FWA) allegations from both internal and external sources. With a sustained focus on effective triage, timely investigation, and appropriate case resolution.
 - In June 2026, the SIU received twenty-one (21) new referrals, of which zero (0) were determined to be potentially FWA related, and reportable to DHCS,

reflecting continued monitoring and intake across established reporting channels.

- During the reporting period, the SIU advanced ongoing process refinement efforts tied to previously identified DHCS audit focus areas. Work has increasingly centered on reinforcing verification of services practices, with an emphasis on improving documentation reliability, standardizing review approaches, and supporting audit outcomes.
- Concurrently, the SIU continued progressing active investigations, with two (2) cases completed and closed in June 2026. Efforts remain focused on advancing cases efficiently while aligning investigative activity with risk prioritization and available resources.
- The structured case-management review framework continues to be utilized in operations to guide and prioritize oversight. Ongoing collaboration with cross-functional partners supports identification of emerging patterns and informs targeted review of higher-risk areas, including those with increased potential for financial exposure and program integrity impact.

Enterprise Risk Management (ERM) and Operational Oversight Updates

- The ERM team continues to partner with organizational leaders to assess and calibrate identified risks in alignment with the Alliance's emerging risk taxonomy, risk assessment methodology, and COSO framework principles. This work supports a consistent, enterprise-wide approach to evaluating, prioritizing, and managing risks across the organization.
- Internal Audit continues to execute the approved risk-based audit plan while advancing the organization's transition to a more proactive, risk-focused audit model.
- To support this evolution, ERM and Internal Audit conducted the first of two planned Office Hours sessions, achieving participation from more than 50% of attendees invited. Topics included common audit process gaps and proactive mitigation strategies, root cause analysis techniques, effective internal controls, and ERM fundamentals,
- These efforts are strengthening organizational understanding of risk management principles, enhancing internal control awareness, and supporting the continued maturation of the Enterprise Risk Management and Internal Audit programs.

Compliance

Supporting Documents

2026 All Plan Letter (APL) List						
#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
1	1/1/2026	DHCS	26-001	Initial Health Appointment	MEDI-CAL, D-SNP	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding the requirements of the Initial Health Appointment (IHA) beginning January 1, 2023. This APL supersedes APL 22-030. This APL update provides technical fixes only.
2	1/2/2026	DMHC	26-001	National Committee for Quality Assurance Accreditation Compliance Filing	GROUP CARE	The purpose of this All Plan Letter (APL) is to inform health plans of the filing requirements for submitting the NCQA Accreditation Compliance Form (Form) and documentation of National Committee for Quality Assurance (NCQA) accreditation to demonstrate compliance with Health and Safety Code section 1399.871(d). Health plans must submit the Form and supporting documentation to the Department of Managed Health Care (DMHC), pursuant to the instructions below, no later than February 2, 2026.
3	1/15/2026	DMHC	26-002	Delegation of Risk for COVID-19 Testing or Immunizations	GROUP CARE	Senate Bill 510 (Pan, 2021), codified in Health and Safety Code section 1342.2, requires health plans to cover, without prior authorization or utilization management, COVID-19 testing and immunizations. Section 1342.2 further provides that a health plan may not delegate the financial risk for COVID-19 testing or immunizations to a provider unless the “parties have negotiated and agreed upon a new provision of the parties’ contract pursuant to [Health and Safety Code] Section 1375.7.”
4	1/29/2026	DMHC	26-003	Large Group Renewal Notice Requirements	GROUP CARE	This letter provides guidance to plans on the timing and content requirements for renewal notices to large group contractholders under HSC section 1374.21 and HSC section 1385.046.
5	1/30/2026	DMHC	26-004	Plan Year 2027 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department offers current and prospective Qualified Health and Dental Plans, Covered California for Small Business Issuers, and health plans offering nongrandfathered Individual and Small Group product(s) outside of the California Health Benefit Exchange (Covered California), guidance to assist in the preparation of Plan Year 2027 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq.
6	2/2/2026	DHCS	26-002	Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) for the provision or arrangement of clinically appropriate and covered Non-Specialty Mental Health Services (NSMHS) and the regulatory requirements for the Medicaid Mental Health Parity Final Rule (CMS-2333-F). This APL outlines MCP responsibilities for referring and coordinating with County Mental Health Plans (MHPs) for the delivery of Specialty Mental Health Services (SMHS), including providing a list of Department of Health Care Services (DHCS)-approved youth trauma screening tools for the purposes of determining access criteria for the SMHS delivery system. This APL supersedes APL 22-006.
7	3/13/2026	DHCS	26-003	Quality Measures For Encounter Data Update: Quality Measures For Encounter Data 2.0	MEDI-CAL	The purpose of this All Plan Letter (APL) is to notify Medi-Cal managed care plans (MCPs) about an update to the Department of Health Care Services’ (DHCS) Quality Measures for Encounter Data (QMED) requirements. This APL supersedes APL 14-020. MCPs are expected to comply with updated requirements as set forth in their Contracts and APL 25-007.
8	3/16/2026	DHCS	26-004	Medi-Cal Managed Care Plan Responsibilities For Behavioral Health Data-Sharing	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal Managed Care Plans (MCPs) with clarified guidance regarding their existing responsibilities for data sharing, including ensuring data privacy and security of Members’ behavioral health data with Medi-Cal Third-Party Entities in real time pursuant to Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021), Health and Safety Code (H&S) section 130290, the California Health and Human Services Data Exchange Framework (DxF) Policies and Procedures (P&Ps), MCP contract requirements, relevant APLs, and other state and federal statutes and guidance including Health the Insurance Portability and Accountability Act (HIPAA), recent updates to the 42 Code of Federal Regulations (CFR) Part 2 (Part 2) regulations, Information Blocking, Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access Final Rule (May 2020), and CMS Interoperability and Prior Authorization Final Rule (January 2024) (collectively, the Federal Interoperability Rules).
9	3/20/2026	DMHC	26-005	Compliance with Assembly Bill 904, Maternal and Infant Health Equity Program	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to inform health care service plans (plans) covering maternity services of the filing requirements necessary to demonstrate compliance with and implementation of Assembly Bill (AB) 904. The plan filings required by this APL will assist the DMHC in preparing a statutorily required report for the Legislature by January 1, 2027, that describes “the doula coverage and programs established” pursuant to the bill.
10	3/25/2026	DHCS	26-005	Maternity Services for Pregnant and Postpartum Medi-Cal Members	MEDI-CAL	The purpose of this All Plan Letter (APL) is to consolidate and update guidance for Medi-Cal managed care plans (MCPs) on the maternity benefits that MCPs are required to provide to pregnant and postpartum Members. This omnibus APL supersedes APLs 00-012 and 18-022 and Policy Letters (PLs) 98-006, 98-010, and 12-003. This omnibus APL also retires APL 01-003 and PLs 98-001 and 02-004.
11	3/30/2026	DHCS	26-006	Skilled Nursing Facility Workforce Quality Incentive Program	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with instructions on the payment and data sharing process required for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for Rating Periods between January 1, 2023, and December 31, 2025. The Calendar Year (CY) 2023 Rating Period is referred to as Program Year (PY) 1, CY 2024 Rating Period as PY 2, and so forth.
12	4/8/2026	DMHC	26-006	AB 118: Part 2 - Compliance with Individual and Small Group Standardized Evidence of Coverage/Disclosure Form	N/A	Assembly Bill (AB) 118 (Ting, Chapter 42, Statutes of 2023) added Health and Safety Code section 1363.3 and revised Sections 1352.1, 1363, 1367.041, and 1367.24, effective January 1, 2025. Part 2 of the standardized EOC/DF will include the following template components: (1) Exclusions and Limitations, (2) Members’ Rights and Responsibilities, and (3) Definitions, for use in health care service plan contracts in the individual and small group markets issued, amended, or renewed on or after January 1, 2027.
13	4/15/2026	DMHC	26-007	2026 Health Plan Annual Assessments	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide information to health care service plans (health plans) pertaining to the DMHC’s fiscal year (FY) 2026-27 annual assessment.

14	4/24/2026	DHCS	26-007	Medi-Cal Managed Care Plan Guidance on Network Provider Agreements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, the MCP Contract, state law, APLs, and similar instructions.
15	5/12/2026	DHCS	26-008	Interoperability Final Rules, Including Prior Authorization Requirements	MEDI-CAL	To provide information to all Medi-Cal managed care plans (MCPs) regarding the Centers for Medicare and Medicaid Services' (CMS) interoperability requirements. This All Plan Letter (APL) supersedes APL 22-026.
16	5/12/2026	DMHC	26-008	Premium Rate Filing Review: Small Group Geographic Rating Practice	N/A	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide additional information as part of premium rate review submission to health care service plans (health plans) pertaining to the small group geographic rating practices to comply with the requirements of 45 Code of Federal Regulations (CFR) § 147.102(a)(1)(ii)(B).
17	5/26/2026	DMHC	26-009	State of Emergency Due to Orange County Chemical Incident	N/A	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to remind health care service plans of the requirements of Health and Safety Code section 1368.7 and to provide related DMHC filing instructions.
18	5/26/2026	DMHC	26-010	Pharmacy Benefit Manager Licensure	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Licensee Letter (ALL) to inform pharmacy benefit managers (PBMs) of the requirements of Assembly Bill 116 (Committee on Budget, Ch. 21, Stats. 2025) and Senate Bill 41 (Wiener, Ch. 605, Stats. 2025). Specifically, this ALL addresses the licensure requirements of PBMs in Article 6.1, including the requirements that all PBMs be licensed by January 1, 2027.
19	6/1/2026	DMHC	26-011	Compliance with Senate Bill 306 (2025) - First Data Call	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide notice to health care service plans (health plans) of compliance requirements with Senate Bill (SB) 306 (Becker, 2025), which added section 1367.025 to the California Health and Safety Code.
20	6/1/2026	DHCS	26-009	Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age of 21	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify Medi-Cal managed care plan (MCP) obligations to provide case management services to Members under the age of 21 for whom Private Duty Nursing (PDN) services have been authorized pursuant to the federally mandated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) available under Medi-Cal.
21	6/10/2026	DHCS	26-010	Skilled Nursing Facilities - Long Term Care Benefit Under Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) on the Skilled Nursing Facility (SNF) Long-Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including coverage for Medi-Cal members under managed care.
22	6/10/2026	DHCS	26-011	Subacute Care Facilities – Long-Term Care Benefit Under Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) on the Subacute Care Facility Long-Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including coverage for Medi-Cal members under managed care.
23	6/10/2026	DHCS	26-012	Intermediate Care Facilities For Individuals With Developmental Disabilities – Long-Term Care Benefit Under Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) for the Long-Term Care (LTC) Intermediate Care Facility/Home for Individuals with Developmental Disabilities services provisions of the California Advancing and Innovating Medi-Cal (CalAIM) benefit standardization initiative for Medi-Cal managed care Members. This APL contains requirements related to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes.
24	6/23/2026	DHCS	26-013	H.R. 1 – Federal Payment to Prohibited Entities – Important Update: End of One-Year Restriction on Federal Payments	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide updated guidance to Medi-Cal managed care plans (MCPs) on the handling of payments to Medi-Cal Providers who were impacted by Section 71113 of H.R. 1 (Public Law No: 119-21) between the dates of July 4, 2025, and July 3, 2026. This update is specific to claims or Encounters with Dates of Service (DOS) on or after July 4, 2026.

COMPLIANCE DASHBOARD SUMMARY													
OVERALL FINDINGS	Resource	Type										TOTAL	% Completed
			2018	2019	2020	2021	2022	2023	2024	2025	2026		
	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	2	27	
		Total Findings	50	28	7	35	15	26	26	3	2	192	
		Total In Progress	0	0	0	0	0	3	0	0	2	5	97%
		Total Completed	50	28	7	35	15	23	26	3		187	
		Total Findings	50	28	7	35	15	26	26	3	2	192	
	DMHC	Total State Audit Findings			5	6	8	3		16		38	
		Total Self-Identified Issues			3	0	0	0		6		9	
		Total Findings			8	6	8	3		22		47	
		Total In Progress			0	0	0	0		18		18	62%
		Total Completed			8	6	8	3		4		29	
		Total Findings	NA	NA	8	6	8	3	NA	22	NA	47	
	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			1		1	91%	
Total Completed			5			4			1		10		
Total Findings		NA	5	NA	NA	4	NA	NA	2	NA	11		
STATE AUDIT FINDINGS		In Progress	0	0	0	0	0	3	0	13		16	93%
		Completed	38	33	12	39	27	24	20	5		198	
		Total Findings	38	33	12	39	27	27	20	18		214	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	6	2	8	78%	
		Completed	12	0	3	2	0	2	6	3	0		28
		Total Findings	12	0	3	2	0	2	6	9	2		36
TOTAL OVERALL FINDINGS			50	33	15	41	27	29	26	27	2	250	90%

Compliance Dashboard Summary

COMPLIANCE DASHBOARD SUMMARY			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	214	86%
	Total Self-Identified Issues	36	14%
	Total Findings	250	
	Total In Progress	24	10%
	Total Completed	226	90%
	Total Findings	250	
STATE AUDIT FINDINGS	In Progress	16	7%
	Completed	198	93%
	Total Findings	214	
SELF-IDENTIFIED FINDINGS	In Progress	8	22%
	Completed	28	78%
	Total Findings	36	

2026 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	0	0%
	Total Self-Identified Issues	2	100%
	Total Findings	2	
	Total In Progress	0	0%
	Total Completed	0	0%
	Total Findings	2	

Compliance Dashboard Summary

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	1	50%
	Total Completed	1	50%
	Total Findings	2	

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	0	0%
	Total Completed	3	100%
	Total Findings	3	

2025 DMHC Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	16	73%
	Total Self-Identified Issues	6	27%
	Total Findings	22	
	Total In Progress	18	82%
	Total Completed	4	18%
	Total Findings	22	

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	0	0%
	Total Completed	26	100%
	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	0	0%
	Total Completed	3	100%
	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	

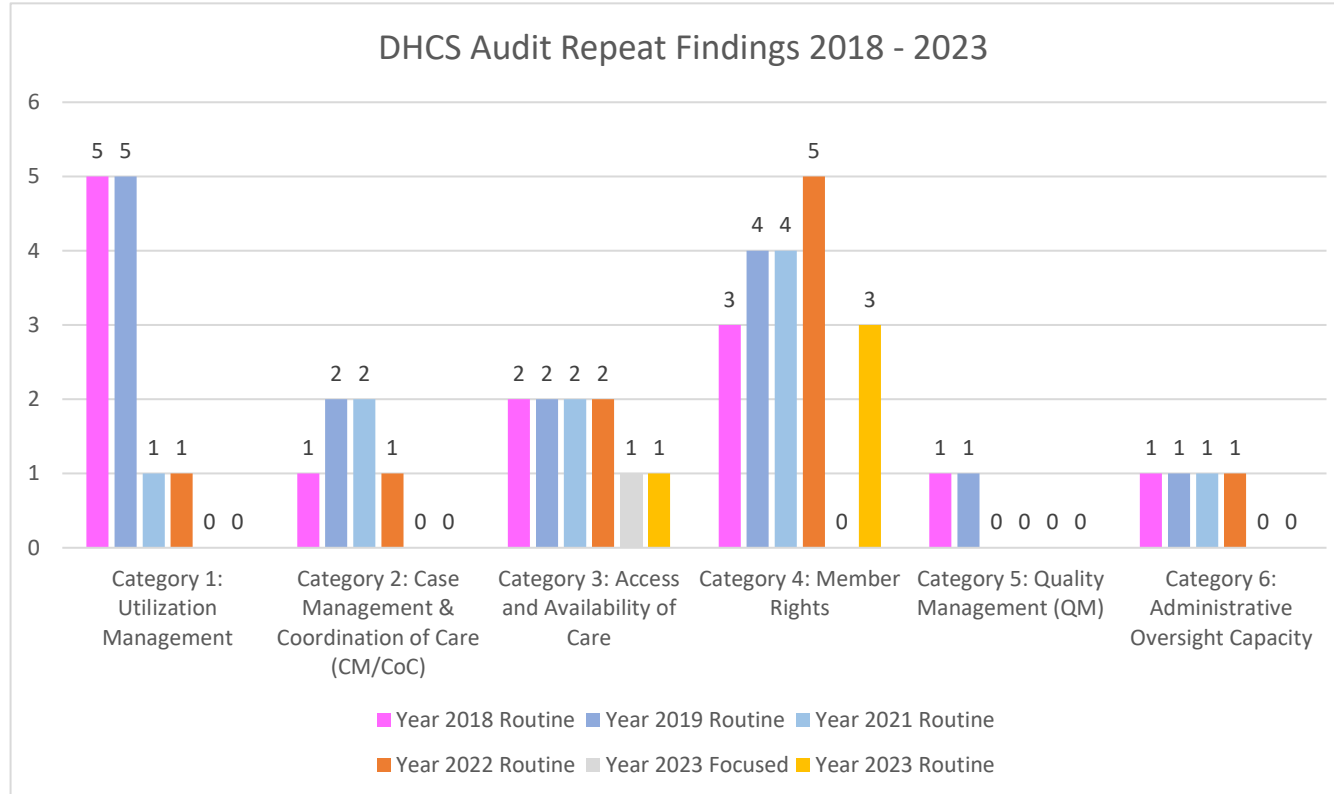
2018 DHCS Medical Services Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	38	76%
	Total Self-Identified Issues	12	24%
	Total Findings	50	
	Total In Progress	0	0%
	Total Completed	50	100%
	Total Findings	50	

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

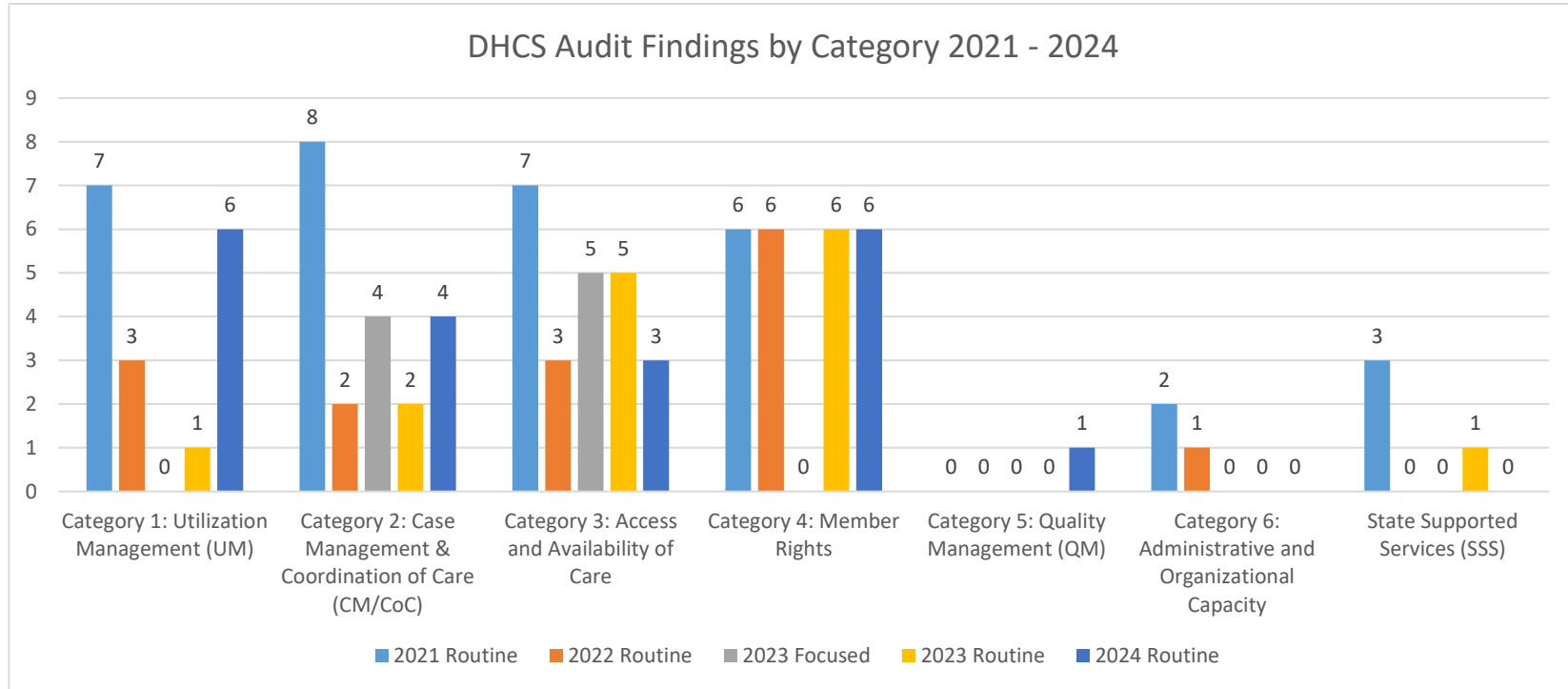


Compliance Dashboard Summary

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



**ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD**

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2026 DHCS Audit - Audit Review Period March 1, 2025 to December 31, 2025 Virtual Audit Dates March 2, 2026 to March 13, 2026						
#	Category	Plan Observations - DHCS Preliminary Findings expected June 2026	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
1	PHM & CoC (Enhanced Care Management)	The Plan's 2025 ECM Provider Directory did not show ECM providers for the months of January-February, and July - December.	The Alliance experienced a glitch in the provider directory data extraction process that caused the ECM providers to be excluded from the extraction. The Alliance has corrected the data template to ensure that required data elements are included in the reporting template and include ECM providers. In addition, on March 11, 2026, we also confirmed requirements with our vendor, KP, who uses the data extraction reports to create a PDF version of the directory. The new data extraction template will also be used going forward for subsequent Provider Directories. Recommend PS to develop an oversight element that addressed whether the directories are reviewed for accuracy and at what cadence so that the Plan may identify and correct errors timely. 5/5/2026 Update: IT and C&O includes Provider Services when sending the Provider Directory files for ongoing oversight.	TBD	Pending	Provider Services
2	PHM & CoC (Pregnant & Postpartum Members)	Regarding CPSP reimbursement, the Plan does not have an oversight mechanism in place for CPSP providers.	CPSP approval is administered by the California Department of Public Health (CDPH) and is not reflected within Medi-Cal enrollment systems or Plan credentialing data sources. The Plan confirmed that there is no CPSP indicator available within the Medi-Cal enrollment portal or other DHCS-managed systems to validate CDPH CPSP approval status. Recommend to develop an oversight mechanism for CPSP claims monitoring and verification for CPSP approved providers.	TBD	Pending	Credentialing Provider Services Claims

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2025 DMHC Routine Fiscal Examination - Audit Review Period January 1, 2025 to March 31, 2025 Audit Date August 4, 2025						
#	Category	Deficiencies	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
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.	On September 10, 2025, prior to issuance of the Preliminary Report, the Plan paid the interest and penalties due on late claim payments resulting in additional payments of interest of \$54,261 and penalties of \$66,120 on 6,612 claims.	9/10/2025	Complete	Claims
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.	The Plan currently forwards claims identified as the responsibility of delegates/capitated providers within regulatory timeframes per Cal. Code Regs. Tit. 28, § 1300.71(b)(2). 3/2/26 Update: To strengthen our oversight of misdirected claims, the Plan reviewed and enhance existing policies and procedures, as applicable, to clearly define the steps to audit forwarded claims and ensure compliance with Sections 1371, 1371.35, and Rule 1300.71. - CLM-009 P&P and CMP-403 Approved at AOC on 2/18/26; P&Ps were submitted to DMHC on 3/2/26. 4/3/26 Update: Compliance implemented the forwarded claims validation process to ensure oversight and compliance. 4/20/26 Update: DMHC confirmed that the CAP is completed and closed. 5/1/26 Update: Monthly forwarded claims validation is ongoing.	Ongoing	In Progress	Compliance - DO Claims

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2025 DMHC Audit - Audit Review Period 10/1/2022 - 9/30/2024 Audit Unsite Dates - March 5, 2025 to March 7, 2025					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
1	Quality Assurance	The Plan did not document that quality of care provided is reviewed, problems are identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.	The PQI CAP workflow was modified (orange) to include the following: 1) QI RN case owner to review response to each CAP question and reviewed by the MD, 2) for non-compliant/responsive providers, added that if noted by the MD, the QI RN case owner will be referred to the Peer Review Committee and/or report the quality issue to the appropriate regulatory bodies, 3) the provider or facility will be tracked on the Escalation Log maintained by Compliance. In addition, the MD will use a templated final note: "Medical Director CAP Review and Attestation" to ensure all CAP issues are addressed and follow up is planned where indicated. The PQI CAP template was revised to include a table with lines to ensure that each deficiency (problem) and corrective action(s) are addressed. 5/2026 Update: Implementation is tied to the BOG meeting scheduled for 5/8/26 to allow formal inclusion in the CEO report and documentation in meeting minutes.	TBD	Quality Assurance
2	Grievance and Appeals	The Plan's governing body did not thoroughly document it periodically reviewed a written record of grievances.	The Plan revised its grievance governance reporting process to ensure that the written grievance report documentation the Board of Governors (BOG) periodically receives specifically includes aggregate grievance trends, categories, representative summaries, dispositions, and identification of systemic or recurring issues. The Plan implemented dedicating a duration of time for standardized grievance and appeals at BOG meetings and updated documentation requirements to ensure meeting minutes explicitly reflect the BOG's review of the written grievance record during each meeting, including reference to the report. 5/2026 Update: Implementation is tied to the BOG meeting scheduled for 5/8/26. 06/03/26 Update: Health Plan audit team is working with stakeholders to validate CAP implementation.	TBD	G&A
3	Grievance and Appeals	181 The Plan did not consistently provide immediate notification to complainants of their right to contact the Department regarding an expedited grievance. Section 1368.01(b); Rule 1300.68.01(a)(1).	The Plan's Member Services Department conducted training on 12/19/2024 to reinforce the requirement to immediately notify members of their rights to contact DMHC when a case is logged as expedited. Additionally, Grievance and Appeals implemented a spot-check process to review all incoming expedited cases to ensure member rights are provided at intake. Monthly internal audits are conducted for expedited grievances and appeals. 06/03/26 Update: Grievance resolution letter template coverage disputes updated. The Plan submitted its CAP and DMHC has reviewed, per DMHC final report, this deficiency has been corrected.	4/1/2026	G&A
4	Grievance and Appeals	The Plan's written response to expedited grievances involving a determination that the requested service was not a covered benefit did not include a notice that the enrollee should contact the Department if they believed a denial was based on lack of medical necessity. Rule 1300.68(d)(5).	5/19/2026 - Corrected per DMHC. The Plan will update its Grievance Resolution template letters to include language for when requested service are not a covered benefit, the enrollee should contact the Department if they believed the denial was based on lack of medical necessity. Once the templates are finalized, the Grievance and Appeals Department will provide training to staff of the new templates to utilize.	TBD	G&A
5	Access and Availability	The Plan did not monitor telephone triage service wait times to ensure the wait times did not exceed 30 minutes.	The Plan provided standard operating procedure file "CM_SOP_Nurse Line" detailing the monitoring workflow. Please also see included example file "Alameda Quarterly Telemetrics 2025_Q4" showing average wait times in seconds for all of 2025.	TBD	CM
6	Access and Availability	The Plan's notification to providers did not include the information required in Section 1367.27(i)(2)(A)-(C).	The Plan will update its Provider Demographic Form to include the information that providers may utilize the Plan's online interface through the Alliance Provider Portal to review the information in the directory (the Provider Demographic Attestation) and that failure to respond may result in a delay of payment or reimbursement of a claim pursuant to Section 1367.27 subdivision (p). In addition, the Plan will create a new provider notice that provides instructions on how providers can use the Alliance Provider Portal to review and attest to the Provider Directory information (the Provider Demographic Attestation) and work with our Provider Portal vendor to see if there are any available options to enhance the use of the Provider Demographic Attestation within the Alliance Provider Portal. 3/30/26 Update: The Plan updated its provider communication document, Provider Demographic Attestation Form.	TBD	Provider Services
7	Access and Availability	The Plan did not have a process to monitor whether its provider networks experienced a 10 percent change.	5/19/2026 - Corrected per DMHC. Plan has updated its policy, PRV-003 Provider Network Capacity Standards, to include a process to monitor whether the network has experienced a 10 percent change. The policy was presented and reviewed in its Administrative Oversight Committee (AOC) Meeting on 1/21/2026 and anticipates it to be approved in the subsequent AOC meeting on 2/18/2026. In addition, the Plan has created a workflow that outlines the steps that will be taken to monitor (see DMHC Significant Network Filing Workflow). 2/18/26 Update: PRV-003 P&P approved at AOC. 06/03/26 Update: Health Plan audit team is working with stakeholders to validate CAP implementation.	TBD	Provider Services
8	UM	The Plan did not consistently notify the requesting provider within 24 hours of a decision to modify or deny a request. Section 1367.01(h)(3).	The Plan has initiated corrective actions to ensure notification timeliness fully complies with DMHC regulatory requirements. Specifically, the Plan will conduct audits of the provider notification timeliness to address previously identified deficiencies. The Plan has updated policy UM-051 Timeliness of UM Decision Making and Notification to include the process for auditing the timeliness of member and provider notifications. The policy will be presented and reviewed at the next QIHEC meeting scheduled for 2/13/2026 and is anticipated to be presented for approval at the subsequent AOC meeting.	TBD	UM
9	UM	The Plan failed to demonstrate that in the case of concurrent review denials, care was not discontinued until the enrollee's treating provider was notified and agreed to an appropriate care plan. Section 1367.01(h)(3).	The Plan has updated its policy, UM 003 Concurrent Review, to clarify the steps for reaching an agreement with the Treating Provider. The Policy will be presented and reviewed at the next QIHEC meeting scheduled for 2/13/2026 and is anticipated to be presented for approval at the subsequent AOC meeting.	TBD	UM
10	UM	The Plan did not conduct adequate oversight of its delegates to ensure written communications to enrollees regarding decisions to deny or modify services were clear and concise. Section 1367.01(h)(4).	In regards to the Carelon/ Beacon findings, the plan has taken the proactive steps to de-delegate Carelon/ Beacon and bring the UM responsibilities for Behavioral and Mental Health in house with all functions performed by the Alliance effective April 2023. For the CFMG Delegate oversight, the plan has identified these same findings during the 2025 Annual Audit. The plan has a Corrective Action Plan (CAP) in place with CFMG that became effective on 11/14/2025. The CAP requires CFMG to provide evidence of efforts to monitor this requirement through internal audits. They must provide quarterly and annual internal audit results to the Alliance showing evidence of compliance/corrected deficiencies and submit documentation via the HICE reports for oversight and monitoring.	TBD	UM Compliance - DO

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2025 DMHC Audit - Audit Review Period 10/1/2022 - 9/30/2024 Audit Unsite Dates - March 5, 2025 to March 7, 2025					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
11	UM	The Plan did not conduct adequate oversight of its delegates to ensure delegates consistently provided the reviewer's required contact information. Section 1367.01(h)(4).	The Plan agrees with the findings. In regards to the Carelon/ Beacon findings, the Plan took proactive steps to de-delegate Carelon/ Beacon and transitioned all UM responsibilities for behavioral and mental health services in house, with all functions performed by the Alliance effective April 2023. With respect to CFMG Delegate oversight, the Plan identified the same findings during the 2025 Annual Audit and implemented a Corrective Action Plan (CAP) effective 11/14/2025. CFMG has corrected the deficiency to ensure that the peer-to-peer phone number listed on adverse decision letters connects directly to CFMG Medical Directors. CFMG completed re-recording of the peer-to-peer line with enhanced instructions in October 2025, and the updated number is now aligned with the adverse determination notices.	TBD	UM Compliance - DO
12	Pharmacy	The Plan did not consistently include a description of the criteria or guidelines used for the decision in formulary exception denial and modification letters. Section 1367.01(h)(4).	Contested: The Plan reviewed DMHC reports and confirmed their applicability to several identified criteria documents. The Plan prepared a narrative explaining how the Alliance develops clinical criteria and applies to them clearly, concisely, and on an individualized basis to member-specific circumstances.	TBD	Pharmacy
13	Pharmacy	(R) The Plan's published formulary did not meet regulatory requirements. Rule 1300.67.205(b), (c)(4)-(6), (d)(2), (4)-(7), (9)-(18).	The Plan has initiated corrective actions to ensure the online searchable formulary fully complies with DMHC regulatory requirements. Specifically, the Plan will update the formulary webpage to incorporate a direct link to the DMHC-approved Formulary Cover Page, thereby addressing previously identified deficiencies. This enhancement will ensure that members, providers, and regulators have immediate access to the approved formulary cover information, including all mandated disclosures.	TBD	Pharmacy
14	Behavioral Health	The Plan did not demonstrate that all staff who conducted utilization review of mental health and substance use disorder treatment services and benefits completed the formal education program for each nonprofit association criteria or guidelines utilized by the Plan. Section 1374.721(a), (b), and (e)(1)	Contested: The Plan documents in the Post-Audit file 145_NPA Guidelines Training that six (6) team members successfully completed training on ASAM, ECSII, LOCUS, and CALOCUS-CASII. Only Behavioral Health staff who have completed training on the Non-Profit Professional Association (NPA) guidelines are authorized to review Group Care mental health (MH) and substance use disorder (SUD) authorization requests (see documents 145_BH NPA Guidelines Training and 145_BH Training Certificates). The Plan further confirms that all utilization management (UM) staff who review transgender care authorizations have completed training on the World Professional Association for Transgender Health (WPATH) standards (see documents AAH WPATH Training Compliance Grid and WPATH Certificates of Completion). As documented in the APL 24-007 comment table (File Number: 20242576-7), the Plan does not conduct medical necessity reviews for applied behavior analysis (ABA) services for Group Care members and therefore does not utilize CASP guidelines. The comment table also documents the Plan's use of the American Psychiatric Association and American Psychological Association guidelines for the review of psychological testing, neuropsychological testing, transcranial magnetic stimulation (TMS), and electroconvulsive therapy (ECT) services.	TBD	Behavioral Health
15	Behavioral Health	The Plan did not conduct interrater reliability testing to ensure consistency in medical necessity decision making covering all aspects of mental health and substance use disorder utilization review. Section 1374.721(b), (e)(5) and (f)(3)(A).	5/19/2026 - Corrected per DMHC. Contested: The Plan develops Inter-Rater Reliability (IRR) testing to ensure consistency in authorization determinations and to confirm that appropriate clinical guidelines are applied throughout the review process. These IRRs are designed to validate that decision-making aligns with established standards for mental health and substance use disorder services. The urgency classification of an authorization request (routine, urgent, or retrospective) does not affect the application of medical necessity criteria; rather, it only determines the applicable turnaround timeframe for the authorization decision. The Plan believes that utilization management staff have been appropriately tested through IRR processes to ensure accurate and consistent application of medical necessity guidelines. 06/03/26 Update: Health Plan audit team is working with stakeholders to validate CAP implementation.	TBD	Behavioral Health
16	Behavioral Health	The Plan did not ensure its delegate used only those criteria from nonprofit associations listed in the All Plan Letter 21-002 Attachment A, and alternative criteria approved by the Department, when making medical necessity determinations for requested mental health and substance use disorder services. Section 1367.01(j), Section 1374.721(a), (b) and (h).	5/19/2026 - Corrected per DMHC. Contested: The Plan documented in its APL 22-002 comment table (File Number: 20211181) that it confirmed with its delegate the required utilization management Non-Profit Professional Association (NPA) guidelines would be used to determine medical necessity for Group Care/HSS members. At that time, the delegate submitted a written attestation and training logs as part of the DMHC comment table, which were accepted by the DMHC. The Plan also reviewed the delegate's policies requiring use of the applicable guidelines and completion of annual Inter-Rater Reliability (IRR) testing. In addition, the Plan audited a random sample of Notices of Action, which documented use of the appropriate guideline by service type and line of business. The Plan did not conduct a separate audit of this specific requirement because the delegate had provided written confirmation of compliance with SB 855, and this documentation was accepted by DMHC. The Plan subsequently insured all behavioral health utilization review activities in April 2023. In August 2025, DMHC accepted the Plan's comment table (File Number: 20242576-7) documenting implementation of SB 855 and compliance with APL 24-007. 06/03/26 Update: Health Plan audit team is working with stakeholders to validate CAP implementation.	TBD	Behavioral Health
A	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. 06/03/26: Guidance provided at Internal kick-offs meeting and adhoc meetings.	Already in Place Already in Place Already in Place TBD	Compliance

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2025 DMHC Audit - Audit Review Period: 10/1/2022 - 9/30/2024 Audit Onsite Dates - March 5, 2025 to March 7, 2025					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
B	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
C	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
D	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
E	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
F	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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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 MCOD. 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. 5/9/2025: 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 reviewed 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. <u>Update 10/16/2025</u>; IA conducted an audit for this area beginning 08/26/25; the audit was closed on 10/16/25 with no CAPs. 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. <u>Update 10/16/2025</u>; IA conducted an audit for this area beginning 08/26/25; the audit was closed on 10/16/25 with no CAPs. 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. <u>Update 10/16/2025</u>; IA conducted an audit for this area beginning 08/26/25; the audit was closed on 10/16/25 with no CAPs.	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. <u>Update 5/9/2025</u> ; 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. <u>Update 5/9/2025</u> ; 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. <u>Update 5/9/2025</u> ; Internal audits were started in February 2025. <u>Update 7/11/2025</u> ; 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. <u>Update 5/9/2025</u> ; 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. <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. <u>Update 12/17/2025</u> ; Audit reports were presented during AOC meeting. <u>Update 10/21/2025</u> ; IA conducted an audit of this area starting 04/04/2025; the audit was closed 07/09/2025. The CAPs were closed on 10/21/2025.	12/17/2025	Completed	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. <u>Update 5/9/2025</u> ; 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 <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. <u>Update 12/17/2025</u> ; Audit reports were presented during AOC meeting. <u>Update 10/21/2025</u> ; IA conducted an audit of this area starting 04/04/2025; the audit was closed 07/09/2025. The CAPs were closed on 10/21/2025.	12/17/2025	Completed	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. <u>Update 8/15/2025</u> : IA conducted an audit of this area beginning 5/7/25; the final report was issued on 8/1/25. This audit was closed on 8/15/25. 4. The Plan will include review of the Internal Audit results at the Compliance Committee meetings.	7/11/2025	Completed	Compliance		State	DHCS
			1. The Plan will review and update the following impacted P&Ps as needed: PRV-005 & CRE-002. 3/14/2025: 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. 3/14/2025: 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		1. Completed 4/15/2025 2. Completed 4/15/2025 3. Completed 4/15/2025 4. Completed 4/15/2025				

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2024 DHCS Audit - Audit Review Period 6/1/2023 - 5/31/2024 Audit Onsite Dates - June 17, 2024 - June 28, 2024							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self-Identified	Agency
20	Quality Management	(5.3.1) Notification of Provider Terminations The Plan did not meet DHCS reporting and member notification requirements for provider terminations.	log was completed. Update 7/11/2025: 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. 2/15/2025: 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. <u>Update 06/03/26</u> : The Plan continues to monitor the quarterly credentialing report to ensure identified suspended or terminated providers due to QOC are appropriately reported 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. Update 2/27/2026: IA conducted an audit for this area beginning 6/20/25; the audit was closed on 2/27/26. CAPs are ongoing. The results for this audit will be presented to the AOC. <u>Update 06/03/26</u> : The CAP was closed on 05/29/26, and it will be reported at AOC this month.	In Progress	5. Completed 4/15/2025 6. Completed 4/15/2025 7. Completed 8. Completed 9. Completed	Operations		State	DHCS



Health Care Services

Donna Carey, MD

To: Alameda Alliance for Health Board of Governors

From: Dr. Donna White Carey, Chief Medical Officer

Date: July 10th, 2026

Subject: Health Care Services (HCS) Report

Credentialing Committee

- At the Peer Review and Credentialing (PRCC) meetings held on June 16, 2026, there were one hundred and eighty-two (182) initial network providers approved; two (2) primary care providers, five (5) specialists, twenty-six (26) ancillary providers, eight (8) midlevel providers, and one hundred and forty-one (141) behavioral health providers.
- Additionally, seventy-six (76) providers were re-credentialed at this meeting; six (6) primary care providers, fifteen (15) specialists, five (5) ancillary providers, ten (10) midlevel providers, and forty (40) behavioral health providers.
- The report shows 431 facilities that are currently credentialed.

Utilization Management: Outpatient

- The prior authorization and benefits grid revision was completed and the searchable code tool is now posted on the external website. The goal was to create a more provider-friendly reference document to delineate code-specific authorization rules. The searchable code tool was updated on June 25th to enable providers to see if codes are covered or non-covered codes. The benefit will be maintained monthly in alignment with DHCS Medi-Cal TAR and non-standard benefit code list articles to ensure ongoing accuracy and compliance. OP processed a total of 3,537 authorizations for the month of June. We also processed 452 CCS referrals, of which 115 cases were submitted to our regional CCS office for review (45 approved, 24 denied, 46 pending). CBAS 12 New CEDT, 4 Discharge, 5 ERS, 49 renewals.
- Overall OP Turnaround times exceeded the threshold of 95% for the month of June 2026. The OP UM team, in collaboration with the MDs, continue to explore process improvements to streamline efficiency and reduce missed TATs. The D-SNP LOB
- The top 5 categories remain unchanged TQ, Radiology, Home Health, Outpatient Rehab and Outpatient Facility. These 5 categories represent ~75% of this volume.
- The Home Health pilot launched in July 2025 continues to be effective, reducing the number of manual reviews for selected HH services and diagnoses. Currently, 9

providers are utilizing the process for their initial home health requests. . The pilot is being monitored and will be expanded in the future.

- The number of D-SNP authorizations created continue to rise as April was the first month that the 90-day Continuity of Care provisions were lifted for the original D-SNP members. There were 23 Outpatient D-SNP Authorizations created April 2026, 36 in May however June saw a decline of only 7 authorizations processed. .

Total Outpatient Authorization Volumes						
	April 2026 Approvals	April 2026 Denials	May 2026 Approvals	May 2026 Denials	June 2026 Approvals	June 2026 Denials
Medi-Cal	N/A	N/A	N/A	N/A	3,020	377
IHSS	N/A	N/A	N/A	N/A	114	19
D-SNP	N/A	N/A	N/A	N/A	7	0
Overall	3,396	554	3,054	427	3,141	396

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

Outpatient Authorization Denial Rates			
Denial Rate Type	April 2026	May 2026*	June 2026
Denial Rate Excluding Partial Denials	4.3%	2.7%	3.0%
Partial Denial Rate	0.1%	0.3%	0.2%
Overall Denial Rate	4.4%	3.0%	3.2%

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

Outpatient Turn Around Time Compliance (benchmark: 95%)			
Line of Business	April 2026	May 2026	June 2026
Overall	99.6%	98.5%	99.7%
Medi-Cal	99.6%	99.7%	99.3%
IHSS	100%	98.6%	100%
D-SNP	95.7%	97.2%	100%

Source: #02569_AuthTAT_Summary

Utilization Management: Inpatient

- Total inpatient auth volume (including all IP authorization types processed by department: Acute, LTACH, Skilled SNF, and OP auths related to discharge) increased slightly from 3,484 in May 2026 to 3,526 in June 2026.
- 26 DSNP Authorizations were processed by the inpatient department in June.
- Inpatient overall average LOS decreased from 5.5 in April to 5.2 in May Admits per thousand also decreased from 53.6 in April to 50.6 in May. The same pattern was seen in days per thousand - decreasing from 292.1 in April to 260.5 in May.
- IP overall denial rate decreased slightly from 2% in May to 1.9% in June.

- IP Auth TAT –100% overall continues to surpass 95% benchmark across all lines of business in June 2026.
- IP UM successfully launched D-SNP workflows and is actively processing requests on behalf of D-SNP members, in compliance with TAT, in alignment with Medicare guidelines and established processes. There were 21 D-SNP Authorization reviewed by the Inpatient Team in April, 20 in May, and 26 in June.
- External hospital rounds are ongoing with UCSF, Stanford, Alameda Health System, Kindred LTACH, Kentfield LTACH, Washington, Eden, Alta Bates, and Summit, to review members' current active admissions discuss UM issues, address discharge barriers, offer other opportunities for supporting throughput and appropriate discharge.
- Alameda Alliance IP UM RN onsite nurse pilot program completed its 5th month at Washington Hospital. Data shows decrease in readmission rates for Washington Hospital by 0.3% FYE 2025 to FYE 2026. Preliminary data also suggests significant decrease in length of stay: 5.8 in FYE 2025 vs 5.1 in FYE 2026. Report outs in the coming next months, with confirmed data after 3-month claims lag. The IP UM Onsite RN meets with members in the ED and on the inpatient floors, interacting with hospital care management staff and providers to ensure appropriate care coordination, follow ups, and discharge authorizations are in place.

Total Inpatient Authorization Volumes						
	April 2026 Approvals	April 2026 Denials	May 2026 Approvals	May 2026 Denials	June 2026 Approvals	June 2026 Denials
Medi-Cal	N/A	N/A	N/A	N/A	3,403	57
IHSS	N/A	N/A	N/A	N/A	39	0
D-SNP	N/A	N/A	N/A	N/A	25	1
Overall	3, 869	59	3,484	73	3,467	58

Source: #02569_AuthTAT_Summary

Authorization breakdown per LOB began in June 2026

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	March 2026	April 2026	May 2026
Authorized LOS	5.5	5.5	5.2
Admits/1,000	52.1	53.6	50.6
Days/1,000	287.2	292.1	260.5

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

Inpatient Authorization Denial Rates			
Denial Rate Type	April 2026	May 2026	June 2026
Full Denials Rate	1.4%	0.8%	1.0%
Partial Denials	1.8%	1.2%	0.9%
All Types of Denials	3.2%	2.0%	1.9%

Source: #01292_AllAuthDenialsRate

Inpatient Turn Around Time Compliance (benchmark: 95%)			
Line of Business	April 2026	May 2026	June 2026
Overall	99%	100%	100%
Medi-Cal	99%	100%	100%
IHSS	100%	100%	100%
D-SNP	100%	94%	100%

Utilization Management: Long-Term Care

- LTC census during June 2026 was 2,253 members. This is a decrease of -6.8% (165 members) from May 2026.

Totals	April 2026	May 2026	June 2026
Medi-Cal	2462	2418	2253
D-SNP	1	1	1

- Month to Month, the admissions and length of stays seem to decrease from March 2026 - May 2026 of 70%, 80%, 67% respectively. Some of this could be due to a lag in claims data being available. NOTE: there were no admissions for D-SNP members in LTC

Medi-Cal Totals	March 2026	April 2026	May 2026
Admissions	147	117	44
Days	1127	611	216
Readmissions	36	27	12

Source: #14236_LTC_Dashboard

- LTC Staff continue to participate in SNF collaboratives around the county to ensure that our facility partners are updated with processes and program enhancements.
- LTC Provider Office Hours are scheduled for SNF and ICF/DD facilities in July 2026 – this is a quarterly forum for providers to ask questions related to operational processes (including claims, authorizations, and appeals)
- Having virtual rounds with AHS, San Leandro, Kyakameena, Elmwood, Jones Convalescent and Eden LTC facilities to coordinate on complex cases

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

Total Medi-Cal LTC Authorization Volume			
Authorization Status	April 2026	May 2026	June 2026
Approvals	1003	783	879
Partial Approvals	0	0	0
Denials	58	41	59
Total	1061	824	938

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

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

Source: #02569_AuthTAT_Summary

Behavioral Health

- In May, the Behavioral Health Department processed 719 authorizations, 777 Care Coordination referrals, and 225 mental health screenings and transition of care tools.

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

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

BHT/ABA TAT			
<i>Goal ≥95%</i>	26-Apr	26-May	26-June
Determination TAT%	100%	98%	98%
Notification TAT%	100%	95%	98%

Behavioral Health Denial Rates

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

*corrected data from <1% to 1.5%

Mental Health Care Coordination

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

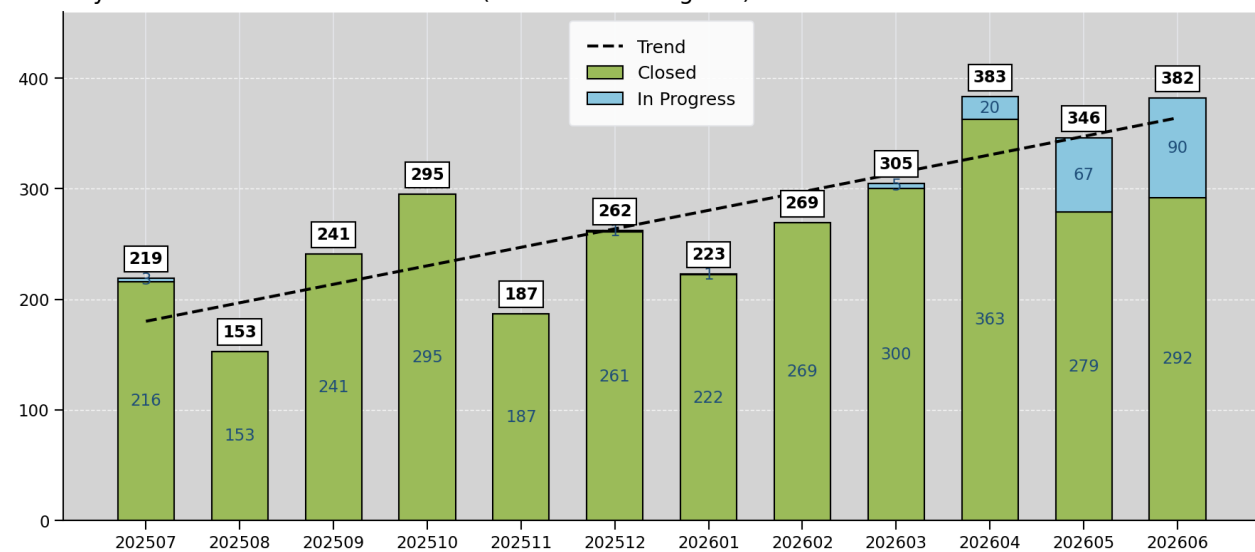
	26-Apr	26-May	26-June
Youth Screenings	62	75	70
Adult Screenings	122	149	118
Incoming ACBH Referrals	159	91	164
Outgoing Referrals to ACBH	32	43	6
Transition of Care Tools to ACBH	1	1	2

Source: 16015_MH_Assessments, 16093_BH Referral Report

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

MH Case Coordination

Monthly MH Case Coordination Volume (Closed vs In Progress)



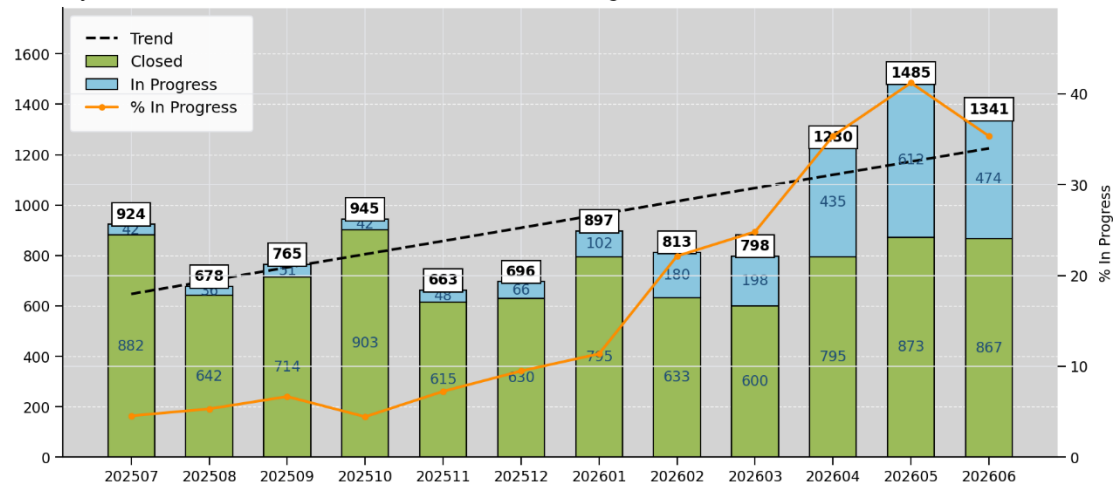
Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA)

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

BHT Case Coordination

Monthly BHT Case Coordination Volume (Closed vs In Progress)

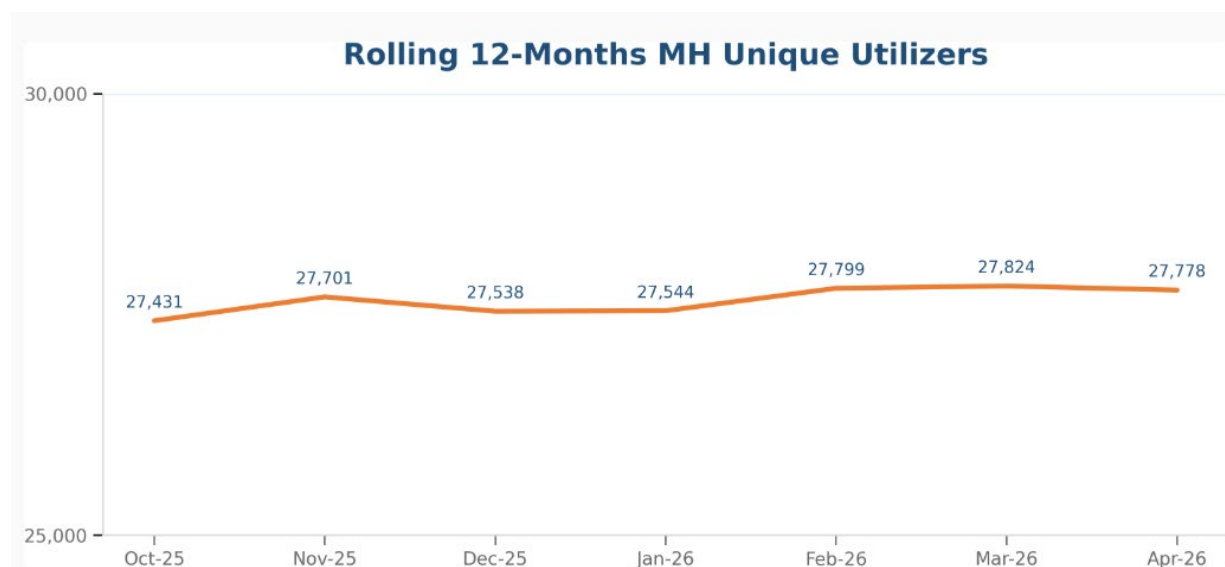


Source: 14665_BH_Cases

Behavioral Health Unique Utilizers

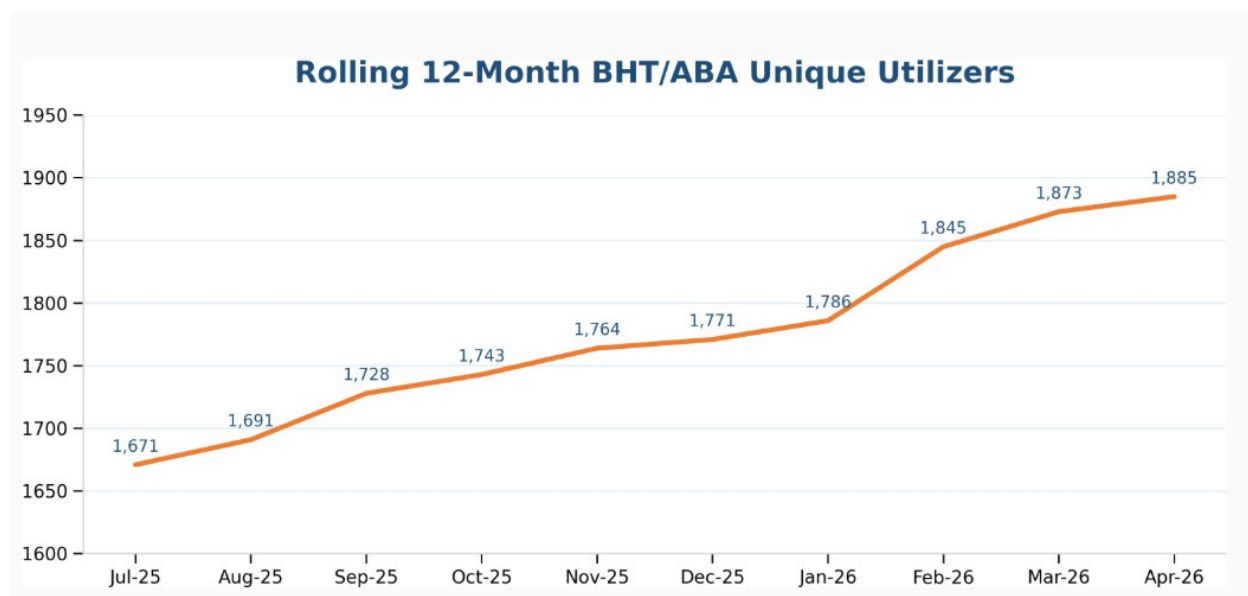
- Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.

Mental Health Unique Utilizers:



- There has been a net increase of 347 unique utilizers from October 2025 to April 2026 (+1.27%).
- Data is based on claims. April 2026 utilization numbers reflect a 2-month claim lag.

BHT/ABA Unique Utilizers:



Source: PBI 14621 BHT Utilization Report

- There has been a 13% increase in unique utilizers from July 2025 to April 2026
- Data is based on claims. April 2026 utilization numbers reflect a 2-month claim lag.

Pharmacy

- Pharmacy Services process outpatient pharmacy claims, and pharmacy prior authorization (PA) has met turn-around time compliance for GroupCare and DSNP line of business (LOB) for June, 2026:

LOB	Number of Outpatient PAs Processed	Turn Around Rate Compliance (%)
Group Care	174	100%
DSNP	14	100%

Decisions	Group Care PAs Processed	DSNP PAs Processed
Approved	59	3
Denied	91	8
Closed	24	3
Total	174	14

- Group Care Medications for weight loss and diabetes are in the top categories for denials.

May Ranking	Drug Name	Common Use
1	LIDOCAINE Patch 5%	Topical pain relief
2	XIFAXAN Tablet 550MG	Travelers' diarrhea, hepatic encephalopathy
3	ZEPBOUND Soln Auto-inj 2.5MG/0.5ML	Weight loss
4	WEGOVY Soln Auto-inj 0.25MG/0.5ML	CV risk reduction, Weight loss, NASH
5	JARDIANCE Tablet 10MG	Diabetes
6	ITRACONAZOLE Capsule 100MG	Antifungal
7	TRETINOIN Cream 0.025%	Acne
8	ADVAIR HFA Aerosol 115/21/MCG/ACT	Asthma, COPD
9	DEXLANSOPRAZOLE Capsule DR 60MG	GERD
10	VTAMA Cream 1%	Plaque psoriasis, atopic dermatitis

- DSNP Medications for diabetes are in the top categories for denials

May Ranking	Drug Name	Common Use
1	LIDOCAINE Patch 5%	Topical pain relief
2	OZEMPIC (0.25 OR 0.5 MG/DOSE) Soln Pen-inj 2MG/3ML	Diabetes
3	ZTLIDO Patch 1.8%	Topical pain relief
4	ZEPBOUND Soln Auto-inj 2.5MG/0.5ML	Weight loss
5	BELBUCA Film 600MCG	Analgesia
6	OZEMPIC (2 MG/DOSE) Soln Pen-inj 8MG/3ML	Diabetes

Turnaround Time and Determinations By Line of Business¹

LOB	Determination	June 2026
IHSS	Approved	59
	Denied/Partials	115
	TAT	100%
DSNP	Approved	3
	Denied/Partials	11
	TAT	100%

¹ Only includes authorizations that have been determined excluding closed authorizations.

DSNP Redetermination (Appeals) Summary June 2026

Summary Table

Decisions	Number of PAs Processed
Overtured	4
Upheld	2
Closed	0
Total	6

72/168 Hour TAT Compliance

	Number of Redeterminations	Percentage of Redeterminations
Compliant	6	100%
Non-Compliant	0	0%
Total	6	100%

- The Pharmacy Transitional Care Services (TCS) program has screened 29 **Heart Failure** cases, 37 **Sepsis** cases, and received 0 **direct referral** for the month of June 2026.
- Pharmacy is collaborating with population health, QI, and disease management on creating clinical programs for HEDIS measures for high blood pressure, asthma, and diabetes.
- The Pharmacy Department continues to monitor members on use of opioids. We send bi-annual mailings to at risk members and their providers. Impacted members receive handouts on medication assisted treatment for opioid dependence, an opioid safety guide, and alternative pain management strategies. Their assigned PCPs receive guides to benzodiazepine and opioid tapering, formulary alternatives to opioids, and opioid dependence treatment approaches.

DSNP Pharmacy STARS outreach

Report Run	Count of Member Outreach Success (Y/N)	Sum of Provider outreach attempts(3)	Count of Pharmacy outreach attempts (3)
2/18/2026	14		
3/2/2026	2		2
3/19/2026	5	8	1
4/6/2026	7	7	4
4/22/2026	2	1	2
5/5/2026	4	4	5

5/19/2026	5	3	5
6/3/2026	2	9	3
Grand Total	41	32	22

Outreach Goals Met			
Report Run	N	Y	Grand Total
2/18/2026	9	5	14
3/2/2026		2	2
3/19/2026	5	1	6
4/6/2026	3	2	5
4/22/2026		1	1
5/5/2026	2	1	3
5/19/2026		2	2
6/3/2026		5	5
Grand Total	19	19	38

STARS Rate

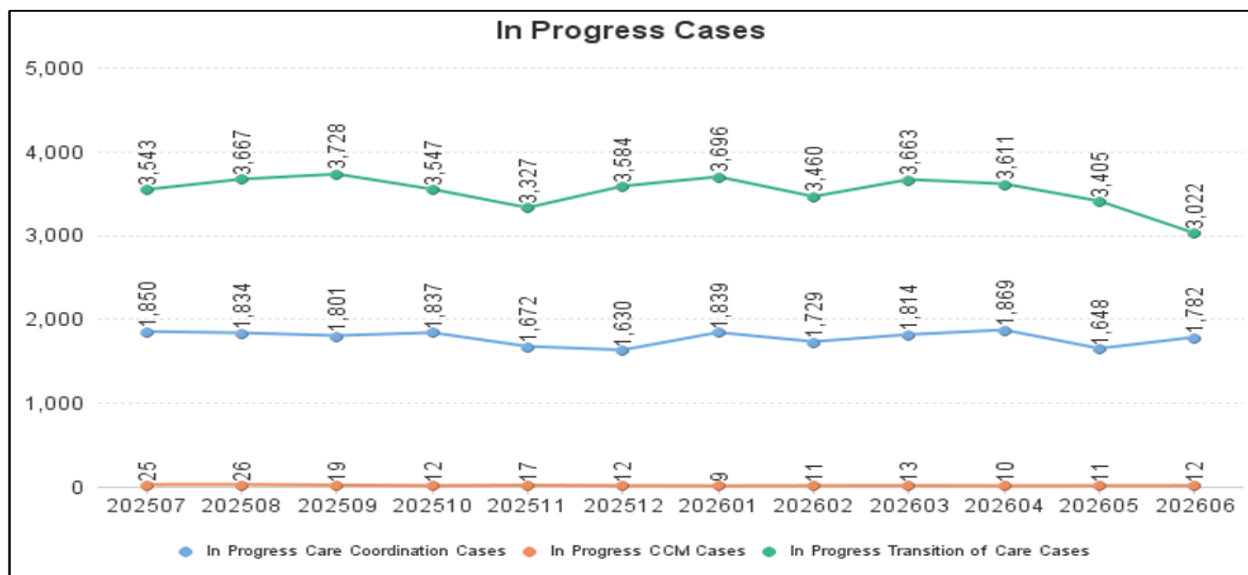
Measure	Rate (6/16/26)
PDIA	87.2%
PRAS	95.5%
PSTA	92.4%
SUPD	79.3%
COB	50%
PACH	25%

Case and Disease Management

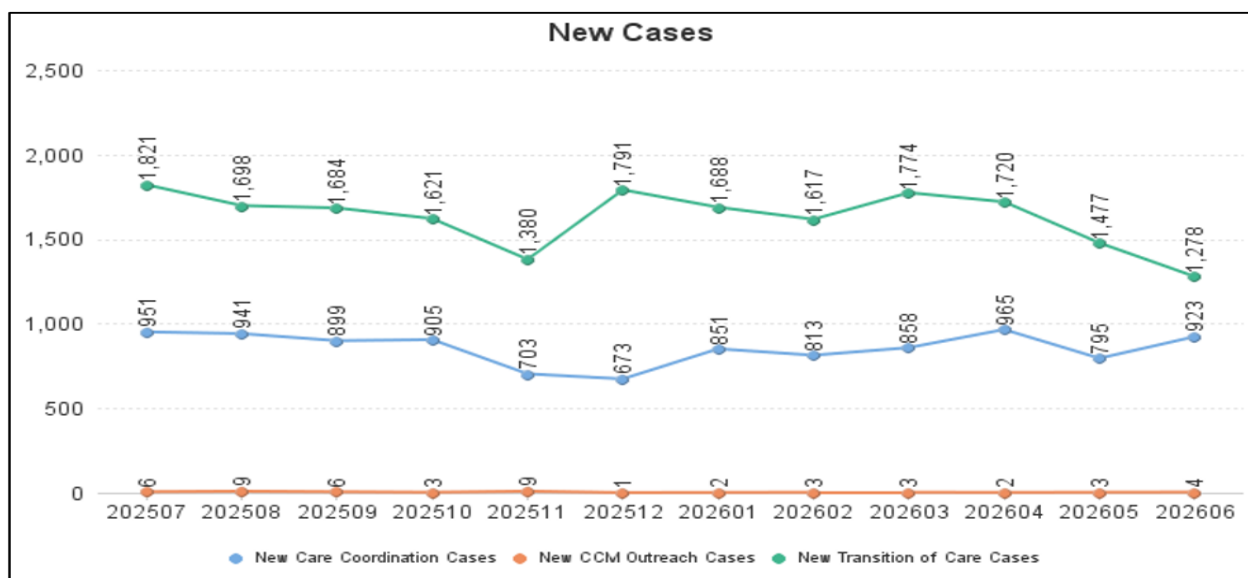
- D-SNP case management is live. The Case Management (CM) team is engaging D-SNP members in completing HRA assessments, building care plans and supporting members to help meet their needs.
- The CM team continues to assist the high volume of members needing Transitional Care Services (TCS) as they transition from one level of care to another. This includes outreaching members who are still hospitalized and following up post-discharge to help meet the members' needs. The CM team has partnered with an in-person provider, Upward Health for the adult high-risk TCS population that went live 6/1/26.
- The TCS work also includes collaboration with clinic partners to ensure the TCS requirements are met, including but not limited to scheduling and ensuring follow-up appointments for members, informing members of CM services, notifying appropriate

individuals of TCS services (hospital discharge planners, members, caregivers, support teams, etc.).

- CM is working closely with UM and LTC teams to support members at hospitals with long-length stays and complex discharge barriers, including facilitating referrals to Community Supports, ECM and other community resources, as needed.
- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues to educate the provider network, including hospital discharge planners, and dialysis centers about PCS form requirements. The transportation liaison has also increased oversight of ModivCare's facility transportation services, including making onsite visits with hospitals to address transportation concerns.

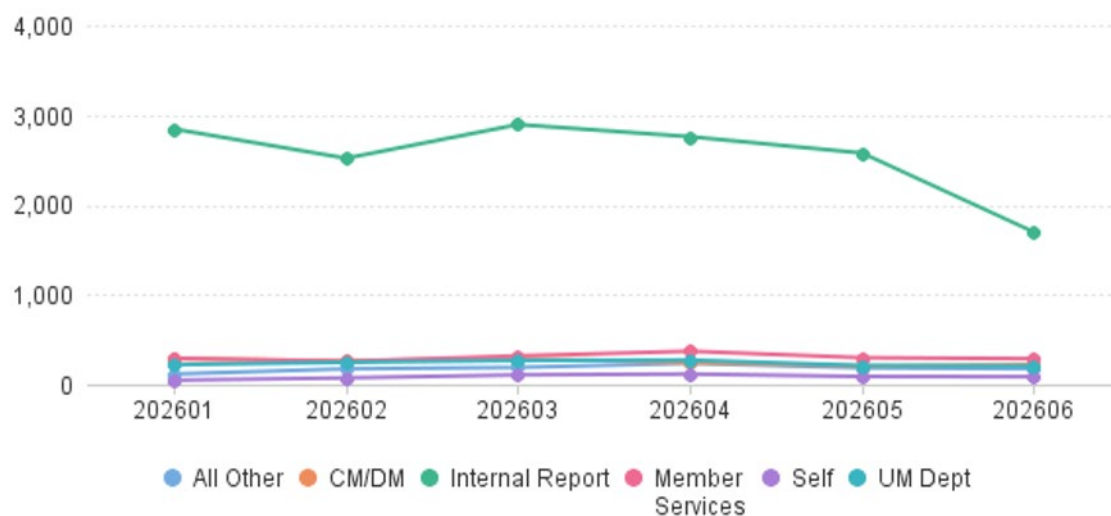


Source: #03342 TruCare Caseload



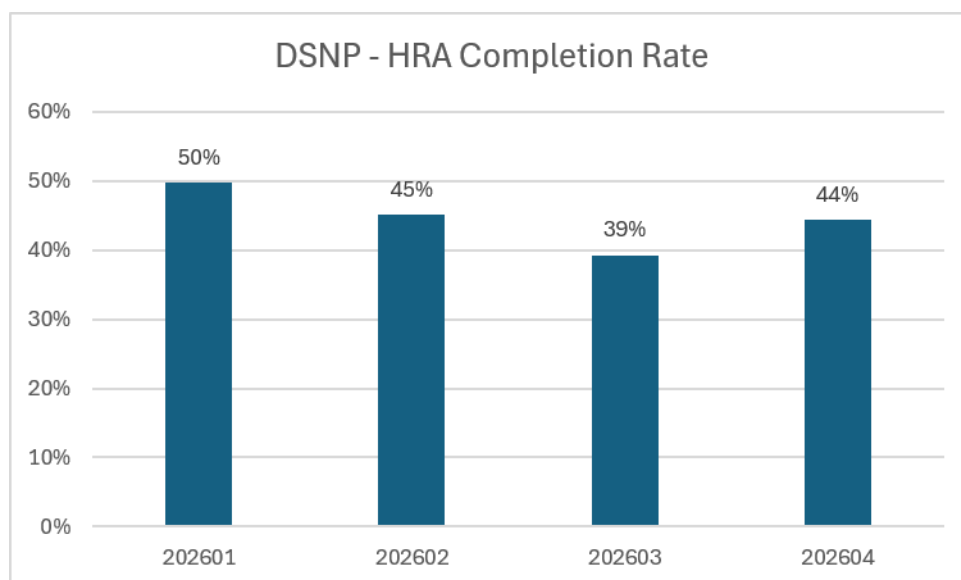
Source: #03342 TruCare Caseload

Top Referral Sources into CM



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

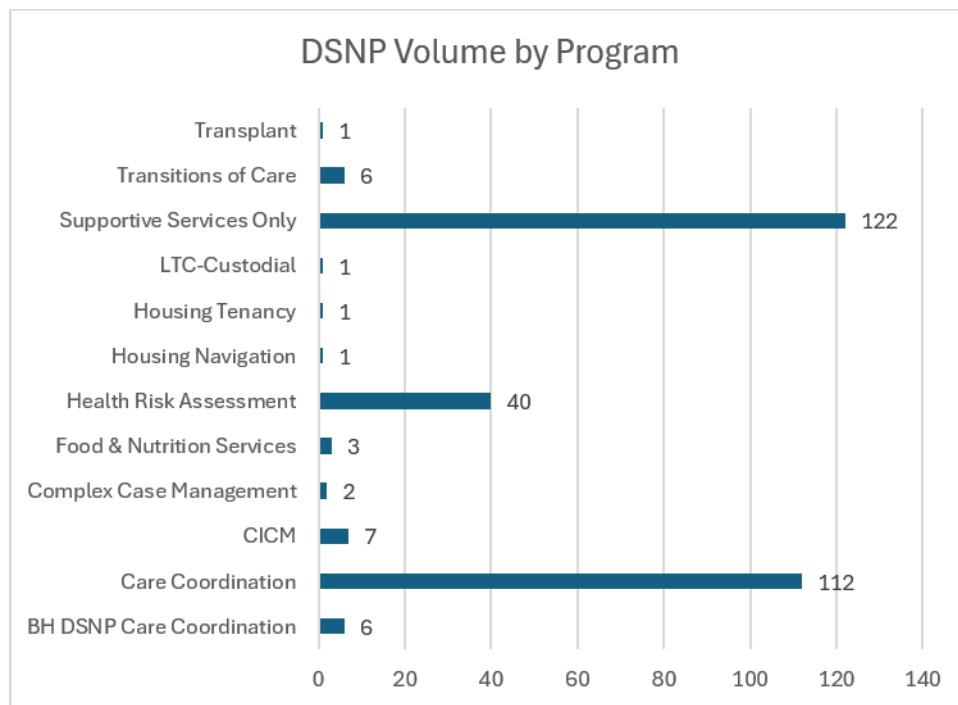
Source: #03881 Case and Disease Management Dashboard -



*Note: HRA's due 90 days from enrollment, so members who enrolled 5/1/26 or later still be outreached

Source: #00835 HRA Dashboard

DSNP CM Volume by Program Type



Source: #17175 CM DSNP Aging

Definitions:

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

CalAIM

Enhanced Case Management

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

- The ECM team continues to build rapport with the ECM providers, meeting to discuss specific cases and work with the ECM providers to assist with moving members through the ECM program by addressing care plan barriers and offering support and services ECM providers may not be aware of. This has led to more collaboration and community referrals to additional resources. Additional meetings are scheduled with ECM providers for individual case conferences as needed. Clinical Operations meetings that support ECM provider leadership and processes continue. These meetings further support the relationship between the ECM provider and AAH, to better understand the barriers ECM providers experience to moving members through the ECM care continuum appropriately and with a higher level of quality of care.
- ECM and CS teams have begun a collaborative meeting to confirm communication is occurring between Community Supports providers and ECM lead care managers. The collaboration further enhances coordination of care, ensuring non-duplicative services and members receive appropriate services to meet their needs. One new area where collaboration is happening is in preparing for Transitional Rent, ensuring smooth transitions into ECM as necessary.
- The ECM team is wrapping up the Spring Audit of the ECM providers. The ECM team continues to meet with Compliance to address findings and develop best practices for consistent communication with the providers to monitor improvements.
- The ECM team continues the ECM Training Academy. The trainings began in April and occur monthly throughout the year. Topics include ECM referrals and documentation for reauthorizations, nonjudgemental language and care, and more. July will focus on Dementia Care.

	March 2026		April 2026		May 2026	
ECM Providers	Outr each	Enro lled	Outr each	Enro lled	Outr each	Enro lled
ACBH	-	13	-	13	-	13
Alameda Health System (AHS)	25	225	28	244	11	234
Bay Area Community Services (BACS)	43	239	29	245	40	264
California Cardiovascular Consultants	-	132	-	131	-	132
California Children's Services (CCS)	9	57	12	60	7	58
CHCN	147	1,346	209	1,408	88	1,399
East Bay Innovations (EBI)	14	164	14	168	9	174
Full Circle	1	148	-	150	-	152
Institute on Aging	175	251	182	266	195	281
La Familia	46	35	47	33	35	32
MedZed	1,404	1,494	1,777	1,589	288	1,714
Pair Team	-	2141	1	1985	-	1950

Roots Community Health Center (includes Street Medicine)	1	600	-	513	2	494
Seneca Family Services	10	58	14	58	7	57
Star Nursing	-	-	-	-	-	-
Titanium Health Care	529	1,832	648	1,927	821	2,035
Tiburcio Vasquez Health Center (Street Medicine)	-	122	-	124	-	120
BACH (Street Medicine)	-	78	-	73	-	69
Lifelong (Street Medicine)	1	427	3	410	-	395

Source: #13360 ECM Dashboard – data available through March 2026

Community Supports (CS)

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

- New HCPCS codes for Housing Navigation and Housing Tenancy & Sustaining Services, along with a restructured payment model, went into effect on 7/1/26 to create better alignment between service delivery and reimbursement rates.

Community Supports	Services Authorized in April 2026	Services Authorized in May 2026	Services Authorized in June 2026
Housing Navigation	1164	1070	999
Housing Deposits	399	392	352
Housing Tenancy	1909	1940	1904
Asthma Remediation	144	147	138
Meals	1348	1411	1241
Medical Respite	54	46	36
Transition to Home	6	2	1
Nursing Facility	1	2	2
Home Modifications	15	15	13
Homemaker Services	33	31	27
Caregiver Respite	1	1	1
Transitional Rent	29	35	37
Total	5,103	5,092	4,751

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

- There has been an increase in the amount of authorization requests by 10% from April 2026 to June 2026.

Total Medi-Cal CS Authorization Volume			
Authorization Status	April 2026	May 2026	June 2026
Approvals	931	888	1028
Partial Approvals	0	0	0
Denials	68	77	83
Total	999	965	1111

Total D-SNP CS Authorization Volume			
Authorization Status	April 2026	May 2026	June 2026
Approvals	2	1	1
Partial Approvals	0	0	0
Denials	0	0	0
Total	2	1	1

Source: #02569_AuthTAT_Summary

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

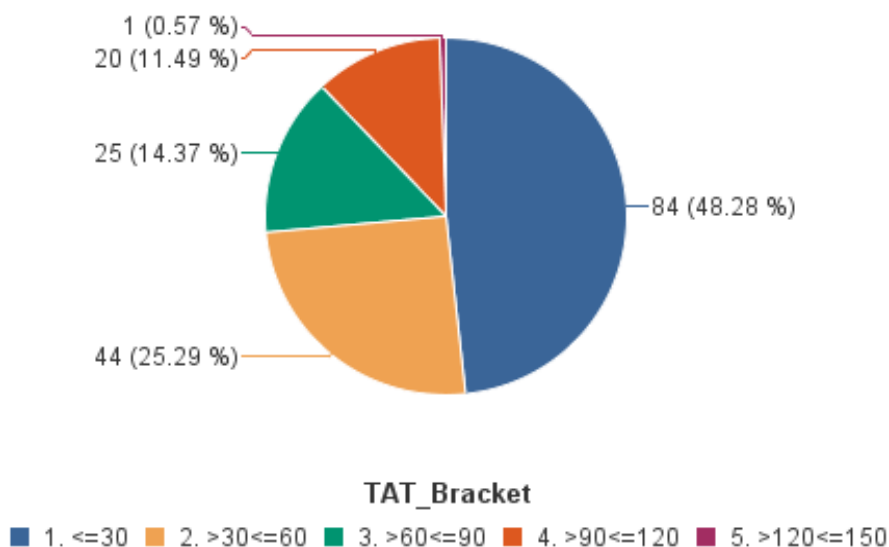
CS Turn Around Time Compliance (benchmark: 95%)			
Line of Business	April 2026	May 2026	June 2026
Medi-Cal	99%	99%	98%
D-SNP	100%	100%	100%

Source: #02569_AuthTAT_Summary

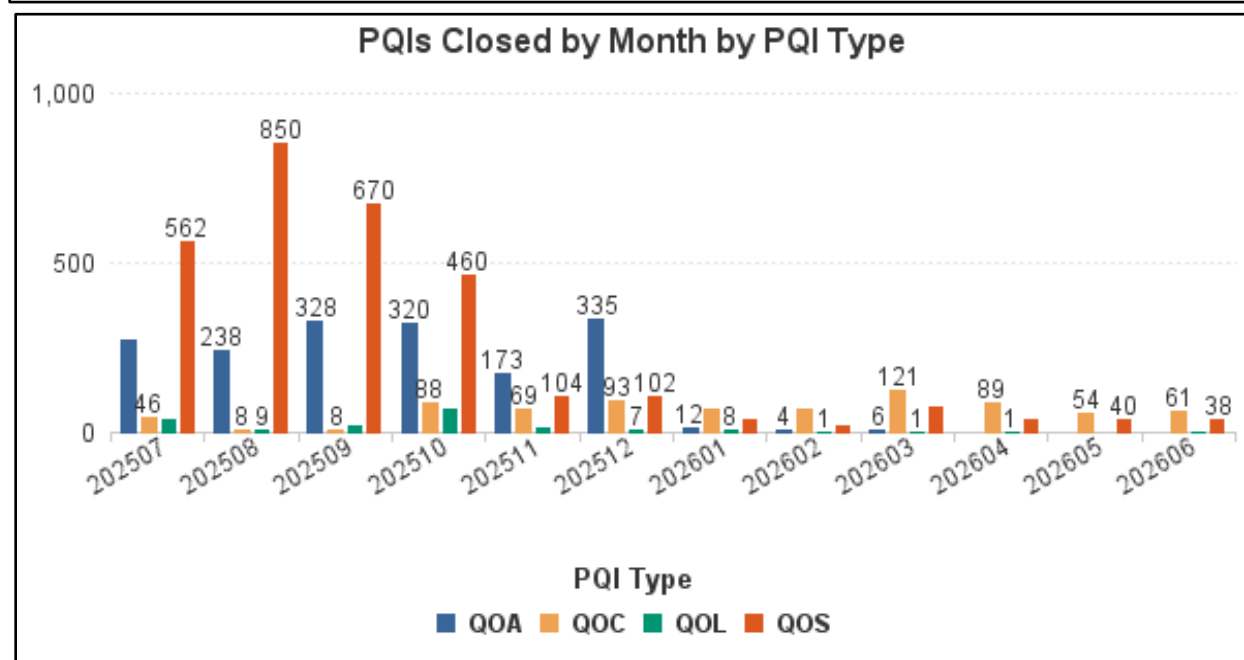
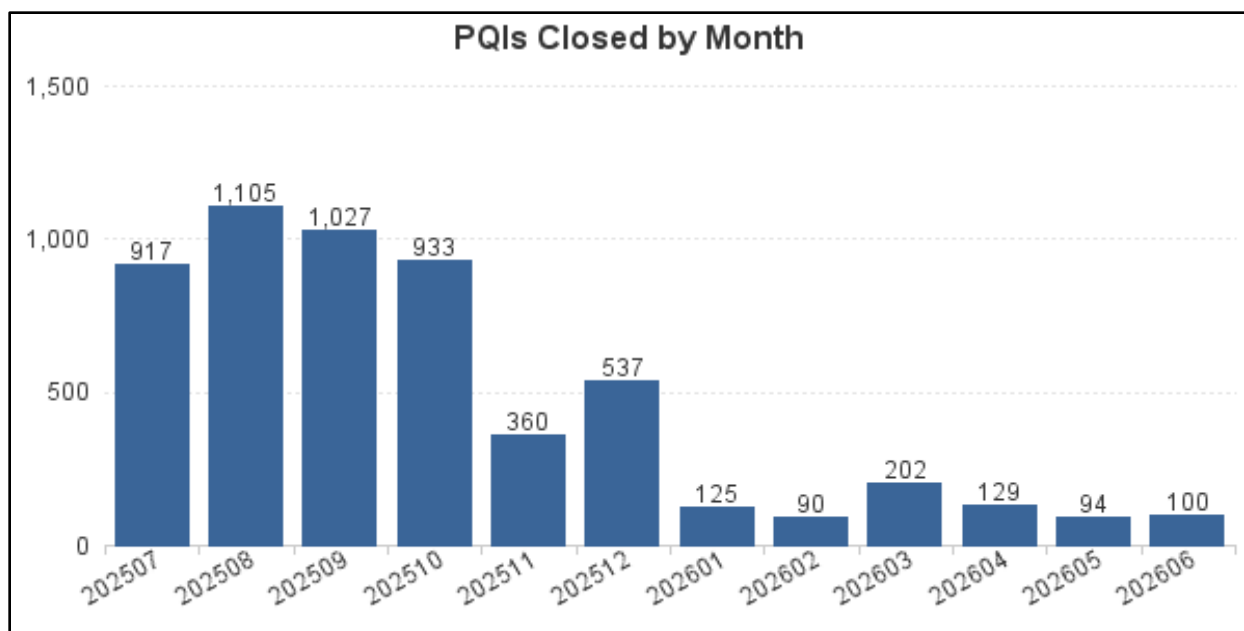
Quality

- As of June 30, 2026, the turnaround time (TAT) for Potential Quality Issues (PQI) is 100% closed within 150 days which exceeded the standard of 95% case closure rate. The majority of the cases were closed within 90 days (88%). The TAT at which PQI cases are being leveled and closed with final MD recommendations was met for the last 3 consecutive months.
- In response to the Department of Managed Health Care (DMHC) audit, the team has strengthened the PQI workflow for the corrective action plan process. The PQI workflow was finalized on June 10, 2026, including training of the PQI team and documentation of cases with non-compliance of CAPs on the Escalation Tracker.

PQI Aging Report as of 06/30/2026 N= 174



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



Provider Satisfaction Survey:

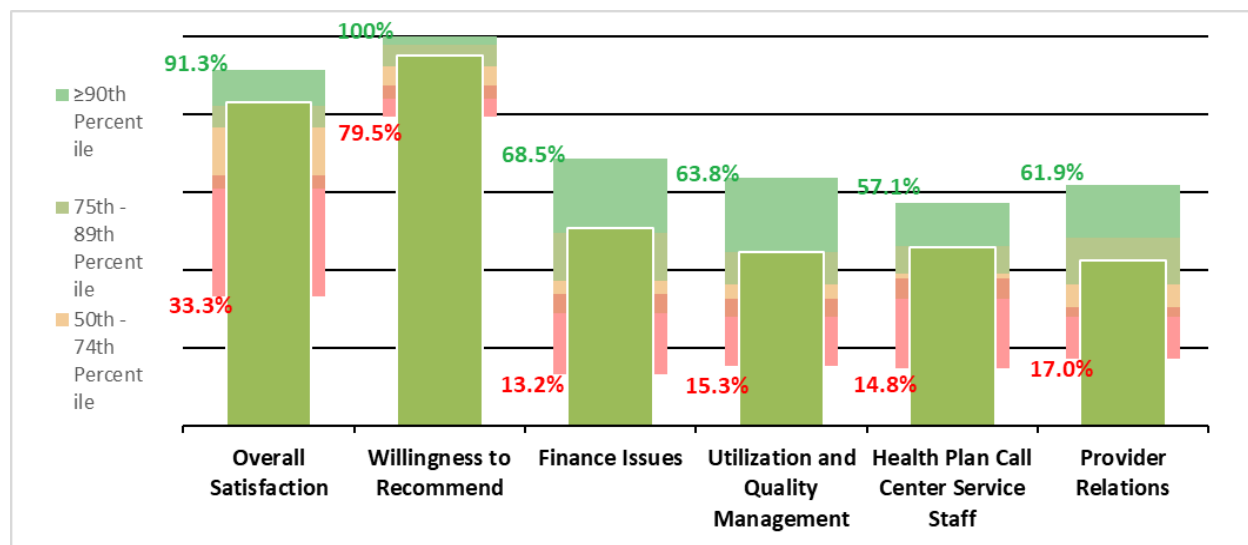
- **Survey Objective:** The Provider Satisfaction Survey targets providers to measure their satisfaction with Alameda Alliance for Health. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Provider Satisfaction Survey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

Provider Satisfaction Composite Scores

Composite	MY 2025 Result	Variance Compared to Previous Year	Variance Compared to PG Commercial Benchmark BoB	MY 2024 Result	MY 2023 Result
Overall Satisfaction	83.1%	Higher	Significantly Higher	80.7%	78.4%
All Other Plans (Comparative Rating)	62.9%	Lower	Significantly Higher	64.1%	55.3%
Finance Issues (Claims)	50.6%	Lower	Significantly Higher	56.3%	49.0%
Utilization and Quality Management	44.7%	Lower	Significantly Higher	50.4%	47.5%
Network/Coordination of Care	33.5%	Higher	N/A	27.0%	41.7%
Pharmacy	33.7%	Lower	N/A	35.6%	38.1%
Health Plan Call Center Service Staff	45.7%	Lower	Significantly Higher	50.9%	49.2%
Provider Relations	42.3%	Lower	Significantly Higher	52.6%	61.8%

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

Comparison Relative to PG Book of Business



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

Red bar = AAH performing below the 25th percentile

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

Key Drivers of Overall Satisfaction with Health Plan

Power: Promote and leverage Strengths (Top 5 Listed)

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

Opportunities: Focus resources on improving processes

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

Community Health Strategy (CHS) – June 2026

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:

- No updates at this time.

June Program Summary:

June was a reminder that Quality begins long before a member walks into a clinic.

It begins in neighborhoods, trusted relationships, community organizations, faith institutions, housing sites, schools, and the countless places where people live their daily lives. At Alameda Alliance for Health, Community Health Strategy (CHS) exists to strengthen that connection by ensuring the voices of our members and the expertise of our community partners remain at the center of how we design, deliver, and continuously improve care.

This month, the Community Health Strategy team continued advancing a vision that extends beyond administering a covered benefit. We are building the bridge between clinical and non-clinical care by connecting healthcare with the social, cultural, and community environments that ultimately influence health outcomes. By intentionally stepping outside the four walls of the health plan, CHS is creating stronger partnerships with community-based organizations, providers, local health jurisdictions, housing partners, and other trusted stakeholders who have long been improving the health and well-being of Alameda County residents.

Rather than duplicating existing efforts, CHS is committed to amplifying the extraordinary work already taking place throughout our communities. Our role is to convene, strengthen, and align community assets with the Alliance's strategic priorities, so members experience a more connected, coordinated, person-centered, and equitable system of care.

This approach reflects our belief that Community Health Workers are not simply an extension of healthcare administration, they are trusted community professionals whose relationships, cultural humility, and lived experience make them uniquely positioned to bridge gaps that traditional healthcare models often cannot.

This month, CHS practiced reflective leadership to unpack; what does it mean to Advance the future of Community Health Work? Advancing the Community Health Worker Benefit Through Statewide Leadership and Advocacy.

As Community Health Worker services continue to evolve across California, CHS remains committed not only to implementing policy but also to helping shape its future through thoughtful partnership, operational expertise, and continuous advocacy.

This month, Alameda Alliance for Health was honored to be invited by the California Department of Health Care Services (DHCS) and the Community Health Synergy Collaborative to present in July 2026 on our Community Health Worker programming and implementation strategies to Medi-Cal managed care plans across California. These opportunities reflect the Alliance's growing reputation as a leader in Community Health Worker integration and provide a meaningful platform to share lessons learned, innovative practices, and implementation strategies that can strengthen Community Health Worker programs statewide.

At the same time, CHS continues working closely with our internal Compliance partners to thoughtfully evaluate emerging policy changes and provide constructive operational feedback to DHCS. As new requirements are implemented, our responsibility extends beyond compliance to ensuring that policy remains aligned with how Community Health Workers effectively engage members in real-world community settings.

One example is the recently adopted non-cumulative time requirement for Community Health Worker services. While intended to establish consistency in service delivery, this operational change has the potential to unintentionally limit the flexibility that makes Community Health Workers effective. Trusted community engagement often occurs through multiple brief interactions that build rapport over time, respond to changing member needs, and meet individuals where they are. These touchpoints, while individually shorter, collectively represent meaningful interventions that foster trust, strengthen engagement, and support improved health outcomes.

By partnering across departments and maintaining open dialogue with DHCS, Alameda Alliance continues advocating for implementation approaches that preserve the integrity of Community Health Worker practice while supporting accountability, measurable outcomes, and meaningful member engagement. Our goal is to ensure that policy advances—not limits—the ability of Community Health Workers to provide culturally responsive, relationship-centered care that reflects the realities of the communities they serve.

This work directly supports the California Department of Health Care Services' vision to expand Community Health Worker services throughout Medi-Cal. As implementation continues, CHS is positioning the Alliance to operationalize this vision by developing innovative partnerships that integrate Community Health Workers into care delivery models that improve member engagement, increase access, strengthen continuity of care, and address barriers that exist outside of traditional clinical settings.

Community Health Workers represent an opportunity to redefine how care is delivered. Rather than viewing the role through a narrow administrative lens, CHS continues exploring new models that leverage Community Health Workers as trusted navigators, educators, advocates, and connectors who improve the member experience while strengthening quality outcomes across the continuum of care.

Quality In the Community: Community Health Worker-Led Interventions

CHS has decided to highlight Quality-In-The-Community, by highlighting our internal Data and Analytics team who is currently supporting moving our vision for CHS into something we can see and feel.

This month, CHS was proud to deepen its partnership with the Analytics team as we collaboratively designed the Alliance's Community Health Worker dashboard. This work represents far more than a reporting tool, it establishes the analytical foundation necessary to understand where Community Health Worker services are creating impact and where additional opportunities exist to advance health equity.

The dashboard is being designed to provide a comprehensive view of Alliance Community Health Worker activity by integrating provider recruitment, member utilization, intervention trends, geographic distribution, and program performance into a single strategic platform. This level of visibility will enable leadership to better understand how Community Health Worker services are reaching members across Alameda County while informing future planning, investment, and resource allocation.

As the dashboard evolves, it will serve as the foundation for the development of a comprehensive Community Health Worker heat map. This next phase will allow us to overlay the Healthy Places Index (HPI) Quartile 1 and 2 communities with the Alliance's contracted Community Health Worker provider network, active member interventions, and member utilization patterns. By bringing these data elements together, the Alliance will be better positioned to identify communities of greatest need, evaluate service penetration, understand where recruited providers are actively delivering interventions, recognize geographic gaps, and strategically expand Community Health Worker capacity where it can have the greatest impact. This integrated view will strengthen the Alliance's ability to intentionally align provider recruitment, member outreach, and intervention strategies with DHCS priorities while ensuring resources are directed toward the communities experiencing the greatest inequities.

This work also strengthens the Alliance's ability to operationalize Department of Health Care Services priorities by ensuring Community Health Worker expansion is informed by both community need and measurable utilization. Rather than relying solely on retrospective reporting, this dashboard will provide actionable insights that support proactive decision-making, strategic provider recruitment, targeted community investment, and continuous quality improvement.

The CHW dashboard exemplifies the power of cross-functional collaboration. By combining the expertise of Analytics with the community-centered perspective of Community Health Strategy, the Alliance is building a data-informed infrastructure that not only measures performance but also guides the future of equitable, community-based care throughout Alameda County.

Provider Recruitment and Community Partnership Development

Provider partnerships remain foundational to Alameda Alliance's ability to translate strategy into meaningful member impact. CHS continues to expand Alameda Alliance's CHW provider network through targeted outreach and relationship building efforts with county agencies, community-based organizations, and community partners.

During June, current outreach targets include:

- Building Futures
- BANANAS
- Alameda County Public Health Department
- City of Fremont Aging & Family Services,
- City Serve of the Tri-Valley, Eden I&R,

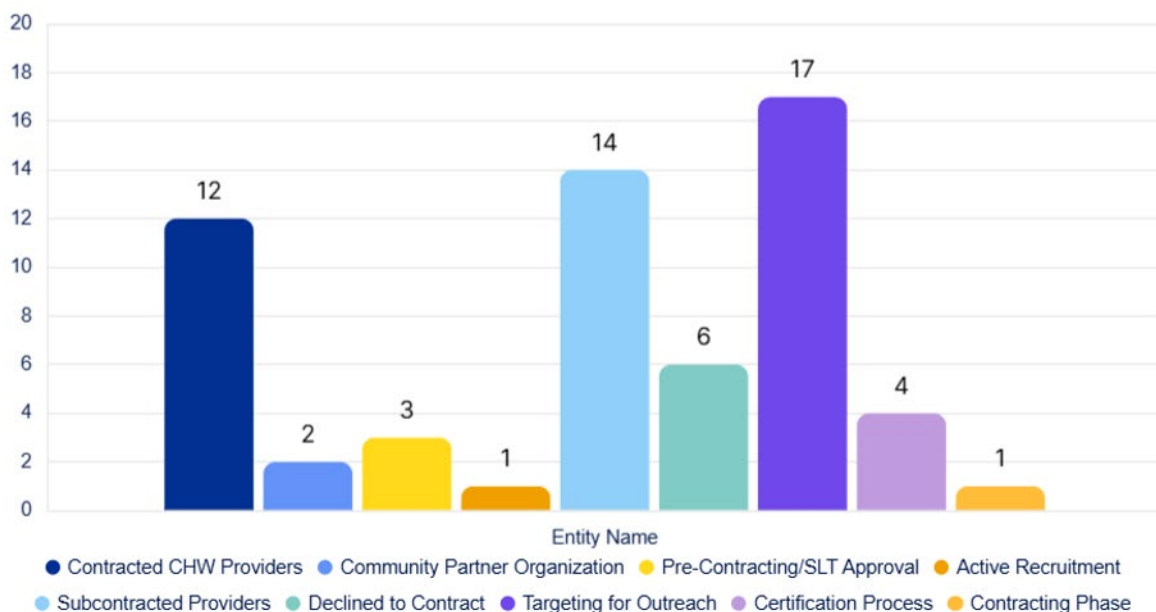
- J-Sei, Korean Community Center of the East Bay
- Mercy Brown Bag Program
- Vietnamese American Community Center of the East Bay
- AC Health
- Jain Clinic Office
- East Bay Housing Organizations

CHS conducted introductory meetings with two prospective organizations, providing an overview of the CHW benefit and assessing interest in becoming a contracted CHW provider within the Alliance network. Additionally, Hume Center and One New Heartbeat advanced from active recruitment into CHW Certification, while East Bay Innovation progressed from targeted outreach to active recruitment after completing an Entity Interest form. CHS also facilitated Provider Showcase for three prospective providers, allowing organizations to present their CHW program and services to representatives from the CHS and Quality Teams. Following review, Clarity Pediatrics Medical Group and One Love Center for Health were selected to advance to Senior Leadership Team (SLT) approval, while Better in Person was not selected to move forward.

In support of the Alameda Alliance's Maternal Health equity goals, CHS is partnering with Case Management to explore utilization of CHW provider, Our Roots, to support maternal health initiatives focused on perinatal depression and Transitional Care Services (TCS). These discussions are intended to strengthen community-based supports for pregnant and postpartum members and advance equitable maternal health outcomes across Alameda County.

Provider Recruitment Snapshot

CHW Recruitment Efforts - YTD



As of June 2026, the CHS provider network includes twenty-six (26) contracted providers, consisting of twelve (12) directly contracted organizations and thirteen (14) subcontracted entities.

Additional recruitment pipeline activity includes:

- One (1) organization actively assessing readiness to pursue certification and contracting.
- Four (4) organizations are currently engaged in the CHW certification process.
- Three (3) organizations are in pre-contracting review pending Senior Leadership Team approval.
- One (1) organization is currently onboarding.
- Six (6) organizations deemed ineligible or elected not to proceed year-to-date.

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

Looking Ahead

As Community Health Strategy continues to evolve, our focus remains on strengthening partnerships, expanding Community Health Worker capacity, leveraging data to guide strategic decision-making, and ensuring members receive coordinated, culturally responsive care wherever they are on their healthcare journey.

We believe the future of healthcare extends beyond clinical settings. By honoring the lived experiences of our members, investing in trusted community partnerships, and empowering Community Health Workers as essential members of the care team, Alameda Alliance for Health is helping shape a more equitable, integrated, and person-centered Medi-Cal system for Alameda County.

Community Health Strategy is proud to serve as the bridge between healthcare and community.

Interpreter Services

Interpreter Services Annual Overview

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

Table 1. Top 10 Languages Requested by Modality, 2025

Alliance Wellness/ D-SNP	Medi-Cal and Group Care
Spanish	Spanish
Chinese Cantonese	Chinese Cantonese
Chinese Mandarin	Vietnamese
Vietnamese	Chinese Mandarin
Tagalog	Mam
Arabic	Arabic
Hindi	Dari
Punjabi	Farsi
French	Punjabi
Turkish	Hindi

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

Table 2. Top 10 Languages Requests, 2026 Q1

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

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

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

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

Table 3. Favorable Responses, CG-CAHPS, 2025

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

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

Quality Improvement: Population Health Management (PHM)

- Completed the annual update of the Alliance population health assessment, evaluation of 2025 PHM Strategy, and NCQA-compliant 2026 PHM Strategy in May 2026. QIHEC approved the documents on May 8, 2026
- Began engagement with PHM consultant HealthBegins. From March to August 2026, HealthBegins will guide Alliance PHM and QI teams in utilizing their Equity-Focused Upstream Quality Improvement Approach to move from data analysis to actionable program roadmaps for two priority HEDIS measures, Well-Child Visits in the First 15 Months of Life (W15) and Controlling High Blood Pressure (CBP). W15

will use a comprehensive approach with three stakeholder sessions, while CBP will use an accelerated approach with one stakeholder session.

- DHCS released new technical specifications and resumed quarterly submissions of PHM KPIs starting January 2026, which had been on hold since November 2023. The KPIs are listed in the table below with the most recent submitted rates in April 2026 (lookback period 1/1/2025-12/31/2025):

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



Information Technology

Sasikumar Karaiyan

To: Alameda Alliance for Health Board of Governors
From: Sasi Karaiyan, Chief Information & Security Officer
Date: July 10th, 2026
Subject: Information Technology Report

Enrollment

- June membership decreased by **5,943** members, representing a **1.6%** month-over-month change. PCP assignment patterns remained balanced at **57%** auto-assigned and **43%** member-selected. All **48** DHCS, CMS, and Public Authority files were processed successfully with no issues or downtime.

Provider & Member Portals

- In May 2026, the Provider Portal's top five most-used pages recorded 2.42-million-page views, a 6.4% increase from April, while the Member Portal's top five most-used pages recorded 11,047 page views. Providers submitted 5,796 authorizations through the portal, members submitted 13 grievances, and active portal account totaled 6,706 providers and 3,027 members.
*Portal metrics are reported in arrears and reflect the period from May 2025 - May 2026.

Call Center Metrics

- Call center systems remained stable in June, with 100% availability and no service interruptions. The Alliance received 13,620 member calls and 8,971 provider calls, while Alliance Wellness extended-hours support handled 77 calls during evening, weekend, and holiday hours.

Encounter Data

- In the month of June 2026, the Alliance submitted 156 encounter files to the Department of Health Care Services (DHCS) with a total of 503,863 encounters.
- In the month of April 2026, the Alliance submitted 977 encounters to the Centers for Medicare Services (CMS) for D-SNP members.

Workflow Automation

- To enhance Claim TAT, our IT Configuration team has identified three key process improvement opportunities that could increase our claims auto-adjudication rate from 85% to 92%.
Alliance is introducing agentic AI to automate portions of the manual claims processing workflow. In June, the IT Configuration team identified a use case and completed the design, development, and testing phases. The pilot successfully passed unit testing, and the next step is to complete end-to-

end testing with larger data sets.

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

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

Our next 3 months plan is to complete automation of PolicyTech documents workflow from AAH to Readily platform.

- Alliance has kicked off AI-driven automation to transform software development by enhancing developer productivity, improving code quality, and accelerating delivery across the full software development lifecycle (SDLC) from design and development to deployment, quality assurance, and maintenance. This initiative includes capabilities such as automated code generation, DevOps and Continuous Integration/Delivery (CI/CD) automation, as well as code reviews and testing. The AI transformation is planned as a 12-month level of effort.
- Alliance developed a high-accuracy (Optical Character Recognition) OCR using OpenAI, automating image interpretation and text extraction from faxes and user prompts, now integrated into key workflows.
 - Automated Phase 2 of Prior Authorization, Health Home, and Pre-Service Authorization in April 2026.
 - CM end-to-end process redesign is underway.
 - Completed Community Support Referral Forms for DSNP & MediCal in the month of April 2026.
 - 10+ Health Care Services workflow processes are in the pipeline for automation in CY2026 which includes Health Ed Wellness, Behavioral Health care - Autism evaluation form etc.
- The enterprise-wide implementation of Speech to Text capabilities has been initiated. Following a comprehensive product assessment, Alliance has selected Nuance Dragon as the preferred solution. The procurement of the product took additional timeline due to vendor licensing error. As of now, the procurement is complete and has started implementation to the pilotusers.

Claims – HEALTHsuite Application

- The Alliance received 366,061 claims in the month of June 2026.
- For the MediCal and Group Care lines of business, a total of 368,763 claims finalized, out of which 299,362 claims auto adjudicated, setting the auto-adjudication rate at 87.6%.
- The D-SNP line handled 1539 finalized claims during the period, out of which 926 were auto adjudicated, resulting in a 60.1% auto-adjudication rate.
- HEALTHsuite Upgrade estimated to go-live in June 2026 was put on hold due to a critical issue that was uncovered during testing. Working closely with the vendor to resolve the issue.
- Actively exploring AI-led solutions to boost claims auto-adjudication percentages and improve processing accuracy. Proof of concept solution being developed.

Quality Suite Application

- High level dashboard of cases for the month of June 2026:
 - G&A cases received in the month of June 2026 were 2473
 - Exempt Grievances received in the month of June 2026 were 1925
 - PQI cases received in the month of June 2026 were 128
 - PDR cases received in the month of June 2026 were 2499
- QS Automation Roadmap - This initiative aims to enhance the application for faster turnaround times and improved quality metrics. The following high impact automation is in progress.
 - Automating the QA Process - High impact project focused on automating the QA Process. The current manual process to be replaced with an automated solution. This is essential to reduce repetitive tasks and allow the QA team to focus on the quality of work. This process will support the coordinator score card for performance as well.

TruCare

- The TruCare application, running version 25.2.1.2 alongside CareWebQI version 17.3 and MCG Health content version 29.1, maintained 99.9% uptime while receiving and processing 23,278 intake authorizations in June 2026, supporting timely care coordination and authorization management.
- OCR technology has streamlined the processing of key operational documents—including Pre-Service Authorizations, Home Health requests, Face Sheets, and Interpreter service requests - improving accuracy, reducing manual effort, and accelerating turnaround times. In June, the solution processed 2,410 prior authorization requests, 207 pre-service authorization form (DSNP & MCAL) 15 home health requests, 3,726 face sheets, and 317 interpreter service requests, enhancing operational efficiency and supporting timely member care.
- The fax infrastructure continues to support critical authorization workflows, provider communications, regulatory compliance, and care coordination activities across the organization. In May, approximately 41,369 outbound faxes were transmitted to providers for authorization approvals, denials, and other required communications, while 24,008 inbound faxes were received from providers and hospitals to support prior authorization requests and clinical documentation intake, including face sheets.

Change Management

- Change Management activity remained steady in June 2026, with 81 CRs closed and 95 submitted, reflecting continued business demand and resulting in a slight increase in the active backlog to 140 open CRs. While aging requests remain an area of focus, with 87 CRs open over 30 days, the team maintained consistent delivery performance against a backdrop of sustained change volume.
- Over the past 13 months, the organization processed 1,298 closures and 1,511 submissions, demonstrating strong operational throughput. June activity was primarily driven by Normal and FastTrack changes, which accounted for 98% of all closures, with Apps & HCS leading delivery efforts at 36 closures (44% of total).

Data Integration

- D-SNP Program Enablement: Delivered key enrollment capabilities (Member ID creation, welcome communications) and progressed core data integrations supporting eligibility, ID card generation and TruCare network enhancements (70%).
- Platform Data Enhancements: Advanced provider data standardization and onboarding to support TruCare upgrade and vendor integrations.
- Operational Data Modernization: Enabled Community Support data integration into DAAS and improved DWH performance through parallel processing optimization.
- Strategic Integrations: Progressed AOR and ECM data integrations to support TruCare and HealthX (70%).

IT Service Desk

- 1,838 Service Desk tickets were opened in June 2026, a 30.35% increase than the previous month May (1,410) and 43.04% above the previous 4-month average of 1,285 (February–May).
- 1,911 Service Desk tickets were closed in June 2026, which is 46.44% higher than the previous month (May: 1,305) and 47.25% higher than the previous 4-month average of 1,297.75 (February–May).

IT Security Program

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

Information Technology

Supporting Documents

Enrollment

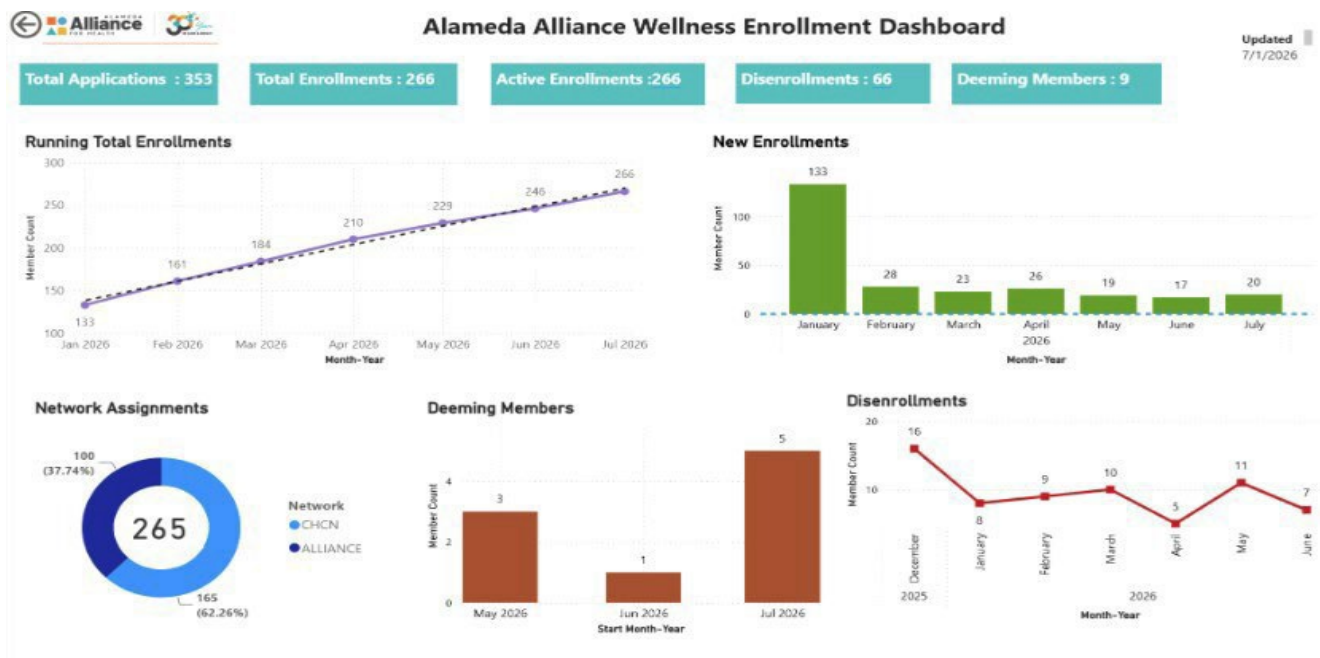
Membership Trend & PCP Assignments

June 2026 membership totaled 370,011. During the month, 5,534 members were added and 11,477 members were disenrolled, resulting in a net decrease of 5,943 members (1.6%). PCP assignments were 53% auto-assigned and 47% member selected.



Alliance Wellness Enrollment Activity

June 2026 Alliance Wellness enrollments totaled 246 active members. During the month, 17 new enrollments, 5 disenrollments, and 1 deeming member were recorded.

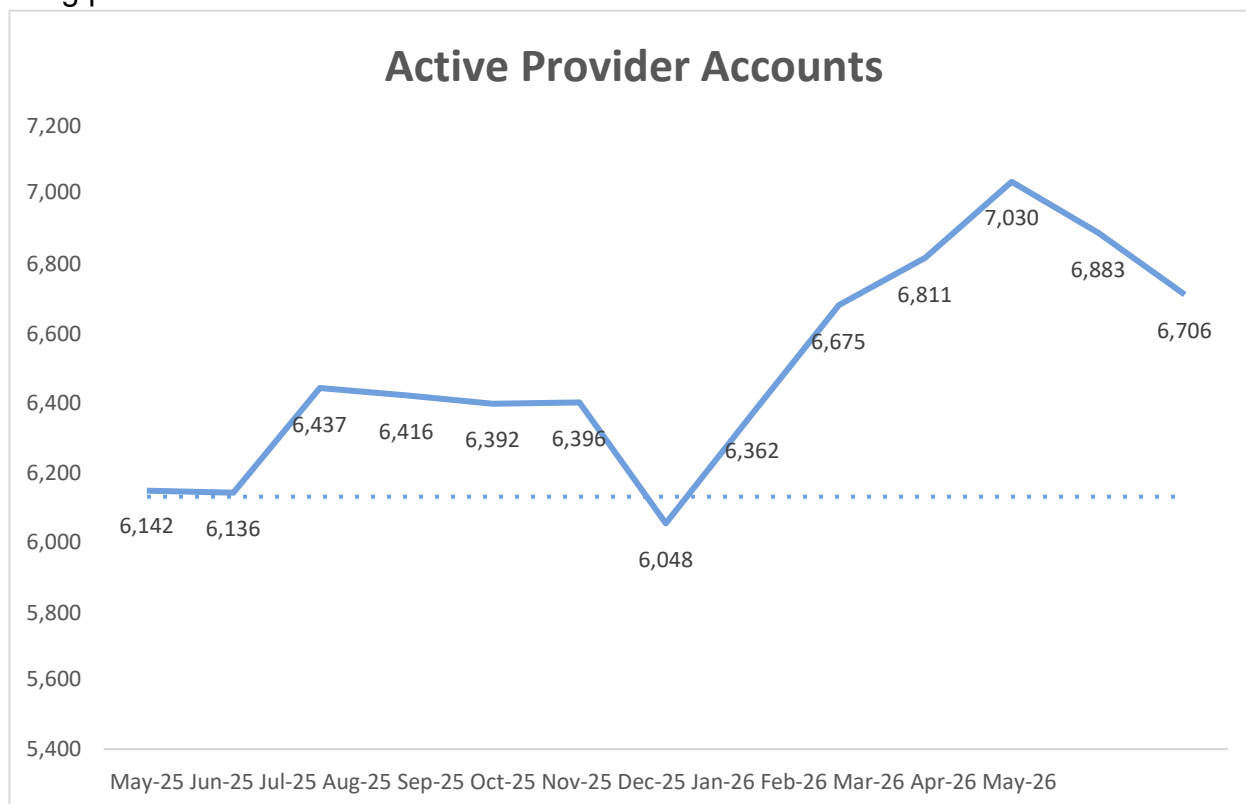


Provider & Member Portals

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

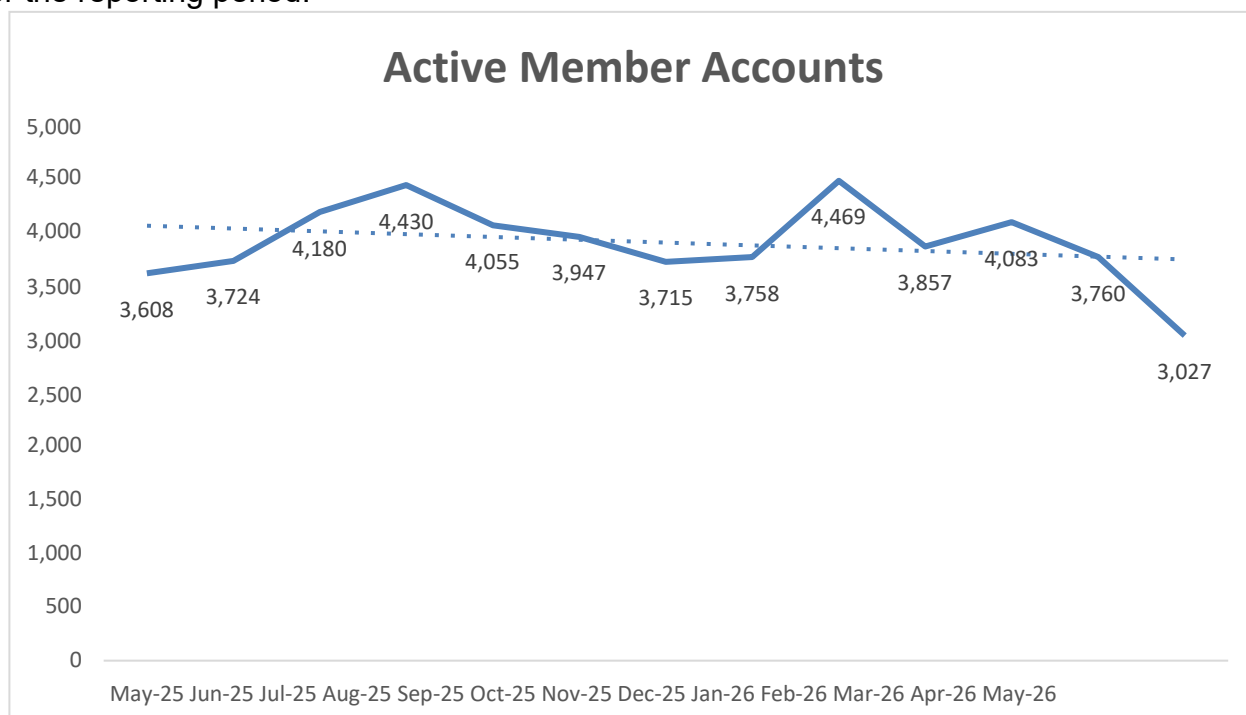
Provider Portal Users

Active provider accounts increased by 564 accounts (9.2%), from 6,142 to 6,706 over the reporting period.



Member Portal Users

Active member accounts decreased from 3,608 to 3,027, a decrease of 581 accounts (16.1%) over the reporting period.



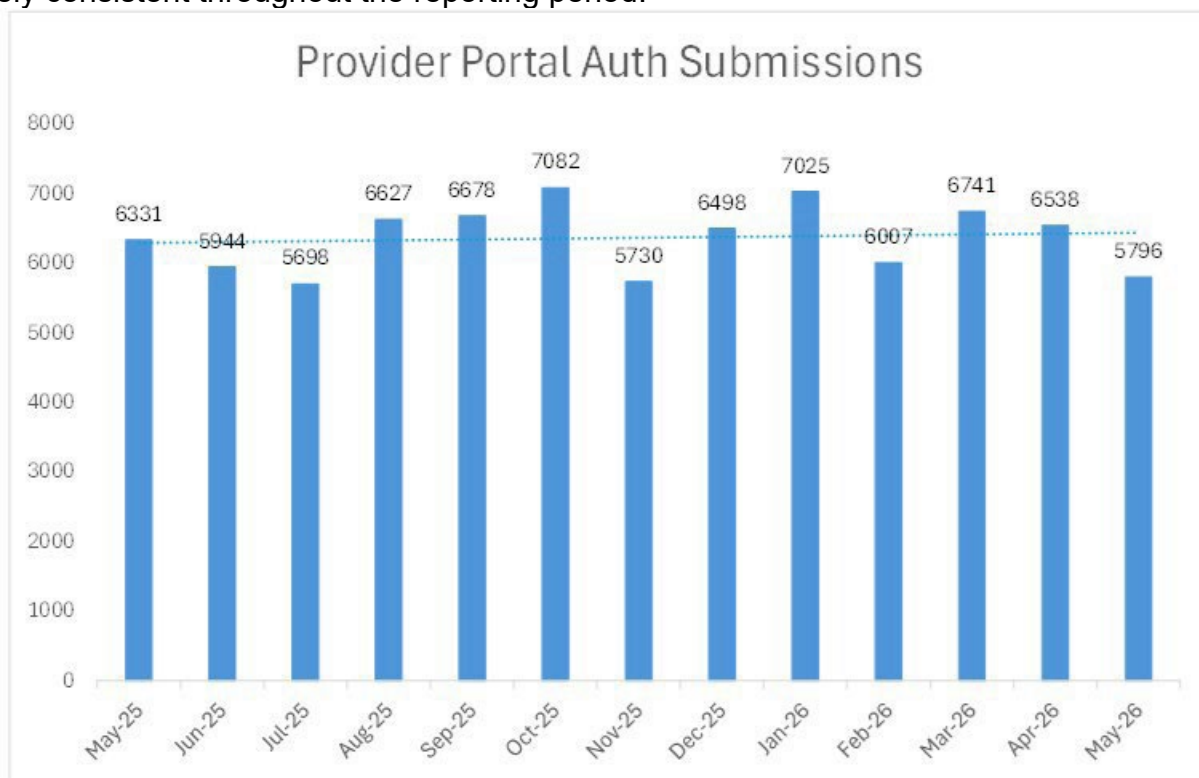
Provider & Member Portal top 5 pages viewed

The most-viewed provider portal page, Member Eligibility, recorded 2,080,398 page views in May, an increase of 74,009 views (3.7%) from April. The most-viewed member portal page, ID Card, recorded 3,385 page views, a decrease of 575 views (14.5%) from April.

Portal	Page	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Provider	Member eligibility	1,563,290	1,504,728	1,585,727	1,690,469	1,755,600	1,856,262	1,842,582	2,080,703	2,170,351	1,664,301	1,886,751	2,006,389	2,080,398
	Claim Status	286,429	284,525	296,663	262,537	270,631	279,789	233,977	267,656	254,452	247,939	255,575	241,762	314,492
	Authorization status	8,164	8,237	9,556	10,237	10,574	11,381	9,103	10,845	11,322	10,422	11,741	11,140	10,051
	Submit authorizations	7,318	7,096	8,638	7,676	7,965	9,874	6,653	8,109	8,561	7,433	8,257	7,981	7,308
	Submit professional claims	5,417	6,011	6,175	7,035	6,304	6,444	5,246	6,025	6,198	6,357	7,379	6,621	6,557
	Total	1,870,618	1,810,597	1,906,759	1,977,954	2,051,074	2,163,750	2,097,561	2,373,338	2,450,884	1,936,452	2,169,703	2,273,893	2,418,806
Member	ID Card	3,836	4,558	5,781	6,175	5,082	4,824	4,436	4,082	4,771	3,953	4,046	3,960	3,385
	Member Eligibility	4,777	5,231	5,620	5,781	5,555	4,903	4,775	4,312	4,421	3,377	3,643	3,173	2,810
	Provider Directory	3,508	3,305	3,533	3,905	3,650	3,229	3,152	2,862	4,051	2,691	3,092	2,667	2,153
	Select/ Change PCP	1,824	2,249	2,100	2,390	2,363	1,990	1,830	1,887	2,337	1,568	1,882	1,599	1,370
	My Claims Services	1,441	1,535	1,592	1,571	1,623	1,606	1,355	1,451	1,589	1,418	1,524	1,371	1,329
	Total	15,386	16,878	18,626	19,822	18,273	16,562	15,548	14,594	17,169	13,907	14,187	12,740	11,047

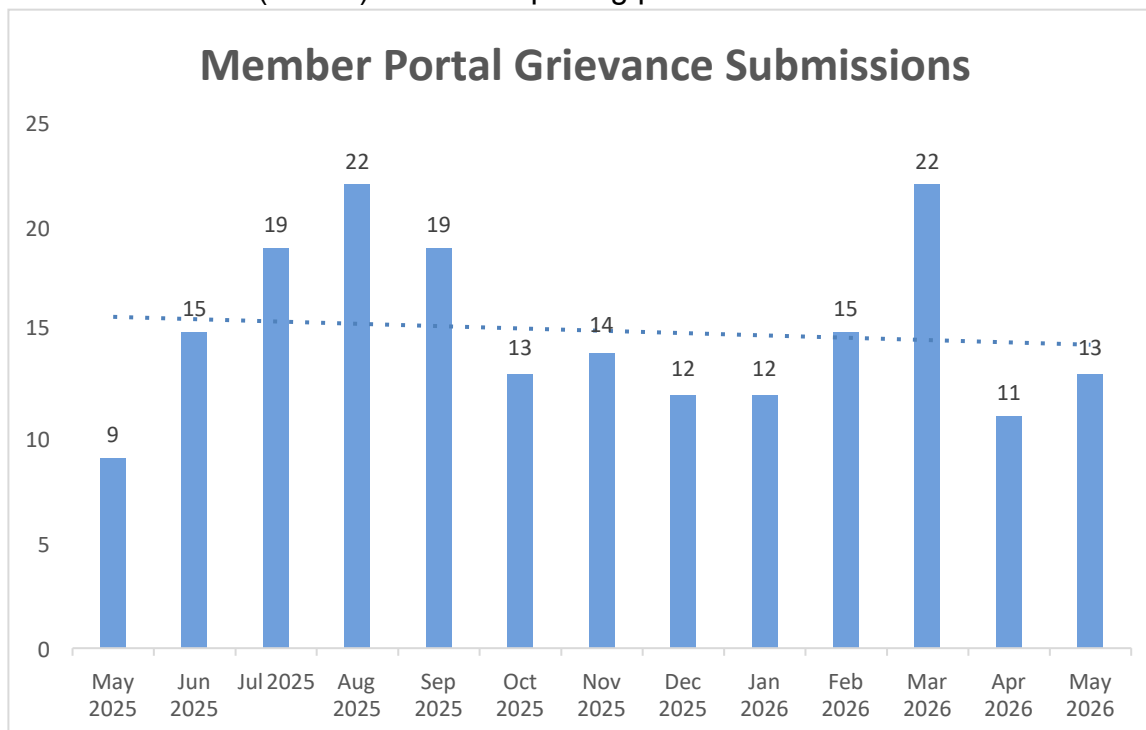
Provider Authorizations (Portal Submissions)

Submissions decreased 8.4% from May 2025 to May 2026, with monthly volumes remaining relatively consistent throughout the reporting period.



Member Grievances (Portal Submissions)

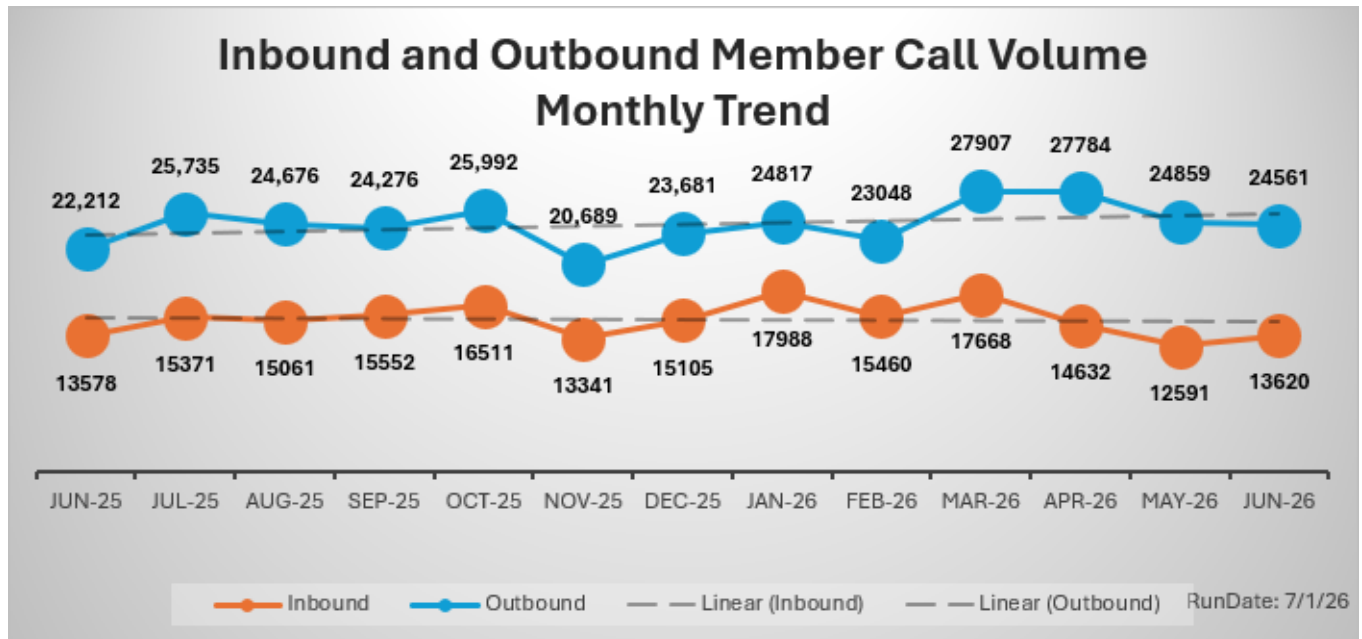
Member Portal grievance submission increased from 9 in May 2025 to 13 in May 2026, an increase of 4 submissions (44.4%) over the reporting period.



Call Center Metrics

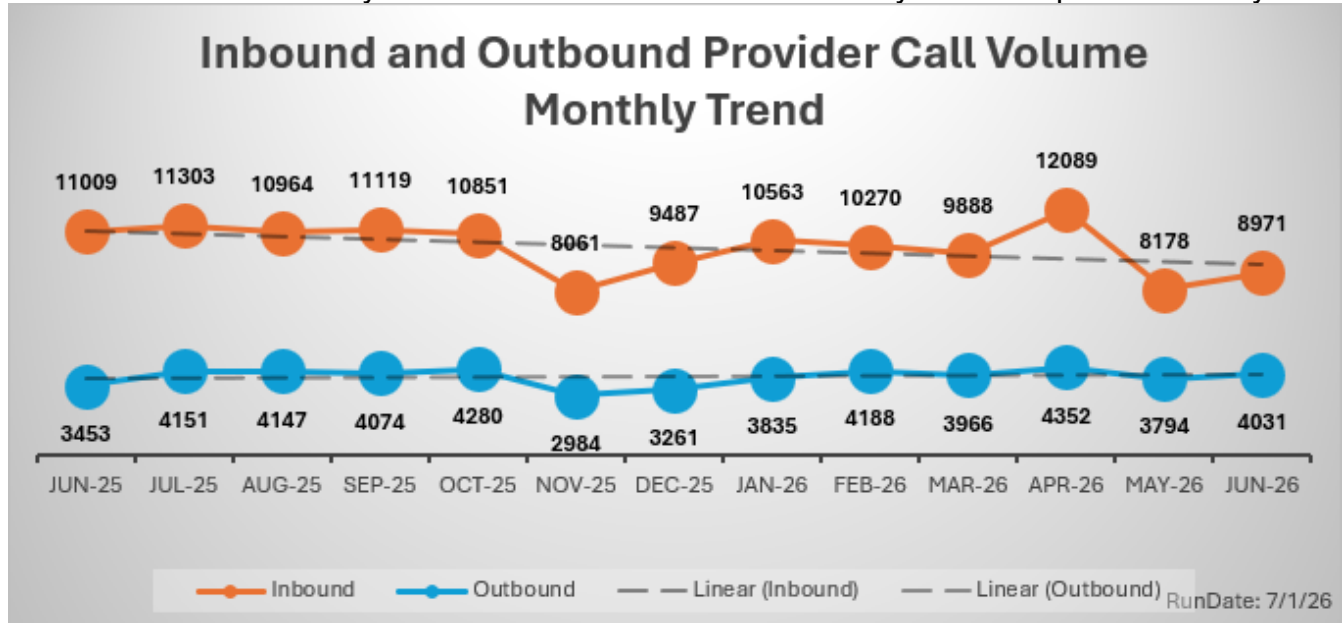
Member Call Utilization

Member call utilization remained stable with no outages or downtime. During June 2026, member-facing call center applications supported 13,620 inbound and 24,561 outbound calls compared with 12,591 inbound and 24,859 outbound calls in May 2026.



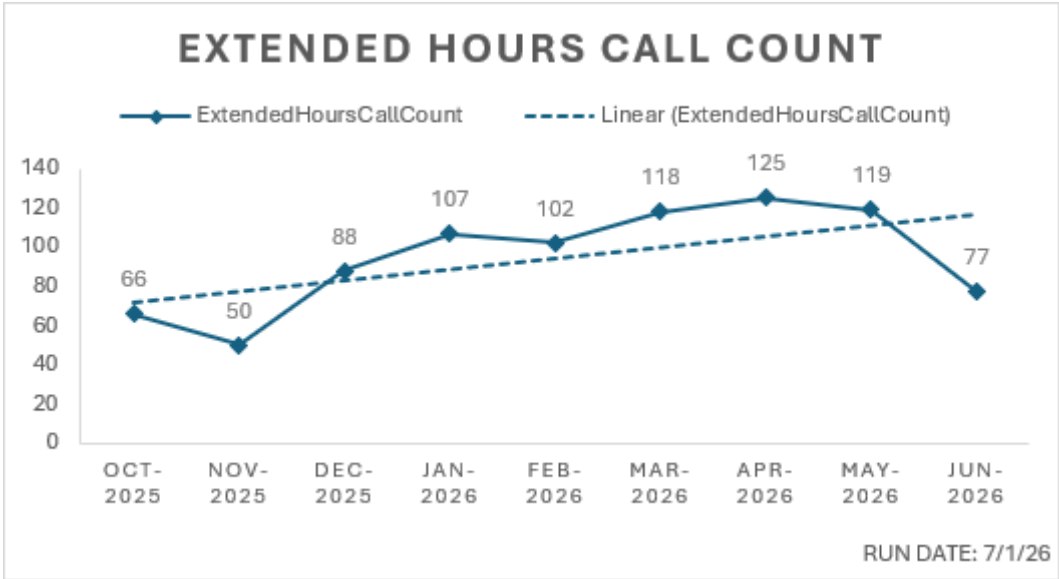
Provider Call Utilization

Provider call utilization remained stable with no application outages or downtime. During June 2026, provider-facing call center applications supported **8,971** inbound and **4,031** outbound calls. Inbound calls increased by **9.7%** and outbound calls increased by **6.2%** compared with May 2026.



Alliance Wellness Extended Hours Utilization

Alliance Wellness extended hours utilization reflects member calls on weekdays from 5–8 p.m., weekends from 8 a.m.–8 p.m., and holidays, excluding Thanksgiving and Christmas. A total of 77 extended-hours calls were received in June 2026, compared with 119 in May 2026.

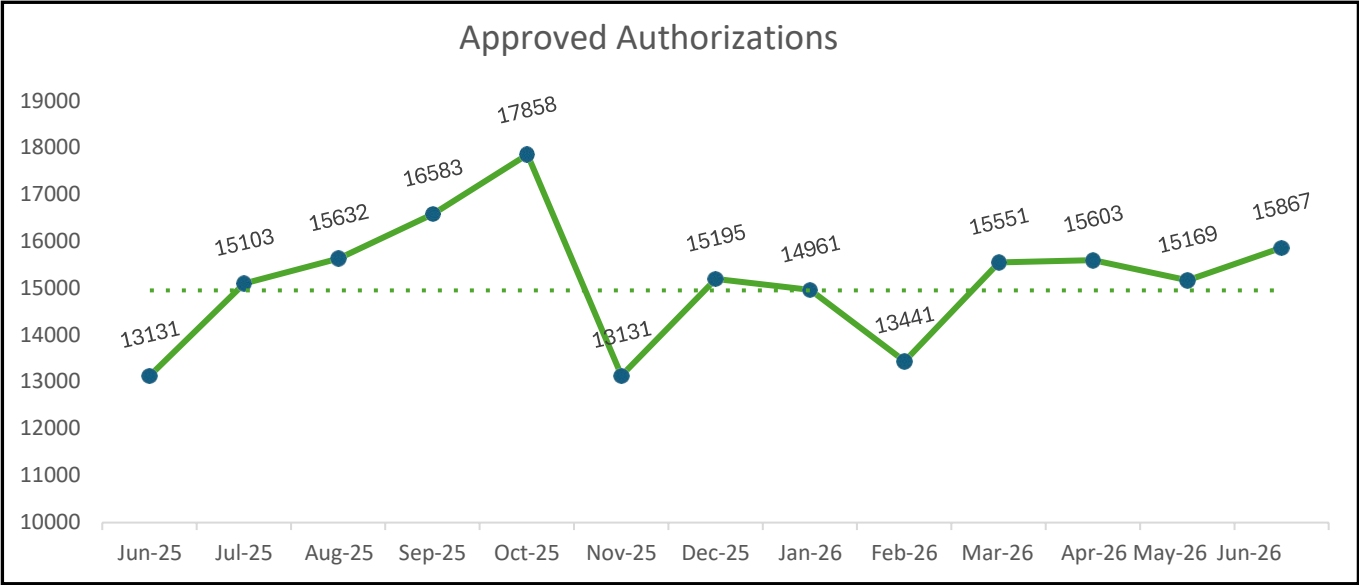


Authorizations

Over a 13-month period, approved authorizations averaged 15,191 monthly cases, peaking at 17,858 in October 2025 before stabilizing between 13,131 and 15,867. Auto-approved authorizations averaged 7,847 cases monthly, representing a 52.1% average automation rate that reached 53.6% in June 2026. Denied authorizations averaged 722 cases monthly, peaking at 928 in June 2026 following an upward climb that began in early spring.

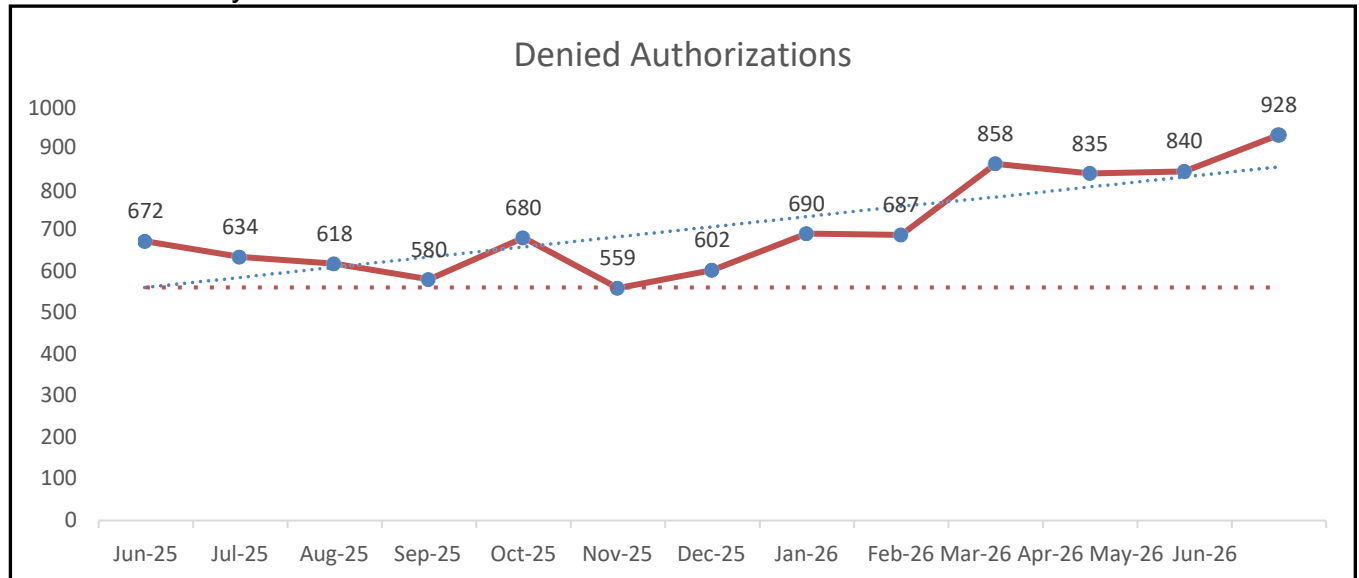
Approved Authorizations:

Authorizations averaged 15,191 monthly over the 13-month period. Volumes peaked significantly in October 2025 at 17,858 approvals before dropping the following month. Since then, demand has normalized into a predictable operational baseline ranging between 13,131 and 15,867 monthly cases.



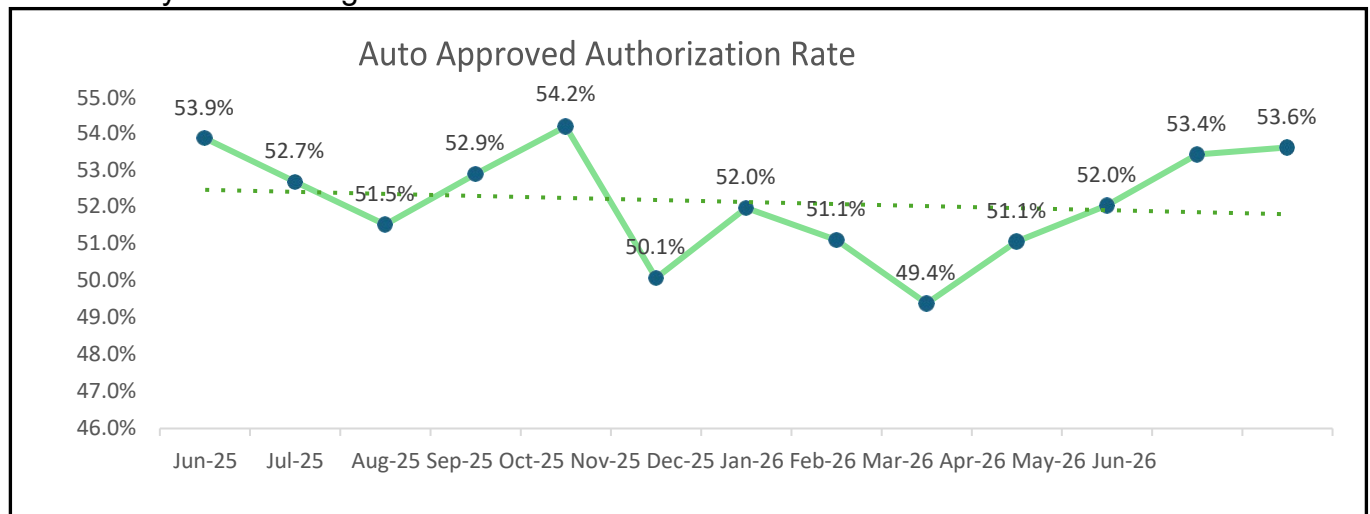
Denied Authorizations:

Denied authorizations averaged 722 cases monthly over the 13-month period. Volumes hit a peak in June 2026, reaching 928 denials, following an upward trend that began in early spring. Prior to this upward climb, denial metrics fluctuated within a lower baseline range between 559 and 690 monthly cases.



Auto Approved Authorization Rate:

The auto-approval rate remained highly stable over the 13-month period, processing an average of **52.1%** of all approved authorizations. System automation peaked at **54.2%** in October 2025, consistently streamlining about half of the total case volume month-over-month.



OCR-Based Form Processing and Automation

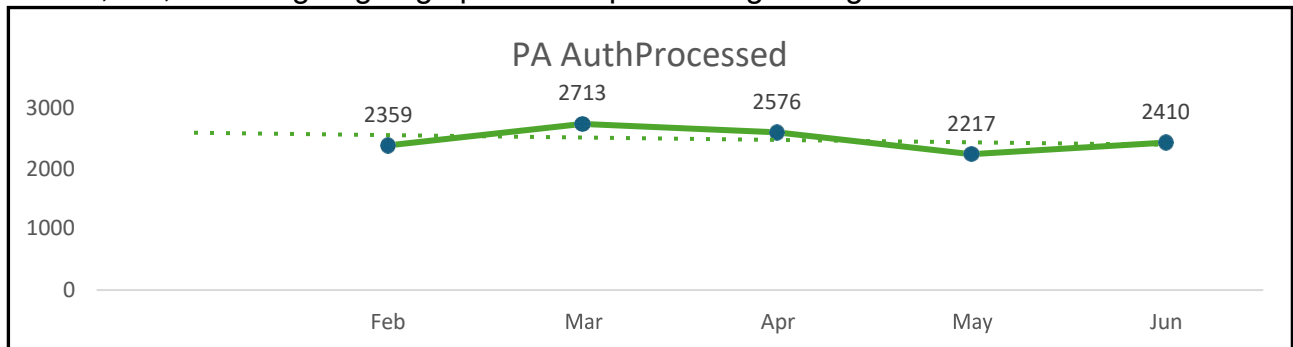
To improve operational efficiency, reduce manual effort, and minimize data-entry errors, the Alliance has implemented Optical Character Recognition (OCR) technology for the automated processing of key authorization and enrollment forms. OCR enables faster document intake, data extraction, and workflow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

Forms currently processed using OCR technology include:

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

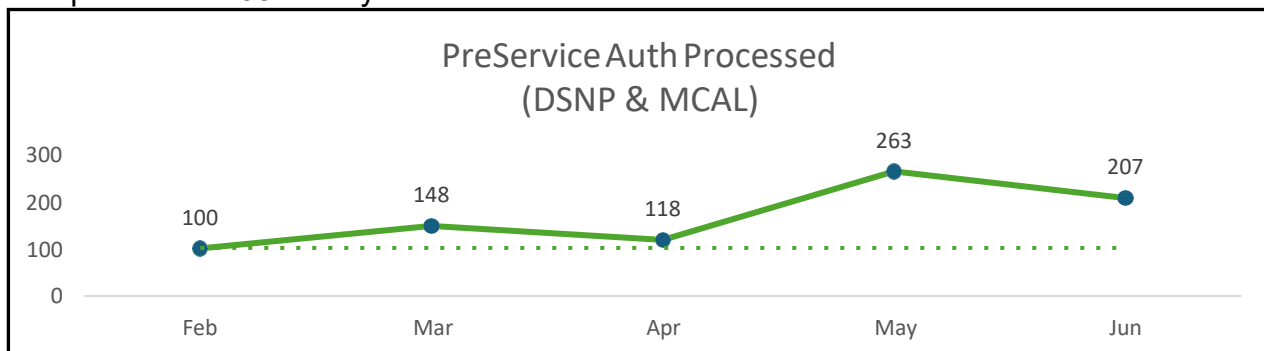
PA Authorization (alternative to DocuStream):

PA Auth processing transitioned from DocuStream to OCR beginning in February, supporting the broader objective of improving processing efficiency, reducing manual touchpoints, and minimizing errors. From February through June, monthly PA Auth volumes ranged between 2217 and 2,713, reflecting ongoing operational processing through the new OCR workflow.



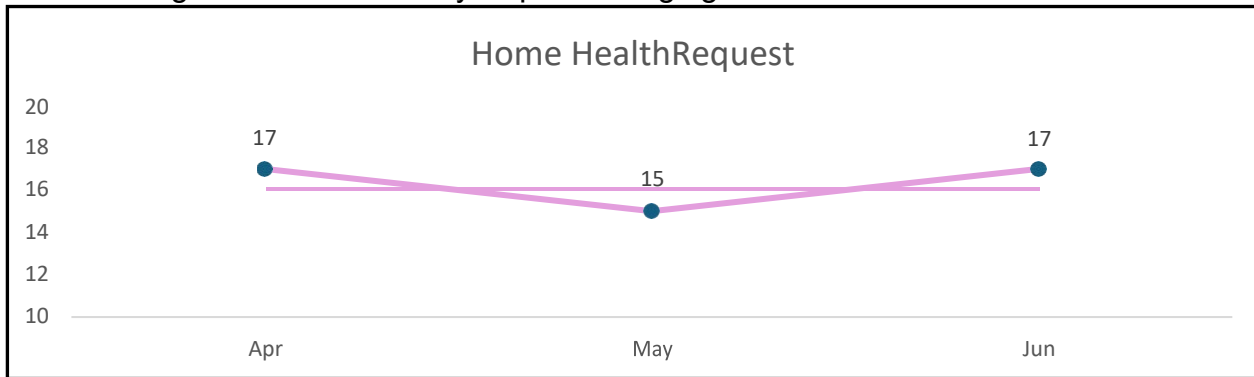
Pre-Service Auth:

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



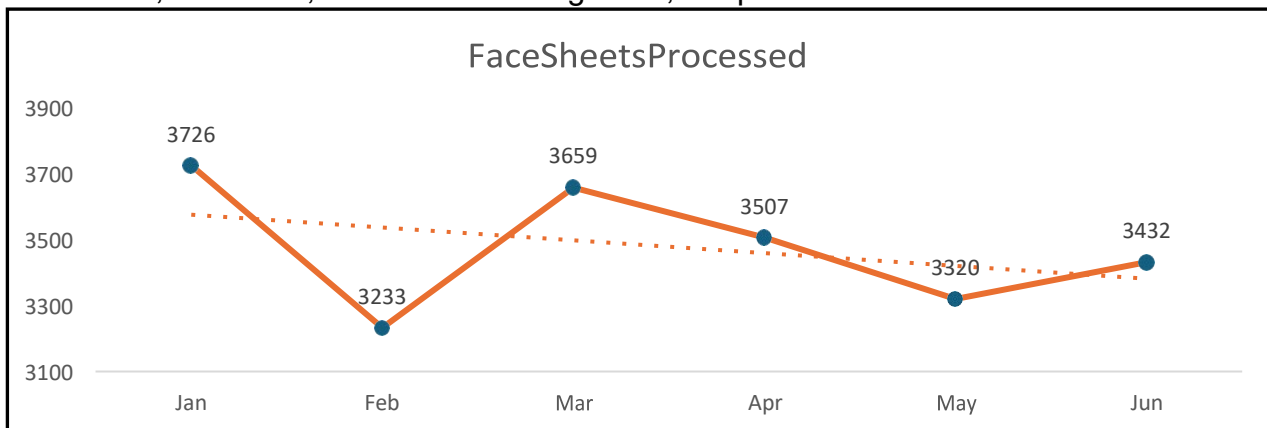
Home Health Request:

Home health request processing transitioned to OCR in April 2026, maintaining stable volume levels through June with monthly requests ranging between 15 and 17.



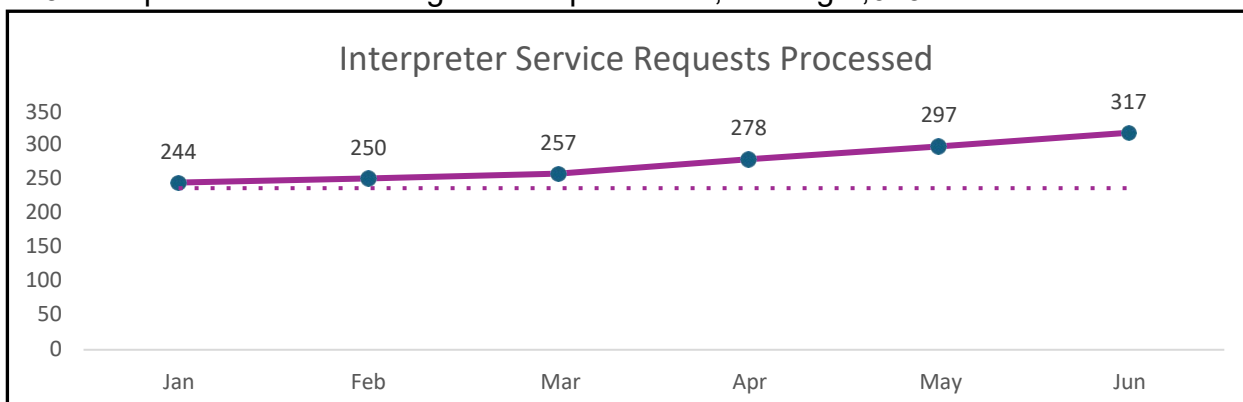
Face Sheet:

Monthly face sheet processing volumes remained stable from January through June, ranging between 3,233 and 3,726 with an average of 3,480 per month.



Interpreter Service Requests:

Monthly interpreter service requests grew steadily from January through June, rising from 244 to 317 requests with an average of 274 per month, totaling 1,643 overall.

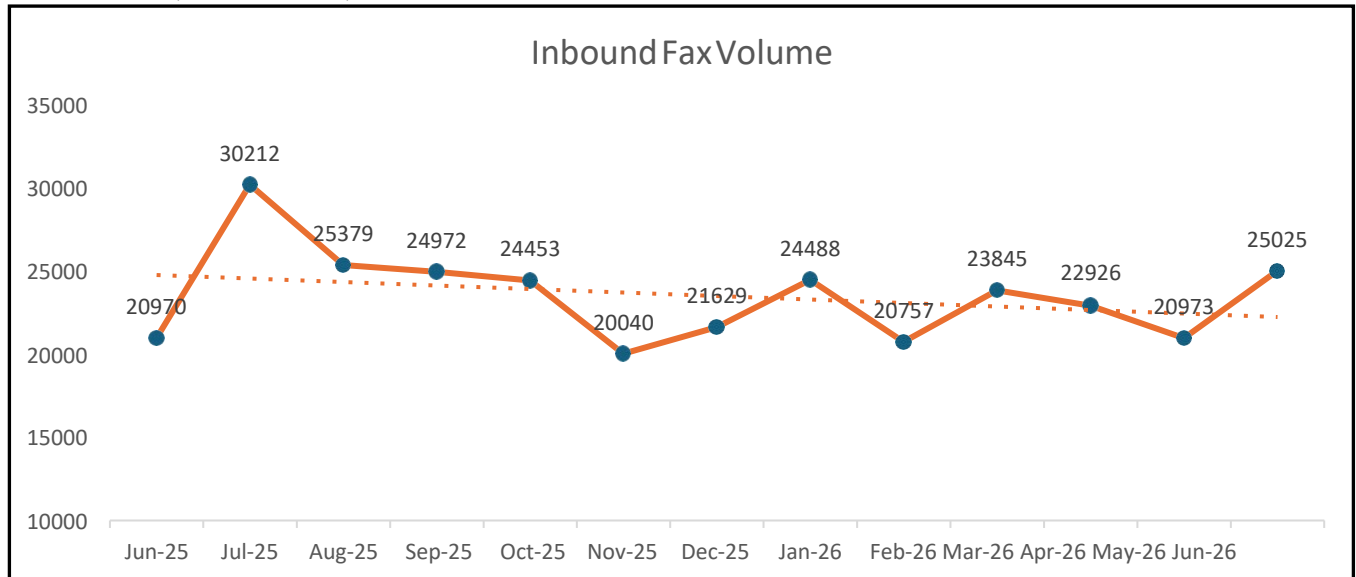


Fax-Based Authorization and Provider Communication

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

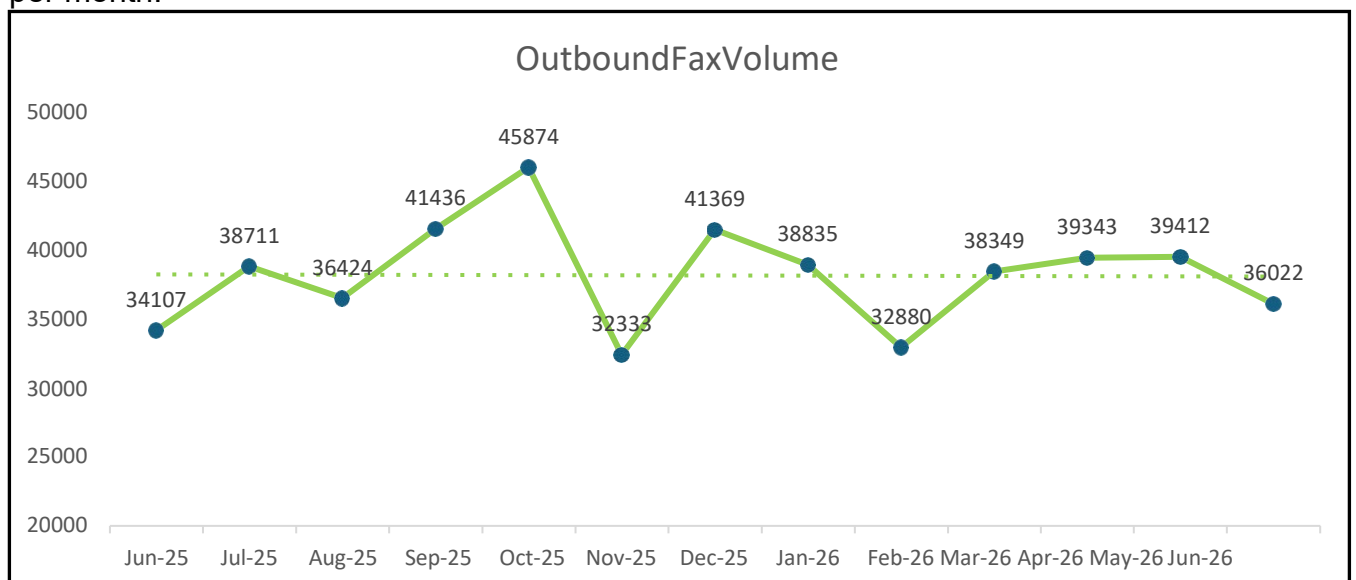
Inbound Fax Processing for Prior Authorization Support:

Inbound faxes averaged **23,513 monthly** over the 13-month period. Volume peaked significantly in July 2025 at 30,212 transmissions before settling into a consistent operational pattern. Since then, the communication channel has maintained a highly stable baseline, with volumetracking between 20,040 and 25,379 faxes each month.



Outbound Fax Delivery for Authorization Decisions:

Outbound faxes averaged **38,084 monthly** over the 13-month period. Volume climbed steadily through the summer and fall, reaching a maximum throughput of 45,874 transmissions in October 2025. Following this high-demand period, outbound traffic maintained a highly consistent and reliable operational range, generally tracking between 32,333 and 41,369 faxes per month.

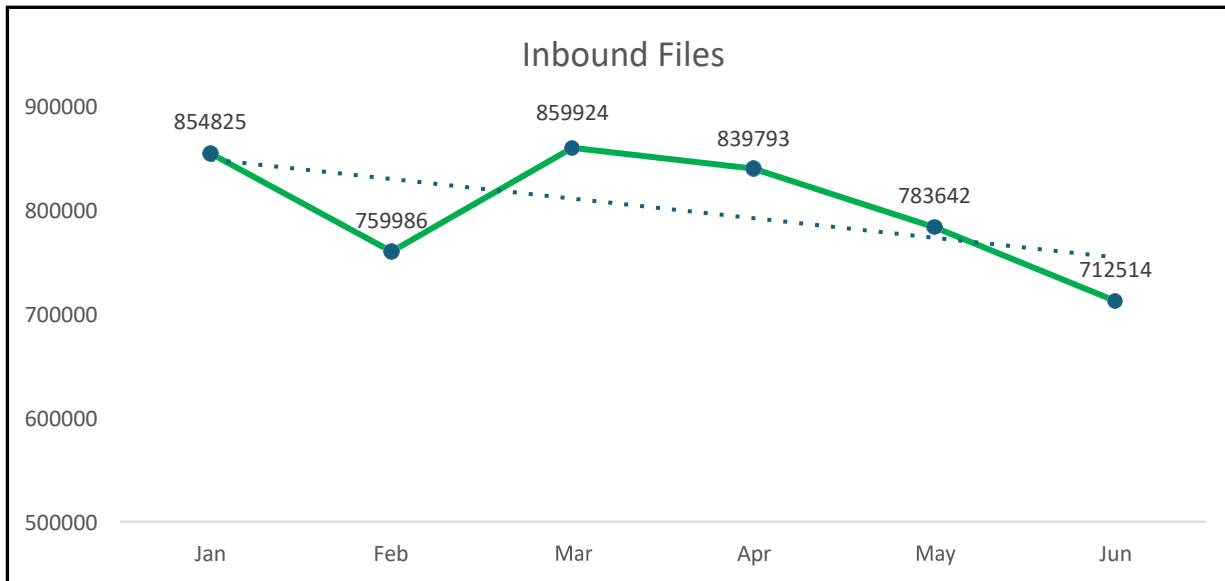


Monthly Inbound and Outbound file processing

From January through June, file processing averaged approximately 811,793 total files per month, with inbound files representing most of the activity each month. Overall volume remained strong across the period, reaching its highest level in March with 870,262 total files, supported by consistent inbound processing and elevated outbound file activity.

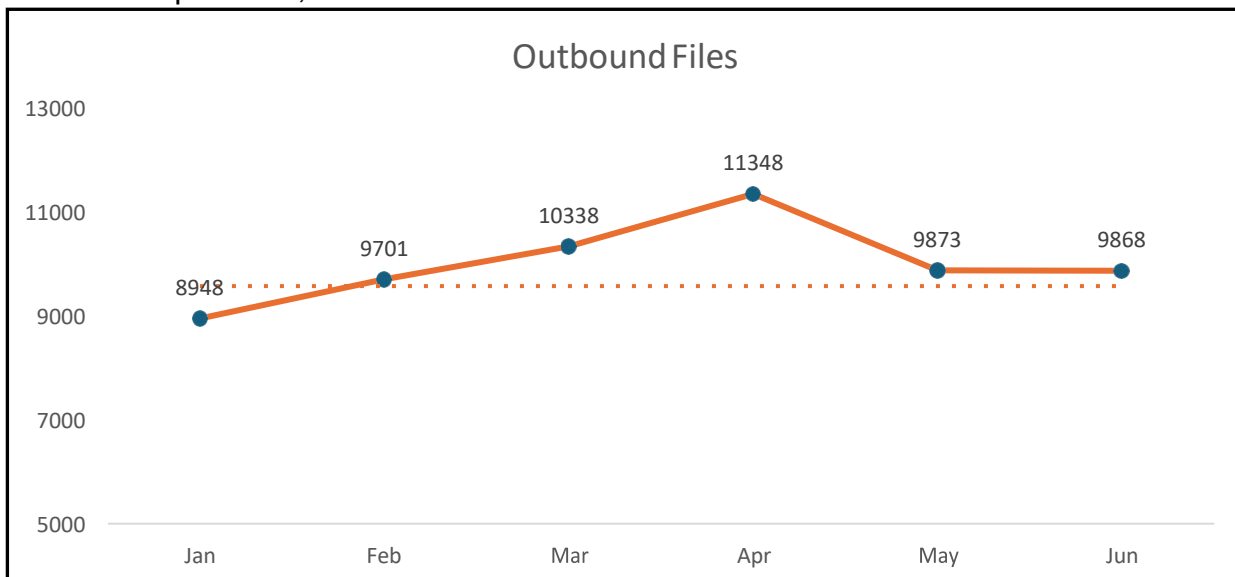
Inbound files processing:

Inbound file processing averaged approximately 801,781 files per month from January through June, with steady activity across the period and the highest volume recorded in March at 859,924 files.



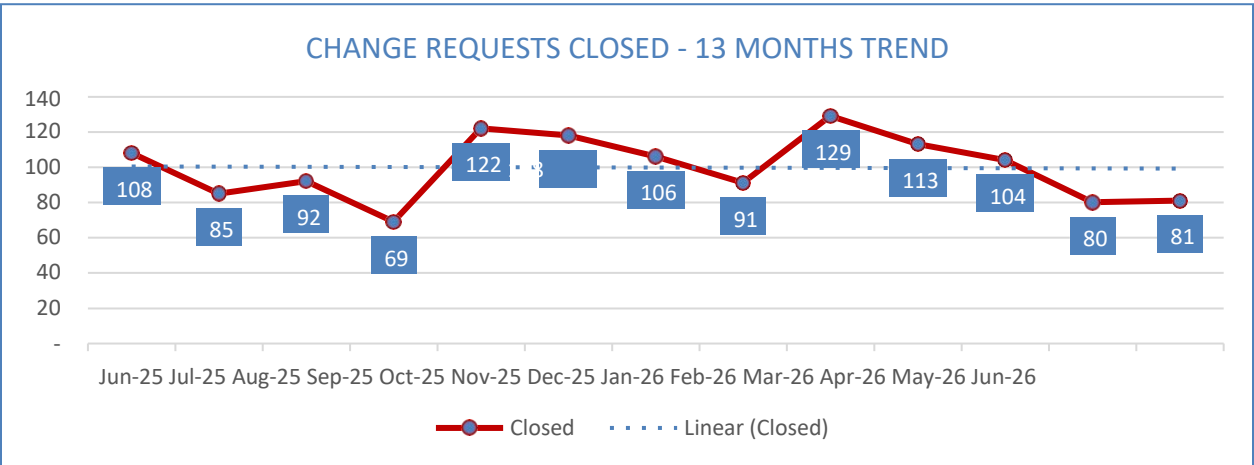
Outbound file processing:

Outbound file processing averaged approximately 10,013 files per month from January through June, consistently representing the smaller share of total file activity and reaching its highest volume in April at 11,348 files.

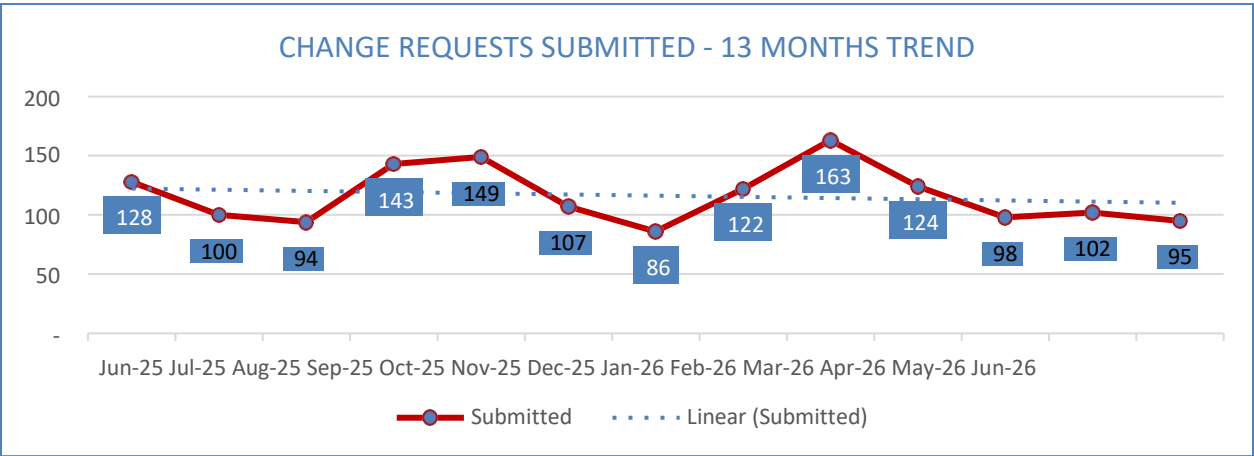


Change Management Key Performance Indicator (KPI)

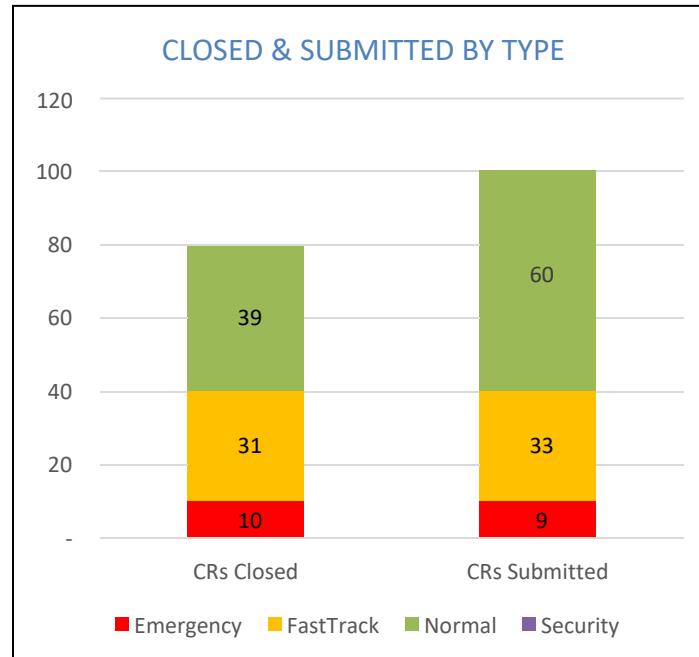
- Change Management operations remained steady in June 2026, with **81** CRs closed and **95** new CRs submitted, reflecting continued organizational activity and demand. The active backlog increased slightly to **140** open CRs, while aging requests remain an area of focus, including **87** open over 30 days, **49** over 60 days, **34** over 90 days, and **4** over one year.
- **CR closure** performance remained consistent over the past 13 months, with **1,298** CRs closed and an average of 100 closures per month. After reaching a low of **69** closures in September 2025, closure activity rebounded strongly, peaking at 129 closures in February 2026



- Over the past 13 months, 1,511 Change Requests (CRs) have been submitted, averaging approximately 116 submissions per month. Submission volumes fluctuated throughout the year, peaking at 163 in February 2026 and reaching a low of 86 in December 2025. In recent months, submissions have moderated, declining to 95 in June 2026.



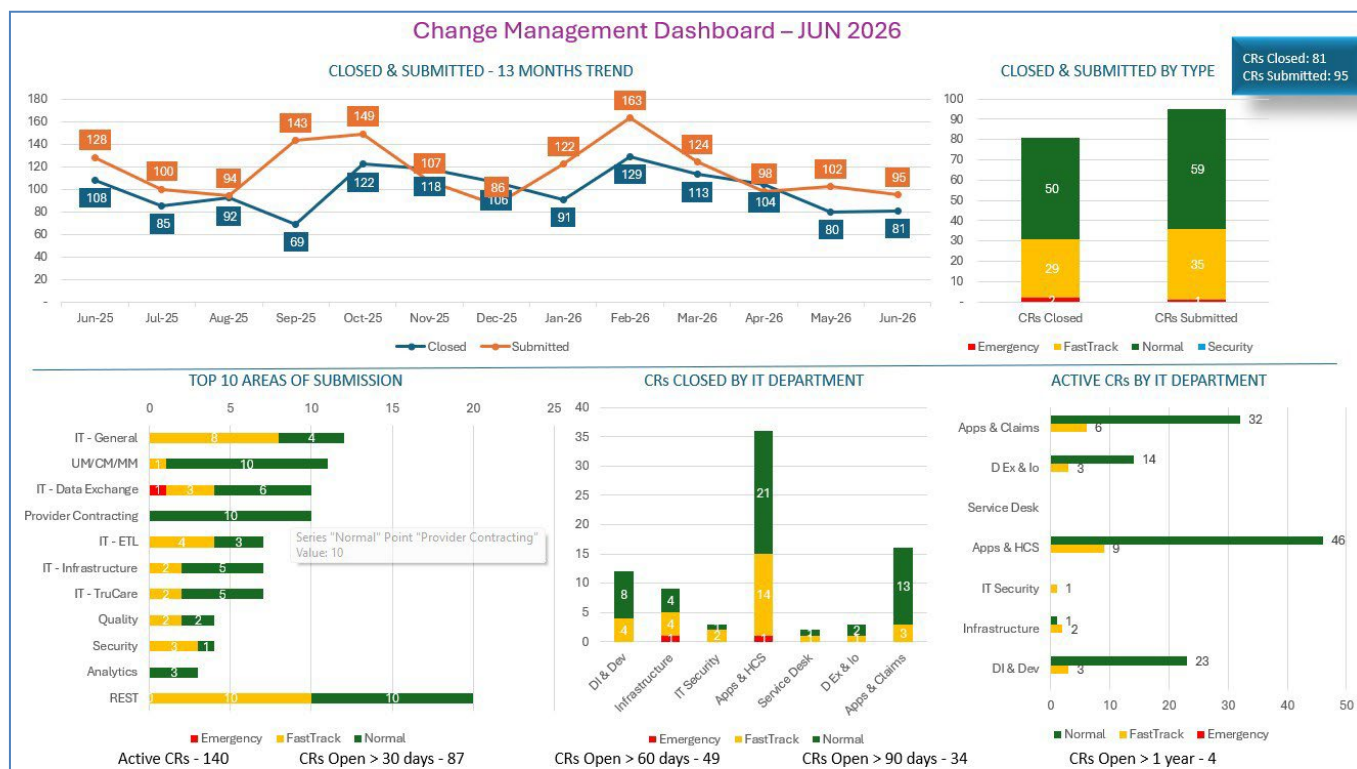
- In June 2026, **95 CRs** were submitted and **81** were closed, resulting in a slight increase in backlog. Normal CRs represented the largest volume of activity, with **59 submitted** and **50 closed**, making them the primary contributor to the gap. FastTrack CRs remained relatively balanced (**35** submitted, **29** closed), while Emergency CRs were effectively managed with 2 closures and 1 submission.



- A total of **81 CRs were closed** in June 2026, with **Normal (50)** and **FastTrack (29)** changes accounting for **98% of all closures**, reflecting a strong focus on planned change delivery. Only **2 Emergency CRs** were completed during the month. Apps & HCS led closure activity with 36 CRs (44% of total closures), followed by Apps & Claims (16) and Data Integration (12). Emergency changes were limited and handled by Infrastructure and Apps & HCS.

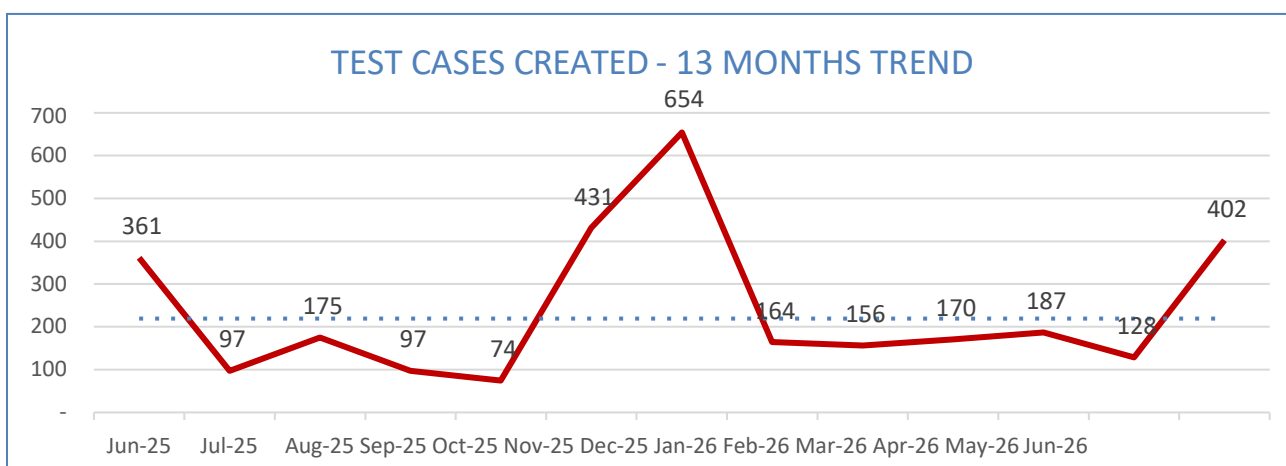
Change Requests Closed in June 2026 (Percentage of Emergency CRs closed by IT Department)					
	CRs Closed			TOTAL	% of Emergency CRs
	<u>Emergency</u>	<u>Fast Track</u>	<u>Normal</u>		<u>%</u>
Data Integration	-	4	8	12	
Infrastructure	1	4	4	9	11%
IT Security	-	2	1	3	
Apps & HCS	1	14	21	36	3%
Service Desk	-	1	1	2	
Data Exchange	-	1	2	3	
Apps & Claims	-	3	13	16	
TOTAL	2	29	50	81	2%

• May 2026 Change Management Dashboard

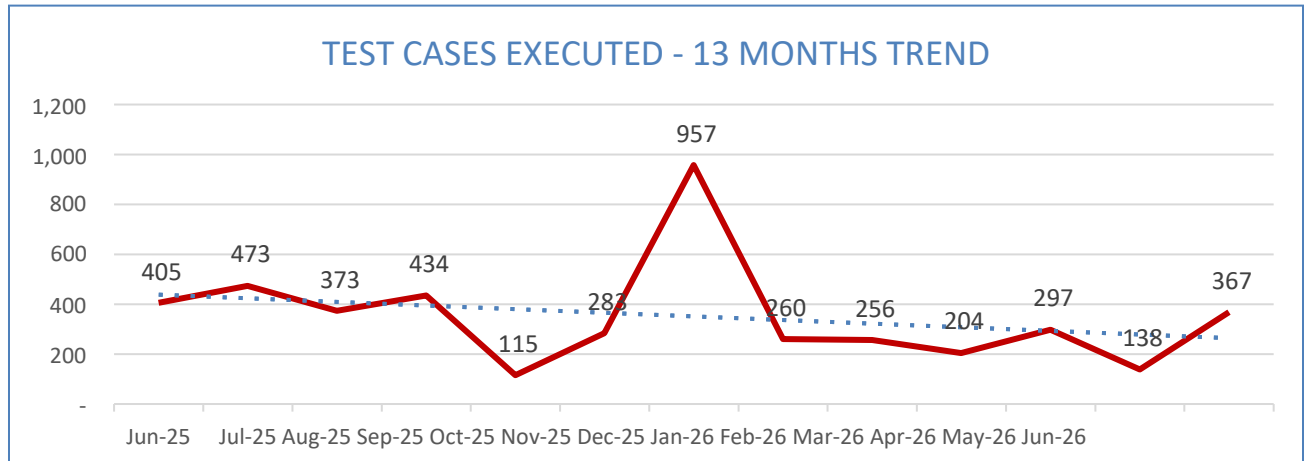


IT Quality Assurance

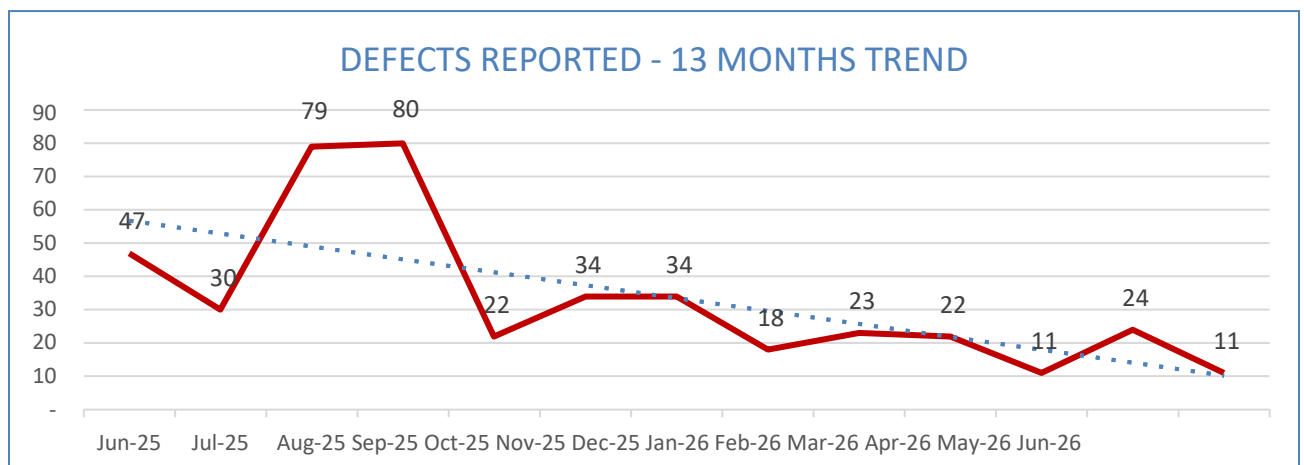
- Test case creation** activity remained strong over the past 13 months, with 3,096 test cases created, averaging approximately 238 test cases per month. Volumes fluctuated based on project and release demands, with a significant increase in November 2025 (431) and December 2025 (654) driven primarily by the D-SNP project, which required substantial test design and coverage expansion. After moderating during the first half of 2026, test case creation increased again to **402** in June 2026, representing the highest monthly total of the year.



- **Test case Execution:** A total of **4,562 test cases were executed** over the past 13 months, averaging approximately 351 executions per month. Execution volumes peaked at 957 test cases in December 2025, primarily driven by D-SNP project testing activities. Following lower volumes in early 2026, execution activity rebounded to **367 test cases** in **June 2026**, reflecting increased testing efforts and continued support for project and release delivery.



- **Defects Reported:** A total of **435 defects** were identified over the past 13 months, averaging approximately **33 defects per month**. Defect volumes peaked in **August (79)** and **September 2025 (80)**, largely driven by testing activities associated with the **D-SNP project**. Since then, defect counts have generally trended downward, reaching 11 defects in June 2026, despite a temporary increase to 24 defects in May 2026.



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

Initiative	Status	Estimated Completion	Notes
Update Change Management Framework	On Track	7/31/2026	Simplifying IT Change Management Framework and making it easier to use
ApplicationXTender Upgrade	On Track	7/31/2026	80% of Configuration completed.
TruCare Correspondence in AppXTender	On Track	7/31/2026	Initial development and discovery phase. KP dependency.
TruCare Environment Sync up	On Track	7/31/2026	40% Completed
Letters Enclosure Automation	On Track	8/30/2026	50% Completed
Call Center Test Automation	On Track	8/31/2026	Complete Production smoke test suite and regression test suite for Call Center
Katalon - Procurement and standardize	On Track	8/31/2026	Procure the tool, train the team and implement Katalon for TruCare/EREx application
QA/Testing Dashboard	On Track	8/31/2026	Automated QA / Testing Dashboard to be published
Delphix - Rebuild Server and Upgrade	Not Started	8/31/2026	Upgrade Delphix to the n-1 version.
SFTP Archiving Strategy	On Track	8/31/2026	67% completed
Letters – Correspondence Metatag	On Track	9/30/2026	40% Completed
Enrollment - End to End test automation	On Track	10/30/2026	Activity to start mid of July. End to End regression test scripts to be delivered as part of this initiative
CM Dashboard automation	Not Started	12/31/2026	This will be initiated in Q2 2026-27
OKTA Single sign on (check all the applications)	Not Started	12/31/2026	This will be initiated in Q2 2026-27
Member Correspondence	On Track	12/31/2026	Initial development and discovery phase.
Liaison ECS/Delta Upgrade	Not Started	12/31/2026	This initiative will be started in Q2 2026-27
ABA and BH Referral Form Automation	On Track	12/31/2026	20% Completed
Metrics and Dashboards	On Track	12/31/2026	Refining and enhancing reporting sections
Inbound 834 Eligibility Process Improvement	On Track	1/31/2027	BRD for new modules complete
Call Center Modernization	On Track	4/30/2027	Conducting vendor interviews based on RFP submissions
Claims End to End test automation	Not Started	6/30/2027	This initiative will be started in Q2 2026-27
Provider Data End to End test automation	Not Started	6/30/2027	End to end test automation is planned to start after the application is stabilized
Automate Upgrade	Not Started	6/30/2027	This initiative will be started in Q3 2026-27

IT Workflow Automation

Past 60 days accomplishments:

- **Enclosure Updates:** Used a semi-automation solution to cut the time needed to update enclosures for **1,000+ TruCare letters** from **80 hours down to under 10 minutes**, replacing a slow, manual process.
- **Letter Setup:** Used the same semi-automation solution to reduce setup time for **300+ letter templates** from **30–60 minutes down to under 5 minutes** per letter, successfully handling difficult layouts like right-to-left Farsi text.

- **Document Review:** Used an OCR solution to identify authorizations and clinical documents from face sheets, saving **250 hours over the last two months** by replacing a fully manual review process.
- **Duplicate Face Sheet Detection:** Used an OCR solution to automatically identify duplicate face sheets, saving approximately **75 hours each month** by replacing a fully manual review process.
- **By automating provider portal referral intake and creating authorization shells directly in TruCare,** this solution eliminated manual data entry to secure strict DHCS compliance, improve data accuracy, and enable the system to scale without increasing headcount. **Approximately 80 hours of saving per month.**

Next 90 days Plan:

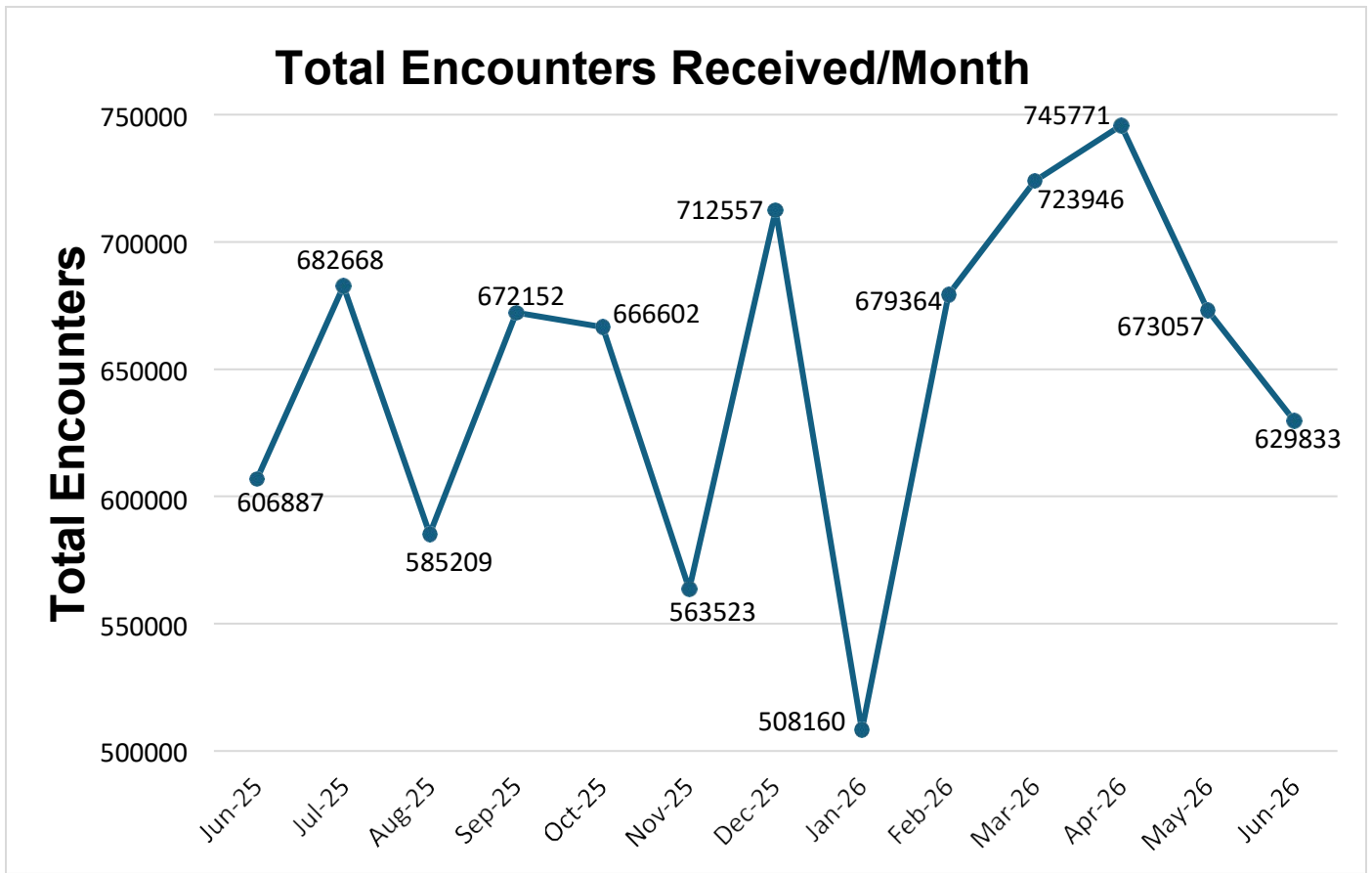
- **Letters Enclosure Automation:** Transition the current semi-automated process into a fully automated solution across all letter categories, eliminating manual intervention and maximizing processing speed.
- **Letters – Correspondence Metatag:** Implement programmatic meta tagging across remaining letter templates to standardize layouts and speed up the configuration process.
- **TruCare Environment Sync:** Standardize environment synchronization. TruCare platforms to better manage the software development life cycle (SDLC) and ensure testing consistency.
- **ApplicationXTender Upgrade:** Complete the system upgrade for ApplicationXTender to enhance file processing performance, maintain platform support, and secure integration stability.
- **SFTP Archiving Strategy:** Establish a structured SFTP archiving strategy to optimize data storage, improve file retrieval times, and maintain long-term compliance standards.
- **Call Center Modernization:** Following the receipt of RFP responses on June 1, 2026, the initiative is on track to finalize its vendor selection by July 16, 2026, which will establish the timeline for project kick-off, development, and production deployment.

Encounter Data from Trading Partners 2026

- **AHS:** June weekly files (11,371 records) were received on time.
- **BACH:** June monthly files (0 records) were received on time.
- **BACS:** June monthly files (278 records) were received on time.
- **CFMG:** June weekly files (11,152 records) were received on time.
- **CHCN:** June weekly files (187,040 records) were received on time.
- **CHME:** June monthly files (8,785 records) were received on time.
- **Docustream:** June monthly files (276 records) were received on time.
- **EBI:** June monthly files (1,627 records) were received on time.
- **FULLCIR:** June monthly files (1,718 records) were received on time.
- **HCSA:** June monthly files (6,705 records) were received on time.
- **IOA:** June monthly files (1,717 records) were received on time.
- **LAFAM:** June monthly files (77 records) were received on time.
- **LIFE:** June monthly files (258 records) were received on time.
- **Logisticare:** June weekly files (16,373 records) were received on time.
- **Magellan:** June monthly files (514,795 records) were received on time.
- **March:** Vision June monthly files (983 records) were received on time.
- **MED:** June monthly files (7,430 records) were received on time.
- **PAIRTEAM:** June monthly files (5,637 records) were received on time.
- **Quest:** June weekly files (17,998 records) were received on time.
- **SENECA:** June monthly files (632 records) were received on time.
- **SERENE:** June monthly files (0 records) were received on time.
- **STAR:** June monthly files (127 records) were received on time.
- **TITANIUM:** June monthly files (6,119 records) were received on time.
- **TVHC:** June monthly files (52 records) were received on time.
- **VSP:** June monthly files (5,412 records) were received on time.

Trading Partner Encounter Inbound Submission History

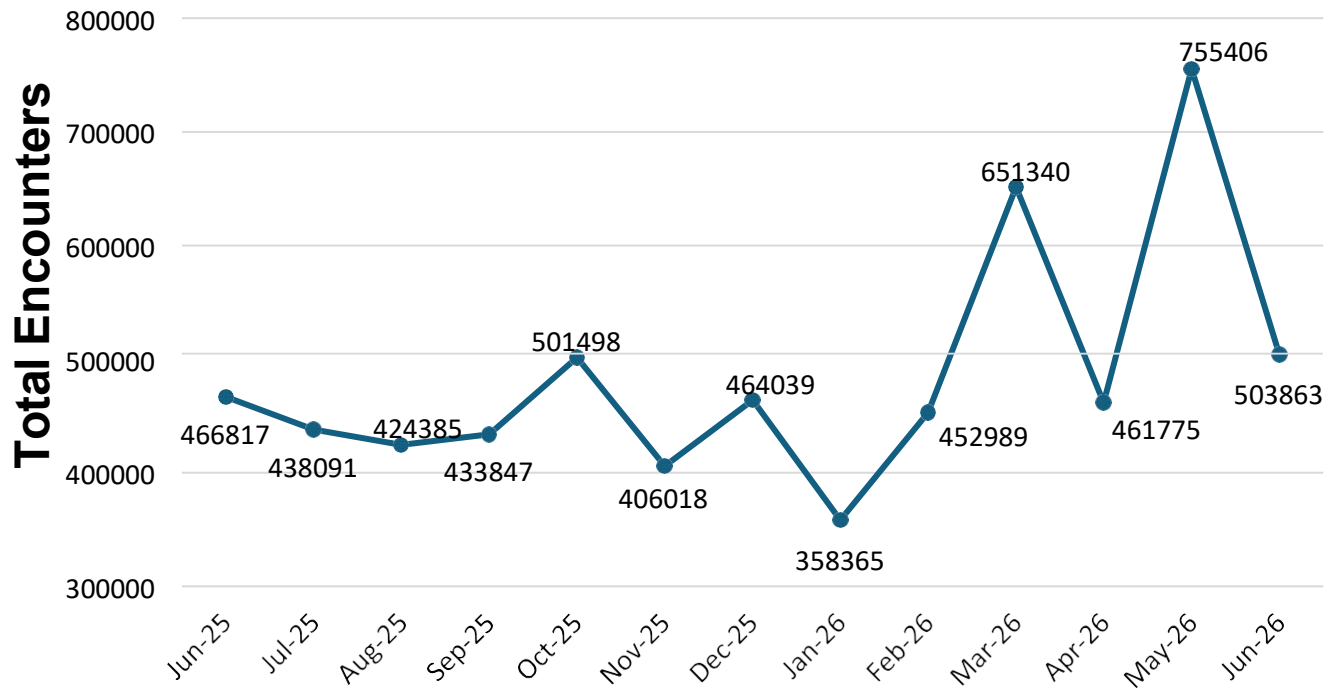
Trading Partner Name	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
AHS	7712	7880	10257	8455	9267	11333	8671	8345	10599	9835	8399	9261	11371
BACH	296	172	172	180	181	0	0	0	0	0	0	0	0
BACS	128	81	82	100	102	114	109	196	140	359	409	248	278
CFMG	15710	13266	13336	20280	15705	20083	16647	10692	22313	17563	13461	18591	11152
CHCN	170810	125697	132885	170744	152102	138524	153899	104101	193474	177607	178392	147494	187040
CHME	8638	8115	8368	8228	7938	9119	7579	8492	8597	7129	6348	7571	8785
Docustream	1052	1215	704	423	829	322	0	1568	852	1292	420	164	276
EBI	1381	2946	1940	1800	1823	1922	1683	1856	1690	1910	1825	1881	1627
FULLCIR	1441	3266	3972	5006	2176	168	1358	462	3150	2698	1077	1641	1718
HCSA	2467	2671	2453	2930	172	2481	2876	2532	3008	3496	4888	5710	6705
Health Suite	339917	429170	326682	348267	415000	296716	413349	291556	381019	396918	452451	381440	338066
IOA	3083	1851	635	1377	1683	0	3095	1697	1672	1660	1485	1570	1717
LAFAM	81	85	83	74	87	247	84	87	85	72	78	86	77
LIFE	412	388	541	245	290	330	361	250	229	255	281	293	258
Logisticare	15025	38834	34040	62760	15649	36206	59563	34215	16237	62637	38508	40646	16373
March Vision	8100	6914	7877	8374	9295	9338	7336	10116	2845	2702	2040	1197	983
MED	958	2722	1246	1172	1468	1299	2894	1443	1434	912	5462	5381	7430
PAIRTEAM	7724	15956	14426	9446	9972	7871	10633	7419	5779	14368	8550	6195	5637
Quest	18000	18000	22500	18001	18001	22500	18004	18001	22499	18000	18002	22501	17998
SENECA	160	76	0	188	66	0	123	360	206	932	395	407	632
SERENE	0	581	0	0	0	0	0	0	0	0	0	0	0
STAR	0	0	0	0	0	0	0	0	0	0	0	0	127
TITANIUM	3792	2782	3010	4102	4796	4950	4244	4746	3536	3558	3300	4824	6119
TVHC	0	0	0	0	0	0	49	26	0	43	0	0	52
VSP	0	0	0	0	0	0	0	0	0	0	0	15956	5412
TOTAL	606887	682668	585209	672152	666602	563523	712557	508160	679364	723946	745771	673057	629833



Trading Partner Encounter Outbound Submission History

Trading Partner Name	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
AHS	14010	7038	10166	8358	9125	11095	8218	8090	10555	9316	8363	9211	10082
BACH	270	138	0	147	139	0	0	0	0	0	0	0	0
BACS	59	60	52	82	77	86	79	96	112	178	332	186	247
CFMG	13853	9238	9252	10764	11978	11518	13611	7425	13874	17300	10228	12177	9867
CHCN	98329	106648	92163	89837	133350	93935	101887	69962	121092	119747	127177	98429	102319
CHME	8471	7991	8232	8090	7822	8407	7470	7697	8191	6682	6170	7386	8386
Docustream	385	381	192	131	247	99	0	338	307	496	148	69	92
EBI	1328	1885	1745	1634	1718	1834	1600	1770	1610	1869	1777	1827	1553
FULLCIR	1236	2889	3407	2713	1748	89	1081	165	2479	2226	634	1121	923
HCSA	2448	2637	2430	2871	149	2462	2840	2505	2979	3451	4832	5661	6637
Health Suite	274828	222783	228707	236163	253075	207026	228028	188845	245896	390092	230072	534368	306039
IOA	1836	1732	551	1176	1304	0	2911	1617	1474	1108	1338	1178	1360
LAFAM	67	80	76	69	84	93	83	87	82	64	73	75	64
LIFE	202	122	142	152	111	222	175	140	119	144	157	188	144
Logisticare	15010	38763	33974	36968	41267	36150	59480	34166	16213	62539	38458	40564	16326
March Vision	4657	3888	4183	4724	5103	4847	3696	6051	1272	518	312	119	292
MED	553	2471	1124	974	1103	1160	1547	1360	1344	65	5010	1482	4756
PAIRTEAM	4549	9364	8386	8229	7901	5824	6500	6777	5157	11205	6835	4360	3413
Quest	21031	16774	16903	16855	20951	16810	20937	16905	16777	20859	16724	16798	20753
SENECA	139	63	0	164	19	0	109	319	190	174	168	92	106
SERENE	0	569	0	0	0	0	0	0	0	0	0	0	0
STAR	0	0	0	0	0	0	0	0	0	0	0	0	94
TITANIUM	3556	2577	2700	3746	4227	4361	3772	4039	3266	3293	2967	4242	5014
TVHC	0	0	0	0	0	0	15	11	0	14	0	0	36
VSP	0	0	0	0	0	0	0	0	0	0	0	15873	5360
TOTAL	466817	438091	424385	433847	501498	406018	464039	358365	452989	651340	461775	755406	503863

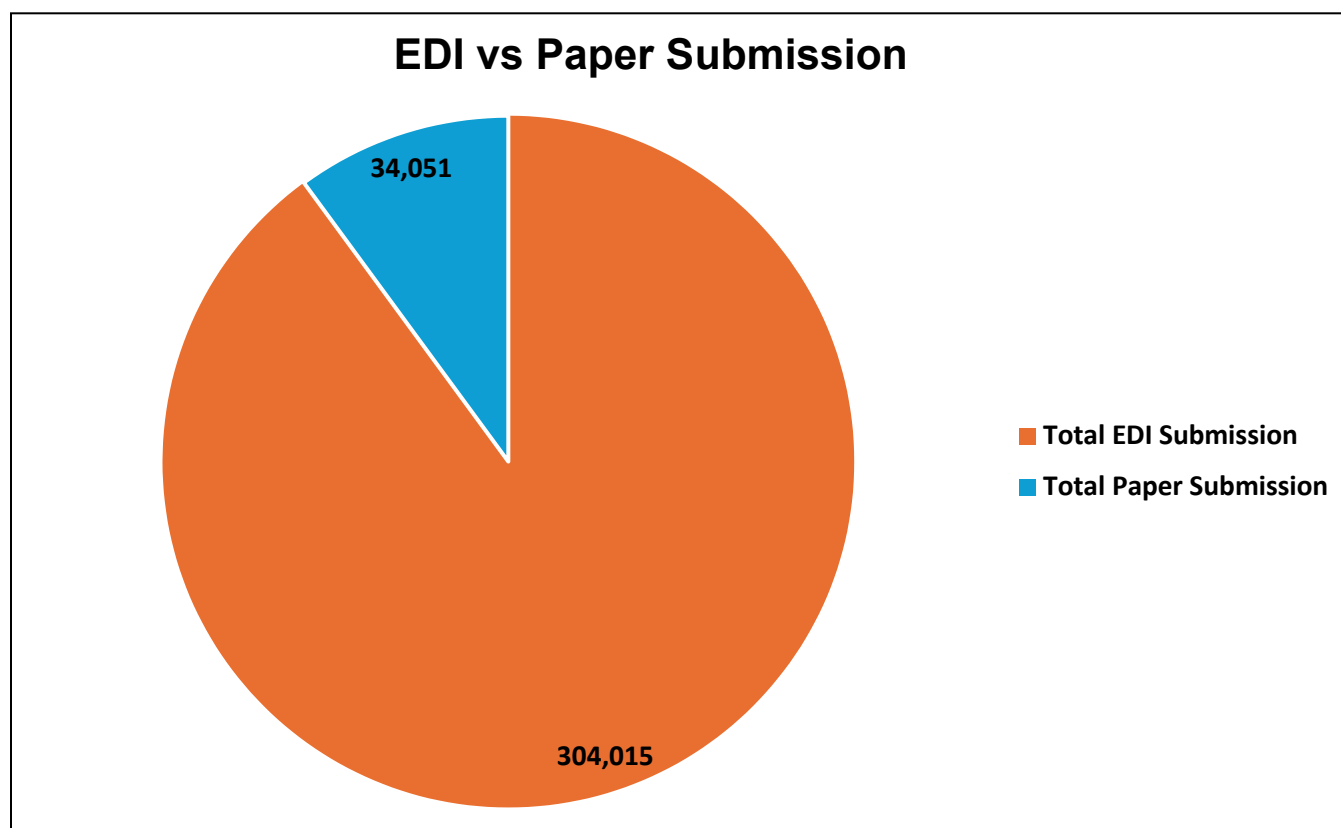
Total Outbound Encounter/Month



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
26-Jun	304,015	34,051	338,066

Key: EDI – Electronic Data Interchange



Onboarding EDI Providers – Updates

June 2026 EDI Claims:

A total of 3619 new EDI submitters has been added since October 2015, with 29 added in June 2026.

The total number of EDI submitters is 4359 providers.

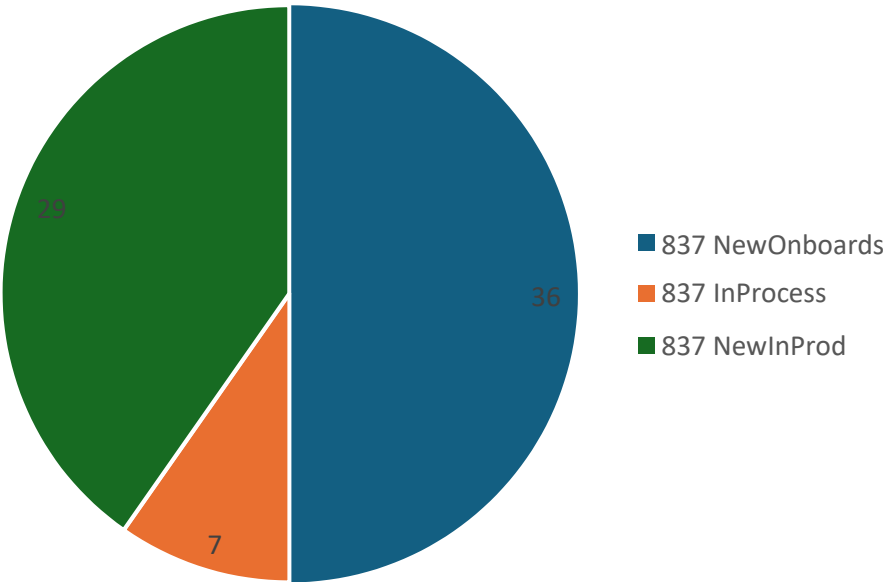
June 2026 EDI Remittances (ERA):

A total of 1697 new ERA receivers have been added since October 2015, with 26 added in June 2026.

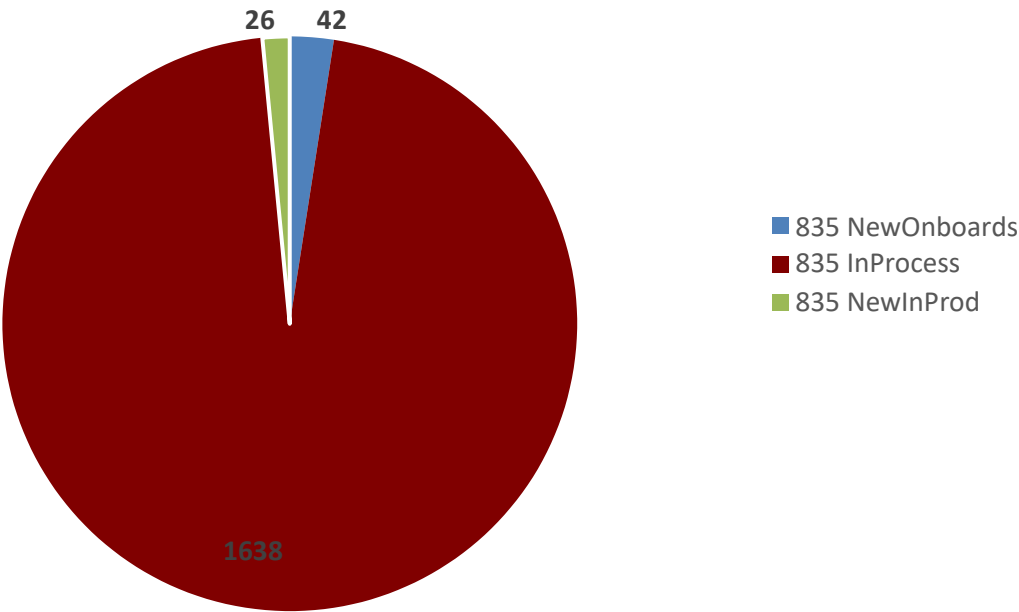
The total number of ERA receivers is 1713 providers.

YearMonth	837 NewOnboards	837 InProcess	837 NewInProd	837 TotalInProd	835 NewOnboards	835 InProcess	835 NewInProd	835 TotalInProd
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	4045	32	1549	19	1587
Jan-26	48	0	48	4143	32	1555	26	1613
Feb-26	35	8	27	4170	18	1563	10	1623
Mar-26	53	0	53	4223	18	1581	5	1628
Apr-26	67	1	66	4289	50	1602	29	1657
May-26	41	0	41	4330	50	1622	30	1687
Jun-26	36	7	29	4359	42	1638	26	1713

837 EDI Submitters



835 EDI Receivers



Encounter Medi-Cal DHCS Rejection and Acceptance

Summary	TotalEncounterSubmissions	Percentages
Submitted Encounters	503863	100.00%
Denied Encounters	198	0.04%
Accepted Encounters	503665	99.96%

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 June 2026.

FILE TYPE	TOTAL COUNT	YEAR MONTH
837 I Files	32	Jun-26
837 P Files	124	Jun-26
Total Files	156	

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	LagPercent	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	94%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	99%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	93%	65%
Timeliness-% Within Lag Time - Professional 0-180 days	99%	80%

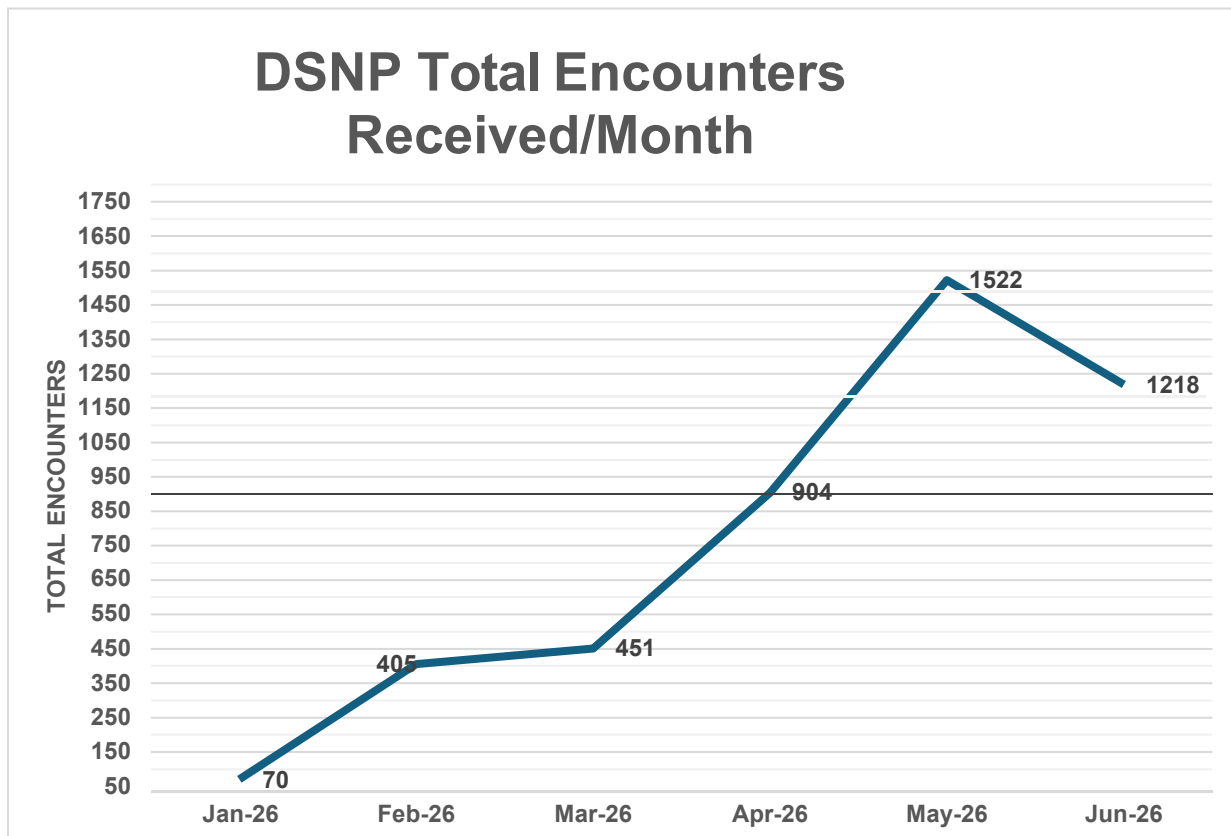
*Note, the Number of Encounters comes from: Total at bottom of this chart:

DSNP Encounter Data from Trading Partners

- **CHME:** June monthly files (46 records) were received on time.
- **Nations Flex Card:** June monthly files (209 records) were received ontime.
- **Vision Service Plan:** June monthly files (4 records) were received ontime.

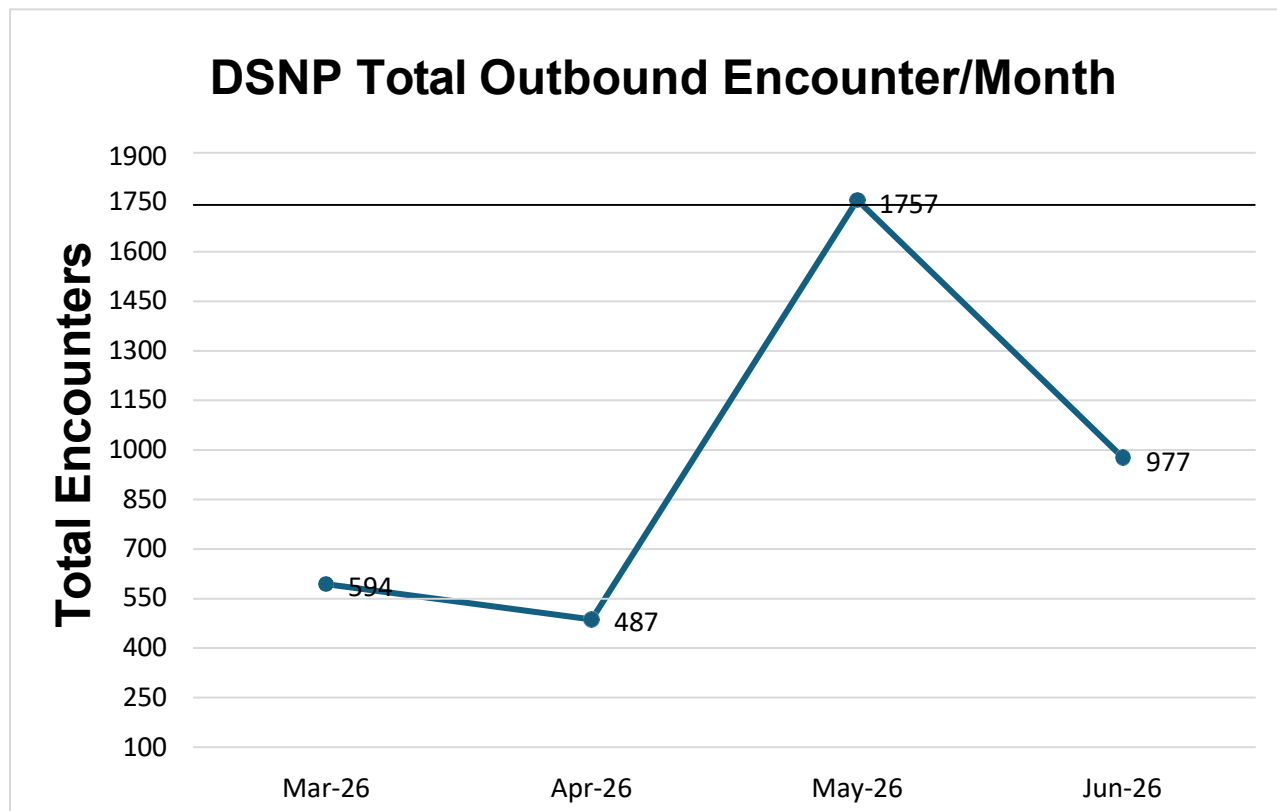
DSNP Trading Partner Encounter Inbound Submission History

Trading Partner Name	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
CHME		10	11	29	31	46
HealthSuite	70	395	440	875	918	959
Nations Benefits					545	209
Vision Service Plan					28	4
TOTAL	70	405	451	904	1522	1218



DSNP Trading Partner Encounter Outbound Submission History

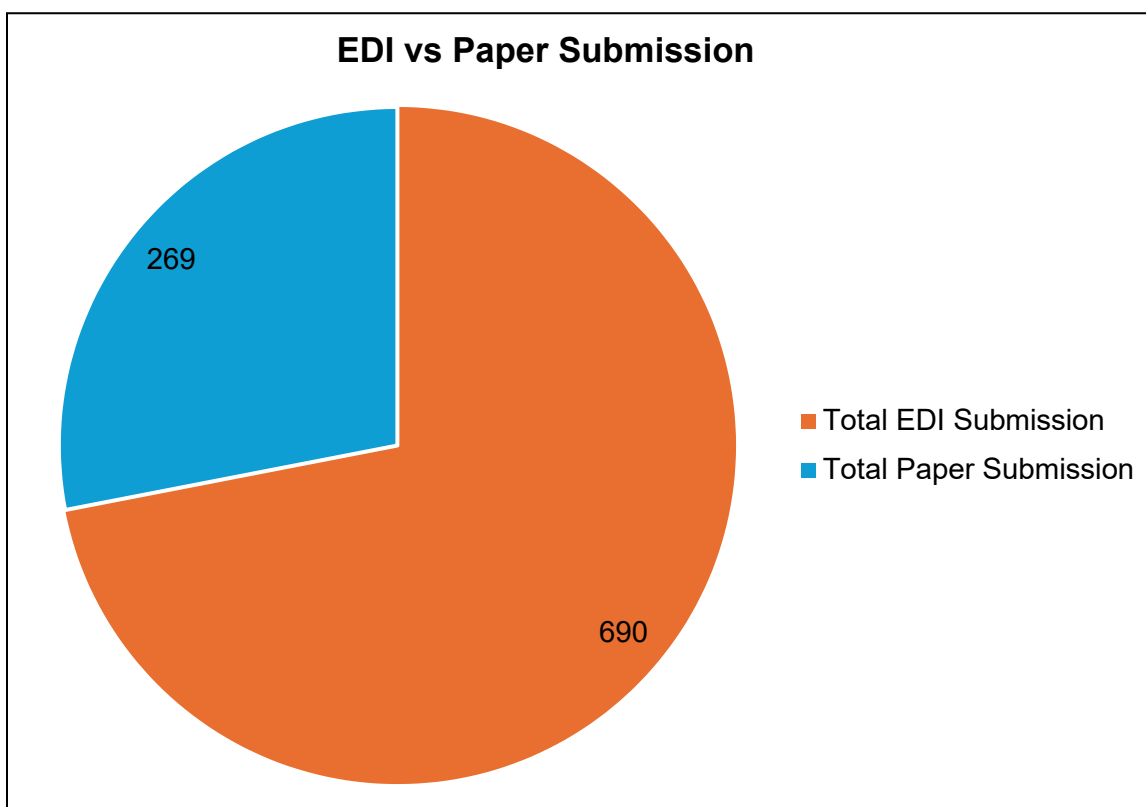
Trading Partner Name	Mar-26	Apr-26	May-26	Jun-26
CHME	20	29	29	40
HealthSuite	574	458	1155	725
Nations Flex Card			542	208
Nations Hearing			3	
Vision Service Plan			28	4
TOTAL	594	487	1757	977



DSNP HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total Claims
26-JUN	690	269	959

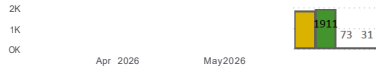
Key: EDI – Electronic Data Interchange



SERVICE DESK DASHBOARD

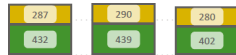
June 2026

Track-It Tickets



Q Tickets Received Tickets Closed Tickets Open Tickets Overdue

Laptops Issued



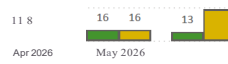
Apr 2026 May 2026

warranty Not Expired Q Warranty Expired

Top Updates During Month

Category	Item	Version
Driver	HAM Mouse Driver Update	31.21.60.1
Driver	Elevoe Technology Driver Update	S.O.S.287
Driver	Intel Bluetooth Driver Update	267.102.88.0
Driver	Intel ComputeAccelerator Driver Update	32.0.100.4724
Driver	Intel Driver Update	1.46.2024.221
Driver	Intel HIDClass Driver Update	2.2.2.18
Driver	Intel MEDIA Driver Update	20.40.12690.2
Driver	Intel SoftwareComponent Driver Update	267.102.88.0
Driver	Intel System Driver Update	20.40.12690.2
Driver	Logitech Extension Driver Update	2.0.998.0
Driver	Microsoft Corporation AudioProcessingObject Driver Update	1.0.3.56670
Software	Mozilla Firefox (x86 installer)	32.0.100.4724

Onboard and Offboard



onboard Q offboard

Laptops Deployed, In Stock, Decommissioned

27 /



Deployed In Stock Decommissioned

Mobile Devices

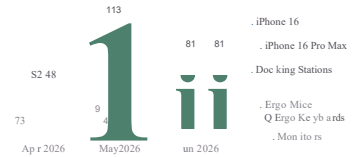


company Issued Phones O Bring Your Own Devices

Top Track-It Ticket Trends During Month

Category	Tickets Received
IT Service Desk - Request ->Access ->Website	
IT Service Desk - Request ->Access ->Windows Password	
IT Service Desk - Troubleshoot ->Software ->Firmware	
IT Service Desk - Request ->Access	
IT Service Desk - Request	
IT Service Desk - Request ->Access ->Weekly Status Updates	
IT Service Desk - Troubleshoot ->Conference Rooms	
IT Service Desk - Request ->Software ->Email	
IT Service Desk - Request ->Access ->Termination	90
IT Service Desk - Request ->Access ->Title and Access Change	102
IT Service Desk - Request ->Access ->Information	132
IT Service Desk - Troubleshoot	200

Equipment in Stock



iPhone 16
iPhone 16 Pro Max
Docking Stations
Ergo Mice
Ergo Keyboards
Monitors

Executive Security Summary

Overall Posture: MODERATE RISK (AMBER)
Risk Trend:  (decreasing)

Top Risks

- Network Segmentation (flat network)
- Critical database excessive permissions security gap
- Shadow IT (Azure, SaaS)

Key Progress

- Network micro-segmentation – completed policy enforcement on non-prod HS and TC
- AI governance SOP in review stage
- Completed email authentication enforcement
- Cert. Mgmt. SOP established

Risk Trends (90 Days – Activity Based ▲ in Exposure)

- Azure Cloud Defender alerts
- AI governance
- Vulnerability visibility on endpoints and DB

Next 90-Day Priorities

- Network micro-segmentation rule enforcement on prod HS, TC, AD
- Cert. Mgmt. SOP – validation
- Cert. Mgmt. – vendor notification / mgmt.
- Wrap up 2025 SRA findings
- Wrap up 2025 Pen test findings

Leadership Support Needed

- Cultural security transformation & awareness (top-down culture where cybersecurity is viewed as a collective responsibility)
- Asserting IT Security review and approval into workflows (Security Architecture Review Board - SARB)
- Alignment on security ownership and patching RASCI models – link 1 and 2

Risk Register

Risk	Likelihood	Impact	Residual (after controls)	Risk Trend	Owner	Status
Penetration test (2025)	Low	High	Low		Various	WIP
Security Risk Assessment (2025)	Medium	Medium	Low		Various	WIP
Cert. Mgmt. - process/renewal/enrollment/revamp	Medium	High	Medium		Various	WIP
Network / Firewall - audit/access (part of SRA)	Medium	High	Low		Aman	WIP - will coordinate with Gobi
AI	Medium	High	Low		ITSec	WIP – blocking started
Access & Permissions (RBAC) – new employees / lateral post changes, etc.	High	Medium	Low		ITSec	Completed
 Endpoint – vuln data	Medium	High	Low		Service Desk	Assign to SD as project
Endpoint – malware events	Medium	Medium	Low		Service Desk	Assign to SD as a daily task
Network Micro-Segmentation	Medium	High	Low		ITSec	WIP

Projects / Annuals

Activity	Due	Lead	% Complete	Status	Level of Effort (LRE)
Network Micro-Segmentation	July '26	Dan +Arwyn	65%	On track	High
M365 + Copilot Security Assessment	June'26	Jilaf\ + Jose	50%	Delayed	Medium
Keeper (password vault)	June'26	TBD	Pending	TBD	Low
Security Risk Assessment (2025)	July '26	Dan	18 of 63 left	On track	High
PenetrationTest (2025)	July '26	Dan	2 of 9 left	On track	High
Authentication(certificate)	July '26	Eddy	50%	On track	High
Audit - CFMG	May '26	Eddy	-	On track	Medium
Audit - SRA Remediation / Compliance Committee Presentation	May '26	Eddy	-	Completed	Medium

P&P

Activity	Due	Lead	Status	Notes
IT-013 (Sys Dev. & Maintenance)	May '26	Eddy	Delayed	Original policy split into seven different policies / Revised IT-013 is under review
Cert <u>Mgmt</u>	June '26	Eddy	Delayed	Drafted, information gathering, alignment
Patching RASCI Matrix	June '26	Eddy	Delayed	Drafted, review, socializing, alignment
SSO Onboarding & Provisioning	May '26	Jose	Delayed	Drafted, review, socializing, alignment



Analytics

Tiffany Cheang

To: Alameda Alliance for Health Board of Governors

From: Tiffany Cheang, Chief Analytics Officer

Date: July 10th, 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: Apr 2025 – Mar 2026 dates of service

Prior reporting period: Apr 2024 – Mar 2025 dates of service

(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 12.9% of members account for 89.8% of total costs.
- In comparison, the Prior reporting period was lower at 11.6% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
 - The SPD/LTC (non duals) and ACA OE categories of aid slightly decreased to account for 53.6% of the members, with SPD/LTCs accounting for 17.7% and ACA OE's at 35.9%.
 - The percent of members with costs >= \$30K slightly increased from 3.0% to 3.3%.
 - Of those members with costs >= \$100K, the percentage of total members remained consistent at 1.0%.
 - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 29.6%.
 - Demographics for member city and gender for members with costs >= \$30K follow the same distribution as the overall Alliance population.
 - However, the age distribution of the top 12.9% is more concentrated in the 45-66 year old category (33.2%) compared to the overall population (20.6%).

Analytics

Supporting Documents

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

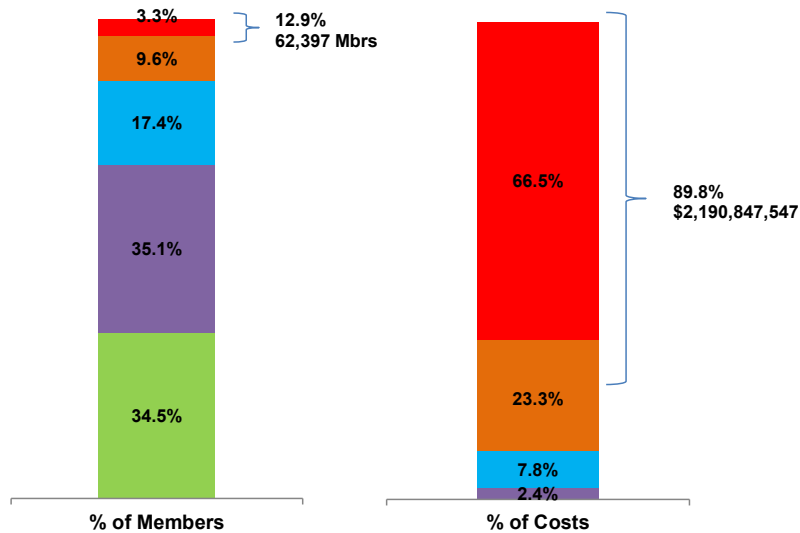
Lines of Business: MCAL, IHSS; Excludes Kaiser Members

Dates of Service: Apr 2025 - Mar 2026

Note: Data incomplete due to claims lag

Run Date: 06/29/2026

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
\$30K+	15,900	3.3%	\$ 1,623,130,647	66.5%
\$5K - \$30K	46,497	9.6%	\$ 567,716,900	23.3%
\$1K - \$5K	83,952	17.4%	\$ 191,479,098	7.8%
< \$1K	169,210	35.1%	\$ 57,957,376	2.4%
\$0	166,542	34.5%	\$ -	0.0%
Totals	482,101	100.0%	\$ 2,440,284,020	100.0%

Top 12.9% of Members = 89.8% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
\$100K+	5,060	1.0%	\$ 1,044,940,655	42.8%
\$75K to \$100K	1,879	0.4%	\$ 163,379,851	6.7%
\$50K to \$75K	3,068	0.6%	\$ 187,528,659	7.7%
\$40K to \$50K	2,300	0.5%	\$ 102,718,420	4.2%
\$30K to \$40K	3,593	0.7%	\$ 124,563,062	5.1%
SubTotal	15,900	3.3%	\$ 1,623,130,647	66.5%
\$20K to \$30K	6,488	1.3%	\$ 158,172,205	6.5%
\$10K to \$20K	17,897	3.7%	\$ 252,318,683	10.3%
\$5K to \$10K	22,112	4.6%	\$ 157,226,012	6.4%
SubTotal	46,497	9.6%	\$ 567,716,900	23.3%
Total	62,397	12.9%	\$ 2,190,847,547	89.8%

Enrollment Status	Members	Total Costs
Still Enrolled as of Mar 2026	386,917	\$ 2,208,605,448
Dis-Enrolled During Year	95,184	\$ 231,678,571
Totals	482,101	\$ 2,440,284,020

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
12.9% of Members = 89.8% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Apr 2025 - Mar 2026

Note: Data incomplete due to claims lag

Run Date: 06/29/2026

12.9% of Members = 89.8% of Costs

17.7% of members are SPD/LTCs and account for 24.1% of costs.

35.9% of members are ACA OE and account for 33.9% of costs.

8.7% of members disenrolled as of Mar 2026 and account for 9.5% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Members	% of Members
IHSS	IHSS	233	1,013	1,246	2.0%
MCAL	MCAL - ADULT	1,410	8,278	9,688	15.5%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	866	4,176	5,042	8.1%
	MCAL - ACA OE	5,223	17,171	22,394	35.9%
	MCAL - DUALS	-	-	-	0.0%
	MCAL - SPD-LTC	3,859	7,173	11,032	17.7%
	MCAL - SPD-LTC/Full Dual	2,636	4,904	7,540	12.1%
D-SNP	DSNP	12	37	49	0.1%
Not Eligible	Not Eligible	1,661	3,745	5,406	8.7%
Total		15,900	46,497	62,397	100.0%

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Costs	% of Costs
IHSS	IHSS	\$ 22,782,559	\$ 12,033,095	\$ 34,815,654	1.6%
MCAL	MCAL - ADULT	\$ 128,682,149	\$ 101,777,251	\$ 230,459,400	10.5%
	MCAL - BCCTP	\$ -	\$ -	\$ -	0.0%
	MCAL - CHILD	\$ 62,678,863	\$ 46,905,281	\$ 109,584,144	5.0%
	MCAL - ACA OE	\$ 531,367,152	\$ 210,874,990	\$ 742,242,141	33.9%
	MCAL - DUALS	\$ -	\$ -	\$ -	0.0%
	MCAL - SPD-LTC	\$ 434,997,042	\$ 93,156,002	\$ 528,153,044	24.1%
	MCAL - SPD-LTC/Full Dual	\$ 276,983,009	\$ 57,765,914	\$ 334,748,923	15.3%
D-SNP	DSNP	\$ 1,171,636	\$ 469,467	\$ 1,641,103	0.1%
Not Eligible	Not Eligible	\$ 164,468,237	\$ 44,734,900	\$ 209,203,137	9.5%
Total		\$ 1,623,130,647	\$ 567,716,900	\$ 2,190,847,547	100.0%

% of Total Costs By Service Type

				Breakout by Service Type/Location						
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
\$100K+	4%	0%	1%	16%	35%	1%	10%	3%	1%	34%
\$75K to \$100K	4%	0%	1%	21%	23%	3%	6%	6%	4%	38%
\$50K to \$75K	5%	0%	2%	27%	25%	5%	7%	8%	3%	24%
\$40K to \$50K	7%	0%	3%	33%	22%	8%	7%	8%	1%	21%
\$30K to \$40K	9%	0%	3%	34%	20%	11%	7%	8%	1%	19%
\$20K to \$30K	2%	1%	6%	35%	21%	6%	9%	9%	1%	18%
\$10K to \$20K	0%	0%	10%	37%	21%	6%	9%	10%	1%	16%
\$5K to \$10K	1%	0%	4%	31%	10%	11%	13%	15%	1%	19%
Total	4%	0%	3%	24%	27%	4%	9%	6%	2%	28%

Notes:

- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.

- CFMG and CHCN encounter data has been priced out.

- Report excludes Capitation Expense

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

25.5% of members are SPD/LTCs and account for 28.5% of costs.

27.9% of members are ACA OE and account for 31.9% of costs.

9.0% of members disenrolled as of Mar 2026 and account for 9.3% of costs.

Member Breakout by LOB

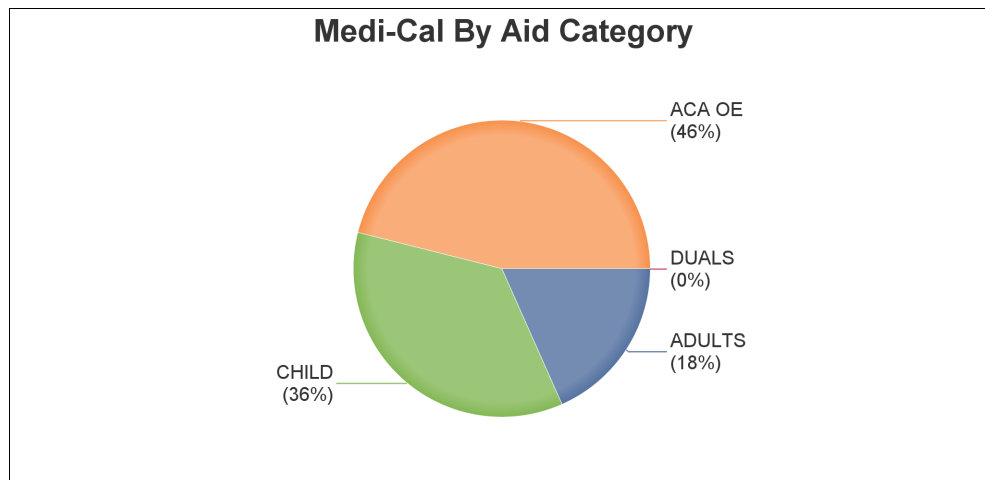
LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	54	1.1%
MCAL	MCAL - ADULT	318	6.3%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	93	1.8%
	MCAL - ACA OE	1,412	27.9%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,289	25.5%
	MCAL - SPD-LTC/Full Dual	1,439	28.4%
D-SNP	DSNP	2	0.0%
Not Eligible	Not Eligible	453	9.0%
Total		5,060	100.0%

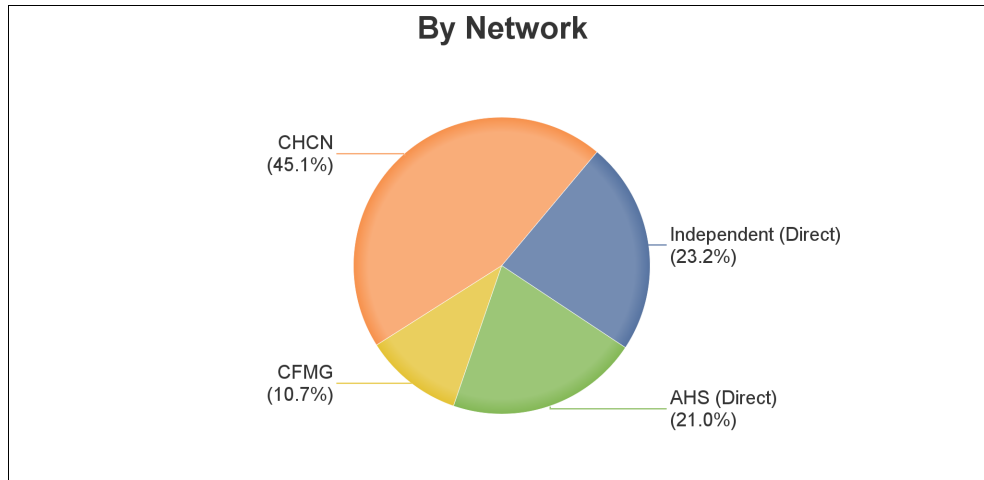
Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	\$ 13,345,175	1.3%
MCAL	MCAL - ADULT	\$ 74,113,553	7.1%
	MCAL - BCCTP	\$ -	0.0%
	MCAL - CHILD	\$ 26,276,454	2.5%
	MCAL - ACA OE	\$ 333,253,534	31.9%
	MCAL - DUALS	\$ -	0.0%
	MCAL - SPD-LTC	\$ 297,414,707	28.5%
	MCAL - SPD-LTC/Full Dual	\$ 202,402,669	19.4%
D-SNP	DSNP	\$ 581,324	0.1%
Not Eligible	Not Eligible	\$ 97,553,239	9.3%
Total		\$ 1,044,940,655	100.0%

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

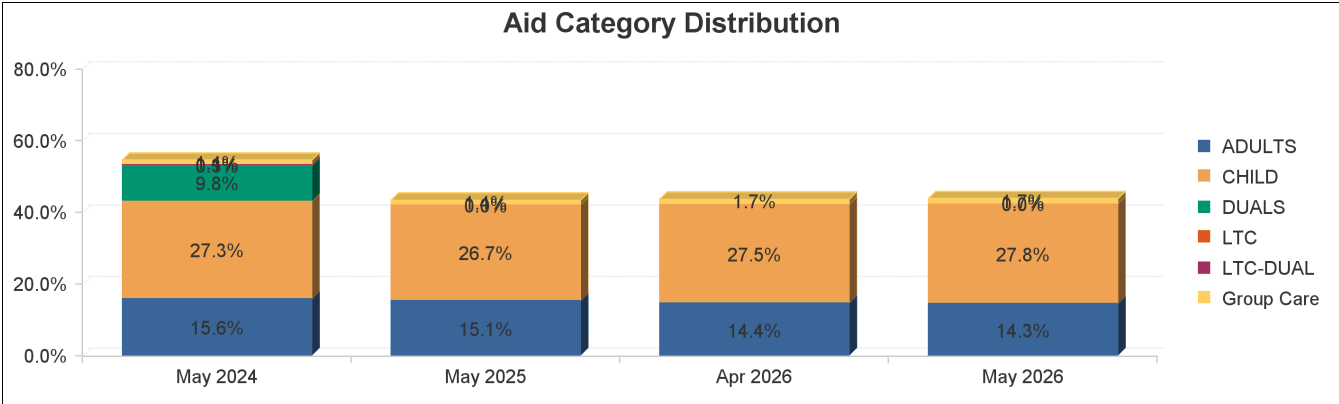
Category of Aid Trend						
Category of Aid	May 2026	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	53,740	15%	11,078	12,643	2	30,017
CHILD	104,137	28%	9,527	13,697	37,295	43,618
SPD	0	0%	0	0	0	0
ACA OE	134,907	37%	25,147	42,728	1,426	65,606
DUALS	5	0%	5	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL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



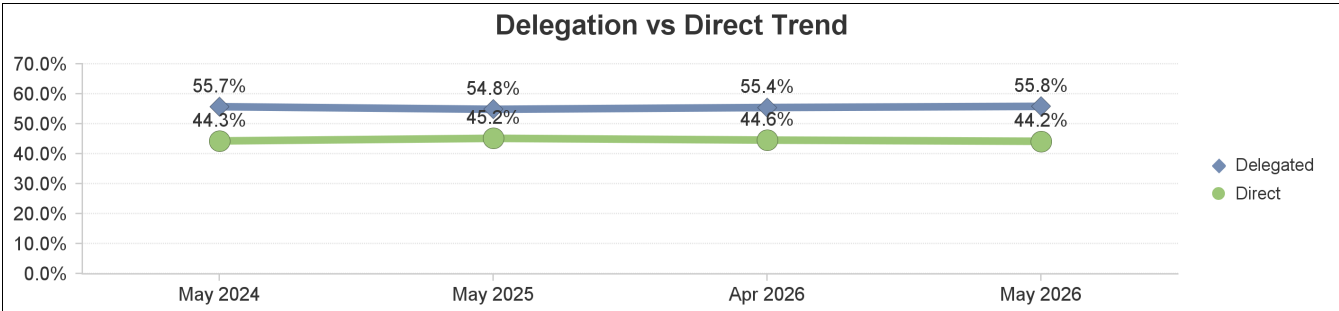


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

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

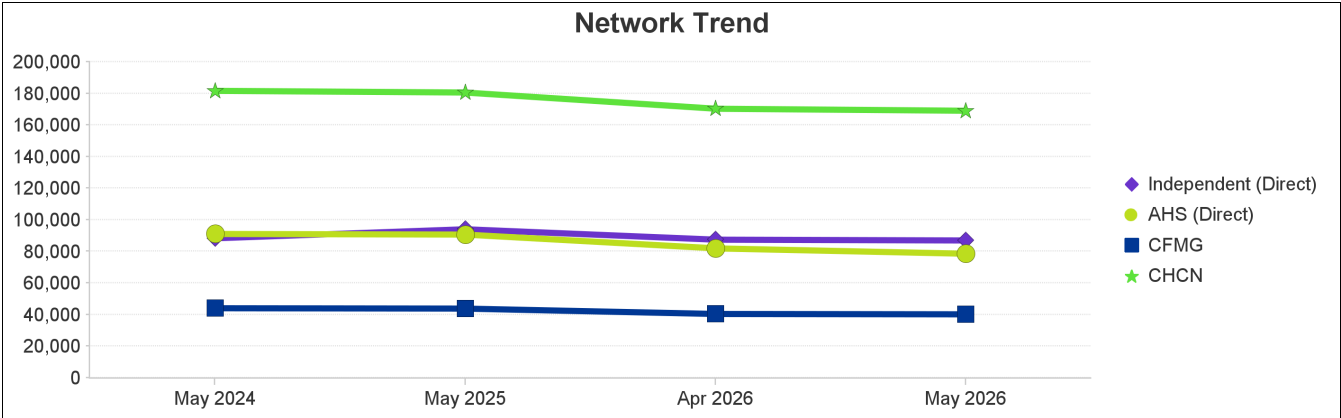


Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2024	May 2025	Apr 2026	May 2026	May 2024	May 2025	Apr 2026	May 2026	May 2024 to May 2025	May 2025 to May 2026	Apr 2026 to May 2026
Delegated	225,844	224,566	210,887	209,395	55.7%	54.8%	55.4%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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

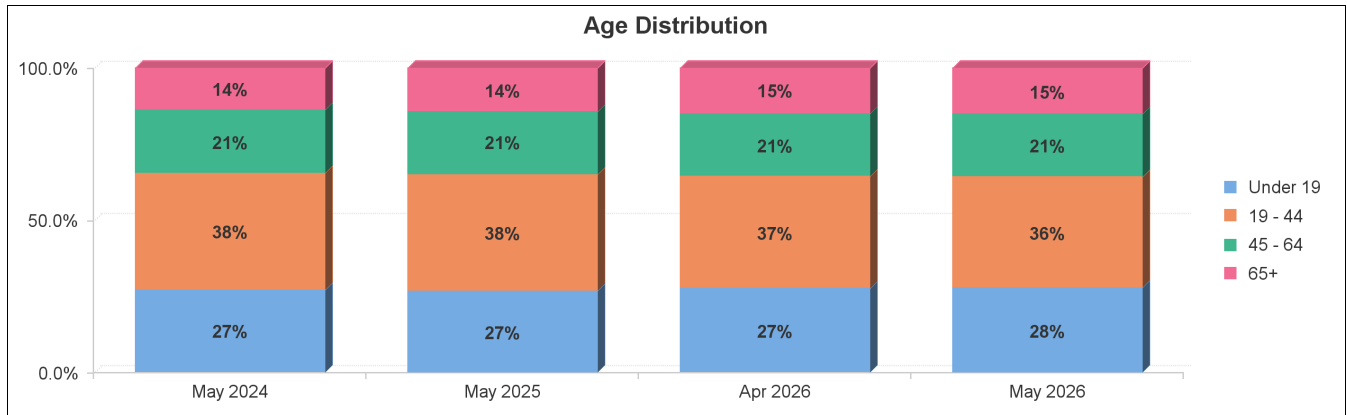
Network Trend											
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	May 2024	May 2025	Apr 2026	May 2026	May 2024	May 2025	Apr 2026	May 2026	May 2024 to May 2025	May 2025 to May 2026	Apr 2026 to May 2026
Independent (Direct)	88,381	94,112	87,505	87,006	21.8%	23.0%	23.0%	23.2%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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

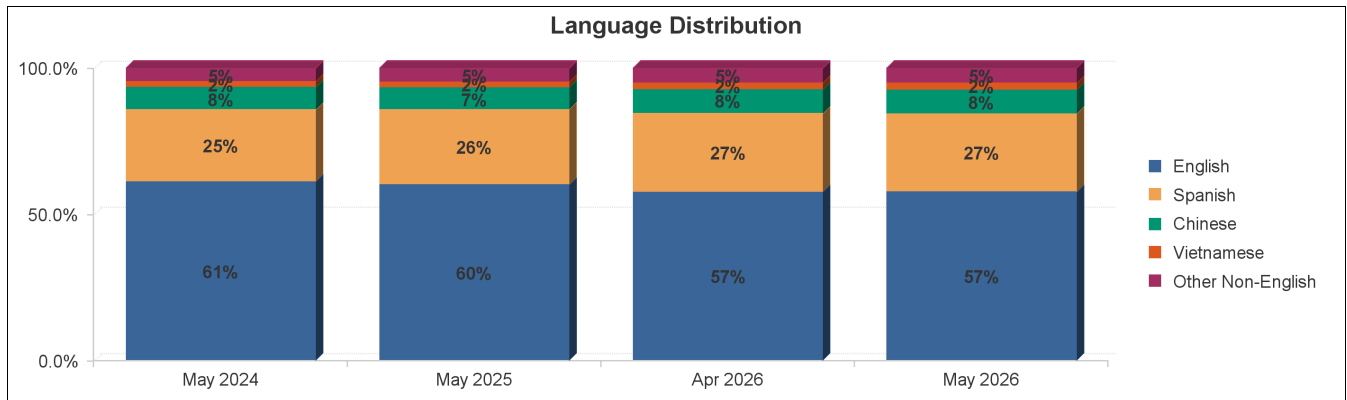
Age Category Trend

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



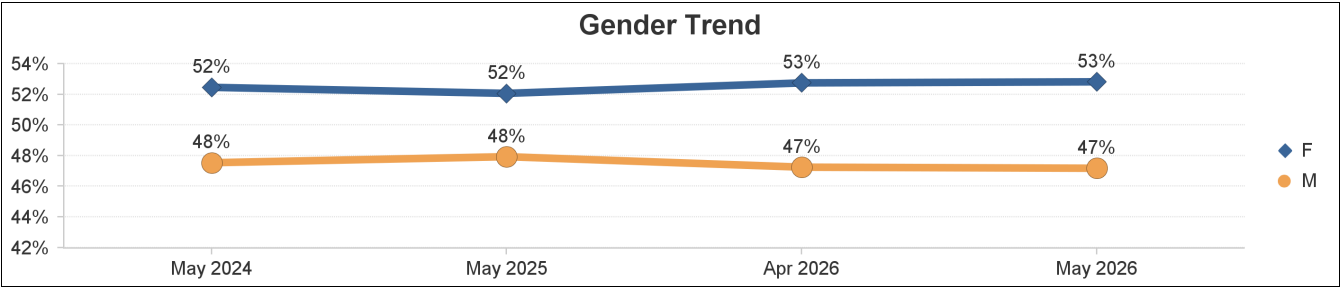
Language Trend

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

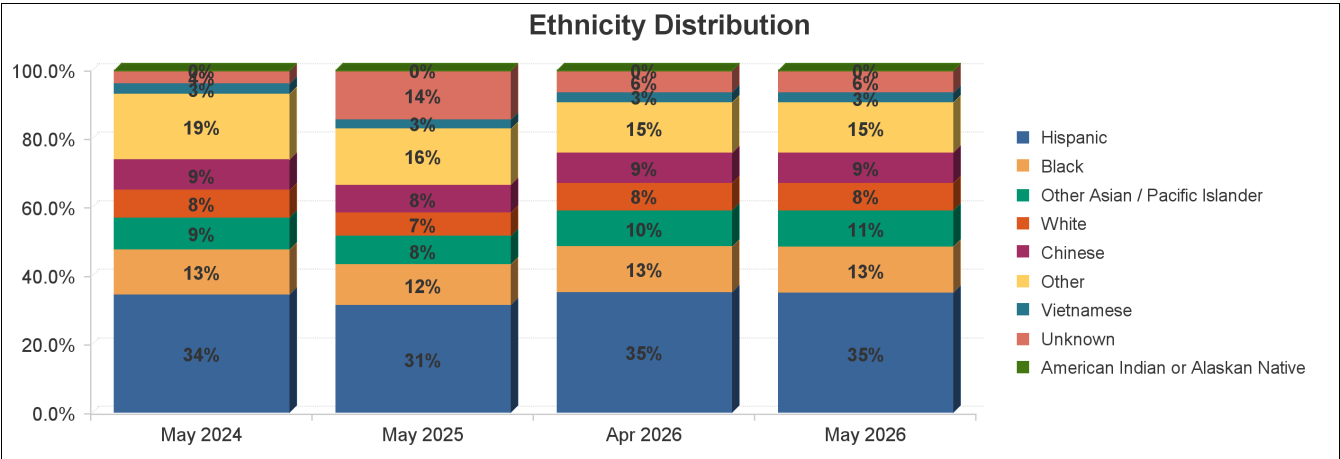


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

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



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



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

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

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

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

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

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

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

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



Human Resources

Anastacia Swift

To: Alameda Alliance for Health Board of Governors

From: Anastacia Swift, Chief Human Resources Officer

Date: July 10th, 2026

Subject: Human Resources Report

Staffing

- As of July 1st, 2026, the Alliance had 636 full time employees and 0 part time employee.
- On July 1st, 2026, the Alliance had 19 open positions in which 5 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 14 positions open to date. The Alliance is actively recruiting for the remaining 14 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by division:

Division	Open Position July 1 st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	7	2	5
Operations	9	2	7
Healthcare Analytics	0	0	0
Information Technology	1	1	0
Finance	0	0	0
Compliance	1	0	1
Human Resources	1	0	1
Executive	0	0	0
Total	19	5	14

- Our current recruitment rate is 3%.

Employee Recognition

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

7 years:

- Lily H (Case/Disease Management)
- Katherine G (Privacy & SIU)
- Rosa S (Provider Services)
- Harinath P (Applications Management, IT Quality & Process Improvement)

9 years:

- Brittany N (Healthcare Analytics)
- Judith F (Member Services)

10 years:

- Sherry R (Utilization Management)

11 years:

- Latrice A (Claims)
- Tiana R (Provider Services)

14 years:

- Marcie S (Claims)
- Thuan L (Claims)

15 years:

- Eileen A (Quality Management)
- Elisea T (Provider Services)

29 years:

- Monina R (Claims)

30 years:

- Angie V (Member Services)